ADES DUII SCREENING MANUAL

Revised May 2012

State of Oregon

OREGON HEATLH AUTHORITY

ADDICTIONS AND MENTAL HEALTH DIVISION

Christopher Hamilton; DUII Coordinator, 503-947-5548

Mary; DUII Information Specialist, 503-945-5964

ADES DUII SCREENING MANUAL
May 2012

TABLE OF CONTENTS

Page
Introduction 5
Overview of the DUII System 6
Oregon DUII Overview 2008 Activity.....7
Oregon DUII Education 8
Oregon DUII Treatment.....9
Completion Certificate Process.....10
ORS 813 Driving Under the Influence of Intoxicants.....11
The Role of Screener 71
Ignition Interlock Devise (IID) 74
The Interview 75
Some Wisdom About Interviewing 77
Referrals 79
Criteria for Referral.....80
Review of Criteria Indicators 81
Reviewing the Evidence.....85
Remember: Refer at the Appropriate Level 87
Comments on Blood Alcohol Concentrations.....89
Refusal to take a Breath Test.....92
Making Treatment Referrals and Treatment Programs.....93
Knowing Local DUII Programs 95
Sample Letter to DUII Providers 96
Sample questionnaire to be sent to DUII Providers 97
Services for Information Program 98
OAR 415 Division 54.....99
Services for Treatment Programs 126
OAR 309 Division 32.....128
Boating Under the Influence of Intoxicants (BUII) 243
Referral Guide.....244
OAR 415 Division 55.....249
Court Monitoring.....258
Sober Diversion.....258
Court Status Report 259
Defendant's Letter.....260
DUII Treatment Completion Certificates (DTCC) 261

Renewal of ADES Certification 263
Request for Recertification.....264
Change of Information Notification.....265
Resources.....266
California Directory Cover.....268
Oregon Directory Cover 269
Washington Directory Cover 270
Substance Abuse & Mental Health Services Admin. (SAMHSA).....271
Guide to Oregon Driving Records.....272
DUII Data Book for Oregon Counties.....273
National Organization of State Impaired Driving Programs 274
Title 42 – Public Health 277
Appendix 316
Acronyms 317
OHA 8050 ADES Monthly Report 318
OHA 8051i TCU Drug Screen II Instructions & Scoring 321
OHA 8051 TCU Drug Screen II.....324
OHA 8052 ADES Screening and Referral Report.....327
OHA 8053 Alcohol and Drug Treatment Status Check 332
OHA 8056 ADES Screening Cover Sheet 334
735-6821 DUII Treatment Completion Certificate (DTCC).....337
Blood Alcohol Concentration Charts 341

INTRODUCTION

Prior to the federally funded Alcohol Safety Action Projects (ASAP) of the early 1970's, there had never been a system of prevention or intervention that addressed problem drinking or other drug abuse before it became addiction. One of the reasons that working with substance abusers have been so frustrating is that we only recognized substance abuse problems by the symptoms of addiction. We believed that people could not be helped until they asked for help, and no one asked for help except as a last resort, after everything else in life had failed. By the time the substance abuser hits bottom and asks for help, there are not many resources left in the person to work with and build on. It does not make sense to have only programs to deal with chronic dependency problems and to wait for the problem to progress into a chronic stage before intervening. An effective intervention program must recognize problem substance abuse and require treatment even for the person who has not yet asked for help. Research suggests that individuals who are mandated to treatment do as well, or better, than those individuals who voluntarily enter a treatment program. It is within the nature of addiction that few ask for help until the problem is quite severe.

The Oregon DUII Treatment system was developed to assure that the DUII offender receives the most appropriate level of care regardless of their status with the court system. The system utilizes law enforcement agencies to apprehend the impaired driver and the courts require the DUII offender to participate in substance abuse treatment programs. An intricate system is involved which includes laws enforcement and judges, district attorneys, defense lawyers, Alcohol and Drug Evaluation and Screening Specialists (ADES), substance abuse treatment centers, and the Department of Motor Vehicles (DMV).

This manual is intended to assist the ADES in the screening, referral, and monitoring of DUII offenders adjudicated for DUII Diversion, DUII Conviction, and/or Marijuana Diversion.

A Word of Caution: This manual and its concepts should not be used without proper training provided by the Oregon Health Authority (OHA) Addictions and Mental Health Division (AMH). The screening tools used by the ADES are not used by the substance abuse programs. Substance abuse programs will complete an ASAM assessment.

OVERVIEW OF THE DUII SYSTEM

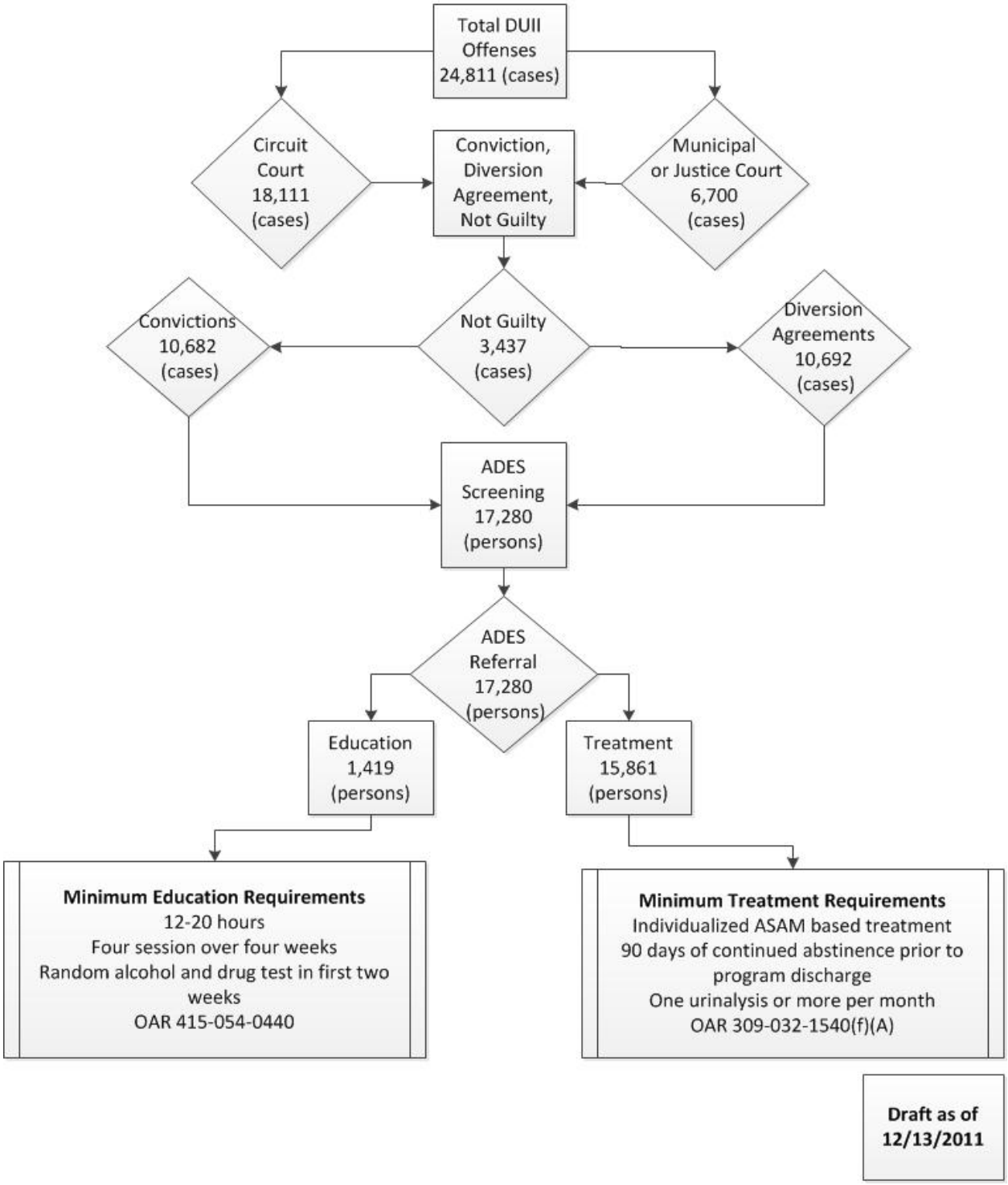
ORS Chapter 813.000 prescribes the requirements that must be met for individuals who are convicted of Driving Under the Influence of Intoxicants (DUII) or who enter into a Diversion Agreement with the courts as a result of being charged with DUII. Regardless of whether the person enters into a Diversion Agreement or is convicted by the courts of DUII, the screening, referral, monitoring, and substance abuse treatment requirements remain the same in either situation.

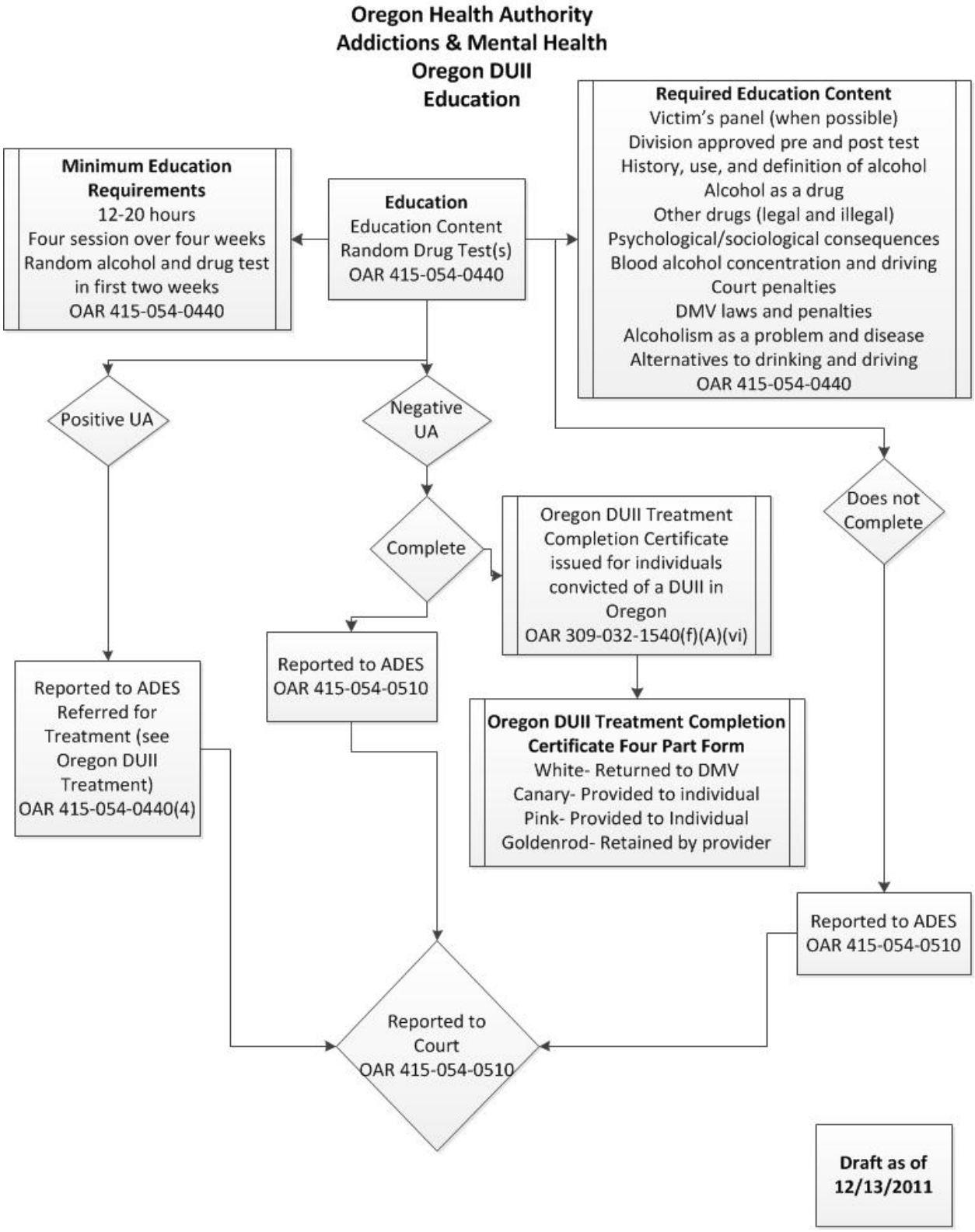
All Oregon DUII offenders who are convicted of DUII are required by law to successfully complete a substance abuse treatment program in order to have their privilege to drive reinstated. A substance abuse treatment system involving the courts, ADESs, DUII approved substance abuse treatment providers, and the DMV was created to assure that DUII offenders receive the substance abuse treatment that is clinically appropriate regardless of their legal status with the courts. In addition, convicted DUII offenders are mandated to provide documentation of successful completion of a substance abuse program as outlined by OHA AMH. DUII Treatment Completion Certificate, Form # 735-6821, is the documentation accepted as proof of successful completion of a substance abuse treatment program.

When an individual is arrested for DUII an arraignment date will be scheduled at which time the DUII offender will be informed of the possibility of a DUII Diversion Agreement with the court. The DUII offender has 30 days to file the diversion petition. The DUII offender will be referred by the court to an ADES designated by that court for screening, referral to an approved substance abuse treatment program, and monitoring of substance abuse treatment, whether the court approves diversion petition or convicts the DUII offender. The court will usually stipulate a time frame by which the DUII offender must contact the ADES for the screening appointment.

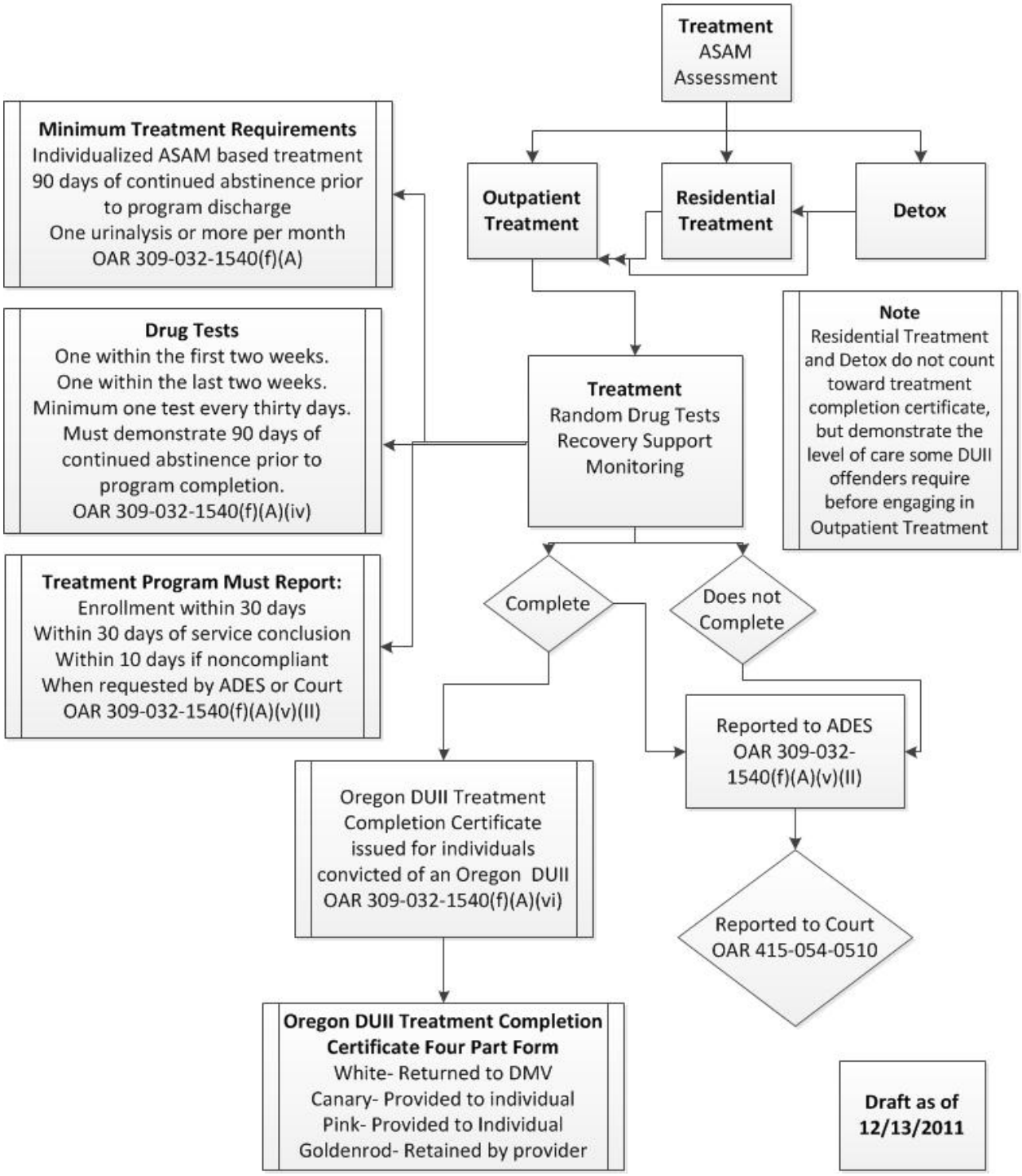
The ADES provides the court with the status of the DUII offender’s substance abuse treatment. The actual depth of involvement by the ADES varies from court to court.

Oregon Health Authority
Addictions & Mental Health
Oregon DUII Overview
2008 Activity

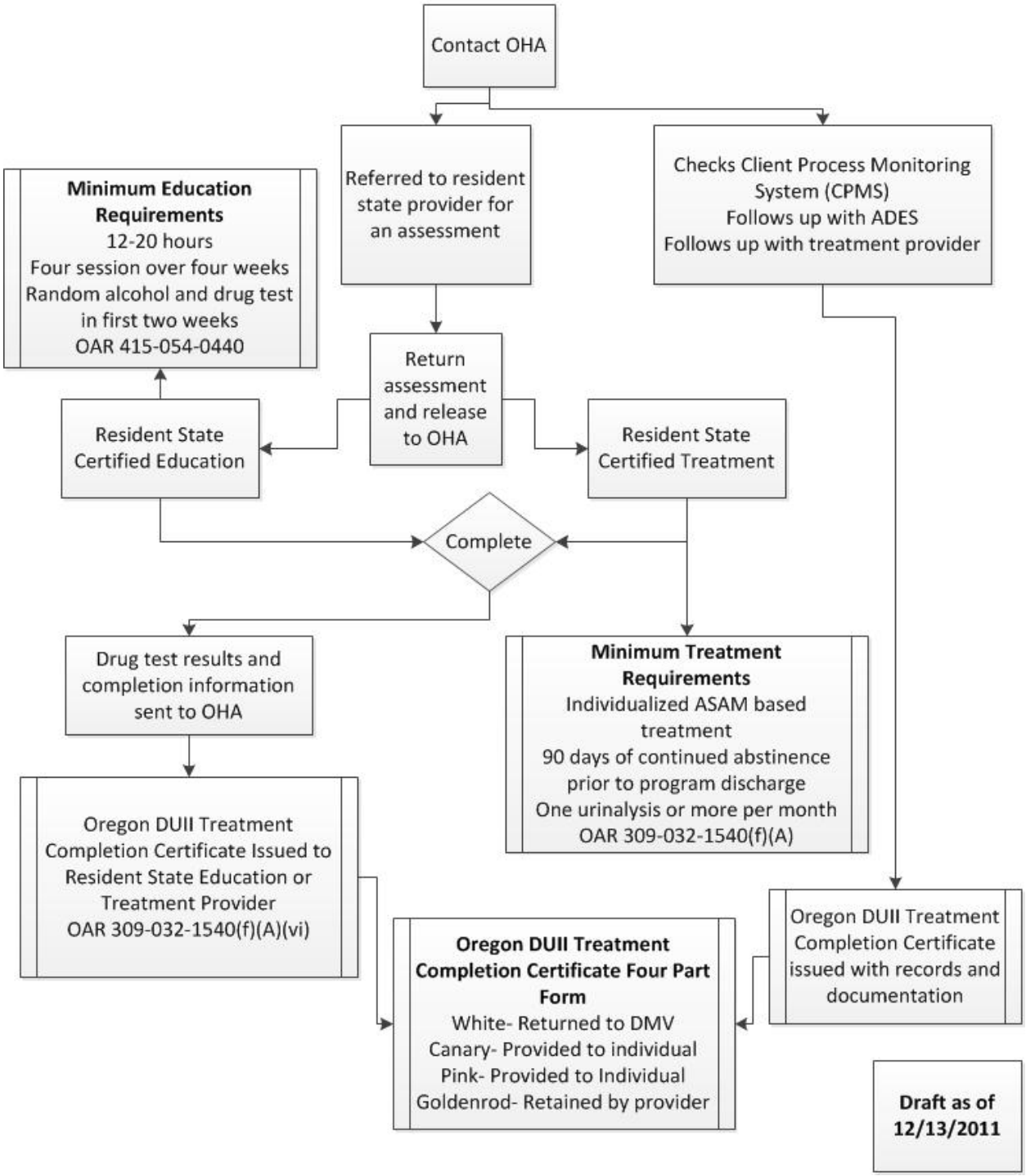



Oregon Health Authority
Addictions & Mental Health
Oregon DUII
Education
Minimum Education Requirements
12-20 hours
Four session over four weeks
Random alcohol and drug test in first two weeks
OAR 415-054-0440
Education
Education Content
Random Drug Test(s)
OAR 415-054-0440
Required Education Content
Victim's panel (when possible)
Division approved pre and post test
History, use, and definition of alcohol
Alcohol as a drug
Other drugs (legal and illegal)
Psychological/sociological consequences
Blood alcohol concentration and driving
Court penalties
DMV laws and penalties
Alcoholism as a problem and disease
Alternatives to drinking and driving
OAR 415-054-0440
Positive UA
Negative UA
Does not Complete
Complete
Oregon DUII Treatment Completion Certificate issued for individuals convicted of a DUII in Oregon
OAR 309-032-1540(f)(A)(vi)
Reported to ADES
OAR 415-054-0510
Reported to ADES Referred for Treatment (see Oregon DUII Treatment)
OAR 415-054-0440(4)
Oregon DUII Treatment Completion Certificate Four Part Form
White- Returned to DMV
Canary- Provided to individual
Pink- Provided to Individual
Goldenrod- Retained by provider
Reported to ADES
OAR 415-054-0510
Reported to Court
OAR 415-054-0510
Draft as of 12/13/2011

Oregon Health Authority
Addictions & Mental Health
Oregon DUII
Treatment



Oregon Health Authority
Addictions & Mental Health
Completion Certificate Process for Convicted Individuals No Longer Working With an ADES



Chapter 813 — Driving Under the Influence of Intoxicants

2011 EDITION

DRIVING UNDER THE INFLUENCE OF INTOXICANTS

OREGON VEHICLE CODE

GENERAL PROVISIONS

813.010 Driving under the influence of intoxicants; penalty

813.011 Felony driving under the influence of intoxicants; penalty

813.012 Crime classification for purposes of rules of Oregon Criminal Justice Commission

813.020 Fee to be paid on conviction; screening and treatment; mandatory imprisonment or community service; attendance at victim impact treatment session; session fee

813.021 Requirements for screening interview and treatment program

813.023 Alternative payment methods for screening, diagnostic assessment or treatment

813.025 Designation of agency to perform screening, diagnostic assessment and treatment; qualifications; rules

813.030 Amount of fee; distribution

813.040 Standards for determination of problem condition involving alcohol, inhalants or controlled substances

813.050 Out-of-service orders for operators of commercial motor vehicles; grounds; duration; rules; penalty

813.055 Civil penalty for violation of out-of-service order or notice

IMPLIED CONSENT

813.095 Offense of refusal to take a test for intoxicants; penalty

813.100 Implied consent to breath or blood test; confiscation of license upon refusal or failure of test

813.110 Temporary permit upon confiscation of license

813.120 Police report to department

813.130 Rights of and consequences for person asked to take test

813.131 Implied consent to urine test; privacy; laboratories for analysis

813.132 Consequences of refusing to take urine test; exception

813.135 Implied consent to field sobriety tests

813.136 Consequence of refusal or failure to submit to field sobriety tests

CHEMICAL TESTS; METHODS AND REQUIREMENTS

813.140 Chemical test with consent; unconscious person

813.150 Chemical test at request of arrested person

813.160 Methods of conducting chemical analyses; duties of Department of State Police; reports; costs

PLEA AGREEMENT

813.170 Plea agreement prohibited

DIVERSION

813.200 Notice of availability of diversion; petition; form; contents

813.210 Petition; filing fee; diagnostic assessment fee; service on prosecutor; objection

813.215 Eligibility for diversion

813.220 Matters to be considered by court in determining to allow diversion agreement; reasons for denial

813.222 Right of victim to be present at hearing

813.225 Petition for extension of diversion period; conditions

813.230 Diversion agreement; record; duration; effect of denial

813.233 Exemption from completing treatment program in this state

813.235 Attendance at victim impact treatment session as condition of diversion; fee

813.240 Amount and distribution of filing fee; diagnostic assessment fee

813.250 Motion to dismiss charge on completion of diversion; admissibility of statements

813.255 Termination of diversion

813.260 Designation of agencies to perform diagnostic assessments; duties of agency

813.270 Intoxicated Driver Program Fund; creation; uses

EVIDENCE

813.300 Use of blood alcohol percentage as evidence; percentage required for being under the influence

813.310 Refusal to take chemical test admissible as evidence

813.320 Effect of implied consent law on evidence

813.322 Department of State Police rules regarding breath tests as evidence; validity of officer's permit

813.324 Use of testimony from implied consent hearing as evidence in prosecution

813.326 Felony driving while under the influence of intoxicants; prior convictions

813.328 Notice of intent to challenge validity of prior convictions

SUSPENSION

(For Conviction)

813.400 Suspension or revocation upon conviction; duration; review

(Of Commercial Driver License)

813.403 Suspension of commercial driver license upon conviction; review

813.404 Duration of suspension of commercial driver license

(Under Implied Consent Law)

813.410 Suspension upon receipt of police report on implied consent test; hearing; validity of suspension; appeal; rules

813.412 Role of police officer in implied consent hearing

813.420 Duration of suspension for refusal or failure of test

813.430 Grounds for increase in duration of suspension

813.440 Grounds for hearing on validity of suspension; rules

813.450 Appeal from suspension for refusal or failure of breath test

813.460 Department procedures upon verification of suspension of driving privileges of wrong person

813.470 Department notation on record of person acquitted after

suspension

HARDSHIP PERMITS

813.500 Restrictions on issuance

813.510 Limitations on privileges granted by permit; conditions of permit

813.520 Limitations on authority to issue hardship permit or reinstate driving privileges

IGNITION INTERLOCK DEVICES

813.600 Ignition interlock program; rules

813.602 Circumstances under which ignition interlock device required; costs; failure to install; penalty; exemptions; rules

813.604 Notice of court order; notation on hardship permit; rules

813.606 Exception for employee otherwise required to have device

813.608 Knowingly furnishing motor vehicle without ignition interlock device; penalty

813.610 Soliciting another to blow into ignition interlock device; penalty

813.612 Unlawfully blowing into ignition interlock device; penalty

813.614 Tampering with ignition interlock device; penalty

813.616 Use of certain moneys to pay for ignition interlock program

GENERAL PROVISIONS

813.010 Driving under the influence of intoxicants; penalty. (1) A person commits the offense of driving while under the influence of intoxicants if the person drives a vehicle while the person:

(a) Has 0.08 percent or more by weight of alcohol in the blood of the person as shown by chemical analysis of the breath or blood of the person

made under ORS 813.100, 813.140 or 813.150;

(b) Is under the influence of intoxicating liquor, a controlled substance or an inhalant; or

(c) Is under the influence of any combination of intoxicating liquor, an inhalant and a controlled substance.

(2) A person may not be convicted of driving while under the influence of intoxicants on the basis of being under the influence of a controlled substance or an inhalant unless the fact that the person was under the influence of a controlled substance or an inhalant is pleaded in the accusatory instrument and is either proved at trial or is admitted by the person through a guilty plea.

(3) A person convicted of the offense described in this section is subject to ORS 813.020 in addition to this section.

(4) Except as provided in subsection (5) of this section, the offense described in this section, driving while under the influence of intoxicants, is a Class A misdemeanor and is applicable upon any premises open to the public.

(5)(a) Driving while under the influence of intoxicants is a Class C felony if the current offense was committed in a motor vehicle and the person has, at least three times in the 10 years prior to the date of the current offense, been convicted of, or been found to be within the jurisdiction of the juvenile court for an act that if committed by an adult would be, any of the following offenses in any combination:

(A) Driving while under the influence of intoxicants in violation of:

(i) This section; or

(ii) The statutory counterpart to this section in another jurisdiction.

(B) A driving under the influence of intoxicants offense in another jurisdiction that involved the impaired driving or operation of a vehicle, an aircraft or a boat due to the use of intoxicating liquor, a controlled substance, an inhalant or any combination thereof.

(C) A driving offense in another jurisdiction that involved operating a vehicle, an aircraft or a boat while having a blood alcohol content above that jurisdiction's permissible blood alcohol content.

(b) For the purposes of paragraph (a) of this subsection, a conviction or adjudication for a driving offense in another jurisdiction based solely on a person under 21 years of age having a blood alcohol content that is lower than the permissible blood alcohol content in that jurisdiction for a person 21 years of age or older does not constitute a prior conviction or adjudication.

(6) In addition to any other sentence that may be imposed, the court

shall impose one or more of the following fines on a person convicted of driving while under the influence of intoxicants as follows:

(a) For a person's first conviction, a minimum of $1,000.

(b) For a person's second conviction, a minimum of $1,500.

(c) For a person's third or subsequent conviction, a minimum of $2,000 if the person is not sentenced to a term of imprisonment.

(d) For a person who drives a vehicle while the person has 0.15 percent or more by weight of alcohol in the blood of the person as shown by chemical analysis of the breath or blood of the person made under ORS 813.100, 813.140 or 813.150, a minimum of $2,000.

(7) Notwithstanding ORS 161.635, $10,000 is the maximum fine that a court may impose on a person convicted of driving while under the influence of intoxicants if:

(a) The current offense was committed in a motor vehicle; and

(b) There was a passenger in the motor vehicle who was under 18 years of age and was at least three years younger than the person driving the motor vehicle. [1983 c.338 §587; 1985 c.16 §293; 1987 c.138 §5; 1991 c.835 §7; 1999 c.619 §3; 1999 c.1049 §1; 2003 c.14 §495; 2003 c.445 §1; 2007 c.879 §3; 2009 c.525 §1; 2009 c.613 §1]

813.011 Felony driving under the influence of intoxicants; penalty. (1) Driving under the influence of intoxicants under ORS 813.010 shall be a Class C felony if the defendant has been convicted of driving under the influence of intoxicants in violation of ORS 813.010, or its statutory counterpart in another jurisdiction, at least two times in the 10 years prior to the date of the current offense.

(2) Once a person has been sentenced for a Class C felony under this section, the 10-year time limitation is eliminated and any subsequent episode of driving under the influence of intoxicants shall be a Class C felony regardless of the amount of time which intervenes.

(3) Upon conviction for a Class C felony under this section, the person shall be sentenced to a mandatory minimum term of incarceration of 90 days, without reduction for any reason. [2011 c.1 §3; 2011 c.598 §2]

Note: 813.011 was enacted into law but was not added to or made a part of the Oregon Vehicle Code or any chapter or series therein by law. See Preface to Oregon Revised Statutes for further explanation.

813.012 Crime classification for purposes of rules of Oregon Criminal Justice Commission. (1) The Oregon Criminal Justice

Commission shall classify felony driving while under the influence of intoxicants that is committed under the circumstances described in ORS 813.010 (5) as crime category 6 of the rules of the Oregon Criminal Justice Commission.

(2) In determining criminal history for a person convicted of a felony that has operation of a motor vehicle as an element, or of a felony that involved death, injury or property damage caused by the use of a motor vehicle, the commission shall:

(a) Consider two prior convictions of misdemeanor driving while under the influence of intoxicants to be equivalent to one conviction of felony driving while under the influence of intoxicants; and

(b) Consider felony driving while under the influence of intoxicants to be a person felony and consider misdemeanor driving while under the influence of intoxicants to be a person Class A misdemeanor. [1999 c.1049 §3; 2011 c.598 §1]

813.020 Fee to be paid on conviction; screening and treatment; mandatory imprisonment or community service; attendance at victim impact treatment session; session fee. When a person is convicted of driving while under the influence of intoxicants in violation of ORS 813.010, a court shall comply with the following in addition to any fine or other penalty imposed upon the person under ORS 813.010:

(1) The court shall require the person to:

(a) Pay to the court the fee described under ORS 813.030 in addition to any fine imposed under ORS 813.010; and

(b) Complete a screening interview and a treatment program as provided in ORS 813.021.

(2) The court must impose and not suspend execution of a sentence requiring the person either to serve at least 48 hours' imprisonment, which shall be served consecutively unless justice requires otherwise, or to perform community service for times specified by the court under ORS 137.129. For purposes of this subsection:

(a) A court may provide for the imprisonment to be served in jail, minimum security facilities or inpatient rehabilitation or treatment centers.

(b) Whenever the judge provides for the mandatory imprisonment to be served other than consecutively, the judgment must specifically so provide and the judge must state the reasons in writing.

(3) In a county that has a victim impact program a court may require the person to attend a victim impact treatment session. If the court requires attendance under this section, the court may require the defendant to pay a

reasonable fee to the victim impact program to offset the cost of the defendant's participation. The fee shall be established for each county by the victim impact panel coordinator and steering committee of that county and shall be not less than $5 or more than $50. [1983 c.338 §588; 1985 c.16 §294 and former 487.549; 1989 c.576 §5; 1991 c.557 §3; 1993 c.13 §4; 1993 c.468 §1; 1999 c.126 §1; 2003 c.14 §496]

813.021 Requirements for screening interview and treatment program. (1) When a court, in accordance with ORS 813.020, requires a person to complete a screening interview and a treatment program, the court shall require the person to do all of the following:

(a) Complete a screening interview for the purpose of determining appropriate placement of the person in a program for treatment for alcoholism, drug dependency or dependency on inhalants.

(b) Pay directly to the agency or organization conducting the screening interview a fee of $150.

(c) Complete the treatment program to which the person is referred.

(d) Pay for the treatment program to which the person is referred.

(2) The screening interview required by this section shall be conducted by an agency or organization designated by the court. The designated agency or organization must meet the standards set by the Director of the Oregon Health Authority to conduct the screening interviews. Wherever possible a court shall designate agencies or organizations to perform the screening interview that are separate from those that may be designated to carry out a treatment program.

(3) An agency or organization doing a screening interview under this section may not refer a person to a treatment program that has not been approved by the Director of the Oregon Health Authority.

(4) The agency or organization conducting a screening interview under this section shall monitor the progress of the person referred to the agency or organization. The agency or organization shall make a report to the referring court stating the person's successful completion or failure to complete all or any part of the screening interview or of the treatment program to which the person was referred by the agency or organization. The report shall be in a form determined by agreement between the court and the agency or organization. [1999 c.126 §3; 1999 c.619 §8a; 2005 c.303 §1; 2009 c.595 §1140]

Note: 813.021 was added to and made a part of the Oregon Vehicle Code by legislative action but was not added to ORS chapter 813 or any

smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

813.023 Alternative payment methods for screening, diagnostic assessment or treatment. A person required to pay for a screening interview, treatment program or diagnostic assessment under ORS 813.021, 813.200, 813.210 or 813.240 who is eligible for the state medical assistance program may utilize the state medical assistance program as a third party resource to support medically necessary chemical dependency services that are covered under the state medical assistance program. The person remains responsible for the costs of the screening interview, treatment program or diagnostic assessment, regardless of the amount of coverage or the failure of the third party resource to pay the costs. [2011 c.468 §1]

Note: 813.023 was enacted into law by the Legislative Assembly but was not added to or made a part of the Oregon Vehicle Code or any chapter or series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

813.025 Designation of agency to perform screening, diagnostic assessment and treatment; qualifications; rules. A court may designate a single agency or organization to perform the screening interviews and treatment programs described in ORS 813.021, or the diagnostic assessment and treatment described in ORS 813.260 (1) when the Director of the Oregon Health Authority certifies that:

(1) An agency or organization may accept such designations due to the lack of alternative agencies or organizations in the service area; or

(2) An agency or organization has applied to and been authorized by the Oregon Health Authority to operate a demonstration project that combines screening interviews and treatment programs or diagnostic assessment and treatment. The authority shall by rule set forth the conditions under which a demonstration project may be authorized. [1991 c.557 §2; 1999 c.126 §4; 2009 c.595 §1141]

Note 1: 813.030 was amended in two bills by the 2011 regular session of the Legislative Assembly. See sections 147 and 324, chapter 597, Oregon Laws 2011 (Enrolled House Bill 2712), and section 3, chapter 671, Oregon Laws 2011 (Enrolled House Bill 3075). Enrolled House Bill 2712 was signed by the Governor on June 30, 2011. Enrolled House Bill 3075 was

signed by the Governor on August 2, 2011. 813.030, as amended by sections 147 and 324, chapter 597, Oregon Laws 2011, is set forth below.

813.030 Amount of fee; distribution. The fee required by ORS 471.432 and 813.020 (1) shall be in the amount of $255, except that the court may waive all or part of the fee in cases involving indigent defendants. The court may make provision for payment of the fee on an installment basis. The court shall deposit the fee in the Criminal Fine Account. [1985 c.16 §296; 1987 c.905 §29; 1989 c.576 §§6a,7a; 1989 c.635 §§1,3; 1991 c.557 §4; 1993 c.13 §5; 1999 c.646 §3; 2009 c.595 §1142; 2011 c.597 §§147,324]

Note 2: 813.030 was amended in two bills by the 2011 regular session of the Legislative Assembly. See sections 147 and 324, chapter 597, Oregon Laws 2011 (Enrolled House Bill 2712), and section 3, chapter 671, Oregon Laws 2011 (Enrolled House Bill 3075). Enrolled House Bill 2712 was signed by the Governor on June 30, 2011. Enrolled House Bill 3075 was signed by the Governor on August 2, 2011. 813.030, as amended by section 3, chapter 671, Oregon Laws 2011, is set forth below.

813.030 Amount of fee; distribution. The fee required by ORS 471.432 and 813.020 (1) shall be in the amount of $155, except that the court may waive all or part of the fee in cases involving indigent defendants. The court may make provision for payment of the fee on an installment basis. The fee shall be ordered paid as follows:

(1) $105 to be credited and distributed under ORS 137.295 as an obligation payable to the state; and

(2) $50 to be paid to the Director of the Oregon Health Authority for deposit in the Intoxicated Driver Program Fund created by ORS 813.270. [1985 c.16 §296; 1987 c.905 §29; 1989 c.576 §§6a,7a; 1989 c.635 §§1,3; 1991 c.557 §4; 1993 c.13 §5; 1999 c.646 §3; 2009 c.595 §1142; 2011 c.671 §3]

Note 3: 137.295 was repealed by section 118, chapter 597, Oregon Laws 2011. Editorial adjustment of 813.030 Note 2 for the repeal of 137.295 has not been made.

813.040 Standards for determination of problem condition involving alcohol, inhalants or controlled substances. This section establishes, for purposes of ORS 471.432, 807.060 and 813.500, when a person has a problem condition involving alcohol, inhalants or controlled substances. For purposes of ORS 471.432, 807.060 and 813.500, a person

has a problem condition involving alcohol, inhalants or controlled substances if it is determined that the person has a problem condition in which the person's health or that of others is substantially impaired or endangered or the person's social or economic function is substantially disrupted because of the person's:

(1) Habitual or periodic use of alcoholic beverages; or

(2) Use of or loss of the ability to control the use of controlled substances, inhalants or other substances with abuse potential including a condition that may have developed:

(a) A physical dependence in which the body requires a continuing supply of a drug, inhalant or controlled substance to avoid characteristic withdrawal symptoms; or

(b) A psychological dependence characterized by an overwhelming mental desire for continued use of a drug, inhalant or controlled substance. [1983 c.338 §589; 1999 c.126 §5; 1999 c.619 §9; 1999 c.646 §4]

813.050 Out-of-service orders for operators of commercial motor vehicles; grounds; duration; rules; penalty. (1) A police officer or a person authorized by the Department of Transportation to perform vehicle safety inspections shall issue an out-of-service order to the operator of a commercial motor vehicle if any of the following applies:

(a) The person has reasonable grounds to believe that the operator has consumed alcohol or other intoxicating beverage within four hours prior to the time the operator began operating the vehicle or at any time while operating the vehicle. As used in this paragraph, "reasonable grounds" includes, but is not limited to, smelling alcohol on the breath or person of the operator.

(b) A chemical test of the operator's breath discloses any amount of alcohol in the blood of the operator.

(c) The operator possesses an intoxicating beverage while operating the vehicle. This subsection does not apply to possession of an intoxicating beverage that is manifested and transported as part of a shipment.

(2) An out-of-service order issued under this section shall become effective upon its issuance and shall remain in effect for 24 hours.

(3) The Department of Transportation shall adopt rules requiring that any driver issued an out-of-service order under this section be required to report the order to the department and to the driver's employer. Rules adopted under this section may include, but need not be limited to, rules specifying the times within which reports must be made and the contents of the reports.

(4) Violation of an out-of-service order issued under this section is a Class A misdemeanor. [1991 c.185 §14; 1993 c.400 §1]

813.052 [1993 c.400 §4; 2003 c.402 §39; 2007 c.122 §4; repealed by 2009 c.395 §15]

813.055 Civil penalty for violation of out-of-service order or notice. (1) The Department of Transportation shall impose a civil penalty on the operator of a commercial motor vehicle if:

(a) The operator has violated an out-of-service order issued under ORS 813.050 or any other out-of-service order or notice issued by the department or an authorized representative of the department; or

(b) The department receives notification that a person has violated any out-of-service order or notice issued by a state or federal agency.

(2) For the purposes of this section, “notification” may include, but is not limited to, a record of conviction or a record of a determination by a state or federal agency with jurisdiction to determine that the operator has violated an out-of-service order or notice.

(3) Civil penalties under this section shall be imposed in the manner provided in ORS 183.745 and may not be reduced. The civil penalties are:

(a) $2,500 for the first violation of an out-of-service order or notice.

(b) $5,000 for a second or subsequent violation of an out-of-service order or notice. [2009 c.395 §14]

Note: 813.055 was added to and made a part of the Oregon Vehicle Code by legislative action but was not added to ORS chapter 813 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

IMPLIED CONSENT

813.095 Offense of refusal to take a test for intoxicants; penalty. (1) A person commits the offense of refusal to take a test for intoxicants if the person refuses to:

(a) Take a breath test when requested to do so in accordance with the provisions of ORS 813.100; or

(b) Take a urine test when requested to do so in accordance with the provisions of ORS 813.131 and 813.132.

(2) The offense described in this section, refusal to take a test for intoxicants, is a specific fine traffic violation. The presumptive fine for

refusal to take a test for intoxicants is $650. The fine described in this section is in addition to any other consequence prescribed by law for refusal to take a test for intoxicants. [2003 c.814 §2; 2009 c.614 §1; 2011 c.597 §102]

813.100 Implied consent to breath or blood test; confiscation of license upon refusal or failure of test. (1) Any person who operates a motor vehicle upon premises open to the public or the highways of this state shall be deemed to have given consent, subject to the implied consent law, to a chemical test of the person's breath, or of the person's blood if the person is receiving medical care in a health care facility immediately after a motor vehicle accident, for the purpose of determining the alcoholic content of the person's blood if the person is arrested for driving a motor vehicle while under the influence of intoxicants in violation of ORS 813.010 or of a municipal ordinance. A test shall be administered upon the request of a police officer having reasonable grounds to believe the person arrested to have been driving while under the influence of intoxicants in violation of ORS 813.010 or of a municipal ordinance. Before the test is administered the person requested to take the test shall be informed of consequences and rights as described under ORS 813.130.

(2) No chemical test of the person's breath or blood shall be given, under subsection (1) of this section, to a person under arrest for driving a motor vehicle while under the influence of intoxicants in violation of ORS 813.010 or of a municipal ordinance, if the person refuses the request of a police officer to submit to the chemical test after the person has been informed of consequences and rights as described under ORS 813.130.

(3) If a person refuses to take a test under this section or if a breath test under this section discloses that the person, at the time of the test, had a level of alcohol in the person's blood that constitutes being under the influence of intoxicating liquor under ORS 813.300, the person's driving privileges are subject to suspension under ORS 813.410 and the police officer shall do all of the following:

(a) Immediately take custody of any driver license or permit issued by this state to the person to grant driving privileges.

(b) Provide the person with a written notice of intent to suspend, on forms prepared and provided by the Department of Transportation. The written notice shall inform the person of consequences and rights as described under ORS 813.130.

(c) If the person qualifies under ORS 813.110, issue to the person, on behalf of the department, a temporary driving permit described under ORS

813.110.

(d) Within a period of time required by the department by rule, report action taken under this section to the department and prepare and cause to be delivered to the department a report as described in ORS 813.120, along with the confiscated license or permit and a copy of the notice of intent to suspend.

(4) If a blood test under this section discloses that the person, at the time of the test, had a level of alcohol in the person's blood that constitutes being under the influence of intoxicating liquor under ORS 813.300, the person's driving privileges are subject to suspension under ORS 813.410 and the police officer shall report to the department within 45 days of the date of arrest that the person failed the blood test. [1983 c.338 §591; 1985 c.16 §298; 1985 c.672 §19; 1993 c.305 §1; 1995 c.568 §1]

813.110 Temporary permit upon confiscation of license.(1) Except as otherwise provided by this section, police officers, on behalf of the Department of Transportation, shall issue temporary driving permits described under this section to persons when required under ORS 813.100.

(2) The department shall provide police departments and agencies with permits for issuance as required by this section. The department shall establish the form and content of permits described in this section as the department determines appropriate, but in a manner consistent with this section.

(3) A permit described in this section is subject to all the following:

(a) Except as provided in paragraph (b) of this subsection, the permit is valid until the 30th day after the date of arrest.

(b) During the 12-hour period following issuance of the permit, the person is subject to ORS 807.570, and the permit is not a defense to a charge under ORS 807.570.

(c) The permit shall be issued without payment of any fee.

(d) The permit grants the same driving privileges as those granted by the person's license taken into possession under ORS 813.100.

(4) A police officer shall not issue a permit under this section if:

(a) Driving privileges of the person were suspended, revoked or canceled at the time the person was arrested;

(b) The person whose license was taken into custody was operating on an invalid license;

(c) The person was not entitled to driving privileges at the time of the arrest for any other reason; or

(d) The person holds a license or permit granting driving privileges that was issued by another state or jurisdiction and that is not taken into custody under ORS 813.100. [1985 c.16 §142; 1985 c.672 §17]

813.120 Police report to department. (1) A report required by ORS 813.100 shall disclose substantially all of the following information:

(a) Whether the person, at the time the person was requested to submit to a test, was under arrest for driving a motor vehicle while under the influence of intoxicants in violation of ORS 813.010 or of a municipal ordinance.

(b) Whether the police officer had reasonable grounds to believe, at the time the request was made, that the person arrested had been driving under the influence of intoxicants in violation of ORS 813.010 or of a municipal ordinance.

(c) Whether the person refused to submit to a test or if the person submitted to a breath or blood test whether the level of alcohol in the person's blood, as shown by the test, was sufficient to constitute being under the influence of intoxicating liquor under ORS 813.300.

(d) Whether the person was driving a commercial motor vehicle and refused to submit to a test or if the person submitted to a breath or blood test whether the level of alcohol in the person's blood, as shown by the test, was 0.04 percent or more by weight.

(e) Whether the person was informed of consequences and rights as described under ORS 813.130.

(f) Whether the person was given written notice of intent to suspend required by ORS 813.100 (3)(b).

(g) If the arrested person took a test, a statement that the person conducting the test was appropriately qualified.

(h) If the arrested person took a test, a statement that any methods, procedures and equipment used in the test comply with any requirements under ORS 813.160.

(2) A report required by ORS 813.100 may be made in one or more forms specified by the Department of Transportation. [1983 c.338 §405; 1985 c.16 §215; 1985 c.672 §20; 1989 c.636 §42; 1993 c.305 §3; 1993 c.751 §70; 1995 c.568 §3]

813.130 Rights of and consequences for person asked to take test. This section establishes the requirements for information about rights and consequences for purposes of ORS 813.100 and 813.410. The following apply to the information about rights and consequences:

(1) The information about rights and consequences shall be substantially in the form prepared by the Department of Transportation. The department may establish any form it determines appropriate and convenient.

(2) The information about rights and consequences shall be substantially as follows:

(a) Driving under the influence of intoxicants is a crime in Oregon, and the person is subject to criminal penalties if a test under ORS 813.100 shows that the person is under the influence of intoxicants. If the person refuses a test or fails, evidence of the refusal or failure may also be offered against the person.

(b) The person will fail a test under ORS 813.100 for purposes of criminal penalties if the test discloses a blood alcohol content of 0.08 percent or more by weight. The person will fail a test for purposes of the Motorist Implied Consent Law if the test discloses a blood alcohol content of:

(A) 0.08 percent or more by weight if the person was not driving a commercial motor vehicle;

(B) 0.04 percent or more by weight if the person was driving a commercial motor vehicle; or

(C) Any amount if the person was under 21 years of age.

(c) If the person refuses or fails a test under ORS 813.100, the person's driving privileges will be suspended. The outcome of a criminal charge for driving under the influence of intoxicants will not affect the suspension. The suspension will be substantially longer if the person refuses a test.

(d) If the person refuses a test or fails a breath test under ORS 813.100 and has an Oregon driver license or permit, the license or permit will be taken immediately and, unless the person does not currently have full valid driving privileges, a temporary driving permit will be issued to the person.

(e) If the person refuses a test under ORS 813.100, the person is not eligible for a hardship permit for at least 90 days, and possibly for three years, depending on the following factors set forth in ORS 813.430:

(A) Whether the person is presently participating in a driving while under the influence of intoxicants diversion program in this state or in any similar alcohol or drug rehabilitation program in this or another jurisdiction; or

(B) Whether within the five years preceding the date of arrest any of the following occurred:

(i) A suspension of the person's driving privileges under ORS 813.410 or 482.540 (1981 Replacement Part) became effective;

(ii) The person was convicted of driving while under the influence of intoxicants in violation of ORS 813.010 or the statutory counterpart to ORS

813.010 in another jurisdiction, as described in ORS 813.430;

(iii) The person was convicted of driving while under the influence of intoxicants in violation of a municipal ordinance in this state or another jurisdiction, as described in ORS 813.430; or

(iv) The person commenced participating in a driving while under the influence of intoxicants diversion program in this state or in any similar alcohol or drug rehabilitation program in this or another jurisdiction, as described in ORS 813.430.

(f) If the person refuses a breath test under ORS 813.100, or refuses a urine test under ORS 813.131 and 813.132, the person is subject to a fine of at least $500 and not more than $1,000.

(g) After taking a test under ORS 813.100, the person will have a reasonable opportunity, upon request, for an additional chemical test for blood alcohol content to be performed at the person's own expense by a qualified individual of the person's choosing.

(h) The person has a right to a hearing to challenge the validity of the suspension before the suspension becomes effective. The person must make a written request to the department for such a hearing. If the person wins at the hearing, the person's driving privileges will not be suspended. If the person loses at the hearing, the suspension will remain in effect during any court review of the hearing.

(i) If the person is issued a temporary driving permit under ORS 813.100, the information provided to the person shall include the number of hours before the driving permit will be effective and the number of days the permit will be effective.

(j) The information provided to the person shall include the number of days within which a person must request a hearing under ORS 813.410.

(k) The information provided to the person shall include the number of days within which a hearing under ORS 813.410 will be held.

(L) The person may possibly qualify for a hardship permit in 30 days if the person fails a test, depending on the person's driving record.

(3) If the person is driving a commercial motor vehicle, the information about rights and consequences shall include, in addition to the provisions of subsection (2) of this section, substantially the following:

(a) If the person refuses a test under ORS 813.100 or submits to a breath or blood test and the level of alcohol in the person's blood is 0.04 percent or more by weight, the person's commercial driver license or right to apply for a commercial driver license will be suspended and no hardship permit authorizing the person to drive a commercial motor vehicle will be issued. The suspension will be substantially longer if the person refuses a

test.

(b) The suspension of the person's commercial driver license or right to apply for a commercial driver license will be for the person's lifetime if the person refuses a test under ORS 813.100 or submits to a breath or blood test and the level of alcohol in the person's blood is 0.04 percent or more by weight and:

(A) The person previously has been convicted of failure to perform the duties of a driver;

(B) The person previously has been convicted of a crime punishable as a felony and the person was driving a motor vehicle at the time the offense was committed;

(C) The person previously has been convicted of driving a commercial motor vehicle while the person's commercial driver license or right to apply for a commercial driver license was suspended or revoked;

(D) The person previously has been convicted of any degree of murder, manslaughter or criminally negligent homicide resulting from the operation of a commercial motor vehicle or assault in the first degree resulting from the operation of a commercial motor vehicle;

(E) The person previously has been convicted of driving while under the influence of intoxicants;

(F) The person's commercial driver license previously has been suspended or revoked for refusal to submit to, or failure of, a breath or blood test under ORS 813.100; or

(G) The person's right to apply for a commercial driver license previously has been suspended or revoked for refusal to submit to, or failure of, a breath or blood test under ORS 813.100 resulting from the operation of a commercial motor vehicle.

(4) Nothing in this section prohibits the department from providing additional information concerning rights and consequences that the department considers convenient or appropriate. [1985 c.672 §22; 1987 c.673 §3; 1987 c.801 §11; 1989 c.171 §92; 1989 c.636 §43; 1991 c.185 §15; 1991 c.860 §10; 1993 c.305 §4; 1995 c.568 §4; 2003 c.814 §3; 2005 c.649 §28; 2009 c.607 §2; 2009 c.614 §2]

813.131 Implied consent to urine test; privacy; laboratories for analysis. (1) Any person who operates a motor vehicle upon premises open to the public or the highways of this state shall be deemed to have given consent, subject to the Motorist Implied Consent Law, to a chemical test of the person's urine for the purpose of determining the presence of a controlled substance or an inhalant in the person's body if the person is

arrested for driving while under the influence of intoxicants in violation of ORS 813.010 or of a municipal ordinance and either:

(a) The person takes the breath test described in ORS 813.100 and the test discloses a blood alcohol content of less than 0.08 percent; or

(b) The person is involved in an accident resulting in injury or property damage. A urine test may be requested under this paragraph regardless of whether a breath test has been requested and regardless of the results of a breath test, if one is taken.

(2) A police officer may not request a urine test unless the officer is certified by the Board on Public Safety Standards and Training as having completed at least eight hours of training in recognition of drug impaired driving and the officer has a reasonable suspicion that the person arrested has been driving while under the influence of a controlled substance, an inhalant or any combination of an inhalant, a controlled substance and intoxicating liquor.

(3) A person asked to give a urine sample shall be given privacy and may not be observed by a police officer when producing the sample.

(4)(a) At the trial of any civil or criminal action, suit or proceeding arising out of the acts committed by a person driving a motor vehicle while under the influence of intoxicants, a valid chemical analysis of a person's urine is admissible as evidence and may be used with other evidence, if any, to determine whether the person was driving while under the influence of intoxicants.

(b) A chemical analysis of a person's urine is valid under this subsection if analysis is performed in an accredited or licensed toxicology laboratory. [1995 c.676 §1; 1999 c.619 §10; 1999 c.752 §1; 2009 c.325 §1]

813.132 Consequences of refusing to take urine test; exception. (1) Except as otherwise provided in this section, a refusal to take a urine test requested under ORS 813.131 shall be treated for all purposes as a refusal to take a breath test. A suspension imposed for refusal to take a urine test shall be consecutive to any other suspension imposed under the Motorist Implied Consent Law. If a person is subject to consecutive suspensions, the length of time that must elapse before the Department of Transportation may reinstate driving privileges or issue a hardship permit under ORS 813.520 shall be doubled.

(2) Before any test of urine may be administered under ORS 813.131, in addition to information described in ORS 813.130, the person asked to take the test shall be informed that if the person refuses the test, the person's driving privileges will be suspended for the same time period and with the

same consequences as if the person had refused the breath test and that a suspension for refusal of the urine test will be consecutive to any other suspension under the Motorist Implied Consent Law.

(3) Notwithstanding subsection (1) of this section, no suspension of driving privileges shall be imposed for refusal to provide a urine sample if the person provides documentation from a physician licensed by this state showing that the person has a medical condition that makes it impossible for the person to provide a sample. [1995 c.676 §2; 1997 c.25 §3]

813.135 Implied consent to field sobriety tests. Any person who operates a vehicle upon premises open to the public or the highways of the state shall be deemed to have given consent to submit to field sobriety tests upon the request of a police officer for the purpose of determining if the person is under the influence of intoxicants if the police officer reasonably suspects that the person has committed the offense of driving while under the influence of intoxicants in violation of ORS 813.010 or a municipal ordinance. Before the tests are administered, the person requested to take the tests shall be informed of the consequences of refusing to take or failing to submit to the tests under ORS 813.136. [1989 c.576 §15]

813.136 Consequence of refusal or failure to submit to field sobriety tests. If a person refuses or fails to submit to field sobriety tests as required by ORS 813.135, evidence of the person's refusal or failure to submit is admissible in any criminal or civil action or proceeding arising out of allegations that the person was driving while under the influence of intoxicants. [1989 c.576 §14]

CHEMICAL TESTS; METHODS AND REQUIREMENTS

813.140 Chemical test with consent; unconscious person. Nothing in ORS 813.100 is intended to preclude the administration of a chemical test described in this section. A police officer may obtain a chemical test of the blood to determine the amount of alcohol in any person's blood or a test of the person's blood or urine, or both, to determine the presence of a controlled substance or an inhalant in the person as provided in the following:

(1) If, when requested by a police officer, the person expressly consents to such a test.

(2) Notwithstanding subsection (1) of this section, from a person without

the person's consent if:

(a) The police officer has probable cause to believe that the person was driving while under the influence of intoxicants and that evidence of the offense will be found in the person's blood or urine; and

(b) The person is unconscious or otherwise in a condition rendering the person incapable of expressly consenting to the test or tests requested. [1983 c.338 §593; 1985 c.16 §299; 1999 c.619 §11]

813.150 Chemical test at request of arrested person. In addition to a chemical test of the breath, blood or urine administered under ORS 813.100 or 813.140, upon the request of a police officer, a person shall be permitted upon request, at the person's own expense, reasonable opportunity to have any licensed physician and surgeon, licensed professional nurse or qualified technician, chemist or other qualified person of the person's own choosing administer a chemical test or tests of the person's breath or blood for the purpose of determining the alcoholic content of the person's blood or a chemical test or tests of the person's blood or urine, or both, for the purpose of determining the presence of a controlled substance or an inhalant in the person. The failure or inability to obtain such a test or tests by a person shall not preclude the admission of evidence relating to a test or tests taken upon the request of a police officer. [1983 c.338 §594; 1985 c.16 §300; 1999 c.619 §12]

813.160 Methods of conducting chemical analyses; duties of Department of State Police; reports; costs. (1) A chemical analysis is valid under ORS 813.300 if:

(a) It is an analysis of a person's blood for alcohol content and is performed in:

(A) A laboratory certified or accredited under 42 C.F.R. part 493 and approved for toxicology testing;

(B) A laboratory licensed under ORS 438.110 and approved for toxicology testing; or

(C) A forensic laboratory established by the Department of State Police under ORS 181.080 that is accredited by a national forensic accrediting organization.

(b) It is an analysis of a person's breath and is performed by an individual possessing a valid permit to perform chemical analyses issued by the Department of State Police and is performed according to methods approved by the Department of State Police. For purposes of this paragraph, the Department of State Police shall do all of the following:

(A) Approve methods of performing chemical analyses of a person's breath.

(B) Prepare manuals and conduct courses throughout the state for the training of police officers in chemical analyses of a person's breath, which courses shall include, but are not limited to, approved methods of chemical analyses, use of approved equipment and interpretation of test results together with a written examination on these subjects.

(C) Test and certify the accuracy of equipment to be used by police officers for chemical analyses of a person's breath before regular use of the equipment and periodically thereafter at intervals of not more than 90 days. Tests and certification required by this subparagraph must be conducted by trained technicians. Certification under this subparagraph does not require a signed document.

(D) Ascertain the qualifications and competence of individuals to conduct chemical analyses in accordance with one or more methods approved by the department.

(E) Issue permits to individuals according to their qualifications. Permits may be issued to police officers only upon satisfactory completion of the prescribed training course and written examination. A permit must state the methods and equipment that the police officer is qualified to use. Permits are subject to termination or revocation at the discretion of the Department of State Police.

(2) In conducting a chemical test of the blood, only a duly licensed physician or a person acting under the direction or control of a duly licensed physician may withdraw blood or pierce human tissue. A licensed physician, or a qualified person acting under the direction or control of a duly licensed physician, is not civilly liable for withdrawing any bodily substance, in a medically acceptable manner, at the request of a peace officer.

(3) An individual who performs a chemical analysis of breath or blood under ORS 813.100 or 813.140 shall prepare and sign a written report of the findings of the test that must include the identification of the police officer upon whose request the test was administered.

(4) Any individual having custody of the report mentioned in subsection (3) of this section shall, upon request of the person tested, furnish that person or that person's attorney, a copy of the report.

(5) The expense of conducting a chemical test as provided by ORS 813.100 or 813.140 must be paid by the governmental unit on whose equipment the test is conducted or by the governmental unit upon whose request the test was administered if no governmental unit's equipment is

used to conduct the test. [1983 c.338 §173; 1985 c.16 §57; 1985 c.337 §2; 1995 c.351 §1; 2003 c.19 §1]

PLEA AGREEMENT

813.170 Plea agreement prohibited. (1) Notwithstanding ORS 135.405 to 135.445, a person charged with the offense of driving under the influence of intoxicants shall not be allowed to plead “guilty” or “no contest” to any other offense in exchange for a dismissal of the offense charged. No district attorney or city attorney shall make any motion and no judge shall enter any order in derogation of this section. This section does not prohibit diversion as provided under ORS 813.200.

(2) Notwithstanding ORS 135.881 to 135.901, a person charged with the offense of driving under the influence of intoxicants shall not be allowed to enter into any program of supervised performance or diversion except as provided under ORS 813.200. [1983 c.338 §382; 1999 c.1051 §294]

DIVERSION

813.200 Notice of availability of diversion; petition; form; contents. (1) The court shall inform at arraignment a defendant charged with the offense of driving while under the influence of intoxicants as defined in ORS 813.010 or a city ordinance conforming thereto that a diversion agreement may be available if the defendant meets the criteria set out in ORS 813.215 and files with the court a petition for a driving while under the influence of intoxicants diversion agreement.

(2) The petition forms for a driving while under the influence of intoxicants diversion agreement shall be available to a defendant at the court.

(3) The form of the petition for a driving while under the influence of intoxicants diversion agreement and the information and blanks contained therein shall be determined by the Supreme Court under ORS 1.525. The petition forms made available to a defendant by any city or state court shall conform to the requirements adopted by the Supreme Court.

(4) In addition to any other information required by the Supreme Court to be contained in a petition for a driving while under the influence of intoxicants diversion agreement, the petition shall include:

(a) A plea of guilty or no contest to the charge of driving while under the influence of intoxicants signed by the defendant;

(b) An agreement by the defendant to complete at an agency or

organization designated by the city or state court a diagnostic assessment to determine the possible existence and degree of an alcohol or drug abuse problem;

(c) An agreement by the defendant to complete, at defendant's own expense based on defendant's ability to pay, the program of treatment indicated as necessary by the diagnostic assessment;

(d) Except as provided in subsection (5) of this section, an agreement by the defendant to not use intoxicants during the diversion period and to comply fully with the laws of this state designed to discourage the use of intoxicants;

(e) A notice to the defendant that the diversion agreement will be considered to be violated if the court receives notice that the defendant at any time during the diversion period committed the offense of driving while under the influence of intoxicants or committed a violation of ORS 811.170;

(f) An agreement by the defendant to keep the court advised of the defendant's current mailing address at all times during the diversion period;

(g) A waiver by the defendant of any former jeopardy rights under the federal and state Constitutions and ORS 131.505 to 131.525 in any subsequent action upon the charge or any other offenses based upon the same criminal episode;

(h) A sworn statement, as defined in ORS 162.055, by the defendant certifying that the defendant meets the criteria set out in ORS 813.215 to be eligible to enter into the driving while under the influence of intoxicants diversion agreement; and

(i) An agreement by the defendant to pay court-appointed attorney fees as determined by the court.

(5) A person may use intoxicants during the diversion period if:

(a) The person consumes sacramental wine given or provided as part of a religious rite or service;

(b) The person has a valid prescription for a substance and the person takes the substance as directed; or

(c) The person is using a nonprescription drug, as defined in ORS 689.005, in accordance with the directions for use that are printed on the label for that nonprescription drug. [1983 c.338 §369; 1985 c.16 §191; 1987 c.441 §4; 2003 c.816 §1; 2011 c.468 §3]

813.210 Petition; filing fee; diagnostic assessment fee; service on prosecutor; objection. (1) After an accusatory instrument has been filed charging the defendant with the offense of driving while under the influence of intoxicants, a defendant may file with the court a petition for a driving

while under the influence of intoxicants diversion agreement described in ORS 813.200. The petition:

(a) Must be filed within 30 days after the date of the defendant's first appearance on the summons, unless a later filing date is allowed by the court upon a showing of good cause. For purposes of this paragraph, the filing of a demurrer, a motion to suppress or a motion for an omnibus hearing does not constitute good cause.

(b) Notwithstanding paragraph (a) of this subsection, may not be filed after entry of a guilty plea or a no contest plea or after commencement of any trial on the charge whether or not a new trial or retrial is ordered for any reason.

(2) The defendant shall pay to the court, at the time of filing a petition for a driving while under the influence of intoxicants diversion agreement, a filing fee established under ORS 813.240. The court may make provision for payment of the filing fee by the defendant on an installment basis. The court may waive all or part of the filing fee in cases involving indigent defendants. The filing fee paid to the court under this subsection shall be retained by the court if the petition is allowed. The filing fee shall be distributed as provided by ORS 813.240.

(3) The defendant shall pay to the agency or organization providing the diagnostic assessment, at the time the petition is allowed, the fee required by ORS 813.240 (3).

(4)(a) Unless otherwise provided under paragraph (b) of this subsection, the defendant shall pay to the court any court-appointed attorney fees agreed to under ORS 813.200 (4)(i). Payments shall be made prior to the end of the diversion period on a schedule determined by the court.

(b) The court may waive all or part of the court-appointed attorney fees agreed to under ORS 813.200 (4)(i).

(5) The defendant shall cause a copy of the petition for a driving while under the influence of intoxicants diversion agreement to be served upon the district attorney or city attorney. The district attorney or city attorney may file with the court, within 15 days after the date of service, a written objection to the petition and a request for a hearing. [1983 c.338 §370; 1985 c.16 §192; 1987 c.441 §5; 1987 c.534 §1; 1993 c.13 §6; 2003 c.816 §2; 2011 c.595 §170]

813.215 Eligibility for diversion. (1) A defendant is eligible for diversion if the defendant meets all of the following conditions:

(a) On the date the defendant filed the petition for a driving while under the influence of intoxicants diversion agreement, the defendant had no

charge, other than the charge for the present offense, pending for:

(A) An offense of driving while under the influence of intoxicants in violation of:

(i) ORS 813.010; or

(ii) The statutory counterpart to ORS 813.010 in another jurisdiction;

(B) A driving under the influence of intoxicants offense in another jurisdiction that involved the impaired driving of a vehicle due to the use of intoxicating liquor, a controlled substance, an inhalant or any combination thereof; or

(C) A driving offense in another jurisdiction that involved operating a vehicle while having a blood alcohol content above that jurisdiction's permissible blood alcohol content.

(b) The defendant has not been convicted of an offense described in paragraph (a) of this subsection within the period beginning 15 years before the date of the commission of the present offense and ending on the date the defendant filed the petition for a driving while under the influence of intoxicants diversion agreement.

(c) The defendant has not been convicted of a felony offense described in ORS 813.010 (5)(a).

(d) The defendant was not participating in a driving while under the influence of intoxicants diversion program or in any similar alcohol or drug rehabilitation program, other than a program entered into as a result of the charge for the present offense, in this state or in another jurisdiction on the date the defendant filed the petition for a driving while under the influence of intoxicants diversion agreement.

(e) The defendant did not participate in a diversion or rehabilitation program described in paragraph (d) of this subsection, other than a program entered into as a result of the charge for the present offense, within the period beginning 15 years before the date of the commission of the present offense and ending on the date the defendant filed the petition for a driving while under the influence of intoxicants diversion agreement.

(f) The defendant had no charge of an offense of aggravated vehicular homicide or of murder, manslaughter, criminally negligent homicide or assault that resulted from the operation of a motor vehicle pending in this state or in another jurisdiction on the date the defendant filed the petition for a driving while under the influence of intoxicants diversion agreement.

(g) The defendant has not been convicted of an offense described in paragraph (f) of this subsection within the period beginning 15 years before the date of the commission of the present offense and ending on the date the defendant filed the petition for a driving while under the influence of

intoxicants diversion agreement.

(h) The defendant did not hold a commercial driver license on the date of the commission of the offense.

(i) The defendant was not operating a commercial motor vehicle at the time of the offense.

(j) The present driving while under the influence of intoxicants offense did not involve an accident resulting in:

(A) Death of any person; or

(B) Physical injury as defined in ORS 161.015 to any person other than the defendant.

(2) For the purposes of subsection (1)(a) of this section, a conviction for a driving offense in another jurisdiction based solely on a person under 21 years of age having a blood alcohol content that is lower than the permissible blood alcohol content in that jurisdiction for a person 21 years of age or older does not constitute a prior conviction.

(3) A defendant is eligible for a second or subsequent diversion if the defendant meets all of the conditions of subsection (1) of this section and the defendant has not been convicted of any other criminal offense involving a motor vehicle within the period beginning 15 years before the date of the commission of the present offense and ending on the date the defendant filed the petition for the second or subsequent driving while under the influence of intoxicants diversion agreement. [1987 c.441 §3; 1997 c.749 §5; 1999 c.445 §1; 1999 c.1051 §295; 2005 c.649 §29; 2007 c.122 §11; 2007 c.867 §14; 2007 c.879 §10; 2009 c.515 §1]

813.220 Matters to be considered by court in determining to allow diversion agreement; reasons for denial. After the time for requesting a hearing under ORS 813.210 has expired with no request for a hearing, or after a hearing requested under ORS 813.210, the court shall determine whether to allow or deny a petition for a driving while under the influence of intoxicants diversion agreement. In making a determination under this section, the court:

(1) Shall consider whether the diversion will be of benefit to the defendant and the community.

(2) May take into consideration whether there was an early recognition by the defendant during the proceeding that a course of diagnosis and treatment of problem drinking, alcoholism or drug dependency would be beneficial.

(3) May take into consideration whether there is a probability that the defendant will cooperate with the diagnostic assessment and treatment

agencies.

(4) May take into consideration whether the defendant will observe the restrictions contained in the diversion agreement.

(5) May take into consideration whether the offense was committed in a motor vehicle and whether there was a passenger in the motor vehicle who was under 18 years of age and at least three years younger than the defendant.

(6) Shall deny the petition for a driving while under the influence of intoxicants diversion agreement if the defendant failed to appear at an arraignment on the present offense without good cause.

(7) Shall deny the petition for a driving while under the influence of intoxicants diversion agreement if, after the date the defendant filed the petition, the defendant was charged with or convicted of:

(a) An offense of driving while under the influence of intoxicants in violation of:

(A) ORS 813.010; or

(B) The statutory counterpart to ORS 813.010 in another jurisdiction;

(b) A driving under the influence of intoxicants offense in another jurisdiction that involved the impaired driving of a vehicle due to the use of intoxicating liquor, a controlled substance, an inhalant or any combination thereof; or

(c) A driving offense in another jurisdiction that involved operating a vehicle while having a blood alcohol content above that jurisdiction's permissible blood alcohol content.

(8) Shall deny the petition for a driving while under the influence of intoxicants diversion agreement if the defendant participated in a driving while under the influence of intoxicants diversion program or in any similar alcohol or drug rehabilitation program, other than a program entered into as a result of the charge for the present offense, in this state or in another jurisdiction after the date the defendant filed the petition.

(9) Shall deny the petition for a driving while under the influence of intoxicants diversion agreement if the defendant was charged with or convicted of an offense of aggravated vehicular homicide or of murder, manslaughter, criminally negligent homicide or assault that resulted from the operation of a motor vehicle in this state or in another jurisdiction after the date the defendant filed the petition.

(10) Shall deny the petition for a driving while under the influence of intoxicants diversion agreement if the defendant has been convicted of a felony offense described in ORS 813.010 (5)(a).

(11) For the purposes of subsection (7) of this section, may not consider

a conviction for a driving offense in another jurisdiction based solely on a person under 21 years of age having a blood alcohol content that is lower than the permissible blood alcohol content in that jurisdiction for a person 21 years of age or older as a prior conviction.

(12) May not deny the petition for a driving while under the influence of intoxicants diversion agreement solely on the basis that the defendant is a member of the Armed Forces of the United States, the reserve components of the Armed Forces of the United States or the National Guard and has been called or demonstrates that the defendant will be called to active duty, and the military service will impair the defendant's ability to complete the diversion program. [1983 c.338 §371; 1987 c.441 §6; 1997 c.749 §6; 1999 c.1051 §296; 2003 c.445 §2; 2007 c.867 §15; 2007 c.879 §7; 2011 c.197 §1]

813.222 Right of victim to be present at hearing. (1) If a driving while under the influence of intoxicants offense involves damage to property of a person other than the defendant, the victim of the property damage has a right to be present and to be heard at any hearing on a petition for a diversion agreement.

(2) The district attorney or city attorney shall notify the victim that the defendant may be eligible for diversion and that if there is a hearing on a petition for diversion, the victim has a right to be present and to be heard at the hearing. [1999 c.445 §3]

813.225 Petition for extension of diversion period; conditions. (1) A defendant may apply by motion to the court in which a driving while under the influence of intoxicants diversion agreement described in ORS 813.230 was entered for an order extending the diversion period:

(a) Within 30 days prior to the end of the diversion period; or

(b) If the defendant is serving on active duty as a member of the Armed Forces of the United States, or is a member of the reserve components of the Armed Forces of the United States or the National Guard, at any time prior to the end of the diversion period.

(2) Petition forms for an application for an extension under this section shall be available to a defendant at the court.

(3) The form of the petition for an extension under this section shall be determined by the Supreme Court under ORS 1.525. The petition forms made available to a defendant by any city or state court shall conform to the requirements of the Supreme Court.

(4) The court may grant a petition for an extension filed under this

section if the court finds that the defendant made a good faith effort to complete the conditions of the diversion agreement and that the defendant can complete the conditions of the diversion agreement within the requested extended diversion period.

(5) An extension granted under this section may be for no more than 180 days from the ending date of the original diversion period or for another time period the court allows under subsection (7) of this section.

(6) Except as provided in subsection (7) of this section, a court may grant a defendant only one extension of a diversion period under this section.

(7) The court may extend the diversion period as necessary to allow the defendant sufficient time to complete the conditions of the diversion agreement if the defendant:

(a) Is a member of the Armed Forces of the United States, the reserve components of the Armed Forces of the United States or the National Guard;

(b) Is on active duty or has received orders that the defendant will be called to active duty; and

(c) Demonstrates that the military service will impair the defendant's ability to complete the conditions of the diversion agreement and no comparable treatment program described in ORS 813.233 is available.

(8) If the court grants the petition for an extension under this section, the following apply:

(a) If the defendant fully complies with the conditions of the diversion agreement within the extended diversion period, the court may dismiss the charge with prejudice under ORS 813.250.

(b) If the court finds that the defendant failed to comply with the diversion agreement within the extended diversion period, the court shall enter the guilty plea or no contest plea filed as part of the petition for a diversion agreement, shall enter a judgment of conviction and shall sentence the defendant.

(9) If the court denies the petition for an extension under this section, the court shall enter the guilty plea or no contest plea filed as part of the petition for a diversion agreement, shall enter a judgment of conviction and shall sentence the defendant. [1997 c.749 §7; 2003 c.816 §3; 2011 c.197 §2]

813.230 Diversion agreement; record; duration; effect of denial. (1) When the court allows a petition for a driving while under the influence of intoxicants diversion agreement filed as provided in ORS 813.210, the

judge taking that action shall:

(a) Accept the guilty plea or no contest plea filed as part of the petition for a diversion agreement but withhold entry of a judgment of conviction; and

(b) Sign the petition and indicate thereon the date of allowance of the diversion period, the length of the diversion period and the date upon which the driving while under the influence offense occurred.

(2) The petition when signed and dated becomes the diversion agreement between the defendant and the court. The court shall make the agreement a part of the record of the case. The court shall notify the Department of Transportation of the diversion agreement in a form agreed to by the department and the State Court Administrator within 48 hours after allowing the petition. The department shall make the fact of the diversion agreement a part of the defendant's operating record.

(3) A driving while under the influence of intoxicants diversion agreement shall be for a period of one year after the date the court allows the petition. During the diversion period the court shall stay the driving while under the influence of intoxicants offense proceeding pending completion of the diversion agreement or its termination.

(4) When the court denies a petition for a driving while under the influence of intoxicants diversion agreement, it shall continue the offense proceeding against the defendant. The guilty plea or no contest plea filed as part of the petition for the diversion agreement may not be used in the offense proceeding under this subsection. [1983 c.338 §372; 1985 c.16 §193; 1985 c.710 §7; 1993 c.751 §71; 2003 c.816 §4]

813.233 Exemption from completing treatment program in this state. In lieu of completing a treatment program in this state as a part of completing the conditions of a driving while under the influence of intoxicants diversion agreement in this state, the court may allow a defendant who is a member of the Armed Forces of the United States, the reserve components of the Armed Forces of the United States or the National Guard and who is serving on active duty to participate in a comparable treatment program conducted by or authorized by a government entity in another jurisdiction. [2011 c.197 §5]

Note: 813.233 was added to and made a part of the Oregon Vehicle Code by legislative action but was not added to ORS chapter 813 or any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

813.235 Attendance at victim impact treatment session as condition of diversion; fee. In a county that has a victim impact program a court may require as a condition of a driving while under the influence of intoxicants diversion agreement that the defendant attend a victim impact treatment session. If the court requires attendance under this section, the court may require the defendant, as part of the diversion agreement, to pay a reasonable fee to the victim impact program to offset the cost of the defendant's participation. The fee shall be established for each county by the victim impact panel coordinator and steering committee of that county and shall be not less than $5 or more than $50. [1987 c.830 §2; 1993 c.468 §2]

Note 1: 813.240 was amended in two bills by the 2011 regular session of the Legislative Assembly. See sections 167 and 186, chapter 595, Oregon Laws 2011 (Enrolled House Bill 2710), and section 4, chapter 671, Oregon Laws 2011 (Enrolled House Bill 3075). Enrolled House Bill 2710 was signed by the Governor on June 30, 2011. Enrolled House Bill 3075 was signed by the Governor on August 2, 2011. 813.240, as amended by sections 167 and 186, chapter 595, Oregon Laws 2011, is set forth below.

813.240 Amount and distribution of filing fee; diagnostic assessment fee. (1) The filing fee paid by a defendant at the time of filing a petition for a driving while under the influence of intoxicants diversion agreement as provided in ORS 813.210 is $386. A fee collected under this subsection in the circuit court shall be deposited by the clerk of the court in the Criminal Fine Account. If the fee is collected in a municipal or justice court, $163 of the fee shall be forwarded by the court to the Department of Revenue for deposit in the Criminal Fine Account, and the remainder of the fee shall be paid to the city or county treasurer.

(2) If less than the full filing fee is collected under subsection (1) of this section in a municipal or justice court, the money received shall be allocated first to the Department of Revenue for deposit in the Criminal Fine Account.

(3) In addition to the filing fee under subsection (1) of this section, the court shall order the defendant to pay $150 directly to the agency or organization providing the diagnostic assessment. [1983 c.338 §373; 1985 c.16 §194; 1985 c.277 §3; 1987 c.905 §30; 1989 c.576 §§8a,9a; 1989 c.635 §§2,4; 1991 c.557 §6; 1993 c.13 §7; 1999 c.1051 §297; 2003 c.737 §§71,72; 2005 c.303 §§2,3; 2005 c.702 §§85,86,87; 2009 c.595 §1143; 2011 c.595 §§167,186]

Note 2: 813.240 was amended in two bills by the 2011 regular session of the Legislative Assembly. See sections 167 and 186, chapter 595, Oregon Laws 2011 (Enrolled House Bill 2710), and section 4, chapter 671, Oregon Laws 2011 (Enrolled House Bill 3075). Enrolled House Bill 2710 was signed by the Governor on June 30, 2011. Enrolled House Bill 3075 was signed by the Governor on August 2, 2011. 813.240, as amended by section 4, chapter 671, Oregon Laws 2011, is set forth below.

813.240 Amount and distribution of filing fee; diagnostic assessment fee. (1) The filing fee paid by a defendant at the time of filing a petition for a driving while under the influence of intoxicants diversion agreement as provided in ORS 813.210 shall be $286 and shall be ordered paid as follows if the petition is allowed:

(a) $136 to be credited and distributed under ORS 137.295 as an obligation payable to the state;

(b) $100 to be treated as provided for disposition of fines and costs under ORS 153.630; and

(c) $50 to be paid to the Director of the Oregon Health Authority for deposit in the Intoxicated Driver Program Fund created under ORS 813.270, to be used for purposes of the fund.

(2) In addition to the filing fee under subsection (1) of this section, the court shall order the defendant to pay $150 directly to the agency or organization providing the diagnostic assessment. [1983 c.338 §373; 1985 c.16 §194; 1985 c.277 §3; 1987 c.905 §30; 1989 c.576 §§8a,9a; 1989 c.635 §§2,4; 1991 c.557 §6; 1993 c.13 §7; 1999 c.1051 §297; 2003 c.737 §§71,72; 2005 c.303 §§2,3; 2005 c.702 §§85,86,87; 2009 c.595 §1143; 2011 c.671 §4]

Note 3: 137.295 and 153.630 were repealed by section 118, chapter 597, Oregon Laws 2011. Editorial adjustment of 813.240 Note 2 for the repeal of 137.295 and 153.630 has not been made.

813.250 Motion to dismiss charge on completion of diversion; admissibility of statements. (1) At any time after the conclusion of the period of a driving while under the influence of intoxicants diversion agreement described in ORS 813.230, a defendant who has fully complied with and performed the conditions of the diversion agreement may apply by motion to the court wherein the diversion agreement was entered for an order dismissing the charge with prejudice.

(2) The defendant shall cause to be served on the district attorney or city

attorney a copy of the motion for entry of an order dismissing with prejudice the charge of driving while under the influence of intoxicants. The motion shall be served on the district attorney or city attorney at the time it is filed with the court. The district attorney or city attorney may contest the motion.

(3) If the defendant does not appear as provided by subsection (1) of this section within six months after the conclusion of the diversion period, and if the court finds that the defendant fully complied with and performed the conditions of the diversion agreement, and if it gives notice of that finding to the district attorney or city attorney the court may on its own motion enter an order dismissing the charge of driving while under the influence of intoxicants with prejudice.

(4) No statement made by the defendant about the offense with which the defendant is charged shall be offered or received in evidence in any criminal or civil action or proceeding arising out of the same conduct which is the basis of the charge of driving while under the influence of intoxicants, if the statement was made during the course of the diagnostic assessment or the rehabilitation program and to a person employed by the program. [1983 c.338 §374; 1985 c.16 §195; 1987 c.441 §7]

813.255 Termination of diversion. (1) At any time before the court dismisses with prejudice the charge of driving while under the influence of intoxicants, the court on its own motion or on the motion of the district attorney or city attorney may issue an order requiring defendant to appear and show cause why the court should not terminate the diversion agreement. The order to show cause shall state the reasons for the proposed termination and shall set an appearance date.

(2) The order to show cause shall be served on the defendant and on the defendant's attorney, if any. Service may be made by first class mail, postage paid, addressed to the defendant at the mailing address shown on the diversion petition and agreement or at any other address that the defendant provides in writing to the court.

(3) Except as provided in subsection (4) of this section, the court shall terminate the diversion agreement and enter the guilty plea or no contest plea that was filed as part of the petition for the diversion agreement if:

(a) At the hearing on the order to show cause, the court finds by a preponderance of the evidence that any of the reasons for termination described in this section exist; or

(b) The defendant fails to appear at the hearing on the order to show cause.

(4) If a defendant is a member of the Armed Forces of the United States,

the reserve components of the Armed Forces of the United States or the National Guard and is on active duty, the court shall:

(a) Allow the defendant to appear at the hearing by telephone or other communication device approved by the court, if the defendant's military service permits such an appearance; or

(b) Stay the termination proceeding if the defendant's military service prohibits the defendant's appearance by telephone or other communication device and prohibits the defendant from aiding and assisting the attorney who would appear on the defendant's behalf.

(5) If the court terminates the diversion agreement and enters the guilty plea or no contest plea, the court may take into account at time of sentencing any partial fulfillment by the defendant of the terms of the diversion agreement.

(6) The court shall terminate a diversion agreement under this section for any of the following reasons:

(a) The defendant fails to fulfill the terms of the diversion agreement.

(b) The defendant does not qualify for the diversion agreement under the criteria in ORS 813.215. [1987 c.441 §9; 2003 c.816 §5; 2011 c.197 §3]

813.260 Designation of agencies to perform diagnostic assessments; duties of agency. (1) Courts having jurisdiction over driving while under the influence of intoxicants offenses shall designate agencies or organizations to perform the diagnostic assessment and treatment required under driving while under the influence of intoxicants diversion agreements described in ORS 813.200. The designated agencies or organizations must meet minimum standards established pursuant to ORS 430.357 to perform the diagnostic assessment and treatment of problem drinking, alcoholism and drug dependency and must be certified by the Director of the Oregon Health Authority. Wherever possible a court shall designate agencies or organizations to perform the diagnostic assessment that are separate from those that may be designated to carry out a program of treatment.

(2) Monitoring of a defendant's progress under a diversion agreement shall be the responsibility of the diagnostic assessment agency or organization. It shall make a report to the court stating the defendant's successful completion or failure to complete all or any part of the treatment program specified by the diagnostic assessment. The form of the report shall be determined by agreement between the court and the diagnostic assessment agency or organization. The court shall make the report of the diagnostic assessment agency or organization that is required by this

subsection a part of the record of the case. [1983 c.338 §375; 1991 c.557 §7; 2009 c.595 §1144; 2011 c.673 §43]

813.270 Intoxicated Driver Program Fund; creation; uses. The Intoxicated Driver Program Fund is created to consist of moneys placed in the fund under ORS 813.030 and 813.240 or as otherwise provided by law and of gifts and grants made to the fund for carrying out the purposes of the fund. The moneys in the fund may be used only for the following purposes:

(1) To pay for providing treatment for individuals who enter diversion agreements under ORS 813.200 and who are found to be indigent. Payment for treatment under this subsection may include treatment for problem drinking, alcoholism or drug dependency. Payment shall be made as provided by the Director of the Oregon Health Authority by rule to agencies or organizations providing treatment.

(2) To pay for evaluation as provided by law of programs used for diversion agreements.

(3) To pay the cost of administration of the fund by the Oregon Health Authority.

(4) To pay for materials, resources and training supplied by the authority to those persons, organizations or agencies performing the diagnostic assessments or providing education or treatment to persons under diversion agreements.

(5) To pay for providing treatment programs required under ORS 813.020 and treatment or information programs required under ORS 471.432 for individuals who are found to be indigent.

(6) To pay for special services required to enable a person with a disability, or a person whose proficiency in the use of English is limited because of the person's national origin, to participate in treatment programs that are used for diversion agreements under ORS 813.200 or are required under ORS 813.020. This subsection applies:

(a) Whether or not the person is indigent; and

(b) Only to special services required solely because of the person's disability or limited proficiency in the use of English. [1983 c.338 §141; 1985 c.16 §42; 1989 c.576 §10; 1991 c.557 §8; 1993 c.757 §1; 1999 c.126 §6; 1999 c.646 §5a; 2007 c.70 §343; 2009 c.595 §1145]

EVIDENCE

813.300 Use of blood alcohol percentage as evidence; percentage

required for being under the influence. (1) At the trial of any civil or criminal action, suit or proceeding arising out of the acts committed by a person driving a motor vehicle while under the influence of intoxicants, if the amount of alcohol in the person's blood at the time alleged is less than 0.08 percent by weight of alcohol as shown by chemical analysis of the person's breath or blood, it is indirect evidence that may be used with other evidence, if any, to determine whether or not the person was then under the influence of intoxicants.

(2) Not less than 0.08 percent by weight of alcohol in a person's blood constitutes being under the influence of intoxicating liquor.

(3) Notwithstanding subsection (2) of this section, for purposes of the Motorist Implied Consent Law as defined in ORS 801.010, for a person who is under 21 years of age, any amount of alcohol in the blood constitutes being under the influence of intoxicating liquor.

(4) Percent by weight of alcohol in the blood shall be based upon grams of alcohol per 100 milliliters of blood or based upon grams of alcohol per 210 liters of breath. [1983 c.338 §590; 1985 c.16 §297; 1989 c.715 §7; 1991 c.860 §8; 2011 c.260 §1]

813.310 Refusal to take chemical test admissible as evidence. If a person refuses to submit to a chemical test under ORS 813.100 or refuses to consent to chemical tests under ORS 813.140, evidence of the person's refusal is admissible in any civil or criminal action, suit or proceeding arising out of acts alleged to have been committed while the person was driving a motor vehicle on premises open to the public or the highways while under the influence of intoxicants. [1983 c.338 §595; 1985 c.16 §301]

813.320 Effect of implied consent law on evidence. (1) The provisions of the implied consent law, except ORS 813.300, shall not be construed by any court to limit the introduction of otherwise competent, relevant evidence in any civil action, suit or proceedings or in any criminal action other than a violation of ORS 813.010 or a similar municipal ordinance in proceedings under ORS 813.410.

(2) The provisions of the implied consent law shall not be construed by any court to limit the introduction of otherwise competent, relevant evidence of the amount of alcohol in the blood of a defendant in a prosecution for driving while under the influence of intoxicants if:

(a) The evidence results from a test of blood taken from the defendant while the defendant was hospitalized or otherwise receiving medical care, whether or not the defendant consented to the drawing of blood or to the

test; or

(b) The evidence is obtained pursuant to a search warrant. [1983 c.338 §596; 1985 c.16 §302; 1999 c.437 §1]

813.322 Department of State Police rules regarding breath tests as evidence; validity of officer's permit. (1) A court shall, at the request of a party to the case, admit into evidence, without certification, a copy of administrative rules of the Department of State Police addressing methods of conducting chemical tests of a person's breath in a proceeding arising from the arrest of a person for driving while under the influence of intoxicants.

(2) If a police officer testifies in a proceeding arising from the arrest of a person for driving while under the influence of intoxicants that the officer has a valid permit to perform analysis of a person's breath, the defendant has the burden of moving forward with evidence to show that the officer does not have a valid permit. [1999 c.446 §2]

Note: 813.322 was added to and made a part of the Oregon Vehicle Code by legislative action but was not added to ORS chapter 813 or any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

813.324 Use of testimony from implied consent hearing as evidence in prosecution. (1) If the prosecuting attorney or the attorney for the defendant in a prosecution for driving while under the influence of intoxicants obtains a tape or a transcript of a hearing held for the defendant under ORS 813.410, the attorney must provide a copy of the tape or transcript to the attorney for the other party at least seven days prior to the first date set for trial. If the attorney fails to supply the material in the time required, testimony from the hearing may not be admitted in evidence in the trial for any purpose, unless the attorney shows good cause for the failure to make the material available.

(2) The cost of a copy of a tape or transcript furnished under subsection (1) of this section shall be borne by the party who receives the copy.

(3) Nothing in this section requires a tape to be transcribed by the attorney who is required to provide a tape or transcript under subsection (1) of this section. [1999 c.831 §3]

Note: 813.324 was enacted into law by the Legislative Assembly but was not added to or made a part of the Oregon Vehicle Code or any

chapter or series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

813.326 Felony driving while under the influence of intoxicants; prior convictions. (1) In a prosecution for felony driving while under the influence of intoxicants under ORS 813.010, the state shall plead the prior convictions and shall prove the prior convictions unless the defendant stipulates to that fact prior to trial. If the defendant so stipulates and the trial is by jury:

(a) The court shall accept the stipulation regardless of whether or not the state agrees to it;

(b) The defendant's stipulation to the prior convictions constitutes a judicial admission to that element of the accusatory instrument. The stipulation shall be made a part of the record of the case, but shall not be offered or received in the presence of the jury;

(c) For the purpose of establishing the prior convictions solely as an element of the crime under ORS 813.010, neither the court nor the state shall reveal to the jury the prior convictions, but the prior convictions are established in the record by the defendant's stipulation; and

(d) The court shall not submit the accusatory instrument or evidence of the prior convictions to the jury.

(2) In a proceeding under ORS 813.010, the state may offer, and the court may receive and submit to the jury, evidence of the prior convictions for impeachment of the defendant or another purpose, other than establishing the prior convictions as an element of the offense, when the evidence of the prior convictions is otherwise admissible for that purpose. When evidence of the prior convictions has been admitted by the court, the state may comment upon, and the court may give instructions about, the evidence of the prior convictions only to the extent that the comments or instructions relate to the purpose for which the evidence was admitted.

(3) When the defendant stipulates to the prior convictions required as an element of felony driving while under the influence of intoxicants under ORS 813.010, if the jury finds the defendant guilty upon instruction regarding the balance of the elements of the crime, the court shall enter a judgment of guilty of felony driving while under the influence of intoxicants.

(4) As used in this section, "conviction" includes a juvenile adjudication. [1999 c.1049 §5; 2009 c.525 §2]

Note: 813.326 was enacted into law by the Legislative Assembly but was not added to or made a part of the Oregon Vehicle Code or any

chapter or series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

813.328 Notice of intent to challenge validity of prior convictions. (1) A defendant who challenges the validity of prior convictions alleged by the state as an element of felony driving while under the influence of intoxicants must give notice of the intent to challenge the validity of the prior convictions at least seven days prior to the first date set for trial on the felony charge. The validity of the prior convictions shall be determined prior to trial by the court.

(2) As used in this section, “conviction” includes a juvenile adjudication. [1999 c.1049 §4; 2009 c.525 §3]

SUSPENSION

(For Conviction)

813.400 Suspension or revocation upon conviction; duration; review. (1) Except as provided in subsection (2) of this section, upon receipt of a record of conviction for misdemeanor driving while under the influence of intoxicants, the Department of Transportation shall suspend the driving privileges of the person convicted. The suspension shall be for a period described under Schedule II of ORS 809.428, except the department shall not reinstate any driving privileges to the person until the person complies with future responsibility filings. A person is entitled to administrative review under ORS 809.440 of a suspension imposed under this subsection.

(2) A person convicted of felony driving while under the influence of intoxicants, or a person convicted of misdemeanor driving while under the influence of intoxicants for a third or subsequent time, is subject to revocation of driving privileges as provided in ORS 809.235. [1983 c.338 §353(8); 1985 c.16 §166(8); 1985 c.393 §10a(8); 1985 c.669 §2a(8); 1991 c.702 §13; 2001 c.786 §3; 2003 c.346 §1; 2003 c.402 §40; 2005 c.436 §2]

(Of Commercial Driver License)

813.403 Suspension of commercial driver license upon conviction; review. Driving a commercial motor vehicle upon any highway or on premises open to the public while under the influence of intoxicants constitutes grounds for commercial driver license suspension. The

following apply to this section:

(1) Upon receipt of a record of conviction for driving while under the influence of intoxicants, the Department of Transportation shall suspend the person's commercial driver license if the person was driving a commercial motor vehicle at the time the person committed the offense.

(2) The suspension shall be for a period described under ORS 813.404.

(3) A person is entitled to administrative review under ORS 809.440 of a suspension imposed under this section.

(4) Suspension under this section is in addition to any suspension under ORS 813.400. [1989 c.636 §40; 1991 c.702 §14; 2003 c.402 §41]

813.404 Duration of suspension of commercial driver license. When the Department of Transportation imposes a suspension of a commercial driver license under ORS 813.403 or 813.410 (2), or when the department imposes a suspension of a commercial driver license under ORS 809.413 (11) or (12) for conduct in another jurisdiction that is substantially similar to that described in either ORS 813.403 or 813.410 (2), the suspension shall be:

(1) For a period of one year if:

(a) The person has not previously been convicted of an offense described in ORS 809.404 or had a commercial driver license suspended as described in ORS 809.404;

(b) The person was not driving a commercial motor vehicle containing a hazardous material at the time of the offense; and

(c) The suspension is either because the person was convicted under ORS 813.010 or because a breath or blood test under ORS 813.100 disclosed that the person had a level of alcohol in the person's blood that was 0.04 percent or more by weight.

(2) For a period of three years if:

(a) The person has not previously been convicted of an offense described in ORS 809.404 or had a commercial driver license suspended as described in ORS 809.404;

(b) The person was not driving a commercial motor vehicle containing a hazardous material at the time of the offense; and

(c) The suspension is for refusal of a test under ORS 813.100.

(3) For a period of three years if:

(a) The person has not previously been convicted of an offense described in ORS 809.404 or had a commercial driver license suspended as described in ORS 809.404;

(b) The person was driving a commercial motor vehicle containing a

hazardous material at the time of the offense; and

(c) The suspension is either because the person was convicted under ORS 813.010 or because a breath or blood test under ORS 813.100 disclosed that the person had a level of alcohol in the person's blood that was 0.04 percent or more by weight.

(4) For a period of five years if:

(a) The person has not previously been convicted of an offense described in ORS 809.404 or had a commercial driver license suspended as described in ORS 809.404;

(b) The person was driving a commercial motor vehicle containing a hazardous material at the time of the offense; and

(c) The suspension is for refusal of a test under ORS 813.100.

(5) For the lifetime of the person if the person has previously been convicted of an offense described in ORS 809.404 or had a commercial driver license suspended as described in ORS 809.404. [1989 c.636 §41; 1991 c.185 §16; 1993 c.305 §5; 1995 c.568 §5; 2003 c.402 §42; 2005 c.649 §25]

(Under Implied Consent Law)

813.410 Suspension upon receipt of police report on implied consent test; hearing; validity of suspension; appeal; rules. (1) If the Department of Transportation receives from a police officer a report that is in substantial compliance with ORS 813.120, the department shall suspend the driving privileges of the person in this state on the 30th day after the date of arrest or, if the report indicates that the person failed a blood test, on the 60th day after receipt of the report, unless, at a hearing described under this section, the department determines that the suspension would not be valid as described in this section. A suspension of driving privileges imposed under this subsection shall be for a period of time established under ORS 813.420.

(2) If the department receives from a police officer a report pursuant to ORS 813.120 that discloses that the person holds a commercial driver license and that the person was driving a motor vehicle or commercial motor vehicle and refused to submit to a test under ORS 813.100 or that the person was driving a commercial motor vehicle and submitted to a breath or blood test and the person's blood, as shown by the test, had 0.04 percent or more by weight of alcohol, the department shall suspend the person's commercial driver license on the 30th day after the date of arrest or, if the report indicates that the person failed a blood test, on the 60th day

after receipt of the report, unless, at a hearing described under this section, the department determines that the suspension would not be valid as described in this section. A commercial driver license suspension imposed under this subsection shall be for a period of time established under ORS 813.404.

(3) If within 10 days from the date of arrest, or, if the person fails a blood test, within 10 days from the date the department sends notice of suspension, the department receives a written request for a hearing from a person whose driving privileges or commercial driver license the department proposes to suspend under this section, the department shall provide a hearing in accordance with this section. Except as otherwise provided under this section, a hearing held by the department under this section shall be subject to the provisions for contested cases, other than appeal provisions, under ORS chapter 183. The applicable appeal provisions are as provided under ORS 813.450 and section 24, chapter 672, Oregon Laws 1985. Notwithstanding ORS 809.430, the department is not required to give any notice of intent to suspend or suspension in addition to that provided under ORS 813.100.

(4) Except as provided in subsection (5) of this section, a hearing required by this section is subject to all of the following:

(a) The hearing shall be conducted by an administrative law judge assigned from the Office of Administrative Hearings established under ORS 183.605.

(b) The administrative law judge shall conduct the hearing by telephone or other two-way electronic communication device.

(c) The department may authorize the administrative law judge to issue a final order in any case.

(d) A person who requests a hearing under this section and who fails, without just cause, to appear personally or through an attorney waives the right to a hearing. If a person waives a right to a hearing under this paragraph, the department is not required to make any showing at hearing.

(e) Except as provided in ORS 813.440 or upon remand under ORS 813.450, the department shall hold the hearing and issue a final order within 30 days of the date of the arrest or, if the person fails a blood test, within 60 days from the date the department received the report of the failure.

(f) In connection with the hearing, the department or its authorized representative may administer oaths and shall issue subpoenas for the appearance of witnesses by telephone or other two-way electronic communication device at the hearing requested by the person or the

department and the production of relevant documents.

(g) The hearing shall be recorded by whatever means may be determined by the department and shall include testimony and exhibits, if any. The record of the proceedings shall not be transcribed unless requested by a party to the proceeding.

(5)(a) A person or a police officer may request that a hearing required by this section be conducted in person.

(b) The department, by rule, shall establish the manner and time limitation requirements by which a person or a police officer may request that a hearing be conducted in person.

(c) Unless there is an agreement between the person and the department that the hearing be conducted elsewhere, a hearing requested under this subsection shall be held either in the county where the alleged offense occurred or at any place within 100 miles of the place where the offense is alleged to have occurred, as established by the department by rule.

(d) In connection with the hearing, the department or its authorized representative may administer oaths and shall issue subpoenas for the attendance of witnesses at the hearing requested under this subsection by the person and the production of relevant documents.

(6) This subsection shall be narrowly construed so as to effect the legislative purpose of limiting the scope of hearings under this section. The scope of a hearing under this section shall be limited to whether the suspension is valid as described in this subsection. A suspension under this section is valid if all of the following requirements have been met:

(a) The person, at the time the person was requested to submit to a test under ORS 813.100, was under arrest for driving while under the influence of intoxicants in violation of ORS 813.010 or a municipal ordinance.

(b) The police had reasonable grounds to believe, at the time the request was made, that the person arrested had been driving under the influence of intoxicants in violation of ORS 813.010 or of a municipal ordinance.

(c) The person refused a test under ORS 813.100, or took a breath or blood test and the test disclosed that the level of alcohol in the person's blood at the time of the test was:

(A) 0.08 percent or more by weight if the person was not driving a commercial motor vehicle;

(B) 0.04 percent or more by weight if the person was driving a commercial motor vehicle; or

(C) Any amount if the person was under 21 years of age.

(d) If the report under ORS 813.120 indicates that the person was driving a commercial motor vehicle, the vehicle was in fact a commercial motor vehicle as defined in ORS 801.208.

(e) The person had been informed under ORS 813.100 of rights and consequences as described under ORS 813.130.

(f) The person was given written notice required under ORS 813.100.

(g) If the person arrested submitted to a test under ORS 813.100, the person administering the test was qualified to administer the test under ORS 813.160.

(h) If the person arrested submitted to a test under ORS 813.100, the methods, procedures and equipment used in the test complied with requirements under ORS 813.160.

(7) A suspension imposed under this section shall remain in effect pending any appeal or remand of a final order issued under this section and there shall be no stay of the suspension pending appeal or remand.

(8) Unless a person fails, without just cause, to appear personally or through an attorney at a hearing requested under this section, a person shall have the right to appeal any final order by the department after a hearing under this section by filing a petition. The following apply to this subsection:

(a) The person shall file the petition in the circuit court for the county where the person resides or, if the person does not reside in Oregon, in the circuit court of the county in which the arrest took place within 30 days after issuance of the final order of the department.

(b) The court upon receipt of the petition shall set the matter for hearing upon 10 days' notice to the department and the petitioner unless hearing is waived by both the department and the petitioner. [1983 c.338 §358; 1985 c.16 §167; 1985 c.672 §13; 1987 c.158 §170; 1989 c.636 §44; 1991 c.860 §11; 1993 c.305 §6; 1993 c.600 §1; 1995 c.568 §6; 1999 c.831 §2; 1999 c.849 §§193,194; 2003 c.75 §67; 2005 c.649 §27; 2007 c.288 §18; 2010 c.37 §1]

813.412 Role of police officer in implied consent hearing. Notwithstanding ORS 9.160 and 9.320, in any hearing under ORS 813.410 in which a city attorney or district attorney does not appear, a police officer actively involved in the investigation of the offense may present evidence, examine and cross-examine witnesses and make arguments relating to:

(1) The application of statutes and rules to the facts in the case;

(2) The literal meaning of the statutes or rules at issue in the case;

(3) The admissibility of evidence; and

(4) Proper procedures to be used in the hearing. [1999 c.831 §4; 2010 c.37 §2]

Note: 813.412 was enacted into law by the Legislative Assembly but was not added to or made a part of the Oregon Vehicle Code or any chapter or series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

813.420 Duration of suspension for refusal or failure of test. When the Department of Transportation imposes a suspension under ORS 813.410, the suspension shall be for a period of time determined according to the following:

(1) If the suspension is for refusal of a test under ORS 813.100 and the person is not subject to an increase in the suspension time for reasons described in ORS 813.430, the suspension shall be for a period of one year.

(2) If the suspension is for refusal of a test under ORS 813.100 and the person is subject to an increase in the suspension time for reasons described in ORS 813.430, the suspension shall be for a period of three years.

(3) If the suspension is because a breath or blood test under ORS 813.100 disclosed that the person had a level of alcohol in the person's blood that constituted being under the influence of intoxicating liquor under ORS 813.300 and the person is not subject to an increase in the suspension time for reasons described in ORS 813.430, the suspension shall be for a period of 90 days.

(4) If the suspension is because a breath or blood test under ORS 813.100 disclosed that the person had a level of alcohol in the person's blood that constituted being under the influence of intoxicating liquor under ORS 813.300 and the person is subject to an increase in the suspension time for reasons described in ORS 813.430, the suspension shall be for a period of one year. [1985 c.16 §171; 1993 c.305 §7; 1995 c.568 §7]

813.430 Grounds for increase in duration of suspension. This section establishes circumstances under which ORS 813.420 requires an increase in the time for suspension of driving privileges and under which ORS 813.520 requires an increase in the time before the Department of Transportation may issue a hardship permit. A person is subject to an increase in suspension time under this section if any of the following apply:

(1) The person is presently participating in a driving while under the

influence of intoxicants diversion program in this state or in any similar alcohol or drug rehabilitation program in this or another jurisdiction.

(2) Within the five years preceding the date of arrest any of the following occurred:

(a) A suspension of the person's driving privileges under ORS 813.410 or 482.540 (1981 Replacement Part) became effective.

(b) The person was convicted of:

(A) Driving while under the influence of intoxicants in violation of:

(i) ORS 813.010;

(ii) The statutory counterpart to ORS 813.010 in another jurisdiction; or

(iii) A municipal ordinance in this state or another jurisdiction;

(B) A driving under the influence of intoxicants offense in another jurisdiction that involved the impaired driving of a vehicle due to the use of intoxicating liquor, a controlled substance, an inhalant or any combination thereof; or

(C) A driving offense in another jurisdiction that involved operating a vehicle while having a blood alcohol content above that jurisdiction's permissible blood alcohol content.

(c) The person commenced participating in a driving while under the influence of intoxicants diversion program in this state or in any similar alcohol or drug rehabilitation program in this or another jurisdiction.

(3) For the purposes of subsection (2)(b) of this section, a conviction for a driving offense in another jurisdiction based solely on a person under 21 years of age having a blood alcohol content that is lower than the permissible blood alcohol content in that jurisdiction for a person 21 years of age or older does not constitute a prior conviction. [1985 c.16 §173; 1985 c.672 §15; 1987 c.801 §12; 2007 c.879 §8]

813.440 Grounds for hearing on validity of suspension; rules. (1) Notwithstanding ORS 813.410, the Department of Transportation may provide a hearing to determine the validity of a suspension under ORS 813.410 only if the time requirements under ORS 813.410 could not be met because of any of the following:

(a) The person's physical incapacity, verified by a physician to the satisfaction of the department to be of a nature that would prevent the person from making the appropriate request or attending the hearing.

(b) A death in the immediate family of the person, verified to the satisfaction of the department.

(c) An error of the department.

(d) The inability of a subpoenaed police officer to appear due to the

officer's illness, vacation or official duty conflicts. The department shall set forth by rule the conditions that constitute "official duty conflicts." A hearing may not be rescheduled more than once for reasons described in this paragraph.

(e) A request for a change of administrative law judge under ORS 183.645.

(f) The inability of the person's attorney to appear due to the attorney's illness, vacation or scheduling conflict arising from other court or administrative hearing appearances. A hearing must be rescheduled no later than 45 days after the date of the original hearing and may not be rescheduled more than once for reasons described in this paragraph.

(g) Other just cause as defined by the department by administrative rule.

(2) A hearing held under this section is subject to the same provisions as a hearing held under ORS 813.410, except that the department is not required to hold the hearing and make the determination within the time required by ORS 813.410.

(3) The granting of a hearing under this section shall not delay the imposition of a suspension under ORS 813.410 within the time required under ORS 813.410. However, if a person establishes that the person was deprived by either department error or a subpoenaed police officer's illness, vacation or official duty conflicts of an opportunity to appear at a hearing, the department shall rescind the suspension and shall promptly schedule a subsequent hearing to determine the validity of the suspension under ORS 813.410. In other cases under this section, when the department is unable to hold the hearing within the time required by ORS 813.410, the department shall rescind any suspension imposed under ORS 813.410 only if the department determines, at a hearing held under this section, that the suspension was not valid as described under ORS 813.410.

(4) The following apply to this section:

(a) The department shall issue a final order within 10 days after the hearing described in this section.

(b) If the department has rescinded a suspension under subsection (3) of this section and if the department, at the hearing described in this section, determines that the suspension is valid as described under ORS 813.410, the department shall reinstate the suspension effective five days after the final order is issued.

(c) Notwithstanding ORS 809.430, no additional notice or order of suspension need be given. [1985 c.16 §169; 1985 c.672 §14; 1987 c.272 §5; 1993 c.600 §2; 1999 c.831 §1; 2001 c.294 §§9,10; 2003 c.75 §68; 2009 c.520 §1]

813.450 Appeal from suspension for refusal or failure of breath test. (1) The petition to the circuit court appealing an order of the Department of Transportation after a hearing under ORS 813.410 shall state the nature of the petitioner's interest and the ground or grounds upon which the petitioner contends the order should be reversed or remanded.

(2) The court shall conduct the review without a jury. Review shall be limited to the record of the department's hearing.

(3) Any party to the proceedings before the circuit court may appeal from the judgment of the court to the Court of Appeals.

(4) Upon review in the circuit court and Court of Appeals, the court may affirm, reverse or remand the order as follows:

(a) If the court finds that the department has erroneously interpreted a provision of law and that a correct interpretation compels a particular action, it shall:

(A) Set aside or modify the order; or

(B) Remand the case to the department for further action under a correct interpretation of the provision of law.

(b) The court shall remand the order to the department if it finds the department's exercise of discretion to be any of the following:

(A) Outside the range of discretion delegated to the agency by law.

(B) Inconsistent with a department rule, an officially stated department position, or a prior department practice, if the inconsistency is not explained by the department.

(C) Otherwise in violation of a constitutional or statutory provision.

(c) The court shall set aside or remand the order if it finds that the order is not supported by substantial evidence in the record.

(5) Upon review, the court shall affirm the department's order unless the court finds a ground for setting aside, modifying or remanding to the department under a specified provision of this section.

(6) In any review under this section, the court shall also review de novo determinations made by an agency that are subject to ORS 183.650 (4). [1985 c.672 §23; 1999 c.849 §§196,197; 2003 c.75 §69]

813.460 Department procedures upon verification of suspension of driving privileges of wrong person. If the Department of Transportation verifies to its satisfaction that it has suspended the driving privileges of the wrong person under ORS 813.410 because a person arrested for driving under the influence of intoxicants gave false identification at the time of the arrest, all the following apply:

(1) The department shall immediately rescind the suspension order under the false name and shall issue a suspension order for the period set forth in ORS 813.420 to the person arrested.

(2) The department shall issue the order in the manner set forth in ORS 809.430.

(3) No further notice of suspension need be given.

(4) The time limitations in ORS 813.410 (1), (2), (3) and (4)(e) do not apply to a suspension order issued under this section. [1985 c.672 §25; 1989 c.636 §47]

813.470 Department notation on record of person acquitted after suspension. The Department of Transportation shall make a notation on the driving record of a person indicating that the person was acquitted of a charge of driving under the influence of intoxicants if:

(1) The person's driving privileges were suspended because a breath or blood test under ORS 813.100 disclosed that the person had a level of alcohol in the person's blood that constituted being under the influence of intoxicating liquor under ORS 813.300;

(2) An accusatory instrument was filed charging the person with driving under the influence of intoxicants in violation of ORS 813.010 arising out of the same incident that led to the suspension of the person's driving privileges;

(3) The person was acquitted of the charge; and

(4) The person presents the department with a certified copy of the judgment of acquittal from the court clearly showing the location of the court, the date of the arrest and the findings of the court. [1987 c.303 §2; 1993 c.305 §8; 1995 c.568 §8]

HARDSHIP PERMITS

813.500 Restrictions on issuance. (1) If a person's license is suspended for driving while under the influence of intoxicants under ORS 813.400 and the suspension period is determined by ORS 809.428 (2)(b) or (c), the Department of Transportation may only issue a hardship permit to the person under ORS 807.240 if the person, in addition to any requirement under ORS 807.240 and any applicable requirements under ORS 807.250 and 813.520:

(a) Is examined by the Oregon Health Authority to determine whether the person has a problem condition involving alcohol, inhalants or controlled substances as described in ORS 813.040; and

(b) Complies with the requirements of this section.

(2) If the authority determines that the person has a problem condition involving alcohol, inhalants or controlled substances, as described in ORS 813.040, the department may issue the permit to the person only if both the following apply:

(a) The person enrolled in a program for rehabilitation for alcoholism or drug dependence approved by the authority.

(b) The authority recommends, on the basis of the person's progress in the rehabilitation program, such reinstatement in writing to the department. If the authority makes a recommendation under this paragraph, the authority shall state specifically in the recommendation the times, places, routes and days of the week minimally necessary for the person to seek or retain employment, to attend any alcohol or drug treatment or rehabilitation program or to obtain necessary medical treatment for the person or a member of the person's immediate family.

(3) If the authority determines that the person does not have a problem condition involving alcohol, inhalants or controlled substances as described in ORS 813.040, the department may issue the permit to the person only if, in addition to any requirements under ORS 807.240, the person enters an alcohol or drug information program approved by the authority and the department determines that issuance of a permit is appropriate. If the department issues a permit to a person described in this subsection, the department shall require, under ORS 807.240, that the person complete the program as a condition of retaining the permit. [1983 c.338 §328; 1985 c.16 §145; 1987 c.801 §13; 1989 c.401 §2; 1991 c.557 §9; 1999 c.619 §13; 2003 c.23 §4; 2009 c.595 §1146]

813.510 Limitations on privileges granted by permit; conditions of permit. This section establishes limitations that the Department of Transportation is required or permitted to place on hardship permits issued under ORS 807.240 to persons whose suspension is based upon a conviction for driving under the influence of intoxicants or upon ORS 813.100. Limitations placed on a hardship permit under this section are in addition to any limitations placed on the permit under ORS 807.240. A person's permit is subject to suspension or revocation as provided under ORS 807.240 if the department determines that the holder of the permit has violated any limitation placed upon the permit under this section. Violation of a limitation under this section is punishable as provided by ORS 811.175 or 811.182. The limitations are as described in the following:

(1) A hardship permit issued to the person shall limit the person's driving

privileges:

(a) To the times, places, routes and days the department determines to be minimally necessary for the person to seek or retain employment, to attend any alcohol or drug treatment or rehabilitation program or to obtain required medical treatment for the person or a member of the person's immediate family; and

(b) To times, places, routes and days that are specifically stated.

(2) The person's driving privileges under the permit are subject to suspension or revocation if the person does not maintain a good driving record, as defined by the administrative rules of the department, during the term of the permit.

(3) If the person is in a rehabilitation program under ORS 813.500, the person must complete the rehabilitation program.

(4) The department may require the person to complete a driver improvement program under ORS 809.480 as a condition of the permit.

(5) If the person is involved in a diversion agreement under ORS 813.220 and 813.230, the department may require the person to successfully complete the diversion program as a condition of retaining the permit.

(6) The department shall condition the permit so that the permit will be revoked if the person is convicted of any of the following:

(a) Reckless driving under ORS 811.140.

(b) Driving under the influence of intoxicants under ORS 813.010.

(c) Failure to perform the duties of a driver under ORS 811.700 or 811.705.

(d) Fleeing or attempting to elude a police officer under ORS 811.540.

(e) Driving while suspended or revoked under ORS 811.175 or 811.182.

[1983 c.338 §329; 1985 c.16 §146; 1987 c.730 §21; 1987 c.801 §14; 1991 c.208 §5; 2003 c.23 §5]

813.520 Limitations on authority to issue hardship permit or reinstate driving privileges. In addition to any provisions of ORS 807.240 and 813.510 or 807.250, this section establishes limitations on the authority of the Department of Transportation to issue driving privileges under ORS 807.240. The department may not reinstate any driving privileges or issue any hardship permit under ORS 807.240 as provided under any of the following:

(1) For a period of 90 days after the beginning of the suspension if the suspension is for refusal of a test under ORS 813.100 and the person is not subject to an increase in the time before a permit may be issued for

reasons described in ORS 813.430. This period of 90 days shall be reduced by the time the department refused to issue a hardship permit under subsection (5) or (6) of this section if the person's driving privileges were suspended based on the same occurrence.

(2) For a period of 30 days after the beginning of the suspension if the suspension is because a breath or blood test under ORS 813.100 disclosed that the person had a level of alcohol in the person's blood that constituted being under the influence of intoxicating liquor under ORS 813.300 and the person is not subject to an increase in the time before a hardship permit may be issued for reasons described in ORS 813.430. This period of 30 days shall be reduced by the time the department refused to issue a hardship permit under subsection (5) or (6) of this section if the person's driving privileges were suspended based on the same occurrence.

(3) For a period of one year after the beginning of the suspension if the suspension is because a breath or blood test under ORS 813.100 disclosed that the person had a level of alcohol in the person's blood that constituted being under the influence of intoxicating liquor under ORS 813.300 and the person is subject to an increase in the time before a hardship permit may be issued for reasons described under ORS 813.430. This period of one year shall be reduced by the time the department refused to issue a hardship permit under subsection (5) or (6) of this section if the person's driving privileges were suspended based on the same occurrence.

(4) For a period of three years after the beginning of the suspension if the suspension is for refusal of a test under ORS 813.100 and the person is subject to an increase in the time before a hardship permit may be issued for reasons described in ORS 813.430. This period of three years shall be reduced by the time the department refused to issue a hardship permit under subsection (5) or (6) of this section if the person's driving privileges were suspended based on the same occurrence.

(5) For a period of 90 days after the beginning of the suspension under ORS 813.400 if it is the person's second conviction for driving while under the influence of intoxicants if the suspension period is determined by ORS 809.428 (2)(b). This period of 90 days shall be reduced by the time the department refused to issue a hardship permit under subsection (1), (2), (3) or (4) of this section if the person's driving privileges were suspended based on the same occurrence.

(6) For a period of one year after the beginning of the suspension under ORS 813.400 for driving while under the influence of intoxicants if the suspension period is determined by ORS 809.428 (2)(c). This period of one

year shall be reduced by the time the department refused to issue a hardship permit under subsection (1), (2), (3) or (4) of this section if the person's driving privileges were suspended based on the same occurrence.

(7) To any person who has a mental or physical condition or impairment that affects the person's ability to safely operate a motor vehicle.

(8) If the suspension is based upon a conviction for a violation of ORS 813.010 or is imposed under ORS 813.410 based upon ORS 813.100 to a person who has available public or private transportation sufficient to fulfill the person's transportation needs while the person is suspended.

(9) For a period of 30 days following imposition of suspension, if the person, within the previous year, has been convicted of a traffic crime and the suspension is based upon a conviction for violation of ORS 813.010 or is imposed under ORS 813.410 based upon ORS 813.100. [1985 c.16 §148; 1985 c.672 §16; 1987 c.673 §1a; 1987 c.801 §15; 1989 c.224 §141; 1989 c.401 §3; 1993 c.305 §9; 1995 c.568 §9; 1999 c.1051 §91; 2005 c.140 §5; 2009 c.607 §1]

IGNITION INTERLOCK DEVICES

813.600 Ignition interlock program; rules. (1) The Department of Transportation, in consultation with the Transportation Safety Committee, shall establish a program for the use of ignition interlock devices by persons convicted of driving while under the influence of intoxicants and granted hardship permits under ORS 807.240 and by persons who have entered into a driving while under the influence of intoxicants diversion agreement.

(2) The department shall adopt rules that specify requirements for ignition interlock devices that may be used and shall publish a list of devices that meet the requirements. The list may include devices that:

(a) Do not impede the safe operation of the vehicle;

(b) Have the fewest opportunities to be bypassed;

(c) Correlate well with established measures of alcohol impairment;

(d) Work accurately and reliably in an unsupervised environment;

(e) Require a deep lung breath sample or other accurate measure of blood alcohol content equivalence;

(f) Resist tampering and give evidence if tampering is attempted;

(g) Are difficult to circumvent, and require premeditation to do so;

(h) Minimize inconvenience to a sober user;

(i) Operate reliably over the range of automobile environments or automobile manufacturing standards;

(j) Are manufactured by a party who is adequately insured for product liability; and

(k) Have a label affixed in a prominent location warning that any person tampering with, circumventing or otherwise misusing the device is subject to civil penalty. [1987 c.746 §1; 1991 c.453 §14; 1993 c.382 §2; 2011 c.671 §1]

813.602 Circumstances under which ignition interlock device required; costs; failure to install; penalty; exemptions; rules. (1) When a person is convicted of driving while under the influence of intoxicants in violation of ORS 813.010 or of a municipal ordinance, the Department of Transportation, in addition to any other requirement, shall require that an approved ignition interlock device be installed and used in any vehicle operated by the person:

(a) Before the person is eligible for a hardship permit. The requirement is a condition of the hardship permit for the duration of the hardship permit.

(b) For a first conviction, for one year after the ending date of the suspension or revocation caused by the conviction. Violation of the condition imposed under this paragraph is a Class A traffic violation.

(c) For a second or subsequent conviction, for two years after the ending date of the suspension or revocation caused by the conviction. Violation of the condition imposed under this paragraph is a Class A traffic violation.

(2) The court shall require as a condition of a driving while under the influence of intoxicants diversion agreement that an approved ignition interlock device be installed in any vehicle operated by the person during the period of the agreement when the person has driving privileges. In addition to any action taken under ORS 813.255, violation of the condition imposed under this subsection is a Class A traffic violation.

(3) Except as provided in subsection (4) of this section, if an ignition interlock system is ordered or required under subsection (1) or (2) of this section, the person so ordered or required shall pay to the provider the reasonable costs of leasing, installing and maintaining the device. A payment schedule may be established for the person by the department.

(4) The department may waive, in whole or in part, or defer the defendant's responsibility to pay all or part of the costs under subsection (3) of this section if the defendant meets the criteria for indigence established for waiving or deferring such costs under subsection (5) of this section. If the defendant's responsibility for costs is waived, then notwithstanding ORS 813.270, the costs described in subsection (3) of this section must be paid from the Intoxicated Driver Program Fund.

(5) The department, by rule, shall establish criteria and procedures it will use for qualification to waive or defer costs described under subsection (3) of this section for indigence. The criteria must be consistent with the standards for indigence adopted by the federal government for purposes of the Supplemental Nutrition Assistance Program.

(6) At the end of the suspension or revocation resulting from the conviction, the department shall suspend the driving privileges or right to apply for driving privileges of a person who has not submitted proof to the department that an ignition interlock device has been installed or who tampers with an ignition interlock device after it has been installed. If the suspension is for failing to submit proof of installation, the suspension continues until the department receives proof that the ignition interlock device has been installed or until one year after the ending date of the suspension resulting from the first conviction or two years after the ending date of the suspension resulting from a second or subsequent conviction, whichever comes first. If the suspension is for tampering with an ignition interlock device, the suspension continues until one year after the ending date of the suspension resulting from the first conviction or two years after the ending date of the suspension resulting from a second or subsequent conviction. A person whose driving privileges or right to apply for privileges is suspended under this subsection is entitled to administrative review, as described in ORS 809.440, of the action.

(7) The department shall adopt rules permitting medical exemptions from the requirements of installation and use of an ignition interlock device under subsection (1) of this section.

(8) When a person is required to install an ignition interlock device under subsection (2) of this section, the provider of the device shall provide notice of any installation or removal of the device or any tampering with the device to the court that ordered installation of the device or to the court's designee, including but not limited to an agency or organization certified by the Oregon Health Authority under ORS 813.025. [1987 c.746 §2; 1989 c.576 §1; 1991 c.453 §15; 1993 c.382 §3; 1993 c.627 §6; 1999 c.770 §7; 2001 c.786 §4; 2003 c.26 §1; 2007 c.655 §1; 2009 c.599 §26; 2011 c.671 §2]

813.604 Notice of court order; notation on hardship permit; rules. (1) When a court orders installation of an ignition interlock device pursuant to ORS 813.602, the court shall send a copy of the order to the Department of Transportation. The department shall note the requirement on the driving record of the person required to install the device.

(2) The department may not issue a hardship permit under ORS

807.240 to any person who is ordered to install an ignition interlock device on the person's vehicle until the person furnishes the department satisfactory proof that the device has been installed on any vehicle owned or operated by the person. The department shall determine by rule what constitutes satisfactory proof under this subsection.

(3) When the department issues a hardship permit to a person who is required to have an ignition interlock device, the department shall note on the permit that the device is required. The notation constitutes a limitation on the permit and a person who violates the limitation is punishable as provided in ORS 811.182 for criminal driving while suspended or revoked. [1987 c.746 §3; 1989 c.398 §2; 1997 c.249 §235]

813.606 Exception for employee otherwise required to have device. Notwithstanding ORS 813.604, if a person is required, in the course and scope of the person's employment, to operate a motor vehicle owned by the person's employer, the person may operate that vehicle without installation of an ignition interlock device if:

(1) The employer has been notified:

(a) That the employee is operating with a hardship permit restricted as provided in ORS 813.604;

(b) That the employee is operating on a fully reinstated license within the first year following suspension or revocation for the employee's first conviction of driving while under the influence of intoxicants; or

(c) That the employee is operating on a fully reinstated license within the second year following suspension or revocation for the employee's second or subsequent conviction of driving while under the influence of intoxicants; and

(2) The employee has proof of the notification or fully reinstated license in the possession of the employee while operating the employer's vehicle in the course of employment. [1987 c.746 §4; 1999 c.770 §8; 2001 c.786 §5; 2011 c.355 §17]

813.608 Knowingly furnishing motor vehicle without ignition interlock device; penalty. (1) A person commits the offense of knowingly furnishing a motor vehicle without an ignition interlock device to someone who is not authorized to drive such a vehicle if the person rents, leases, lends or otherwise furnishes a motor vehicle to someone the person knows to have been ordered or required under ORS 813.602, to install an ignition interlock device, and the motor vehicle is not equipped with such a device that is in working order.

(2) The offense described in this section, knowingly furnishing a motor vehicle without an ignition interlock device to someone who is not authorized to drive such a vehicle, is a Class A traffic violation. [1987 c.746 §5; 1989 c.576 §2]

813.610 Soliciting another to blow into ignition interlock device; penalty. (1) A person commits the offense of unlawfully soliciting another to blow into an ignition interlock device or start a motor vehicle equipped with an ignition interlock device if the person has such a device as a result of an order or requirement under ORS 813.602 and the person requests or solicits another to blow into the device or start the motor vehicle so as to circumvent the device.

(2) The offense described in this section, unlawfully soliciting another to blow into an ignition interlock device or start a motor vehicle equipped with an ignition interlock device, is a Class A traffic violation. [1987 c.746 §6; 1989 c.576 §3]

813.612 Unlawfully blowing into ignition interlock device; penalty. (1) A person commits the offense of unlawfully blowing into an ignition interlock device or starting a motor vehicle equipped with an ignition interlock device if, for the purpose of providing an operable motor vehicle for someone required under ORS 813.602 to have such a device, the person blows into an ignition interlock device or starts an automobile equipped with the device.

(2) This section does not apply to a person who is required to have an ignition interlock device and who blows into or starts the person's own vehicle that is so equipped.

(3) The offense described in this section, unlawfully blowing into an ignition interlock device or starting a motor vehicle equipped with an ignition interlock device, is a Class A traffic violation. [1987 c.746 §7]

813.614 Tampering with ignition interlock device; penalty. (1) A person commits the offense of tampering with an ignition interlock device if the person does anything to a device that was ordered installed pursuant to ORS 813.602 that circumvents the operation of the device.

(2) The offense described in this section, tampering with an ignition interlock device, is a Class A traffic violation. [1987 c.746 §9]

813.616 Use of certain moneys to pay for ignition interlock program. Notwithstanding ORS 813.270, moneys in the Intoxicated Driver

Program Fund may be used to pay for administration and evaluation of the ignition interlock program established by ORS 813.600 to 813.616 and for the costs of participation in the program for indigents. [1987 c.746 §8; 1993 c.382 §4]

THE ROLE OF SCREENER

A DUII offender is ordered by the court to obtain a screening, as a result of one of two possible situations. First, if the DUII offender has been convicted of a DUII (first or multiple convictions) or secondly, if the court has approved a diversion petition for a DUII Diversion Agreement (first offense in a 15 year time frame).

In the first situation, the DUII offender has pled guilty or “Nolo Contendere” (No Contest) or has been found guilty of the offense. In the second situation, the DUII offender has been charged with the offense, but has petitioned the court to have the charge dropped by agreeing to satisfactorily complete the Diversion Agreement.

In either case, the DUII offender is required to obtain a screening from an individual approved by OHA AMH and designated by the court to conduct DUII screenings within their county. In most cases the court refers the DUII offender upon conclusion of the court proceedings to the ADES. The ADES will then set up a time to meet with the DUII offender to conduct the screening. In conducting the screening, the ADES will utilize the forms and policies approved by OHA AMH to determine whether the DUII offender should be referred to a substance abuse treatment program for an education or treatment level.

The criteria used to determine the referral is spelled out in the OHA AMH administrative rules and on the forms utilized by the ADES. The primary tool for the screening will be the Texas Christian University Drug Screen II and the referral criteria from OHA 8053, ADES Screening ad Referral Report. Used in conjunction with a personal interview, this should give the ADES a reliable means of making an appropriate screening classification with referral for either a substance abuse education or treatment program.

Working with the DUII offender, the ADES will provide a choice of substance abuse treatment programs which takes into consideration any barriers to successful completion of a substance abuse treatment program. Keep in mind that the first substance abuse treatment program may not be a good fit for the DUII offender and the DUII offender may need to be re-referred to another program which provides the level of care needed.

In addition to conducting the screenings and making referrals, the ADES is required by state law to monitor the DUII offender's status in substance abuse treatment. As a result, the ADES is generally familiar with the substance abuse treatment providers within their region and have personal knowledge as to which providers may work best with a particular DUII offender. This information is utilized when a referral is made to a particular program by the ADES. Because of the ADES's relationship with the courts, the ADES will often go to court to provide an update on the DUII offender's status and be asked to provide information about the substance abuse treatment. It is critical for the ADES to have current information regarding the DUII offender's status in treatment.

The monitoring the screener providers may vary by court and/or due to the DUII offender's level of commitment. Some DUII offenders may complete treatment within the first few months of their arrest and be through the system. Others, will have done nothing and remain involved with the court for several years. It is the job of the screener to work with the DUII offender until the court closes out the case or the case is dismissed. It is not uncommon for the court to dismiss the case when the DUII offender has completed a portion of the requirements, but has not yet successfully completed a treatment program. In these cases, the DUII offender's driver license is still suspended regardless of the court status. The suspension will remain in effect until DMV obtains the DUII Treatment Completion Certificate. The court order for substance abuse treatment does not go away.

If the DUII offender is a resident of another state, it is the responsibility of the screener to approve the substance abuse education or treatment to be received at a state certified substance abuse program. The standards of substance abuse education and treatment vary by state. The screener works with the out of state substance abuse program to assure the DUII offender will meet the same treatment standards that they would have met if they received their substance abuse education or treatment in Oregon. This includes the requirement of random Urinalysis testing.

The maximum fee allowed by statue for screening and monitoring of DUII offenders is $150.00, although, some local judges have ordered DUII offenders to pay to the screener additional fees based on specific circumstances. These circumstances are outlined in a court order signed by the judge. Circumstances the court may allow for additional

compensation may include “no shows,” cancelations, re-referrals, or other situations which require additional time or paperwork. Minus any specific court order, no additional fees can be acquired from the DUII offender beyond the $150.00.

The maximum fee allowed for a Marijuana Diversion screening is $90.00.

IGNITION INTERLOCK DEVISE (IID) MONITORING FOR THE COURT

The ADES may be requested by the court to monitor IID installation and compliance for individuals who enter a DUII Diversion Agreement with a court for a DUII offense occurring on or after January 1, 2012. The court will determine whether the ADES may charge and the amount to charge the DUII Offender for the IID monitoring.

THE INTERVIEW

The interview should have a secondary purpose of preparing the DUII offender for entry into a substance abuse education or treatment program. As an interviewer, you must realize the DUII offender's experience in the DUII system, until meeting you, has been negative. The DUII offender has first met a police office, then a judge, and possibly a prosecuting attorney. Each of these meetings was probably unpleasant. You must work to convince the DUII offender that the treatment system is not out to get them but is there to help.

It is not a function of the interview to convince the DUII offender that they have a substance abuse problem. Of course, if you can convince them it may help them to accept treatment. But you cannot expect that every DUII offender will graciously accept your results. Indeed, there will be some that become hostile about being told they are exhibiting danger signals of substance abuse.

Hostility is often a reflection of the denial that is typically present with DUII offenders who are experiencing problems with substance abuse. DUII offenders who are in the earlier stages of a problem will often complain that they are being labeled as an "alcoholic" or "addict." The response to this is to explain that you are not placing a diagnostic label upon them, but you do see concrete signs or danger signals that indicate that a problem may be present or may be developing. These warning signs or danger signals require further investigation or assessment by a state certified substance abuse provider. The DUII offender needs further education and assistance to help decide what must be done to avoid further concerns.

Be honest and direct in your conversation with the DUII offender, explaining exactly, point for point, how you made the screening classification on the basis of the self-report. For example, if problem drinking is indicated from a high Blood Alcohol concentration (BAC) and report of blackouts, then explain why those are danger signs. Explain exactly what must happen – "You will report to the substance abuse treatment provider for an intake. When you report to the provider, using assessment tools they will work with you to develop a treatment plan for you to follow." Do not expect the DUII offender to like what you have said. The substance abuse treatment provider is prepared to deal with the DUII offender's hostility and denial of the problem. Your job is to start the process which will get the DUII offender

to the substance abuse treatment provider. And then monitor the DUII offender's treatment progress and report to the court.

Be appropriately direct if you feel that the symptoms indicate more chronic stages of substance abuse. For example, you might begin by saying:

> "I think you need to realize that what you have told me about your patterns of use has 'chemical dependency' written all over it. The substance abuse treatment provider is going to require that you get involved in a program where you can begin to deal with your substance abuse. It is not going to be easy for you. Going to jail would probably be easier. However, going to jail will not meet the requirements of a DUII Treatment Completion Certificate, which is one of the obligations to reinstating your privilege to drive. It appears things have been going down hill for you for several years. If you want things to get better, you are going to have to quit. That is something only you can do for yourself. But you will need help. If it did not require help, you would have quit before this. So the court is giving you the opportunity it get the help you need."

The introduction to this manual explains that your role is just one of many in a long, comprehensive program. You should become familiar with the overall DUII system to better assist the DUII offender through the process.

SOME WISDOM ABOUT INTERVIEWING

You have an unusual opportunity to meet a number of interesting and diverse DUII offenders, each with their own life experiences. Avoid labeling; seek out information by asking yourself, “What is unique about this individual?” Then engage the DUII offender in friendly, casual conversation. Bear in mind, the information that you do need to obtain and you will find ways to get it. If you think of yourself as a person interested in another person, the DUII offender will perceive you in that role rather than as some bureaucrat or “shrink-type” behind a desk. If it helps you, remember that you have the court system behind you.

The following are areas of discuss were developed to be a routine part of every DUII screening. Remember, alcohol is a drug.

Confidentiality: Discuss confidentiality of disclosed information with the individual being screened. Discuss who will receive the information (the treatment agency, court, probation, AMH), the purpose of release and under what conditions the information may be released.

Drug use: ask questions pertaining to the Texas Christian University Drug Screen II. Ask questions about other drug use regardless of the presence or absence of use reported. “What other drugs have you used besides alcohol?” “How often do you use other drugs and what are they?”

Be sure to inquire about prescribed medications. “Do you take medication prescribed by your doctor(s)?” Pay particular attention to medication for:

1. pain-including headaches, low back pain, pain secondary to dental work or problems: possible opiate use
2. nervousness, to relax or for sleep; possible minor tranquilizer or barbiturate use
3. weight/appetite control; possible stimulant use

Inquire about use of stimulants (e.g., “speed”) for individuals whose occupations involve night work or which require long periods of sustained alertness (e.g., truck driving, interrupted sleep due to being on-call, such as emergency workers).

Gather alcohol and drug treatment history. Include questions regarding previous alcohol and drug treatment, and hospitalization for detox or treatment. Has the individual ever been hospitalized for an overdose? Has the individual ever had hepatitis and which hepatitis was it?

Inquire about arrests for possession, manufacturing, or sale of illegal drugs or for illegally obtaining prescribed drugs.

REFERRALS

It is not necessary to identify the exact severity of a problem; that should be left to the treatment provider. However, it is necessary to learn as much as possible about the individual's problem so that the most appropriate referral can be made.

When an individual begins to have substance abuse problems, no matter how slight the problem, it is no longer "casual" use. There can be a very fine line of distinction between casual use and abuse. Once substance abuse begins, it is usually progressive, with the problems becoming more and more severe.

The main function of the screening is to determine which side of the fine line between "casual" use and "abuse" the individual is on. The intent is to identify a drinking or other drug problem at the earliest possible point. Early detection is preventative rather than curative. The preliminary screening classification is "social" rather then medical or psychological. If one were called upon to testify in court as to an individual's problem with substance use, it should be pointed out that the problem use pattern was determined according to a self-report, any previous arrest record(s), and the BAC.

In conjunction with the individual's self report on the Texas Christian University Drug Screen II, you should secure several pieces of hard evidence: the arrest report, any previous arrest record(s), if available, and the driving record. This combined information will give you some insight concerning the honesty of the individual's answers on the Texas Christian University Drug Screen II. **You will see in the criteria for referral that these documents may reveal problems areas regardless of what the individual says.**

You probably also have some form of social background information about the individual. Knowledge of the individual's biography often opens areas of questioning from the answers on the Texas Christian University Drug Screen II.

CRITERIA FOR REFERRAL

The following are the referral criteria indicators as found on the ADES Screening and Referral Report.

- BAC over .15
- Self-admission of problems involving alcohol and/or other drugs
- Previous alcohol and/or other drug arrest
- Prior diagnosis or treatment for alcohol and/or other drugs
- Personality changes
- Passed out on more than one occasion
- Regular pattern of use
- Concern of others regarding alcohol and/or other drug use
- Symptoms of withdrawal
- Blackout on more than one occasion
- Unsuccessful attempts to quit or cut back
- Alcohol and/or other drug related problems, such as health, including cirrhosis or fatty liver, psychological, social, employment/school, and family

Utilizing the referral criteria indicators you will make a referral for either a DUII Information Program or DUII Rehab.

Information Program Referrals – Individuals who do not exhibit any indicators of alcohol and/or other drug problems on the Screening and Referral Report will be referred to DUII Information Programs as outlined in OAR 415-054-0020.

Rehabilitation Program Referrals – Individuals who exhibit at least one indicator will be referred to DUII rehabilitation Programs for further assessment and treatment. These individuals are presumed to be minimally in the early stages of an alcohol or other drug problem.

REVIEW OF CRITERIA INDICATORS

Most people think they know the symptoms of addiction: morning alcohol use, loss of control, employment concerns, etc. They fail to realize that problems begin long before these symptoms occur so they ignore their problems until they actually become alcohol and/or drug dependent. The intent of the screening process is to spot the earliest signs of problems so that intervention may take place. If an individual is periodically missing a day's work because of substance abuse, we don't need to wait until the job is lost to identify that there is a problem. If the spouse is complaining about the substance abuse, we don't have to wait for a divorce before suggesting that something be done.

This type of early screening classification must be very strict. Experience has shown that ADES are more prone to refer an individual to a lower level of care than what might be necessary to effectively intervene in their substance abuse problem. There is no harm in recommending a borderline case to treatment. Failure to refer to treatment when such a referral is needed, however, can have very serious consequences for public safety and the individual's health. Things to look for include the following:

1. BAC over 0.15: It takes quite a bit of drinking to reach the legal limit of 0.08. A reading above 0.15 indicates an amount of drinking that is hard to justify under any conditions. Most people will reveal other problems they are having if they try to justify why they drink so much. Also. Remember the tolerance level. A high reading will almost always be a clue that the individual is a heavy drinker. When the BAC is above 0.25, it is probably a good indicator of alcohol dependence. A BAC of 0.50 can kill.

2. Self-admission of problems involving alcohol and/or other drugs: If an individual admits that there is a problem, this is all that is needed to identify the severity of the problem for the sake of making an appropriate referral.

3. Previous alcohol and/or other drug arrest: It shouldn't take more than one DUII-related arrest for an individual to learn a lesson. Even if the individual claims to have only been intoxicated twice in their life and was arrested on both of those occasions, it certainly speaks loudly for the effect substance use has upon their

behavior. It is also wise to consider the odds against an individual under the influence or impaired actually getting caught. Many arrest records reveal substance abuse problems where there are no alcohol/drug related charges. Always suspect a Hit and Run charge. People who are too intoxicated to know they have hit a parked car often leave the scene and are arrested the next day when they are sober. Many substance abusers will admit that the only time they ever get into trouble of any kind is when they have been using.

4. Prior diagnosis or treatment for alcohol and/or other drugs: Anyone coming to you with a prior diagnosis of alcohol/drug-related problems or treatment on their record should be considered for treatment referral.

5. Personality changes: Does substance use cause the individual to exhibit a different type of character than normal? Some people regret that they become violent or abusive. Their problem is obvious. Some people feel they are a better person. Their problem is less obvious – at least to them. They are psychologically dependent.

6. Passed out on more than one occasion: Like blackouts. This does not happen to everyone and should be considered a danger sign. Many people don't know that they pass out because they always manage to make it home to bed before it happens. If they have actually drugged themselves to sleep, it counts as passing out.

7. Regular pattern of use: Any regular pattern of use of substances indicates that the use has become part of the individual's lifestyle. As such, the risk for physical or psychological dependence should be taken into consideration and be ruled out by the treatment provider.

8. Concern of others regarding alcohol and/or other drug use: The individual is usually the last person to recognize a substance abuse problem. They will usually, in an interview, understate the spouse's complaints about their substance use. They may give up on friends before friends give up on them. Substance abusers often group together. An individual may use regularly with friends

from work and they may all have habits which are problematic. The individual will not recognize their use as a problem because they are not doing anything that their friends don't do. In the same way, an individual who grew up with substance abusing parents may declare never to become an alcoholic/addict. They will ignore the early signs of problem abuse because they have had the worst possible example.

9. Symptoms of withdrawal: Not everyone who stops abusing experiences withdrawal symptoms. But most people who have been abusing for a long period of time or who abuse frequently or use in large quantities will experience some form of withdrawal symptoms if they suddenly stop. Symptoms may include headaches, sweating, nausea, vomiting, loss of appetite, or insomnia. The DTs or "delirium tremens": is a severe condition requiring immediate medical attention. It is characterized by shaking, sweating, nausea, hallucinations, confusion, and/or convulsions, and can be fatal.

10. Blackout on more than one occasion: this should not be confused with passing out. Some people remember going home but not how they got home. It is minor, but it counts as a blackout. Blackouts begin with minor incidents and become more serious to the point where an individual may not know what the arrest warrant for vehicular homicide is all about. An individual may experience blackouts with greater frequency and intensity the more they abuse. Many people assume that blacking out is just a part of the process. It does not happen to everyone and should be considered a danger sign.

11. Unsuccessful attempts to quit or cut back: This is the inability to stop using at a given point. An individual in the early stage of dependency may control their use for given periods of time but, at some point, will again lose control over the amount, duration, and frequency.

12. Alcohol and/or other drug related problems: Medical or health problems may include insomnia, frequent falls, elevated liver enzymes, cirrhosis, hepatitis, or Tuberculosis.

Cirrhosis is a serious, often fatal, disease of the liver. The liver is the organ that metabolizes whatever your body has taken in. Occasionally people can have cirrhosis without a history of drinking, but the medical diagnosis of cirrhosis, especially when coupled with one or more of the indicators, is usually indicative of a substance abuse problem.

Psychological dependence is difficult to ascertain. Basically it has to do with the reasons why an individual is abusing. Worry and depression are definitely not good reasons. Individuals may call their abuse “social” if there are other people abusing.

Social and family interaction may decline as the individual removes themselves from others who are not abusing or who are expressing concern regarding the substance abuse. Remember, the individual is usually the last person to identify their substance abuse problem.

Employment/school may suffer due to substance abuse. Symptoms may include tardiness, absence at work or school, performance problems, loss of employment, or financial difficulties.

REVIEWING THE EVIDENCE

When studying the evidence for problem use, make no allowance for time. If ten years have passed since the individual's last blackout or last arrest, it does not excuse the present arrest. It could well be an indication of a ten year old problem. The passage of time does not reduce the significance of symptoms or warning signs. Remember that alcohol is a drug. And for the purpose of the screening you will examine the use of alcohol, prescription medications, over the counter medications, inhalants, and illicit drugs to make an appropriate referral.

An individual who says they were under heavy emotional stress at the time of the arrest and admits heavy use but claims to have quit using since the personal problems have been solved should still be recommended for treatment. They have admitted psychological dependence and will surely resort to using again during future periods of stress. There are bound to be some tough times in their future and treatment may help prevent future substance abuse problems.

Most people come to you at their best. Since their arrest, they may have cut back or quit completely. Don't bet on current habits and attitudes to continue. Ask if they have ever quit using before. Many people may have been abstinent for years but have started using again.

Just the fact that an individual reports having quit using in the past may be a clue. Why would an individual bother to quit using unless there was some personal concern about the use?

Substance use/abuse is a common denominator, but no two people have exactly the same problem. Some of the people who come in on their first DUII charge may need only to learn to make better choices. Please allow that if an individual totally denies heavy involvement, they may be telling the truth.

A final point to remember in making the screening referral decision for a person arrested for DUII is that very rarely does anyone who really would be classified as a casual drinker get arrested. Casual drinkers by definition would not risk driving if they felt they had too much. Driving is, however, one of the most common abuses of alcohol, and the drinker who drives, does so frequently. The police often only arrest the most blatant offenders.

At the time you do the interview, the individual has a totally different character than the one the police encountered. It is probably wise not to be overly sympathetic to stories of police brutality. Besides, how the individual has been treated by the system is not the point. If you find indications of problem use, the system may not have worked smoothly but it did get the right individual. Don't offer anything, which the individual can use to feed denial. Be direct about the evidence you have.

For many people, the indications of substance abuse or dependency will be clear. The job gets tough when you have someone who looks like a careless user. Why, then, did the individual get arrested? Are you sure you haven't missed something?

REMEMBER: REFER AT THE APPROPRIATE LEVEL!!!!

All of us are aware that alcohol is frequently used in conjunction with other drugs. If questioned, people will sometimes admit hat they use other drugs in addition to alcohol although that may not have been the case when they were arrested for DUII. There are three areas of use that you will want to give special attention: a) prior/pending substance abuse related arrests, b) prior/pending substance abuse related treatment, and c) general drug use history. Be sure to also inquire about the use of prescription and over the counter medications.

People may be reluctant to admit their use of illicit drugs, but if you assure them that the information is to help you in determining where they should be referred for treatment and will not be reported to law enforcement officials, they may cooperate and confide in you.

When making a referral to an out-of-state program, be sure to provide program requirements pursuant to Oregon Administrative Rules. The individual will need to meet the alcohol and drug treatment requirements just as if the individual was still in this state. The individual will have greater chance of success if the out-of-state program knows the expectations before the individual starts classes.

AMH receives a number of calls every day from individuals who have an old DUII charge and want to know what they have to do to get a completion certificate and their driving privilege reinstated. In most cases, the individual reports that the DUII occurred several years ago.

The issue to clarify is whether the individual needs to see an ADES in order to be referred to a certified DUII program. It is the position of AMH that when the court has closed the case, the individual no longer needs to be referred by the ADES to a certified DUII program. The ADES is designated by the court to screen, refer, and monitor the alcohol and drug treatment of the individual for the court. When the court closes the case, the ADES will also close the file. The ADES will maintain the individual's file for seven years. Individuals should contact AMH for assistance in determining the status of their DUII treatment.

DUII providers should only accept individuals into the DUII service elements when a referral has been provided. However, when the court has

closed the case, there will not be a referral from the ADES as there will no longer be someone monitoring the alcohol and drug treatment. The DUII provider should check with the courts to make sure that there are no outstanding warrants. If there are no warrants the DUII provider should complete the alcohol and drug assessment and make a determination regarding the appropriate DUII level of care based on the Placement Criteria.

When screening an individual with a Marijuana Diversion, you have two options. If none of the indicators on the ADES Screening and Referral Report have been checked, report to the court that the screening was completed and no referral was made. When one or more indicators have been checked on the ADES Screening and Referral Report then refer the individual to a certified outpatient alcohol and drug program. This would be for Marijuana Diversion only. Individuals who were simultaneously charged with DUII and Marijuana possession must be referred to an approved DUII program.

Local communities, like Umatilla County, may develop marijuana education/information programs. Communities with these programs may refer marijuana diversion offenders who do not meet the rehabilitation referral threshold.

COMMENTS ON BLOOD ALCOHOL CONCENTRATIONS

The 1983 Oregon Legislative Assembly took a “get tough” stance with DUII offenders. One change that was brought about was the Blood Alcohol Concentration (BAC) reduction from 0.10 to 0.08 as legal proof of DUII. AT the time, a BAC of 0.10 is standard throughout most of the United States. In 2000, Congress passed the DOT Appropriations Act of FY 2001, adopting 0.08 BAC as the national illegal limit for impaired driving and required states to adopt 0.08 BAC laws by October 1, 2003. The standard BAC in other countries is 0.05 and there is concern that it might be too high.

For an average male of 150-pounds, each drink (1 oz. of 86 proof whiskey or 12-oz beer) in one hour’s time will result in a VAC of approximately 0.025. That means it would take four drinks in one hour to reach a BAC of about 0.10. How would you feel after four drinks in one hour?

The BAC **DOES NOT** indicate how “drunk” an individual is. It only indicates how much that individual has had to drink. There are variables which must be taken into account. The major variables are body weight. Amount of time spent drinking, and the number of drinks. Other variables would include physical and mental health, tolerance, and current medications.

Many small people experience serious problems drink because they drink with bigger friends and try to keep up with them. If a 180-pound male with a recorded BAC of 0.17 says that three hours were spent in a bar after work, we can compute on the Drink/Drive Calculator that the individual must have had one dozen drinks in that time.

Time is important in both the intoxication process and the getting sober process. A high BAC obtained over a long period of time will not have the same intoxicating effect as a high BAC obtained over a short period of time.

Referring again to the 150-pound male above, we saw that it took four drinks in one hour to reach a level of 0.10, above the legally indicative concentration of driving under the influence of 0.08. That seems like a lot. However, one more drink in each following hour will cause the BAC to continue to rise.

The reason for this is time. The average metabolization of alcohol will cause the BAC to fall by about 0.015 per hour. So the BAC reduces by 0.015 for each hour. Add one drink per hour and you are increasing the alcohol in the blood faster than it can be metabolized.

It is useful to question an individual about the length of time between the last drink and taking the breathalyzer test. It can be as long as three hours at which you can add another 0.045 to the reading.

At the turtle-slow rate of elimination of alcohol, it is possible for an individual to blow above 0.08 who has not had a drink all day and who feels fine but was drinking heavily the night before.

It does not matter what the individual drinks. The alcohol content is approximately equivalent for:

12 oz. beer at 4%	=	48 units
1 oz. liquor at 43%	=	43 units
4 oz. wine at 12%	=	48 units

Time again is the major factor. The drinker will consume hard liquor in a gulp but will take more time to drink beer or wine.

Everyone says, “I only had a coupla drinks.” It is important to find out what the drinks were. A “coupla” martinis mixed at home may gave as much as two ounces of liquor each. In that way, a female weighing 150 pounds, two drinks over one hour could result in a BAC of 0.10 or more.

Drinks mixed at home or at a party usually have much higher alcohol content than drinks from a bar. Some other variations on the standard drink are the tall glassware, 10 oz. cans of ale or malt liquor, or 100-proof liquor.

The Blood Alcohol Concentration as a Function of Drinks Consumed and Time Taken to Consume charts are located in the Appendix at the back of this manual.

Individual tolerance for alcohol varies from individual to individual, day to day. If an individual has a high BAC and claims not to feel drunk, this would indicate the individual has a high tolerance to alcohol. Tolerance is built by frequent use. High tolerance is an indication of problem drinking. We

consider it a problem to build a tolerance for any other drug; why not alcohol?

Other drugs will not ordinarily affect the breath test result. People will plead that their high BAC was a result, not of drinking, but a prescription medicine. Not so! The breathalyzer or breathalyzer is a device for estimating blood alcohol content from a breath sample. More sophisticated machines such as the gas chromatograph actually separate the various chemicals in the blood and give a reading.

Low blood sugar, as in a diabetic, may have a higher holding capacity of alcohol but it should not change the BAC more than about 0.03 when a breathalyer is used.

The combination of sedative drugs (barbiturates) and alcohol has a multiplying effect on the intoxicating qualities. If a pill has the same effect as one drink, then one pill and one drink should have the effect of two drinks but may actually act like four or more drinks. This is called a synergistic effect. In other words, the individual who claims to have taken Valium, Librium, Dilantin or something similar was certainly more “under the influence” than if they had just been drinking.

A high BAC is an indicator of tolerance. For this reason, the ADES who refers an individual with a BAC above 0.15 for an Information Program must submit a detailed justification of their decision to AMH within three working days of the screening interview. A justification must include the rationale for determining that the BAC above 0.15 does not represent tolerance. An acceptable justification cannot be based solely upon the fact that there are no other indicators. An ADES who makes multiple unjustified classifications may be cited during the onsite review for non-compliance with OAR 415-054-0480(1), “The ADES must use documents and procedures designated by the Division.”

It cannot be overemphasized that an inappropriate referral to an information program with DUII offenders can be very dangerous. An inappropriate referral may provide an individual with fuel for their denial, thereby jeopardizing public safety and seriously delaying or impeding the recovery process.

REFUSAL TO TAKE A BREATH TEST

You will screen individuals who refused to take a breath test at the time of their arrest. The individual who refused a breath test was informed of the consequences and their rights by law enforcement. Refusal results in the suspension of driving privileges. In screening individuals who have refused a breath test, it is important to discuss the circumstances of the arrest and the individual's behavior at the time of arrest. It is also important to examine carefully the arrest report. Examining the individual's behavior at the time of the arrest can often reveal that the individual experiences personality changes as a result of substance abuse. Individuals who have refused the breath test often exhibit abusive, combative, or violent behavior at the time of arrest. Such behavior can be a result of substance abuse-related personality changes and must be considered an indicator of a problem.

MAKING TREATMENT REFERRALS AND TREATMENT PROGRAMS

Depending upon your location, referral sources may be scarce or many. If they are scarce, then the individual does not have much choice in deciding which provider to attend. But if there are several options, you should work with the individual to locate the best fit.

Referring an individual to the proper treatment provider is not a simple, rubber stamp procedure. First of all, it requires that an adequate screening for substance abuse problems has been performed to provide an initial estimate of the type of service needed.

REFERRALS ARE MADE ACCORDING TO THE NEEDS AND BARRIERS THE INDIVIDUAL PRESENTS

1. Need for Particular Type of Treatment: The type of treatment is of critical importance. Some agencies specialize in certain types of treatment or in working with particular populations. If a person needs Antabuse, other types of medications or have a Marijuana Card, you want to refer to an agency that is equipped to provide that need. Acknowledging language needs and other cultural issues that are important to the individual should be considered. A personal knowledge of every available local program and its staff is needed in order to know that you are making the best possible referral. Is the individual in need of a Restricted Driver License? Remember the individual can only be in a Restricted Driver License program in the county in which they live.

2. Accessibility: Consider the proximity of the treatment center to the individual's residence or job. If the individual has transportation problems, refer to the nearest appropriate agency.

3. Cost: Most agencies are able to adjust their fees on a sliding scale according to the individual's ability to pay. This is based on income. Heavy debt does not excuse a person from paying the bill. The sliding scale is comparable among most publicly funded agencies, though it may not be exactly the same.

4. Court Obligation: Occasionally a court will direct an offender to attend a particular program. If the individual is court-ordered to a

program that is not state-approved for DUII services, review the "Referral of Individuals who are already in treatment at the time of screening" found in section six of the referral guide. The driving privilege will only be reinstated for individuals who complete a state-approved DUII program.

5. Health Plan Eligibility: If the individual is Oregon Health Plan (OHP) eligible, it would be appropriate to refer the individual to a program that is on the panel of the individual's prepaid health plan.

6. Barriers to successful treatment: Take into consideration the following barriers when making an appropriate referral:

   A. Not fluent in English

   B. Housing instability

   C. Employment instability

   D. Income instability

   E. Transportation issues

   F. Health issues

   G. Mental health issues

   H. Recent hospitalizations

   I. Lack of family support

KNOWING LOCAL DUII PROGRAMS

Complying a list of services offered by local DUII programs will assist you and the individual in determining which DUII program will best fit the individual's needs according to the referral indicators and barriers to successful treatment.

Introduce yourself to the local DUII providers and gather information about the services they provide. Inquire about the location, cost per session, cost of UAs, and classes for individuals not fluent in English. The information can than be presented during the screening to open a dialog about the programs available to the individual.

As the ADES, you are responsible for informing the DUII offender of all DUII treatment providers in the area. A best practice would be to laminate a portion of Oregon Alcohol & Other Drug Services Directory pertaining to your county(ies). Show the laminated copy to individuals when discussing available treatment options so they are aware of all the DUII treatment providers in their community.

NOTE: the following example should be placed on your agency letterhead.

INSERT CONTACT NAME
INSERT AGENCY NAME
INSERT MAILING ADDRESS

Dear INSERT CONTACT NAME;

I am the Alcohol and Drug Evaluation and Screening Specialist designated by INSERT COURT. I am putting together a packet of DUII programs in the area to assist the individual in determining where a referral will be made.

Please fill out the enclosed form and return it to me by INSERT DATE. If you wish, you may include other pertinent information regarding your DUII services. You may want to include information regarding the program philosophy, fee schedule, or special features in which an individual may use to determine which DUII program is the best fit for them.

If you have any questions about this process, please call me at INSERT YOUR PHONE NUMBER.

Sincerely;

INSERT YOUR NAME

(Sample questionnaire to be sent to DUII providers)

Date: _____

Contact Person: _____

Program Name: _____

Location: _____

Phone: _____ Fax: _____

Hours of operation: _____

DUII Information Program (include fees, sessions, any other features):

_____

_____

_____

_____

_____

_____

_____

DUII Rehabilitation Program (include fees, sessions, any other features):

_____

_____

_____

_____

_____

_____

_____

Other treatment available (domestic violence, anger management, etc.)

_____

_____

_____

_____

_____

SERVICES FOR INFORMATION PROGRAM

Alcohol and other drug information programs are not designed as therapy sessions. They are intended to provide background education about alcohol and other drug problems so that an individual may decide whether or not any changes need to be made in their personal substance use patterns. If the individual should decide to change, then they at least have some knowledge on which to base the decision. These programs are of specific length, usually from four to eight weeks. They are required to include an assessment by the provider upon completion of the information program. If there is need for further services beyond the information that was provided, the individual can usually obtain the services from the same provider. Otherwise the case may be terminated.

The short-term didactic program should only be used for the careless casual user. Research indicates that when individuals with substance abuse problems are sent to only this type of program; the results are counterproductive, i.e., high recidivism regarding offenses and crashes.

Following the ADES' screening and referral, the DUII treatment provider's assessment may indicate that an individual convicted of DUII assesses at the DUII Information/Education level of care. In these limited situations, the DUII treatment provider is reminded of the 90 day abstinence requirement in OAR 309-032-1540(f)(A)(i) for treatment completion and are urged to use their discretion in issuing treatment completion certificates immediately following an individual's completion of four weeks of DUII Information/Education. A hybrid approach for the individuals in these limited situations is to have the individual complete the DUII Information/Education and retain the individual for an additional 60 days with the individual subject to random alcohol and drug tests. This may occur in combination with a limited level of care.

OREGON HEALTH AUTHORITY, ADDICTIONS AND MENTAL HEALTH DIVISION: ADDICTION SERVICES

DIVISION 54

STANDARDS FOR APPROVAL OF DUII ALCOHOL/OTHER DRUG INFORMATION AND DUII ALCOHOL/OTHER DRUG REHABILITATION PROGRAMS

415-054-0020

DUII Alcohol/Other Drug Information Program Detail

(1) A DUII information program shall include a minimum of four sessions over a four-week period and provide 12-20 hours of education.

(2) Required Content/Topics of Education Curriculum:

(a) Victim's panel when possible;

(b) A pre- and post-test that has been approved by the Division;

(c) History, use, and definition of alcohol;

(d) Alcohol as a drug;

(e) Physiological effects of alcohol;

(f) Other drugs -- legal and illegal -- and their effects on driving when used separately and/or in combination with alcohol;

(g) Psychological and sociological consequences of abuse of alcohol or drugs to include the effect on families;

(h) Blood alcohol concentration and effects on driving performance;

(i) Court penalties;

(j) Motor Vehicles Division laws and penalties;

(k) Alcoholism as a problem and a disease (one hour minimum); and

(l) Alternatives to drinking and driving.

(3) Urinalysis Testing: A minimum of one urinalysis sample shall be observed and collected during the first two weeks of a client's DUII information program:

(a) The sample shall be tested for at least three controlled drugs from a list of targeted drugs specified by the Division using the process set out in the definition of "urinalysis testing" in OAR 415-054-0010; and

(b) The program may use methods of testing for the presence of alcohol or other drugs in the client's body other than urinalysis tests if the program has obtained the prior review and approval of such methods by the Division.

(4) Client Evaluation and Rehabilitation Services: The DUII information program shall establish and follow a procedure to assure communication with the evaluation specialist about whether a client should be referred to a rehabilitation program. Clients who test positive for illicit drugs must be referred to a DUII rehabilitation program for assessment and further treatment.

Stat. Auth.: ORS 409.410 & 409.420
Stats. Implemented: ORS 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHD 6-1981(Temp), f. & ef. 11-25-81; MHD 10-1982, f. & ef. 5-7-82; ADAP 3-1992, f. 12-3-92, cert. ef. 3-31-93, Renumbered from 309-054-0020; ADAP 1-1996, f. & cert. ef. 5-17-96; ADS 2-2008, f. & cert. ef. 11-13-08

415-054-0030

Program Approval

(1) Letter of Approval: In order to receive a Letter of Approval from the Division under the process set forth in OAR 415-012-0000 to 415-012-

0090, a DUII information program shall meet the standards set forth in these rules and any other administrative rules applicable to the program.

(2) A DUII information program seeking approval under these rules shall establish to the satisfaction of the Division that the local alcoholism and other drug planning committee was actively involved in the review of the DUII information program as it relates to the CMHP plan.

(3) Inspection: The Division shall inspect at least every two years each information program under these rules.

(4) Renewals: The renewal of a letter of approval shall be governed by OAR 415-012-0040.

(5) Denial, Revocation, Nonrenewal, or Suspension: The denial, revocation, nonrenewal, or suspension of a letter of approval/license for an information program may be based on any of the grounds set forth in OAR 415-012-0060.

(6) In addition to the grounds set forth in OAR 415-012-0060, the Assistant Director may deny, revoke, refuse to renew, or suspend a letter of approval when he or she determines that the issuance or continuation of the letter of approval would be inconsistent with the public interest. In determining the public interest, the Assistant Director shall consider the following factors, or any one of them, which apply to the applicant, licensee, or any person holding a 5 percent or greater financial interest in the program or which apply to the medical director, clinical supervisor, or staff:

(a) Any convictions under any federal or state law relating to any controlled substance;

(b) Furnishing of false, misleading, or fraudulent material in any application for a letter of approval; or

(c) Any other factors relevant to, and consistent with, the public health or safety.

(7) Without the approval of the Assistant Director, no agency or person may provide DUII information program services to a client who has also been referred by a judge to the same agency or person for a DUII related diagnostic assessment. Failure to comply with this section will be

considered a violation of ORS Chapter 813. If the Assistant Director finds such a violation, the Assistant Director may deny, suspend, revoke, or refuse to renew a Letter of Approval.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 409.410 & 409.420
Stats. Implemented: ORS 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHD 6-1981(Temp), f. & ef. 11-25-81; MHD 10-1982, f. & ef. 5-7-82; ADAP 3-1992, f. 12-3-92, cert. ef. 3-31-93, Renumbered from 309-054-0030; ADAP 1-1996, f. & cert. ef. 5-17-96; ADS 2-2008, f. & cert. ef. 11-13-08

415-054-0040

Variances

A variance from these rules may be granted to any agency in accordance with the procedures described in OAR 415-012-0090.

Stat. Auth.: ORS 409.410 & 409.420
Stats. Implemented: ORS 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHD 10-1982, f. & ef. 5-7-82; ADAP 3-1992, f. 12-3-92, cert. ef. 3-31-93, Renumbered from 309-054-0040; ADAP 1-1996, f. & cert. ef. 5-17-96; ADS 2-2008, f. & cert. ef. 11-13-08

Standards for Certification as an Alcohol and Other Drug Screening Specialist (ADSS)

415-054-0400

Purpose

These rules prescribe the standards and requirements for DUII Information Programs, for certification and services provided by Alcohol and Drug Evaluation and Screening Specialists and for approval to establish a demonstration project, both related to individuals ordered by the court for DUII screening, diagnostic and referral to treatment services.

Stat. Auth.: ORS 409.410, 413.042
Stats. Implemented: ORS 409.410, 813.021, 813.206

Hist.: ADS 4-2010(Temp), f. & cert. ef. 9-20-10 thru 3-9-11; ADS 2-2011. f. 3-8-11, cert. ef. 3-9-11

415-054-0410

Definitions

(1) “Alcohol and Drug Evaluation and Screening Specialist” (ADES) means an individual who possesses a valid certificate issued by the Addictions and Mental Health Division (Division) of the Oregon Health Authority (Authority), as prescribed in these rules.

(2) “Assistant Director” means the Assistant Director of the Addictions and Mental Health Division of the Oregon Health Authority.

(3) “Certificate” means a document issued to a person by the Division which authorizes the person to practice as an ADES.

(4) “CFR 42 Part 2” means the Code of Federal Regulations, Title 42, Volume 1, Chapter 1, Part 2 entitled Confidentiality of Alcohol and Drug Abuse Patient Records.

(5) “Conflict of Interest” means use of a personal relationship to obtain financial gain or avoidance of financial detriment; making business decisions which create a pattern of biased or preferential treatment; or initiating a professional role with someone with whom there was a pre-existing personal relationship. The conflict of interest may be actual or potential.

(6) “Diversion Agreement” means a petition approved by the court meeting the criteria established in ORS 813.200 through 813.260.

(7) “Division” means the Addictions and Mental Health Division of the Oregon Health Authority.

(8) “DUII” means driving under the influence of intoxicants.

(9) “DUII Diagnostic Assessment” means an examination by an ADES to determine if a person has a problem condition involving alcohol or controlled substance as described in ORS 813.040.

(10) “DUII Demonstration Project” means an agency approved by the Assistant Director to demonstrate the effectiveness of combining diagnostic assessment and treatment services in a single agency or organization for persons charged with the offense of driving under the influence of intoxicants.

(11) “DUII Information Program” means a short term (12-20) hours in duration), didactic alcohol and drug education program which meets the minimum curriculum, instructor and hourly standards established by the Division.

(12) “Individual” means any person being considered for or receiving services regulated by these rules including adolescents referred pursuant to ORS 419C.443.

(13) “Individual Record” means the confidential, permanent individual record including all documentation, written or electronic, from the point of entry through service conclusion.

(14) “Marijuana Diversion Agreement” means a petition approved by the court pursuant to ORS 135.907 through 135.921.

(15) “Re-referral” means a referral which occurs after an individual disengages from initial treatment and then receives a new referral to the same or different treatment program.

(16) “Risk” means an individual’s use of alcohol or drugs is a problem indicated by a substantial impairment or endangerment to the individual’s health or that of others, or because the individual’s social or economic function is substantially disrupted.

(17) “Screening Interview” means determining the most appropriate treatment provider and making a referral to that provider for an individual convicted of a DUII.

(18) "Single Agency or Organization" means any one person or business entity, any combination of persons or business entities acting together as a program, an agency or any other arrangement which provides or has a financial interest in providing DUII diagnostic assessment and screening interview services approved by the Assistant Director under OAR 415-054 and any DUII treatment services defined in OAR 309-032.

(19) “Transfer” means an individual is referred from one approved DUII treatment program to another as requested by the individual, the ADES or the first treatment program.

(20) “Treatment Program” means an approved alcohol and drug treatment program which meets all standards established by the Division evidenced by a current letter of approval and which specializes in services to individuals with court ordered DUII convictions or diversions, or marijuana diversions.

(21) “Treatment Services” means those services provided by the treatment program which are individualized, planned and medically appropriate and which are designed to remediate the problem condition involving alcohol or drugs.

(22) “Variance” means an exception from a requirement in these rules, granted in writing by the Division on a case by case basis.

Stat. Auth.: ORS 409.410, 413.042
Stats. Implemented: ORS 419C.443, 409.410, 813.021, 813.206, 813.040
Hist.: ADS 4-2010(Temp), f. & cert. ef. 9-20-10 thru 3-9-11; ADS 2-2011. f. 3-8-11, cert. ef. 3-9-11

415-054-0420

Screening and Referral

(1) Each individual shall be assured the same civil and human rights as other persons. The ADES shall provide services in a manner that protects individual privacy and dignity.

(2) The ADES must provide the rights to the individual in written form or in a requested primary language or other alternative format, explain the rights and respond to the individual’s related questions.

(3) The ADES must place in the individual record the individual’s signed acknowledgement that the individual received these rights.

(4) In addition to all applicable statutory and constitutional rights, every individual receiving services has the right to:

(a) Participate in the selection of the treatment program;

(b) Have the role of the court, treatment program and ADES monitoring process explained where the DUII system is concerned;

(c) Confidentiality and the right to consent to disclosure in accordance with 42 CFR Part 2.

(d) Give informed consent in writing prior to the start of services, except as otherwise permitted by law;

(e) Pursuant to ORS 179.505, inspect all parts of their individual record which originated from the ADES within five working days of the request. The individual must obtain copies of documents which originated from other sources from the original source. The individual may be responsible for the cost of duplication.

(f) Receive prior notice of service conclusion or transfer, unless the circumstances necessitating service conclusion or transfer pose a threat to health and safety;

(g) Be free from harassment, abuse or neglect and to report any incident of harassment, abuse or neglect without being subject to retaliation;

(h) Have religious freedom;

(i) Be informed of the policies and procedures, service agreements and fees applicable to the services provided;

(j) Have a custodial parent, guardian or representative assist with understanding any information presented;

(k) Receive a copy of the ADES's or demonstration project's grievance process which shall include the Division and Disability Rights of Oregon telephone numbers. The individual shall:

(A) File a written grievance without any form of reprisal;

(B) Receive a written response to the grievance within 30 days and

(C) File an appeal with the Division if dissatisfied with the ADES's response.

(I) Exercise all rights described in this rule without any form of reprisal or punishment

Stat. Auth.: ORS 409.410, 413.042
Stats. Implemented: ORS 409.410, 109.675, 179.505, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 461.549, 743A.168, 813.010 - 813.055 & 813.200 - 813.270
Hist.: ADS 4-2010(Temp), f. & cert. ef. 9-20-10 thru 3-9-11; ADS 2-2011. f. 3-8-11, cert. ef. 3-9-11

415-054-0430

Administrative Requirements for Information Programs

(1) An information program that contracts directly with the Division or indirectly with the Division through the (CMHP) administered by the Division shall comply with the contracting rules of the Division and contract agents governing reimbursement for services and refunds.

(2) An information program shall develop and implement written policies and procedures that describe program operations. Policies and procedures shall include a quality assurance process ensuring that clients receive appropriate services and that the program is in compliance with relevant administrative rules.

(3) Instructors shall have one year of education, experience, and/or training in one or more of the following areas: social science, psychology, counseling, alcohol/drug rehabilitation, education, or other related field approved by the Division.

(4) If two or more staff provide services, the program shall have and implement the personnel policies and procedures which address:

(a) Rules of conduct and standards for ethical practices of program practitioners, including conflict of interest;

(b) The requirement of a Drug Free Workplace with procedures for managing incidents of use and abuse and

(c) Compliance with the federal and state personnel regulations including the Civil Rights Act of 1964 as amended in 1972, Equal Pay Act of 1963, the Age Discrimination in Employment Act of 1967, Title I of the Americans with Disabilities Act, Oregon civil rights laws related to employment practices, and any subsequent amendments effective on or before the effective date of these rules. The DUII information program shall give individualized consideration to all applicants who, with or without reasonable accommodation, can perform the essential functions of the job position.

(5) Personnel records for each member of the program's staff, volunteers, and interns/students shall be kept and shall include:

(a) Résumé and/or employment application and job description;

(b) Documentation of applicable qualification standards and requirements;

(c) Annual performance appraisals based on pre-established performance criteria founded on the specific responsibilities of the position as stated in the job description;

(d) Documentation of any performance problem and formal corrective action taken due to the problem and

(e) For volunteers or interns/students, the record need only include information required by subsections (5)(a) and (5)(d) of this rule and the written work plan for such person.

(6) Records shall be maintained and utilized in such a way as to ensure program staff confidentiality and shall be retained for a period of three years following the departure of a program staff person.

(7) Information programs receiving public funds must comply with Title 2 of the Americans with Disabilities Act of 1990, 42 USC ? 1231 et seq. after July 26, 1992.

(8) Each program shall maintain the following client record requirements:

(a) Each record shall include all information about clients as required by these rules in permanent client records;

(b) Maintain each client record to assure permanency, identification, accessibility, uniform organization, and completeness of all components required by these rules and in a manner to protect against damage or separation from the permanent client or program record;

(c) Keep all documentation in the permanent client record current (unless specified otherwise), within seven days of delivering the service or obtaining the information;

(d) Include the signature of the person providing the documentation and service;

(e) Not falsify, alter, or destroy any client information required by these rules to be maintained in a client record or program records;

(f) Document all procedures in these rules requiring client consent and the provision of information to the client on forms describing what the client has been asked to consent to or been informed of, and signed and dated by the client. If the program does not obtain documentation of consent or provision of required information, the reasons must be specified in the client record and signed by the person responsible for providing the service to the client;

(g) Require that errors in the permanent client record shall be corrected by lining out the incorrect data with a single line in ink, adding the correct information, and dating and initialing the correction. Errors may not be corrected by removal or obliteration through the use of correction fluid or tape so they cannot be read; and

(h) Permit inspection of client records upon request by the Division to determine compliance with these rules.

(9) Client records shall be kept for a minimum of seven years. If a program is taken over or acquired by another program, the original program is responsible for assuring compliance with the requirements of 42 CFR ?2.19(a)(1) and/or (b), whichever is applicable. If a program discontinues operations, the program is responsible for:

(a) Transferring fiscal records required to be maintained under section (1) of this rule to the Division if it is a direct contract or to the CMHP administering the contract, whichever is applicable; and

(b) Destroying client records or, with client consent, transferring client records to another program.

Stat. Auth.: ORS 409.010, 409.050, 409.410
Stats. Implemented: ORS 813.260
Hist.: ADS 4-2010(Temp), f. & cert. ef. 9-20-10 thru 3-9-11; ADS 2-2011. f. 3-8-11, cert. ef. 3-9-11

415-054-0440

Information Program Detail

(1) A DUII information program shall include a minimum of four sessions over a four-week period and shall include 12-20 hours of education.

(2) Required Content/Topics of Education Curriculum:

(a) Victim's panel when possible;

(b) A pre- and post-test that has been approved by the Division;

(c) History, use, and definition of alcohol;

(d) Alcohol as a drug;

(e) Physiological effects of alcohol;

(f) Other drugs — legal and illegal — and their effects on driving when used separately and/or in combination with alcohol;

(g) Psychological and sociological consequences of abuse of alcohol or drugs to include the effect on families;

(h) Blood alcohol concentration and effects on driving performance;

(i) Court penalties;

(j) Motor Vehicles Division laws and penalties;

(k) Alcoholism as a problem and a disease (one hour minimum); and

(l) Alternatives to drinking and driving.

(3) A minimum of one urinalysis sample shall be observed and collected during the first two weeks of a client's DUII information program:

(a) The sample shall be tested for at least three controlled drugs from a list of targeted drugs specified by the Division using the process set out in the definition of "urinalysis testing" in OAR 415-054-0010; and

(b) The program may use methods of testing for the presence of alcohol or other drugs in the client's body other than urinalysis tests if the program has obtained the prior review and approval of such methods by the Division.

(4) The DUII information program shall establish and follow a procedure to assure communication with the evaluation specialist about whether a client should be referred to a rehabilitation program. Clients who test positive for illicit drugs must be referred to a DUII rehabilitation program for assessment and further treatment.

Stat. Auth.: ORS 409.410 & 413.042
Stats. Implemented: ORS 813.010 - 813.052 & 813.200 - 813.270
Hist.: ADS 4-2010(Temp), f. & cert. ef. 9-20-10 thru 3-9-11; ADS 2-2011. f. 3-8-11, cert. ef. 3-9-11

415-054-0450

Information Program Approval

(1) In order to receive a Letter of Approval (LOA) from the Division, a DUII information program shall meet the standards set forth in these rules and any other administrative rules applicable to the program.

(2) A DUII information program seeking approval under these rules shall establish to the satisfaction of the Division that the local alcoholism and other drug planning committee was actively involved in the review of the DUII information program as it relates to the CMHP plan.

(3) The Division shall inspect at least every two years each information program under these rules.

(4) The renewal of a letter of approval shall be governed by OAR 415-012-0040.

(5) The denial, revocation, nonrenewal, or suspension of a letter of approval/license for an information program may be based on any of the grounds set forth in OAR 415-012-0060.

(6) In addition to the grounds set forth in OAR 415-012-0060, the Assistant Director may deny, revoke, refuse to renew or suspend a letter of approval when he or she determines that the issuance or continuation of the letter of approval would be inconsistent with the public interest. In determining the public interest, the Assistant Director shall consider the following factors, or any one of them, which apply to the applicant, licensee, or any person holding a 5 percent or greater financial interest in the program or which apply to the medical director, clinical supervisor, or staff:

(a) Any convictions under any federal or state law relating to any controlled substance;

(b) Furnishing of false, misleading, or fraudulent material in an application for a letter of approval; or

(c) Any other factors relevant to, and consistent with, the public health or safety.

(7) Without the approval of the Assistant Director, no agency or person may provide DUII information program services to a client who has also been referred by a judge to the same agency or person for a DUII related diagnostic assessment. Failure to comply with this section will be considered a violation of ORS Chapter 813. If the Assistant Director finds such a violation, the Assistant Director may deny, suspend, revoke, or refuse to renew a Letter of Approval.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 409.410 & 413.042
Stats. Implemented: ORS 813.010 - 813.052 & 813.200 - 813.270
Hist.: ADS 4-2010(Temp), f. & cert. ef. 9-20-10 thru 3-9-11; ADS 2-2011. f. 3-8-11, cert. ef. 3-9-11

415-054-0460

ADES Application and Certification Process

(1) Minimum qualifications for ADES certification include:

(a) A Bachelor Degree in social sciences, psychology, sociology, substance abuse or a related subject with course work specific to alcohol or other drug treatment; or

(b) Four years of full time supervised experience in alcohol or drug evaluation, treatment or counseling; or

(c) A combination of two years of education or training in alcohol or drug treatment, evaluation, education or counseling and two years of full-time supervised experience in alcohol or drug service delivery.

(2) A person who wishes to be certified as an ADES must submit a packet of information which includes at minimum an application, three letters of reference, the completed conflict of interest form designated by the Division and a written court Designation that explains the need for an additional ADES in that court's jurisdiction. Examples of need are an increased number of DUII cases or the need for an ADES with specific language proficiency.

(3) An applicant may be denied a certificate for reasons which include but are not limited to insufficient education or experience, poor reference feedback, a confirmed or potential conflict of interest or if the Division determines a lack of need for an ADES in the applicant's geographical area.

(4) Prior to final certification the applicant must have completed ADES specific training curriculum pre-approved by the Division, which includes the following subjects:

(a) The scope, authorities and responsibilities of the ADES as addressed in related Oregon Revised Statutes (ORS), Oregon Administrative Rules (OAR) and Division policies and procedures;

(b) A summary of related roles of the court and the treatment provider and how their roles differ from those of the ADES;

(c) A review of professional issues such as conflict of interest, other ethics standards, confidentiality, releases of information and individuals' rights;

(d) The process of conducting screening interviews, diagnostic assessments, interpreting court and other legal documents, determining risk and formulating a screening summary, referral procedures and reporting requirements;

(e) Determining the appropriate treatment provider for each case based upon the screening or diagnostic assessment results and individual needs and referral procedures;

(f) Interpretation of toxicology and urinalysis tests results and

(g) Standards and requirements of individual permanent records.

Stat. Auth.: ORS 409.410, 413.042
Stats. Implemented: ORS 409.410, 813.021, 813.260
Hist.: ADS 4-2010(Temp), f. & cert. ef. 9-20-10 thru 3-9-11; ADS 2-2011. f. 3-8-11, cert. ef. 3-9-11; ADS 2-2011. f. 3-8-11, cert. ef. 3-9-11

415-054-0470

Other Requirements

(1) The ADES shall fully cooperate with program reviews conducted by the Division and with all corrective actions required by the Division.

(2) During all working hours the ADES shall not be under the influence of nor use or have present in any amounts in his or her body any alcohol or drugs to include controlled substances, unless pursuant to a current prescription from a licensed physician.

(3) The ADES must serve a minimum of twelve individuals over the calendar year.

(4) The ADES must comply with Title 2 of the Americans With Disabilities Act of 1990, 42 USC Section 12131 et seq.

Stat. Auth.: ORS 409.410, 413.042
Statutes Implemented: ORS 409.410, 813.021, 813.260
Hist.: ADS 4-2010(Temp), f. & cert. ef. 9-20-10 thru 3-9-11; ADS 2-2011. f. 3-8-11, cert. ef. 3-9-11

415-054-0480

Screening Interview and Diagnostic Assessments

(1) The ADES must perform a screening interview for individuals convicted of a DUII to determine the most appropriate DUII treatment provider in making a referral to that provider. The ADES must use documents and procedures designated by the Division.

(2) The ADES must perform a diagnostic assessment for individuals under a DUII Diversion Agreement to determine if the individual has a problem condition involving alcohol or drugs including controlled substances and to determine the most appropriate DUII treatment provider. In making the referral to that provider the ADES must use documents and procedures designated by the Division.

(3) Screening interviews and diagnostic assessments shall be conducted in a face-to-face interview whenever possible. If a telephone interview is used the ADES shall document in the individual's record a full explanation for the absence of a face-to-face interview.

Stat. Auth.: ORS 409.410, 413.042
Stats. Implemented: ORS 409.410, 813.021, 813.260
Hist.: ADS 4-2010(Temp), f. & cert. ef. 9-20-10 thru 3-9-11; ADS 2-2011. f. 3-8-11, cert. ef. 3-9-11

415-054-0490

Referrals

(1) The ADES shall perform the referral process by thoroughly completing all documents and following all procedures designated by the Division.

(2) The ADES shall provide to the individual a list of all Division approved treatment programs:

(a) Within the geographic area preferred by the individual and

(b) Those treatment programs in any other geographic area capable of responding to a specific need including, but not limited to ability to pay or

seek reimbursement through insurance, primary language or hours of treatment which allow an individual to maintain a work schedule.

(3) The process of selecting the treatment program shall be collaborative between the ADES and the

individual, however the ADES shall make the final determination in referring the individual to an approved DUII information or treatment program. The ADES shall explain the rationale for the information or treatment program which the ADES believes most closely provides services specific to the individual's treatment needs, including the individual's request for a restricted driver's license.

(a) The ADES shall confirm that the individual participated in the selection of the information or treatment program by documenting in a statement which must be co-signed by the individual and placed in the individual record.

(4) The ADES may not refer an individual to a program if doing so may cause an actual or potential conflict of interest.

(5) Whenever possible referrals of adolescents shall be to programs that specialize in treatment for adolescents.

(6) Within five days of the screening the ADES shall forward to the selected information or treatment program a copy of the referral form, the screening cover sheet and the completed screening instrument.

(7) If the individual has a court approved Marijuana Diversion Agreement the screening and referral process is identical to those for individuals referred for DUII charges.

(8) If the screening results indicate the individual does not have a problem condition as defined in ORS 813.040 for the use of marijuana the ADES shall indicate so on the screening instrument and then refer the individual back to court.

Stat. Auth.: ORS 409.410, 413.042
Stats. Implemented: ORS 409.410, 813.021,813.260
Hist.: ADS 4-2010(Temp), f. & cert. ef. 9-20-10 thru 3-9-11; ADS 2-2011. f. 3-8-11, cert. ef. 3-9-11

415-054-0500

Transfers, Re-Referrals and Out-of-State Offenders

(1) When a transfer from one treatment program to another is requested by the individual or the current treatment program, the ADES shall consider and document the logistic, financial or other reasons for the request and the rationale for either an acceptance or denial of the request.

(2) A transfer may not be approved if the individual refuses to sign a release of information which permits an exchange of verbal and written communications between the current and the proposed next treatment program.

(3) When the individual resides in a state other than Oregon, the ADES may refer the individual to a treatment program licensed by and located in the individual's home state.

(4) The ADES' roles concerning out-of-state offenders shall be identical as those for Oregon residents.

Stat. Auth.: ORS 409.410, 413.042
Statutes Implemented: ORS 409.410, 813.021, 813.260
Hist.: ADS 4-2010(Temp), f. & cert. ef. 9-20-10 thru 3-9-11; ADS 2-2011. f. 3-8-11, cert. ef. 3-9-11

415-054-0510

Monitoring

The ADES shall monitor the individual throughout the information or treatment process by:

(1) Verifying the individual began the information or program within 30 days of the referral;

(2) Verifying whether or not the individual satisfactorily completed all requirements of the program;

(3) Notifying the court concerning the individual's compliance with program requirements and

(4) Documenting in the individual record each contact with the program and the court.

Stat. Auth.: ORS 409.410, 413.042
Stats. Implemented: ORS 409.410, 813.021, 813.260
Hist.: ADS 4-2010(Temp), f. & cert. ef. 9-20-10 thru 3-9-11; ADS 2-2011. f. 3-8-11, cert. ef. 3-9-11

415-054-0520

Individual Records and Fees

(1) The ADES must develop and maintain a confidential permanent individual record for each individual. The record must, at minimum include a copy of:

(a) All legal documents received;

(b) A form signed by the individual acknowledging receipt of confidentiality rights pursuant to 42 CFR Part 2;

(c) All completed documents required in these rules and any related Division procedures;

(d) Documentation of each contact related to the individual's case;

(e) All status reports and other documents received from the DUII approved treatment program;

(f) All documents related to any re-referral or request for transfer from one treatment program to another and

(g) All documents related to any out-of-state referrals.

(2) Any errors in the individual record shall be corrected by drawing a single ink line through the error and adding the correction date and ADES's initials. The use of correction fluid or tape or any other attempt to make the error illegible is unacceptable.

(3) The ADES shall maintain each individual record for seven years in a location which assures accessibility, organization, the individuals' confidentiality and which protects against damage or loss.

(4) Pursuant to ORS 813.021 and 813.240, the ADES may charge $150.00 for their services to each individual.

(a) The ADES must itemize in the individual record all fees received by the individual, indicating the service(s) provided and any outstanding fees.

(5) The ADES shall permit the Division to inspect all permanent records to determine compliance with these rules.

Stat. Auth.: ORS 409.410, 413.042
Stats. Implemented: ORS 409.410, 813.021, 813.260
Hist.: ADS 4-2010(Temp), f. & cert. ef. 9-20-10 thru 3-9-11; ADS 2-2011. f. 3-8-11, cert. ef. 3-9-11

415-054-0530

Reporting Requirements

(1) By the 10th of each month, the ADES shall send to the Division the monthly report of DUII and marijuana diversion individuals served by the ADES caseload.

(2) Any potential or actual conflict of interest must immediately be declared to the Division on the designated form.

(3) An ADES who decides to close the business voluntarily must notify the Division in writing within 60 days of the proposed closure with a plan for:

(a) Transferring service responsibility for each individual the ADES is currently monitoring to another ADES, who agrees in writing to the plan and

(b) Secure storage of all individual records less than seven years old, pursuant to OAR 166.040. The Division may approve a plan to transfer the records to another ADES within the same court jurisdiction who indicates in writing the willingness to accept responsibility for their secure storage.

(4) When a program is discontinued, its current certificate is immediately void and shall be returned to the Division. A discontinued program is one which has terminated its services for which it had been approved or licensed.

Stat. Auth.: ORS 409.410, 413.042
Stats. Implemented: ORS 409.410, 813.021, 813.260
Hist.: ADS 2-2011. f. 3-8-11, cert. ef. 3-9-11

415-054-0540

Revocation, Non-renewal or Suspension of the ADES Certificate

The Division may deny a request for a certificate renewal, or may revoke or temporarily suspend an existing ADES certificate when it finds any of the following:

(1) The ADES has substantially failed to comply with applicable administrative rules, state or federal law or with local codes or ordinances;

(2) Failure to demonstrate competencies specified in these rules;

(3) Received a prior denial, suspension, revocation or refused renewal of any other Authority license or certificate;

(4) The applicant or ADES submits fraudulent or untrue information to the Division;

(5) The applicant or ADES has a history of, or currently demonstrates financial insolvency including but not limited to filing for bankruptcy, a foreclosure or failure to pay taxes;

(6) The applicant or ADES refuses to allow immediate access and onsite inspection by the Division;

(7) The applicant or ADES is found to have permitted, aided or abetted the commitment of an unlawful act;

(8) Deviation by the ADES from the plan or operation originally approved and certified which, in the judgment of the Division, adversely affects the quality or scope of the intended services;

(9) Does not meet the minimum requirement of serving a minimum of one individual per month over the course of one year;

(10) Failure to allow an individual to exercise rights as defined in these rules;

(11) Failure to declare in writing any potential or actual conflict of interest or

(12) Failure to fully comply with any corrective action plan designated by the Division.

Stat. Auth.: ORS 409.410, 413.042
Stats. Implemented: ORS 409.410, 813.021, 813.260
Hist.: ADS 2-2011. f. 3-8-11, cert. ef. 3-9-11

415-054-0550

Demonstration Project Approval Process

(1) Only an ADES with a valid certificate and a single agency or organization with a valid letter of approval to provide treatment services may be approved as a demonstration project.

(2) Requests for approval under these rules must include a narrative which describes or otherwise addresses the following:

(a) That a clearly defined and significant problem exists in the separate provision of diagnostic assessment, information and treatment services as defined in these rules;

(b) The problem cannot be resolved as long as the diagnostic assessment, information and treatment functions are performed by separate agencies or organizations;

(c) There is relevant research or other data which shows that a particular method for combining the performance of these functions in a single agency is an effective and appropriate means of resolving the problem;

(d) The person or agency proposing to conduct a demonstration of the particular method has, and can maintain for the duration of the project:

(A) The appropriate clinical and managerial knowledge, skills and abilities required by administrative rule for ADES services, information and treatment programs and

(B) A process to evaluate the effectiveness of the demonstration project which:

(i) Is conducted independent of the demonstration project;

(ii) Compares the demonstration project program with non-project programs;

(iii) Compares outcomes of post-project service recipients to those in a control group;

(iv) Includes the cost effectiveness of the demonstration project and

(v) Includes cost savings to service recipients.

(e) An assurance the applicant has not previously failed to resolve problems or satisfactorily conduct or complete other programs or projects for private or public entities;

(f) The effect on other ADES, information and treatment programs and whether referrals will also be made to outside agencies and

(g) The geographic location to be served; the participating persons or agencies and their respective roles in the proposed project; the length of time proposed for the project and the expected outcomes.

(3) The application packet must also include:

(a) Letters of endorsement from courts and other relevant persons or agencies;

(b) Written assurances of participation by each proposed participant;

(c) Documentation that the request for approval has been reviewed and a recommendation made by the Community Mental Health Program director of the proposed geographic area and the local alcoholism and drug planning committee and

(d) Any additional information requested by the Division.

(4) Approval of a demonstration project is at the discretion of the Assistant Director. The Division shall review requests and shall notify the requestor of the approval or denial within 60 days of the date the request is received by the Assistant Director.

Stat. Auth.: ORS 409.410, 413.042
Stats. Implemented: ORS 409.410, 813.021, 813.260
Hist.: ADS 2-2011. f. 3-8-11, cert. ef. 3-9-11

415-054-0560

Demonstration Project General Requirements

(1) The approved demonstration project must comply with all ADES, information and treatment program requirements detailed in OAR 415-054 and 309-032.

(2) The effectiveness of the approved demonstration project must be evaluated as agreed upon between the applicant and the Division.

(3) Results of the program evaluation must be submitted to the Division within timelines approved by the Assistant Director.

Stat. Auth.: ORS 409.410, 413.042
Stats. Implemented: ORS 409.410, 813.021, 813.260
Hist.: ADS 2-2011. f. 3-8-11, cert. ef. 3-9-11

415-054-0570

Revocation or Denial of Approval for Demonstration Projects

(1) Approval of an application for a demonstration project is at the Assistant Director’s discretion.

(2) The Assistant Director may deny, revoke or refuse to renew approval for any of the reasons detailed in OAR 415-054 or due to a finding that the demonstration project is not resolving the problems explained in the original application.

(3) The Assistant Director may refuse to renew approval if the program evaluation required under these rules fails to demonstrate the effectiveness of combining the diagnostic assessment and the treatment functions within a single agency or organization.

(4) When a request for approval to operate a demonstration project is denied, a current approval is suspended or revoked, or renewal is denied, notice of the action shall be sent by certified mail and shall include information about contested case hearings.

Stat. Auth.: ORS 409.410, 413.042
Stats. Implemented: ORS 409.410, 813.021, 813.260
Hist.: ADS 2-2011. f. 3-8-11, cert. ef. 3-9-11

415-054-0580

Variances

(1) A variance request must be submitted to the Division in writing and must include:

(a) The section of the rule for which the variance is sought;

(b) The reason for the request and the proposed alternative plan and

(c) If temporary in nature, a timetable for compliance with the related rule.

(2) If the request is denied an appeal may be made to the Assistant Director whose decision shall be final.

(3) The document from the Division granting a variance must remain in the ADES's permanent business file.

Stat. Auth.: ORS 409.410, 413.042
Stats. Implemented: ORS 409.410, 813.021, 813.260
Hist.: ADS 2-2011. f. 3-8-11, cert. ef. 3-9-11

The official copy of an Oregon Administrative Rule is contained in the Administrative Order filed at the Archives Division, 800 Summer St. NE, Salem, Oregon 97310. Any discrepancies with the published version are satisfied in favor of the Administrative Order. The Oregon Administrative

Rules and the Oregon Bulletin are copyrighted by the Oregon Secretary of State. Terms and Conditions of Use

SERVICES FOR TREATMENT PROGRAMS

The duration of the treatment program will be determined by the treatment program's utilization of the placement, continued stay, and discharge criteria based on the criteria described in the ASAM PPC-2R. In addition, the individual must demonstrate abstinence for a minimum of 90-days prior to discharge from the program. Documentation will be by at least one random Urinalysis tests per month showing 90-days of abstinence. This is not to say that 90 days is all that is required, only that there must be a 90-day demonstration of continuous abstinence during the last 90 days of the program. If a urinalysis sample is positive, the 90-days will begin with the next clean UA. The individual may also be placed at a higher level of care with further requirements to obtain the DUII Treatment Completion Certificate.

Programs completed while in a controlled environment such as residential treatment, in-house, inpatient, or treatment obtained while incarcerated does not meet the requirements to obtain a DUII Treatment Completion Certificate. Online Alcohol and Drug Programs are not accepted.

A critical time in an individual's recovery or abstinence comes when the individual transitions from a confined structured environment, such as a residential treatment program or a correctional institution, back into the community. For a variety of reasons we know that many people relapse and go back to using during this time. This is why outpatient DUII programs are the only programs licensed to do DUII Information or DUII Treatment.

It is critical that the individual demonstrates that they can remain clean and sober while in the community in order to have their driving privileges reinstated.

An individual has successfully completion when they are in need of no further treatment or aftercare, financial obligations have been met, and at least 90-days of documented abstinence at time of discharge has occurred.

In some states, the individual's privilege to drive is reinstated upon entry in a treatment program or after 60-days of treatment. The State of Oregon does not re-instate driving privileges after completion of 60-days of

treatment. The individual must successfully complete the program to obtain a DUII Treatment Completion Certificate.

OREGON HEALTH AUTHORITY, ADDICTIONS AND MENTAL HEALTH DIVISION: MENTAL HEALTH SERVICES

DIVISION 32

COMMUNITY TREATMENT AND SUPPORT SERVICES

Mental Health Services For Homeless Individuals

309-032-0301

Purpose and Scope

These rules prescribe the standards for community-based programs that serve individuals with a serious mental illness experiencing homelessness under the Projects for Assistance in Transition from Homelessness (PATH) program.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.610 – 430.695
Hist.: MHS 7-2011, f. & cert. ef. 9-26-11; MHS 9-2011(Temp), f. & cert. ef. 11-22-11 thru 5-18-12; MHS 2-2012, f. & cert. ef. 2-9-12

309-032-0311

Definitions

(1) “Co-Occurring Disorders” (COD) means the existence of at least one diagnosis of a substance use disorder and one diagnosis of a serious mental illness.

(2) “Community Mental Health Program” (CMHP) means an entity that is responsible for planning and delivery of services for individuals with

substance use or mental illness diagnoses, operated in a specific geographic area of the state under an intergovernmental agreement or a direct contract with the Addictions and Mental Health Division (AMH).

(3) “Division” means the Addictions and Mental Health Division of the Oregon Health Authority (OHA).

(4) “Eligible Individual” means an individual who, as defined in these rules:

(a) Is homeless or at imminent risk of becoming homeless and

(b) Who has, or is reasonably assumed to have, a serious mental illness.

(c) The individual may also have a co-occurring substance use disorder.

(5) “Enrolled” means an eligible individual who:

(a) Receives services supported at least partially with PATH funds and

(b) Has an individual service record that indicates enrollment in the PATH program.

(6) “Homeless Individual” means an individual who:

(a) Lacks housing without regard to whether the individual is a member of a family and whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations; or

(b) Is a resident in transitional housing that carries time limits.

(7) “Individual” means an individual potentially eligible for or who has been enrolled to receive services described in these rules.

(8) “Individual Service and Support Plan” (ISSP) means a comprehensive plan for services and supports provided to or coordinated for an eligible individual that is reflective of the intended outcomes of service.

(9) “Imminent Risk of Homelessness” means that an individual is:

(a) Living in a doubled-up living arrangement where the individual’s name is not on the lease;

(b) Living in a condemned building without a place to move;

(c) In arrears in their rent or utility payments;

(d) Subject to a potential eviction notice without a place to move; or

(e) Being discharged from a health care or criminal justice institution without a place to live.

(10) “Individual Service Record” means the written or electronic documentation regarding an enrolled individual that summarizes the services and supports provided from point of entry to service conclusion.

(11) “Literally Homeless Individual” means an individual who lacks housing without regard to whether the individual is a member of a family, including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations.

(12) “Local Mental Health Authority” (LMHA) means one of the following entities:

(a) The Board of County Commissioners of one or more counties that establishes or operates a CMHP;

(b) The tribal council of a federally recognized tribe of Native Americans that elects to enter into an agreement to provide mental health services or

(c) A regional LMHA comprised of two or more boards of county commissioners.

(13) “Outreach” means the process of bringing individuals into treatment who do not access traditional services.

(14) “Projects for Assistance in Transition from Homelessness” (PATH) means the Formula Grants, 42 U.S.C. 290cc-21 to 290-cc-35.

(15) “Qualified Mental Health Professional” (QMHP) means any person who meets one of the following minimum qualifications as authorized by the LMHA or designee:

(a) A Licensed Medical Practitioner;

(b) A graduate degree in psychology, social work, or recreational, art or music therapy;

(c) A graduate degree in a behavioral science field;

(d) A bachelor's degree in occupational therapy and licensed by the State or Oregon; or

(e) A bachelor's degree in nursing and licensed by the State of Oregon.

(16) "Secretary" means the Secretary of the U.S. Department of Health and Human Services.

(17) "Serious Mental Illness" means a psychiatric condition experienced by an individual who is 18 years of age or older and who is:

(a) Diagnosed by a QMHP as suffering from a serious mental disorder as defined in Oregon Revised Statutes (ORS) 426.495 which includes, but is not limited to conditions such as schizophrenia, affective disorder, paranoid disorder, and other disorders which manifest psychotic symptoms that are not solely a result of a developmental disability, epilepsy, drug abuse or alcoholism; and which continue for more than one year, or

(b) Is impaired to an extent which substantially limits the individual's consistent ability to function in one or more of the following areas:

(A) Independent attendance to the home environment including shelter needs, personal hygiene, nutritional needs and home maintenance;

(B) Independent and appropriate negotiation within the community such as utilizing community resources for shopping, recreation, transportation and other needs;

(C) Establishment and maintenance of supportive relationships; or

(D) Maintained employment sufficient to meet personal living expenses or engagement in other age appropriate activities.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.610 – 430.695

Hist.: MHS 7-2011, f. & cert. ef. 9-26-11; MHS 9-2011(Temp), f. & cert. ef. 11-22-11 thru 5-18-12; MHS 2-2012, f. & cert. ef. 2-9-12

309-032-0321

Eligible Services

(1) Effective outreach to engage people in the following array of services:

(a) Identification of individuals in need;

(b) Screening for symptoms of serious mental illness;

(c) Development of rapport with the individual;

(d) Offering support while assisting with immediate and basic needs;

(e) Referral to appropriate resources; or

(f) Distribution of information including but not limited to:

(A) Flyers and other written information;

(B) Public service announcements; or

(C) Other indirect methods of contact.

(2) Methods of active outreach including but not limited to face-to-face interaction with literally homeless people in streets, shelters, under bridges and in other non-traditional settings, in order to seek out eligible individuals.

(3) Methods of in-reach, including but not limited to placing outreach staff in a service site frequented by homeless people, such as a shelter or community resource center, where direct, face to face interactions occur, in order to allow homeless individuals to seek out outreach workers.

(4) Screening and diagnosis.

(5) Habilitation and rehabilitation services.

(6) Community mental health services.

(7) Alcohol or drug treatment services.

(8) Staff training, including the training of those who work in shelters, mental health clinics, substance abuse programs, and other sites where homeless individuals require services.

(9) Case management including the following.

(a) Preparing a plan for the provision of community mental health services to the eligible individual and reviewing the plan not less than once every three months;

(b) Assistance in obtaining and coordinating social and maintenance services for the eligible individual, including services related to daily living activities, personal financial planning, transportation, and housing services;

(c) Assistance to the eligible individual in obtaining income support services including housing assistance, food stamps and supplemental security income benefits;

(d) Referring the eligible individual for such other services as may be appropriate and

(e) Providing representative payee services in accordance with section 1631(a)(2) of the Social Security Act [42 U.S.C. 1383(a)(2)] if the eligible individual is receiving aid under title XVI of such act [42 U.S.C. 1381 et seq.] and if the applicant is designated by the Secretary to provide such services;

(10) Supportive and supervisory services in residential settings;

(11) Housing services, which shall not exceed twenty percent of all total PATH expenses and which may include:

(a) Minor renovation, expansion and repair of housing;

(b) Planning of housing;

(c) Technical assistance in applying for housing assistance;

(d) Improving the coordination of housing services;

(e) Security deposits;

(f) The costs associated with matching eligible individuals with appropriate housing situations; or

(g) One time rental payments to prevent eviction; and

(12) Referrals to other appropriate services or agencies, for those determined ineligible for other PATH services.

(13) Other appropriate services as determined by the Secretary.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.610 – 430.695
Hist.: MHS 7-2011, f. & cert. ef. 9-26-11; MHS 9-2011(Temp), f. & cert. ef. 11-22-11 thru 5-18-12; MHS 2-2012, f. & cert. ef. 2-9-12

309-032-0331

Staff Qualifications and Training Standards

(1) Staff delivering case management and outreach services to individuals shall have demonstrated ability to:

(a) Identify individuals who appear to be seriously mentally ill;

(b) Identify service goals and objectives and incorporate them into an ISSP; and

(b) Refer the individuals for services offered by other agencies.

(2) All staff delivering PATH services shall have training, knowledge and skills suitable to provide the services described in these rules.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.610 – 430.695
Hist.: MHS 7-2011, f. & cert. ef. 9-26-11; MHS 9-2011(Temp), f. & cert. ef. 11-22-11 thru 5-18-12; MHS 2-2012, f. & cert. ef. 2-9-12

309-032-0341

Rights of Eligible Individuals

(1) In addition to all applicable statutory and constitutional rights, every eligible individual receiving services has the right to:

(a) Choose from available services and supports;

(b) Be treated with dignity and respect;

(c) Have all services explained, including expected outcomes and possible risks;

(d) Confidentiality and the right to consent to disclosure in accordance with ORS 107.154, 179.505, 192.515 and 42 CFR Part 2 and 45 CFR Part 205.50;

(e) Give informed consent to services in writing prior to the start of services, except in a medical emergency or as otherwise permitted by law;

(f) Inspect their Individual Service Record in accordance with ORS 179.505;

(g) Not participate in experimentation;

(h) Receive medications specific to the individual's diagnosed clinical needs;

(i) Receive prior notice of service conclusion or transfer, unless the circumstances necessitating service conclusion or transfer pose a threat to health or safety;

(j) Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation;

(k) Have religious freedom;

(l) Be informed at the start of services and periodically thereafter of the rights guaranteed by these rules;

(m) Be informed of the policies and procedures, service agreements and fees applicable to the services provided, and to have a custodial parent, guardian or representative assist with understanding any information presented;

(n) Have family involvement in service planning and delivery;

(o) Make a declaration for mental health treatment, when legally an adult;

(p) File grievances, including appealing decisions resulting from the grievance; and

(q) Exercise all rights described in this rule without any form of reprisal or punishment.

(2) The provider will give to the individual and if applicable, to the guardian, a document that describes the preceding individual rights.

(a) Information given to the individual must be in written form or, upon request, in an alternative format or language appropriate to the individual's need;

(b) The rights and how to exercise them will be explained and

(c) Individual rights will be posted in writing in a common area.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.610 – 430.695
Hist.: MHS 7-2011, f. & cert. ef. 9-26-11; MHS 9-2011(Temp), f. & cert. ef. 11-22-11 thru 5-18-12; MHS 2-2012, f. & cert. ef. 2-9-12

309-032-0351

Enrollment and Record Requirements

(1) An individual's eligibility shall be determined and documented at the earliest possible date.

(2) A record shall be maintained for each enrolled individual receiving services under this rule. The record shall contain the following:

(a) An enrollment form which includes:

(A) The individual's name and PATH enrollment date;

(B) A list or description of the criteria determining the individual's PATH eligibility; and

(C) The individual's PATH services discharge date.

(b) A plan defining the enrolled individual's goals and service objectives including one or more of the following:

(A) Accessing community mental health services for the eligible individual, which includes reviewing the plan not less than once every three months;

(B) Accessing and coordinating needed services for the eligible individual, as detailed in these rules.

(C) Accessing income and income support services, including housing assistance, food stamps, and supplemental security income; and

(D) Referral to other appropriate services.

(c) Progress notes that provide an on-going account of contacts with enrolled individual, a description of services delivered, and progress toward the enrolled individual's service plan goals; and

(d) A termination summary describing reasons for the enrolled individual no longer being involved in service.

(3) A record shall be maintained for individuals served but not yet enrolled under the provisions of these rules. The record shall contain:

(a) A description of the potentially eligible individual, which may include but not be limited to:

(A) A physical description of the individual;

(B) The location where the individual was served; and

(C) A description of the individual's personal belongings.

(b) A preliminary assessment of the potentially eligible individual's needs based on available information; and

(c) A record of where and when contacts with the potentially eligible individual were made and the outcome of those contacts.

(4) Records shall be confidential in accordance with ORS 179.505, 45 CFR Part 2 and OAR 032-1535 pertaining to individuals' records.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.610 – 430.695
Hist.: MHS 7-2011, f. & cert. ef. 9-26-11; MHS 9-2011(Temp), f. & cert. ef. 11-22-11 thru 5-18-12; MHS 2-2012, f. & cert. ef. 2-9-12

Community Treatment and Support Services

309-032-0850

Standards for Regional Acute Care Psychiatric Services for Adults

(1) Purpose: These rules prescribe standards and procedures for regional acute care psychiatric services for adults.

(2) Statutory Authority: These rules are authorized by ORS 413.042 and 430.640 to carry out the provisions of ORS 430.630.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.630 & 430.640
Hist. MHD 8-1994, f. & cert. ef. 11-28-94

309-032-0860

Definitions

As used in these rules:

(I) "Adult" means a person age 18 years or older.

(2) "Clinical record" means a separate file established and maintained under these rules for each patient.

(3) "Community mental health program" or "CMHP" means the organization of all services for persons with mental or emotional disturbances, drug abuse problems, developmental disabilities, and alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a local mental health authority, and operated in a specific geographic area of the state under an omnibus contract with the Division.

(4) “Council” means an organization of persons, with a mission statement and by-laws, comprised of representatives of the regional acute care psychiatric service, state hospital, community mental health programs served, consumers, and family members. The Council is advisory to the regional acute care facility for adults.

(5) “Diagnosis” means a DSM diagnosis determined through the mental health assessment and any examinations, laboratory, medical or psychological tests, procedures, or consultations suggested by the assessment.

(6) “Division” means the Addictions and Mental Health Division of the Oregon Health Authority.

(7) “DSM” means the current edition of the “Diagnostic and Statistical Manual of Mental Disorders,” published by the American Psychiatric Association.

(8) “Goal” means the broad aspirations or outcomes toward which the patient is striving, and toward which all services are intended to assist the patient.

(9) “Guardian” means a person appointed by a court of law to act as a guardian of a legally incapacitated person.

(10) “Independent medical practitioner” means a medically trained person who is licensed to practice independently in the State of Oregon and has one of the following degrees: MD (Medical Doctor), DO (Doctor of Osteopathy), or NP (Nurse Practitioner).

(11) “Legally incapacitated” means having been found by a court of law under ORS 126.103 or 426.295 to be unable, without assistance, to properly manage or take care of one’s personal affairs.

(12) “Linkage agreement” means a written agreement between the regional acute care psychiatric services, the local

community mental health programs, and state hospitals which describes the roles and responsibilities each assumes in order to assure that the goals of the regional acute care psychiatric services are achieved.

(13) “Medical director” means a board eligible psychiatrist who oversees the patient care program. The medical director shall have the final authority concerning inpatient medical care including admissions, continuing care, and discharges.

(14) “Medical history” means a review of the patient’s current and past state of health as reported by the patient or other reliable sources, including, but not limited to:

(a) History of any significant illnesses, injuries, allergies, or drug sensitivities; and

(b) History of any significant medical treatments, including hospitalizations and major medical procedures.

(15) “Mental health assessment” means a process in which the person’s need for mental health services is determined through evaluation of the patient’s strengths, goals, needs, and current level of functioning.

(16) “Mental status examination” means an overall assessment of a person’s mental functioning that includes descriptions of appearance, behavior, speech, mood and affect, suicidal/homicidal ideation, thought processes and content, and perceptual difficulties including hallucinations and delusions. Cognitive abilities are also assessed and include orientation, memory, concentration, general knowledge, abstraction abilities, judgment, and insight.

(17) “Objective” means an interim level of progress or a component step the specification of which is necessary or helpful in moving toward a goal.

(18) “Office” means the Office of Mental Health Services of the Division.

(19) “OPRCS” means the Oregon Patient/Resident Care System. OPRCS is a Division operated, on-line computerized information system which

accepts, stores and returns information about patients from state operated institutions and other designated inpatient services.

(20) “Patient” means a person who is receiving care and treatment in a regional acute care psychiatric service.

(21) “Person committed to the Division” means a patient committed under ORS 161.327 or 426.130.

(22) “Program administrator” means a person, with appropriate professional qualifications and experience, appointed by the governing body to manage the operation of the regional acute care psychiatric services.

(23) “Psychiatrist” means a physician licensed as provided pursuant to ORS 677.010 to 677.492 by the Board of Medical Examiners for the State of Oregon and who has completed an approved residency training program in psychiatry.

(24) “Qualified mental health professional” or “QMHP” means a person who is one of the following:

(a) Psychiatrist or physician, licensed to practice in the State of Oregon; an individual with a graduate degree in psychology, social work, or other mental health related field; a registered nurse with a graduate degree in psychiatric nursing, licensed in the State of Oregon; an individual with registration as an occupational therapist; an individual with a graduate degree in recreational therapy; or

(b) Any other person whose education, experience, and competence have been documented by the CMHP director or designee as able to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social, and work relationships, conduct a mental status assessment; document a DSM diagnosis; write and supervise a rehabilitation plan; and provide individual, family, and/or group therapy.

(25) “Regional acute care psychiatric service” or “service” means a Division funded service provided under contract with the Division or county, and operated in cooperation with a regional or local council. A regional acute care psychiatric service must include 24 hour-a-day psychiatric, multi-disciplinary, inpatient or residential stabilization, care and treatment, for

adults ages 18 and older with severe psychiatric disabilities in a designated region of the State. For the purpose of these rules, a state hospital is not a regional acute care psychiatric service. The goal of a regional acute care service is the stabilization, control and/or amelioration of acute dysfunctional symptoms or behaviors that result in the earliest possible return of the person to a less restrictive environment.

(26) “Supervisor” means a person who has two years of experience as a qualified mental health professional and who, in accordance with Section 309-032-0870 of these rules, reviews the services provided to patients by qualified persons.

(27) “Treatment plan” means an individualized, written plan defining specific rehabilitation objectives and proposed service interventions derived from the patient’s mental health assessment.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.630 & 430.640
Hist. MHD 8-1994, f. & cert. ef. 11-28-94

309-032-0870

Standards for Approval of Regional Acute Care Psychiatric Service

(1) State approvals and licenses. The facility in which a regional acute care psychiatric service is provided shall maintain state approvals and licenses as required by Oregon law for the health, safety, and welfare of the persons served. Non-hospital facilities shall be licensed by the Division as required by ORS 443.410. The facility must also be approved under OAR 309-033-0530 Approval of Hospitals and Nonhospital Facilities that Provide Services to Committed Persons and to Persons in Custody or on Diversion and OAR 309-033-0540, Administrative Requirements for Hospitals and Nonhospital Facilities Approved to Provide Services to Persons in Custody, Psychiatric Hold or Certified for 14 Days of Intensive Treatment.

(2) Clinical record management. A regional acute care psychiatric service shall maintain clinical records as follows:

(a) Clinical records are confidential, as set forth in ORS 179.505 and 192.502 and any other applicable state or federal law, except as otherwise indicated by applicable rule or law. For the purposes of disclosure from

non-medical individual records, both the general prohibition against disclosure of “information of a personal nature” and limitations to the prohibition in ORS 192.502 shall be applicable.

(b) Clinical records shall be secured, safeguarded, stored, and retained in accordance with OAR 166-030-1015.

(c) Clinical record entries required by these rules must be signed by the staff providing the service and making the entry. Each signature must include the person’s academic degree or professional status and the date signed.

(3) Clinical record content. The clinical record shall contain:

(a) Identifying demographic information, including, if available, who to contact in an emergency and the names of persons who encompass the support system of the patient.

(b) Consent to release information and explanation of fee policies. At the time of admission staff shall present the patient with forms for obtaining consent so that information may be shared with family and others. An explanation of fee policies shall also be provided in written form at the earliest time possible. The patient shall be asked to sign each. If the patient is unwilling or unable to sign, staff shall record that the person is unable or unwilling to do so.

(c) Admitting mental health assessment. An admitting mental health assessment shall be completed, by or under the supervision of an independent medical practitioner with supervised training or experience in a mental health related setting, within 24 hours of admission. The admitting mental health assessment shall include a description of the presenting problem(s), a mental status examination, an initial DSM diagnosis, and an assessment of the resources currently available to the person. The assessment shall result in a plan for the initial services to be provided. The admitting mental health assessment shall also include documentation that a medical history and physical examination of the person has been performed within 24 hours after admission by a physician, physician assistant, or nurse practitioner. If the independent medical practitioner believes a new medical history and physical examination are not necessary, and if within 30 days of admission a complete physical history has been recorded and a complete physical examination has been

performed, the signed report of the history and examination may be placed in the clinical record and may be considered to constitute an appropriate physical health assessment.

(d) Psycho-social assessment. A psycho-social assessment shall be completed for each patient within 72 hours of admission. If the patient stays less than 72 hours, a psycho-social assessment need not be written. The assessment must be completed by a qualified mental health professional or supervisor. The assessment does not need to be a single document but must include the following elements:

(A) A description of events precipitating admission and any goal(s) of the patient in seeking or entering services.

(B) When relevant to the patient's service needs, historical information including: mental health history; medical history; substance use and abuse history; developmental history; social history, including family and interpersonal history; sexual and other abuse history; educational, vocational, employment history; and legal history.

(C) An identification of the patient's need for assistance in maintaining financial support, employment, housing, and other support needs.

(D) Recommendations for discharge planning and any additional services, interventions, additional examinations, tests, and evaluations that are needed.

(e) Treatment plan. A treatment plan, individually developed with the patient from the findings of the admitting mental health assessment and psycho-social assessment, must be completed by a QMHP or supervisor within 72 hours of the person's admission. The plan must be written at a level of specificity that will permit its subsequent implementation to be efficiently monitored and reviewed. The recorded plan shall contain the following components:

(A) The rehabilitation and other goals, including those articulated by the patient.

(B) Specific objectives, including discharge objectives, and the measurable or observable criteria for determining when each objective is attained;

(C) Specific services to be used to achieve each objective;

(D) The projected frequency and duration of services;

(E) Identification of the QMHP or supervisor assigned to the patient who is responsible for coordinating services;

(F) The signature of the patient indicating he/she has participated in the development of the plan to the degree possible. If the patient is unwilling or unable to sign the plan, staff shall record on the plan that the patient is unable or unwilling to do so.

(G) The plan must be reviewed weekly and updated with the participation of the patient when needed to reflect significant changes in the patient's status, and when significant new goals are identified.

(f) Progress notes. Progress notes shall document observations, treatment rendered. response to treatment, and changes in the patient's condition, and other significant information relating to the patient. All entries involving subjective interpretation of the patient's progress shall be supplemented by a description of the actual behavior observed.

(g) Reports of medication administration, medical treatments, and diagnostic procedures.

(h) Telephone communications about the patient, releases of information, and reports from other sources.

(i) The record shall contain medical and mental health advance directives or note that the patient has been provided this information.

(j) The record shall contain documentation that the person has been provided information on patient rights, grievance procedure, and abuse reporting.

(k) The record shall contain documentation including physician's orders and reasons for all restraint and seclusion episodes.

(l) Discharge plan. The discharge planning shall begin at the time of admission with the participation of the patient and, when indicated, the family, guardian and significant others. The discharge plan shall include the

results of the admitting mental health assessment; DSM diagnoses; summary of the course of treatment, including prescribed medications; final assessment of the person's condition; recommendations and arrangements for further treatment including prescribed medications and continuing care; and documentation of the planning for, and securing of appropriate living arrangements.

(4) Patient data management. The regional acute care psychiatric service shall supply to the Division, using the Division's on-line Oregon Patient/Resident Client System (OPRCS), via computer and modem, information about persons admitted to and discharged from the service. Such information shall include the patient's name, DSM diagnosis, admission date, discharge date, legal status, Medicaid eligibility, Medicaid Prime Number and various patient demographics. Such information shall be entered on the day of admission and updated on the day of discharge.

(5) Professional staff standards. The regional acute care psychiatric service shall:

(a) Have sufficient appropriately qualified professional, administrative and support staff to assess and address the identified clinical needs of persons served, provide needed services, and coordinate the services provided.

(b) Designate a program administrator to oversee the administration of the services and carry out these rules.

(c) Designate a medical director to oversee the patient care program. The medical director shall have the final authority concerning inpatient medical care including admissions, continuing care, and discharges.

(d) Designate an individual responsible for maintaining, controlling and supervising medical records and be responsible for maintaining the quality of clinical records.

(e) Designate an individual responsible for the development, implementation and monitoring of a written safety management plan and program, who shall keep records of identified concerns and problems and actions taken to resolve them.

(f) Designate an individual responsible for the development, implementation and monitoring of a written infection control plan and program, who shall

keep records of identified concerns and problems and action taken to resolve them.

(g) Designate, or contract with, a licensed pharmacist to be responsible for the development of pharmacy policies and procedures, and to assure that the service adheres to standards of practice and applicable state and federal laws and regulations.

(h) Maintain a schedule of unit staffing which shall be readily available to the Division for a period of at least the three previous years.

(i) Have on duty at least one registered nurse at all times.

(j) Maintain a personnel file for each patient care staff which includes a written job description; the minimum level of education or training required for the position; copies of applicable licenses, certifications, or degrees granted; annual performance appraisals; a biennial, individualized staff development plan signed by the staff; documentation of CPR training; documentation of annual training and certification in managing aggressive behavior, including seclusion and restraint; and other staff development and/or skill training received.

(k) A physician must be available, at least on-call, at all times.

(6) Policies and procedures manual. The regional acute care psychiatric service shall have a policy and procedure manual. The policy and procedure manual must be made available to any person upon request. The manual shall describe:

(a) The following policies and procedures:

(A) Governance and management, including: a table of organization describing the agency structure and lines of authority; a plan for professional services; and a plan for financial management and accountability.

(B) Procedures for the management of disasters, fire, and other emergencies.

(C) Policies and procedures required under OAR 309-033-0700 through 309-033-0740, Standards for the Approval of Community Hospitals and

Nonhospital Facilities to Provide Seclusion and Restraint to Committed Persons and to Persons in Custody or on Diversion addressing seclusion and restraint.

(D) Patient rights, including informed consent, access to records, and grievance procedure. The manual shall assure rights guaranteed by ORS 426.380 to 426.395 for committed persons and ORS 430.205 to 430.210 for those not committed. The grievance procedure must be in writing and include written responses, time limits for responses, use of a neutral party and a method of appeal. Programs shall post copies of the rights and grievance procedures in places accessible to all persons. Programs shall provide written copies of the rights and grievance procedure upon request.

(E) Abuse reporting for mentally ill or developmentally disabled as required by ORS 430.731 through 430.768.

(F) Clinical record content and management policies and procedures, including the requirements of these rules.

(G) Psychiatric, medical, and dental emergency services policies and procedures.

(H) Pharmacy services policies and procedures approved by a licensed pharmacist.

(I) Quality assessment and improvement processes.

(J) Procedures for documenting privileges granted by the service in personnel records or other records.

(K) Policies and procedures for transfer of patients to other hospitals.

(b) The following policies and procedures, developed and amended in consultation with the council:

(A) Patient admission and discharge criteria. Unless the service has a policy and procedure recommended by the council and approved by the Division, the service shall only admit persons age 18 and older.

(B) Quality assessment and improvement processes relating to regional admissions and discharges.

(C) Patient admission, discharge and aftercare planning; including scheduling and planning for transportation of patients to the service by the referring county and from the service to the county of residence.

(D) Procedures for admission and discharge of geropsychiatric patients and persons with physical disabilities, including designation of a county or regional geropsychiatric liaison staff member.

(E) Linkage agreements with community mental health programs it serves and state hospitals.

(F) Medical and emergency care procedures, approved by the Division.

(G) Criteria for accepting pre-admission medical screening.

(H) Billing and collecting reimbursement from patients and third-party payors.

(7) Holding allegedly mentally ill persons. The service shall have an adequate number of hold rooms but at least one holding room and hold a current Certificate of Approval to hold and treat persons who are alleged to be mentally ill under OAR 309-033-0500 through 309-033-0560, Approval of Hospital and Nonhospital Facilities that Provide Services to Committed Persons or to Persons in Custody or on Diversion.

(8) Federal rules and regulations. The facility in which a service is operated shall comply with all applicable federal rules and regulations.

(9) Medical care. If the facility in which the regional acute care psychiatric service is operated is not in a general hospital, it shall have a letter of agreement with a general hospital for both emergency and medical care, which shall be renewed every two years.

(10) Quality assessment and improvement. The regional acute care psychiatric service shall have an ongoing quality assessment and improvement program to objectively and systematically monitor and evaluate the quality of care provided to patients served, pursue opportunities to improve care and correct identified problems. The program shall include:

(a) Policies and procedures that describes the quality assessment and improvement program's objectives, organization, scope, and mechanisms for improving services.

(b) A written annual plan to monitor and evaluate services. The written plan shall result in reports of findings, conclusions, and recommendations. Reports shall address:

(A) The care of patients served, including admission and discharge planning;

(B) Resource utilization, including the appropriateness and clinical necessity of admissions and continued stay, services provided, staffing levels, space, and support services;

(C) Quality and content of clinical records;

(D) Medication usage, including records, adverse reactions, and medication errors;

(E) Accidents, injuries, safety of patients, and safety hazards; and

(F) Uses of seclusion and restraint.

(c) A report to the governing board and council, at least annually, addressing:

(A) Findings and conclusions from studies;

(B) Recommendations, action taken, and results of the action taken; and

(C) An assessment of the effectiveness of the quality assessment and improvement program; including a review of the program's objectives, scope, organization and effectiveness.

(11) Council. The regional acute care psychiatric service shall have a council to ensure appropriate and effective care and treatment. The council shall meet to assess and collaboratively plan for improving care and treatment to patients, including patient transitions into and out of the service.

Stat. Auth.: ORS 413.042 & 430.640
Stats. Implemented: ORS 430.630 & 430.640
Hist. MHD 8-1994, f. & cert. ef. 11-28-94

309-032-0890

Variances

(1) Criteria for a variance. Variances may be granted to a regional acute care psychiatric service if implementation of the proposed alternative services, methods, concepts or procedures would result in service or system that meet or exceeds the standards in these rules.

(2) Variance application. The service requesting a variance shall submit, in writing, an application to the Division which contains the following:

(a) The section of the rule from which the variance is sought;

(b) The reason for the proposed variance;

(c) The alternative practice, service, method, concept or procedure proposed;

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the council indicating its position on the proposed variance.

(3) Office of Mental Health Services review. The Assistant Administrator or designee of the Office shall approve or deny the request for a variance.

(4) Notification. The Office shall notify the regional acute care psychiatric service of the decision. This notice shall be given to the service, with a copy to the council, within 30 days of the receipt of the request by the Office.

(5) Appeal application. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(6) Written approval. The regional acute care psychiatric service may implement a variance only after written approval from the Division. The Intergovernmental Agreement shall be amended to the extent that the variance changes a term in that agreement.

(7) Duration of variance. A variance shall be reviewed by the Division at least every 2 years.

Stat. Auth.: ORS 426.490 - 426.500& 430.630(3)
Stats. Implemented:
Hist. MHD 8-1994, f. & cert. ef. 11-28-94

Integrated Services and Supports Rules

309-032-1500

Purpose and Scope

(1) Purpose: These rules prescribe minimum standards for the services and supports provided by addictions and mental health providers approved by the Addictions and Mental Health Division of the Oregon Health Authority. These rules:

(a) Promote recovery, resiliency, wellness, independence and safety for individuals receiving addictions and mental health services and supports;

(b) Specify standards for services and supports that are person-directed, youth guided, family-driven, culturally competent, trauma-informed and wellness-informed; and

(c) Promote functional and rehabilitative outcomes for individuals that are developmentally appropriate.

(2) Scope: In addition to applicable requirements in OAR 410-120-0000 through 410-120-1980 and 407-120-0000 through 407-120-0400, these rules specify standards for addictions and mental health services and supports provided in:

(a) Outpatient Community Mental Health Services and Supports for Children and Adults;

(b) Intensive Community-based Treatment and Support Services (ICTS) for Children;

(c) Intensive Treatment Services (ITS) for Children;

(d) Outpatient and Residential Alcohol and Other Drug Treatment Services; and

(e) Outpatient and Residential Problem Gambling Treatment Services.

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 4-2010, f. & cert. ef. 3-4-10; MHS 15-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12

309-032-1505

Definitions

(1) "Abuse of an adult" means the circumstances defined in OAR 407-045-0260 for abuse of an adult with mental illness.

(2) “Abuse of a child” means the circumstances defined in ORS 419B.005.

(3) “Addictions and Mental Health Services and Supports” means all services and supports that are regulated by this rule, including, but not limited to, Outpatient Community Mental Health Services and Supports for Children and Adults, ICTS for Children, ITS for Children, Outpatient and Residential Alcohol and Other Drug Treatment Services and Outpatient and Residential Problem Gambling Treatment Services.

(4) “Adolescent” means an individual from 12 through 17 years of age, or those individuals who are determined to be developmentally appropriate for youth services.

(5) "Adult" means a person 18 years of age or older, or an emancipated minor. An Individual with Medicaid eligibility, who is in need of services specific to children, adolescents, or young adults in transition, must be considered a child until age 21 for the purposes of these rules. Adults who are between the ages of 18 and 21, who are considered children for purposes of these rules, must have all rights afforded to adults as specified in these rules.

(6) “Alcohol and Other Drug Treatment and Recovery Services” means outpatient, intensive outpatient, and residential services and supports for individuals with substance use disorders.

(7) “Alcohol and Other Drug Treatment Staff” means a person certified or licensed by a health or allied provider agency to provide alcohol and other drug treatment services that include assessment, development of an Individual Service and Support Plan (ISSP), and individual, group and family counseling.

(a) For treatment staff holding certification in addiction counseling, qualifications for the certificate must have included at least:

(A) 750 hours of supervised experience in substance use counseling;

(B) 150 contact hours of education and training in substance use related subjects; and

(C) Successful completion of a written objective examination or portfolio review by the certifying body.

(b) For treatment staff holding a health or allied provider license, the license or registration must have been issued by one of the following state bodies and the person must possess documentation of at least 60 contact hours of academic or continuing professional education in alcohol and other drug treatment:

(A) Board of Medical Examiners;

(B) Board of Psychologist Examiners;

(C) Board of Licensed Social Workers;

(D) Board of Licensed Professional Counselors and Therapists; or

(E) Board of Nursing.

(8) “Assessment” means the process of obtaining all pertinent biopsychosocial information, as identified by the individual, family and collateral sources as relevant, to determine a diagnosis and to plan individualized services and supports.

(9) "ASAM PPC-2R" means the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-related Disorders, Second Edition Revised, April 2001, which is a clinical guide used in matching individuals to appropriate levels of care, and incorporated by reference in these rules.

(10) “Authority” means the Oregon Health Authority.

(11) "Behavior Support Plan" means the individualized proactive support strategies, consistent with OAR 309-032-1540(8), documented in the ISSP that are used by the provider and family when applicable, to support positive behavior.

(12) “Behavior Support Strategies” means proactive supports designed to replace challenging behavior with functional, positive behavior. The strategies address environmental, social, neurodevelopmental and physical factors that affect behavior.

(13) “Biopsychosocial Information” means the combination of physical, psychological, social, environmental and cultural factors that influence the individual’s development and functioning.

(14) “Care Coordination” means a process-oriented activity to facilitate ongoing communication and collaboration to meet multiple needs. Care coordination includes facilitating communication between the family, natural supports, community resources, and involved providers and agencies; organizing, facilitating and participating in team meetings; and providing for continuity of care by creating linkages to and managing transitions between levels of care and transitions for transition-age young adults to adult services.

(15) "Case Management" means the services provided to assist individuals, who reside in a community setting, or are transitioning to a community setting, in gaining access to needed medical, social, educational, entitlement and other applicable services.

(16) "Chemical Restraint" means the administration of medication for the acute management of potentially harmful behavior. Chemical restraint is prohibited in the services regulated by these rules.

(17) "Child" means a person under the age of 18. An individual with Medicaid eligibility, who is in need of services specific to children, adolescents, or young adults in transition, must be considered a child until age 21 for purposes of these rules.

(18) "Child and Family Team" means those persons who are responsible for creating, implementing, reviewing, and revising the service coordination section of the ISSP in ICTS programs. At a minimum, the team must be comprised of the family, care coordinator, and child when appropriate. The team should also include any involved child-serving providers and agencies and any other natural, formal, and informal supports as identified by the family.

(19) "Children's Emergency Safety Intervention Specialist (CESIS)" means a Qualified Mental Health Professional (QMHP) who is licensed to order, monitor, and evaluate the use of seclusion and restraint in accredited and certified facilities providing intensive mental health treatment services to individuals under 21 years of age.

(20) "Clinical Supervision" means oversight by a qualified Clinical Supervisor of addictions and mental health services and supports provided according to this rule, including ongoing evaluation and improvement of the effectiveness of those services and supports.

(21) "Clinical Supervisor" means a person qualified to oversee and evaluate addictions or mental health services and supports.

(a) For supervisors in alcohol and other drug treatment programs, holding a certification or license in addiction counseling, qualifications for the certificate or license must have included at least:

(A) 4000 hours of supervised experience in substance use counseling;

(B) 300 contact hours of education and training in substance use related subjects; and

(C) Successful completion of a written objective examination or portfolio review by the certifying body.

(b) For supervisors, in alcohol and other drug treatment programs, holding a health or allied provider license, such license or registration must have been issued by one of the following state bodies and the supervisor must possess documentation of at least 120 contact hours of academic or continuing professional education in the treatment of alcohol and other drug-related disorders:

(A) Board of Medical Examiners;

(B) Board of Psychologist Examiners;

(C) Board of Licensed Social Workers;

(D) Board of Licensed Professional Counselors and Therapists; or

(E) Board of Nursing.

(22) “Co-occurring substance use and mental health disorders (COD)” means the existence of a diagnosis of both a substance use disorder and a mental health disorder.

(23) "Community Mental Health Program (CMHP)" means an entity that is responsible for planning and delivery of services for persons with substance use disorders or a mental health diagnosis, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(24) "Conditional Release" means placement by a court or the Psychiatric Security Review Board (PSRB), of a person who has been found eligible under ORS 161.327(2)(b) or 161.336, for supervision and treatment in a community setting.

(25) "Court" means the last convicting or ruling court unless specifically noted.

(26) "Criminal Records Check" means the Oregon Criminal Records Check and the processes and procedures required by OAR 407-007-0000 through 407-007-0370.

(27) "Crisis" means either an actual or perceived urgent or emergent situation that occurs when an individual's stability or functioning is disrupted and there is an immediate need to resolve the situation to prevent a serious deterioration in the individual's mental or physical health or to prevent referral to a significantly higher level of care.

(28) "Cultural Competence" means the process by which people and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientations and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families and communities and protects and preserves the dignity of each.

(29) "Culturally Specific Program" means a program that is designed to meet the unique service needs of a specific culture and that provides services to a majority of individuals representing that culture.

(30) "Declaration for Mental Health Treatment" means a written statement of an individual's preferences concerning his or her mental health treatment. The declaration is made when the individual is able to understand and legally make decisions related to such treatment. It is honored, as clinically appropriate, in the event the individual becomes unable to make such decisions.

(31) "Deputy Director" means the Deputy Director of the Addictions and Mental Health Division, or that person's designee.

(32) "Developmentally Appropriate" means services and supports that match emotional, social and cognitive development rather than chronological age.

(33) "Diagnosis" means the principal mental health, substance use or problem gambling diagnosis listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM). The diagnosis is determined through the assessment and any examinations, tests or consultations suggested by the assessment, and is the medically appropriate reason for services.

(34) "Director” means the Director of the Addictions and Mental Health Division, or that person's designee.

(35) “Division” means the Addictions and Mental Health Division.

(36) "DSM" means the Diagnostic and Statistical Manual of Mental Disorders-IV-R, published by the American Psychiatric Association.

(37) “DSM Five-axis Diagnosis” means the multi-axial diagnosis, consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), resulting from the assessment.

(38) “Driving Under the Influence of Intoxicants (DUII) Alcohol and Other Drug Rehabilitation Program” means a program of treatment and therapeutically oriented education services for an individual who is either:

(a) A violator of ORS 813.010 Driving Under the Influence of Intoxicants; or

(b) A defendant who is participating in a diversion agreement under ORS 813.200.

(39) “Emergency Safety Intervention” means the use of seclusion or personal restraint under OAR 309-032-1540(9) of these rules, as an immediate response to an unanticipated threat of violence or injury to an individual, or others.

(40) “Emergent” means the onset of symptoms requiring attention within 24 hours to prevent serious deterioration in mental or physical health or threat to safety.

(41) “Enhanced Care Services (ECS)" and "Enhanced Care Outreach Services (ECOS)” means mental health services and supports provided to individuals residing in licensed Seniors and People with Disabilities (SPD) facilities.

(42) “Entry” means the act or process of acceptance and enrollment into services regulated by this rule.

(43) “Evaluation Specialist” means a person who possesses valid certification issued by the Division to conduct DUII evaluations.

(44) "Family" means the biological or legal parents, siblings, other relatives, foster parents, legal guardians, spouse, domestic partner, caregivers and other primary relations to the individual whether by blood, adoption, legal or social relationships. Family also means any natural, formal or informal support persons identified as important by the individual.

(45) "Family Support" means the provision of supportive services to persons defined as family to the individual. It includes support to caregivers at community meetings, assistance to families in system navigation and managing multiple appointments, supportive home visits, peer support, parent mentoring and coaching, advocacy, and furthering efforts to develop natural and informal community supports.

(46) "Fully Capitated Health Plan (FCHP)" means a prepaid health plan under contract with the Division of Medical Assistance Programs to provide capitated physical or behavioral health services.

(47) “Gender Identity” means a person’s self-identification of gender, without regard to legal or biological identification, including, but not limited to persons identifying themselves as male, female, transgender and transsexual.

(48) “Gender Presentation” means the external characteristics and behaviors that are socially defined as either masculine or feminine, such as dress, mannerisms, speech patterns and social interactions.

(49) "Grievance" means a formal complaint submitted to a provider verbally, or in writing, by an individual, or the individual’s chosen representative, pertaining to the denial or delivery of services and supports.

(50) "Guardian" means a person appointed by a court of law to act as guardian of a minor or a legally incapacitated person.

(51) “HIPAA” means the federal Health Insurance Portability and Accountability Act of 1996 and the regulations published in Title 45, parts 160 and 164, of the Code of Federal Regulations (CFR).

(52) "Incident Report" means a written description of any incident involving an individual, occurring on the premises of a program, or involving program staff or an ISSP activity, including, but not limited to, injury, major illness, accident, act of physical aggression, medication error, suspected abuse or

neglect, or any other unusual incident that presents a risk to health and safety.

(53) “Individual” means any person being considered for or receiving services and supports regulated by these rules.

(54) "Individual Service and Support Plan" (ISSP) means a comprehensive plan for services and supports provided to or coordinated for an individual and his or her family, as applicable, that is reflective of the assessment and the intended outcomes of service.

(55) “Individual Service Note” means the written record of services and supports provided, including documentation of progress toward intended outcomes, consistent with the timelines stated in the ISSP.

(56) “Individual Service Record” means the documentation, written or electronic, regarding an individual and resulting from entry, assessment, orientation, service and support planning, services and supports provided, and transfer.

(57) "Informed Consent for Services" means that the service options, risks and benefits have been explained to the individual and guardian, if applicable, in a manner that they comprehend, and the individual and guardian, if applicable, have consented to the services on, or prior to, the first date of service.

(58) “Intensive Outpatient Alcohol and Other Drug Treatment Services” means structured nonresidential evaluation, treatment, and continued care services for individuals with substance use disorders who need a greater number of therapeutic contacts per week than are provided by traditional outpatient services. Intensive outpatient services may include, but are not limited to, day treatment, correctional day treatment, evening treatment, and partial hospitalization.

(59) “Intensive Community-based Treatment and Support Services (ICTS)” means a specialized set of comprehensive in-home and community-based supports and mental health treatment services, including care coordination as defined in these rules, for children that are developed by the child and family team and delivered in the most integrated setting in the community.

(60) “Intensive Treatment Services (ITS)” means the range of services in the system of care comprised of Psychiatric Residential Treatment Facilities (PRTF) and Psychiatric Day Treatment Services (PDTS), or other services as determined by the Division, that provide active psychiatric treatment for children with severe emotional disorders and their families.

(61) “Interim Referral and Information Services” means services provided by an alcohol and other drug treatment provider to individuals on a waiting list, and whose services are funded by the Substance Abuse Prevention and Treatment (SAPT) Block Grant, to reduce the adverse health effects of alcohol and other drug use, promote the health of the individual and reduce the risk of disease transmission.

(62) "Interdisciplinary Team" means the group of people designated to advise in the planning and provision of services and supports to individuals receiving ITS services or ECS services and may include multiple disciplines or agencies. For Psychiatric Residential Treatment Facilities (PRTF), the composition of the interdisciplinary team must be consistent with the requirements of 42 CFR Part 441.156.

(63) "Intern" or "Student" means a person who provides a paid or unpaid program service to complete a credentialed or accredited educational program recognized by the state of Oregon.

(64) “Juvenile Psychiatric Security Review Board (JPSRB)” means the entity described in ORS 161.385.

(65) "Level of Care" means the range of available services provided from the most integrated setting to the most restrictive and most intensive in an inpatient setting.

(66) "Level of Service Intensity Determination." means the Division approved process by which children and young adults in transition are assessed for ITS and ICTS services.

(67) "Licensed Health Care Professional" means a practitioner of the healing arts, acting within the scope of his or her practice under State law, who is licensed by a recognized governing board in Oregon.

(68) "Licensed Medical Practitioner (LMP)" means a person who meets the following minimum qualifications as documented by the Local Mental Health Authority (LMHA) or designee:

(a) Physician licensed to practice in the State of Oregon; or

(b) Nurse practitioner licensed to practice in the State of Oregon; or

(c) Physician's Assistant licensed to practice in the State of Oregon; and

(d) Whose training, experience and competence demonstrate the ability to conduct a mental health assessment and provide medication management.

(e) For ICTS and ITS providers, LMP means a board-certified or board-eligible child and adolescent psychiatrist licensed to practice in the State of Oregon.

(69) "Local Mental Health Authority (LMHA)" means one of the following entities:

(a) The board of county commissioners of one or more counties that establishes or operates a CMHP;

(b) The tribal council, in the case of a federally recognized tribe of Native Americans that elects to enter into an agreement to provide mental health services; or

(c) A regional local mental health authority comprised of two or more boards of county commissioners.

(70) "Mandatory Reporter" means any public or private official, as defined in ORS 419B.005(3), who comes in contact with or has reasonable cause to believe that an individual has suffered abuse, or that any person with whom the official comes in contact with, has abused the individual. Pursuant to ORS 430.765(2) psychiatrists, psychologists, clergy and attorneys are not mandatory reporters with regard to information received through communications that are privileged under ORS 40.225 to ORS 40.295.

(71) "Mechanical Restraint" means the use of any physical device to involuntarily restrain the movement of all or a portion of an individual's body

as a means of controlling his or her physical activities in order to protect the individual or other persons from injury. Mechanical restraint is prohibited in the services regulated by these rules.

(72) "Medicaid" means the federal grant-in-aid program to state governments to provide medical assistance to eligible persons, under Title XIX of the Social Security Act.

(73) "Medical Director" means a physician licensed to practice medicine in the State of Oregon and who is designated by an alcohol and other drug treatment program to be responsible for the program's medical services, either as an employee or through a contract.

(74) "Medical Supervision" means an LMP's review and approval, at least annually, of the assessment and the medical appropriateness of services and supports identified in the ISSP for each individual receiving mental health services for one or more continuous years.

(75) "Medically Appropriate" means services and medical supplies required for prevention, diagnosis or treatment of a physical or mental health condition, or injuries, and which are:

(a) Consistent with the symptoms of a health condition or treatment of a health condition;

(b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community and professional standards of care as effective;

(c) Not solely for the convenience of an individual or a provider of the service or medical supplies; and

(d) The most cost effective of the alternative levels of medical services or medical supplies that can be safely provided to an individual.

(76) “Medication Administration Record” means the documentation of the administration of written or verbal orders for medication, laboratory and other medical procedures issued by a LMP employed by, or under contract with, the provider and acting within the scope of his or her license.

(77) "Mental Health Organization (MHO)" means an approved organization that manages most mental health services through a capitated payment mechanism under the Oregon Health Plan. MHOs can be fully capitated health plans, community mental health programs, private mental health organizations or combinations thereof.

(78) “Older Adult” means an individual who is 60 years of age or older.

(79) “Older Adult Services” means age-appropriate services designed for older adults and provided by professionals trained in geriatrics. The services are preventative and include primary prevention efforts including suicide prevention, early identification services, early intervention services and comprehensive local planning for older adult mental health services.

(80) “Oregon Health Authority” means the Oregon Health Authority of the State of Oregon.

(81) “Outpatient Alcohol and Other Drug Treatment Program” means a publicly or privately operated program that provides assessment, treatment, and rehabilitation on a regularly scheduled basis or in response to crisis for individuals with alcohol or other drug use disorders and their family members, or significant others, consistent with Level I or Level II of the ASAM PPC-2R.

(82) “Outpatient Community Mental Health Services and Supports” means all outpatient mental health services and supports provided to children, youth and adults.

(83) “Outpatient Problem Gambling Treatment Services” means all outpatient treatment services and supports provided to individuals with gambling related problems and their families.

(84) "Outreach" means the delivery of addictions, problem gambling or mental health services, referral services and case management services in non-traditional settings, such as, but not limited to, the individual's residence, shelters, streets, jails, transitional housing sites, drop-in centers, single room occupancy hotels, child welfare settings, educational settings or medical settings. It also refers to attempts made to engage or re-engage an individual in services by such means as letters or telephone calls.

(85) “Peer” means any person supporting an individual, or a family member of an individual, who has similar life experience, either as a current or former recipient of addictions or mental health services, or as a family member of an individual who is a current or former recipient of addictions or mental health services.

(86) “Peer Delivered Services” means an array of agency or community-based services and supports provided by peers, and peer support specialists, to individuals or family members with similar lived experience, that are designed to support the needs of individuals and families as applicable.

(87) "Peer Support Specialist" means a person providing peer delivered services to an individual or family member with similar life experience, under the supervision of a qualified Clinical Supervisor. A Peer Support Specialist must complete a Division approved training program and be:

(a) A self-identified person currently or formerly receiving mental health services; or

(b) A self-identified person in recovery from a substance use disorder, who meets the abstinence requirements for recovering staff in alcohol and other drug treatment programs; or

(c) A family member of an individual who is a current or former recipient of addictions or mental health services.

(88) "Performance Improvement Plan" means a plan that describes the provider's quality assessment and performance improvement strategies and measurements.

(89) “Person-directed” means the individual, and others involved in supporting the treatment and recovery of the individual, are actively involved in assessment, planning and revising services and supports and intended outcomes. Individuals are empowered through this process to regain their health, safety and independence to the greatest extent possible and in a manner that is holistic and specific to the individual, including culturally, developmentally, age and gender appropriate.

(90) “Personal Restraint” means the application of physical force without the use of any device, for the purpose of restraining the free movement of

an individual's body to protect the individual, or others, from immediate harm. Personal restraint does not include briefly holding without undue force an individual to calm or comfort him or her, or holding an individual's hand to safely escort him or her from one area to another. Personal restraint can be used only in approved ITS programs as an emergency safety intervention under OAR 309-032-1540(9).

(91) "Problem Gambling Treatment Staff" means persons providing problem gambling treatment services on a quarter-time or greater basis who hold a certification in a mental health or addictions discipline and have completed, within the past two years, at least 30 hours of problem gambling specific education. Problem Gambling Treatment Staff providing services on a half time or greater basis must hold advanced certification in addictions or be a QMHP and be able to document a minimum of 1000 hours of problem gambling treatment experience and have completed 60 hours of problem gambling specific education.

(92) "Program" means a particular type or level of service that is organizationally distinct.

(93) "Program Administrator" or "Program Director" means a person with appropriate professional qualifications and experience, who is designated to manage the operation of a program.

(94) "Program Staff" means an employee or person who, by contract with the program, provides a service and who has the applicable competencies, qualifications or certification, required in this rule to provide the service.

(95) "Provider" means an organizational entity, or qualified person, that is operated by or contractually affiliated with, a community mental health program, or contracted directly with the Division, for the direct delivery of addictions, problem gambling or mental health services and supports.

(96) "Provisional Assessment" means an initial assessment that identifies a presenting problem, provisional diagnosis and sufficient information to support the provisional diagnosis.

(97) "Provisional ISSP" means an initial ISSP that includes short term objectives and medically appropriate services sufficient to address presenting issues as they relate to a provisional diagnosis, including any

engagement strategies, crisis services and activities necessary to complete the assessment and the ISSP.

(98) “Psychiatric Day Treatment Services (PDTS)” means the comprehensive, interdisciplinary, non-residential, community-based program certified under this rule consisting of psychiatric treatment, family treatment and therapeutic activities integrated with an accredited education program.

(99) “Psychiatric Residential Treatment Facility (PRTF)” means facilities that are structured residential treatment environments with daily 24-hour supervision and active psychiatric treatment including Psychiatric Residential Treatment Services (PRTS), Secure Children’s Inpatient Treatment Programs (SCIP), Secure Adolescent Inpatient Treatment Programs (SAIP), and Sub-acute psychiatric treatment for children who require active treatment for a diagnosed mental health condition in a 24-hour residential setting.

(100) “Psychiatric Residential Treatment Services (PRTS)” means services delivered in a PRTF that include 24-hour supervision for children who have serious psychiatric, emotional or acute mental health conditions that require intensive therapeutic counseling and activity and intensive staff supervision, support and assistance.

(101) "Psychiatric Security Review Board (PSRB)" means the entity described in ORS 161.295 through 161.400.

(102) "Psychiatrist" means a physician licensed pursuant to ORS 677.010 to 677.228 and 677.410 to 677.450 by the Board of Medical Examiners for the State of Oregon and who has completed an approved residency training program in psychiatry.

(103) "Psychologist" means a psychologist licensed by the Oregon Board of Psychologist Examiners.

(104) "Qualified Mental Health Associate (QMHA)” means a person delivering services under the direct supervision of a QMHP and meeting the following minimum qualifications as authorized by the LMHA or designee:

(a) Bachelor's degree in a behavioral sciences field; or

(b) A combination of at least three years relevant work, education, training or experience.

(105) "Qualified Mental Health Professional (QMHP)" means a LMP or any other person meeting one or more of the following minimum qualifications as authorized by the LMHA or designee:

(a) Bachelor’s degree in nursing and licensed by the State of Oregon;

(b) Bachelor’s degree in occupational therapy and licensed by the State of Oregon;

(c) Graduate degree in psychology;

(d) Graduate degree in social work;

(e) Graduate degree in recreational, art, or music therapy; or

(f) Graduate degree in a behavioral science field.

(106) "Qualified Person" means a person who is a QMHP, or a QMHA, and is identified by the PSRB in its Conditional Release Order. This person is designated by the provider to deliver or arrange and monitor the provision of the reports and services required by the Conditional Release Order.

(107) "Quality Assessment and Performance Improvement" means the structured, internal monitoring and evaluation of services to improve processes, service delivery and service outcomes.

(108) “Recovery” means a process of healing and transformation for a person to achieve full human potential and personhood in leading a meaningful life in communities of his or her choice.

(109) "Representative" means a person who acts on behalf of an individual, at the individual’s request, with respect to a grievance, including, but not limited to a relative, friend, employee of the Division, attorney or legal guardian.

(110) “Reportable Incident” means a serious incident involving an individual in an ITS program that must be reported in writing to the Division within 24 hours of the incident, including, but not limited to, serious injury or illness,

act of physical aggression that results in injury, suspected abuse or neglect, involvement of law enforcement or emergency services, or any other serious incident that presents a risk to health and safety.

(111) “Residential Alcohol and Other Drug Treatment Program" means a publicly or privately operated program as defined in ORS 430.010 that provides assessment, treatment, rehabilitation, and twenty-four hour observation and monitoring for individuals with alcohol and other drug dependence, consistent with Level III of ASAM PCC-2R.

(112) “Residential Problem Gambling Treatment Program” means a publicly or privately operated program that is licensed in accordance with OAR 309-032-1540(11), that provides assessment, treatment, rehabilitation, and twenty-four hour observation and monitoring for individuals with gambling related problems.

(113) “Residential Transition Program” means an Alcohol and Other Drug residential program that provides a drug-free supportive living environment and provides clinical services consistent with Level III of the ASAM PPC-2R.

(114) “Resilience” means the universal capacity that a person uses to prevent, minimize, or overcome the effects of adversity. Resilience reflects a person’s strengths as protective factors and assets for positive development.

(115) "Respite care" means planned and emergency supports designed to provide temporary relief from care giving to maintain a stable and safe living environment. Respite care can be provided in or out of the home. Respite care includes supervision and behavior support consistent with the strategies specified in the ISSP.

(116) "Screening" means the process to determine whether the individual needs further assessment to identify circumstances requiring referrals or additional services and supports.

(117) "Seclusion" means the involuntary confinement of an individual to an area or room from which the individual is physically prevented from leaving. Seclusion can be used only in approved ITS programs as an emergency safety intervention specified in OAR 309-032-1540(9).

(118) “Secure Children’s Inpatient Programs (SCIP) and Secure Adolescent Inpatient Programs (SAIP)” means ITS programs that are designed to provide inpatient psychiatric stabilization and treatment services to children up to age 14 for SCIP services and individuals under the age of 21 for SAIP services, who require a secure intensive treatment setting.

(119) "Services" means those activities and treatments described in the ISSP that are intended to assist the individual's transition to recovery from a substance use disorder, problem gambling disorder or mental health condition, and to promote resiliency, and rehabilitative and functional individual and family outcomes.

(120) “Signature” means any written or electronic means of entering the name, date of authentication and credentials of the person providing a specific service or the person authorizing services and supports. Signature also means any written or electronic means of entering the name and date of authentication of the individual receiving services, the guardian of the individual receiving services, or any authorized representative of the individual receiving services.

(121) "Skills Training" means providing information and training to individuals and families designed to assist with the development of skills in areas including, but not limited to, anger management, stress reduction, conflict resolution, self-esteem, parent-child interactions, peer relations, drug and alcohol awareness, behavior support, symptom management, accessing community services and daily living.

(122) Sub-Acute Psychiatric Care” means services that are provided by nationally accredited providers to children who need 24-hour intensive mental health services and supports, provided in a secure setting to assess, evaluate, stabilize or resolve the symptoms of an acute episode that occurred as the result of a diagnosed mental health condition.

(123) "Substance Abuse Prevention and Treatment Block Grant" or “SAPT Block Grant” means the federal block grants for prevention and treatment of substance abuse under Public Law 102-321 (31 U.S.C. 7301-7305) and the regulations published in Title 45 Part 96 of the Code of Federal Regulations.

(124) "Substance Use Disorders" means disorders related to the taking of a drug of abuse including alcohol, to the side effects of a medication, and to a toxin exposure. The disorders include substance use disorders such as substance dependence and substance abuse, and substance-induced disorders, including substance intoxication, withdrawal, delirium, and dementia, as well as substance induced psychotic disorder, mood disorder, etc, as defined in DSM criteria.

(125) “Successful DUII Completion” means that the DUII program has documented in its records that for the period of service deemed necessary by the program, the individual has:

(a) Met the completion criteria approved by the Division; and

(b) Met the terms of the fee agreement between the provider and the individual.

(126) “Supports” means activities, referrals and supportive relationships designed to enhance the services delivered to individuals and families for the purpose of facilitating progress toward intended outcomes.

(127) “Systems Integration” means the efforts by providers to work collaboratively with other service systems including, but not limited to, schools, corrections, child welfare and physical health providers, in order to coordinate and enhance services and supports and reduce barriers to service delivery.

(128) “Time out” means the restriction of a child for a period of time to a designated area from which he or she is not physically prevented from leaving, for the purpose of providing him or her an opportunity to regain self-control. When time out is documented as a behavior support strategy in the ISSP, it must be tracked for effectiveness in increasing positive behavior.

(129) “Transfer” means the process of assisting an individual to transition from the current services to the next appropriate setting or level of care.

(130) “Trauma Informed Services” means services that are reflective of the consideration and evaluation of the role that trauma plays in the lives of people seeking mental health and addictions services, including recognition of the traumatic effect of misdiagnosis and coercive treatment. Services are

responsive to the vulnerabilities of trauma survivors and are delivered in a way that avoids inadvertent re-traumatization and facilitates individual direction of services.

(131) "Treatment" means the planned, medically appropriate, individualized program of medical, psychological, and rehabilitative procedures, experiences and activities designed to remediate symptoms of a DSM diagnosis, that are included in the ISSP.

(132) "Urinalysis Test" means an initial test and, if positive, a confirmatory test:

(a) An initial test must include, at a minimum, a sensitive, rapid, and inexpensive immunoassay screen to eliminate "true negative" specimens from further consideration.

(b) A confirmatory test is a second analytical procedure used to identify the presence of a specific drug or metabolite in a urine specimen. The confirmatory test must be by a different analytical method from that of the initial test to ensure reliability and accuracy.

(c) All urinalysis tests must be performed by laboratories meeting the requirements of OAR 333-024-0305 to 333-024-0365.

(133) "Urgent" means the onset of symptoms requiring attention within 48 hours to prevent a serious deterioration in an individual's mental or physical health or threat to safety.

(134) "Variance" means an exception from a provision of these rules, granted in writing by the Division, upon written application from the provider. Duration of a variance is determined on a case-by-case basis.

(135) "Volunteer" means an individual who provides a program service or who takes part in a program service and who is not an employee of the program and is not paid for services. The services must be non-clinical unless the individual has the required credentials to provide a clinical service.

(136) “Wellness” means an approach to healthcare that emphasizes good physical and mental health, preventing illness, and prolonging life.

(137) “Young Adult in Transition” means an individual who is developmentally transitioning into independence, sometime between the ages of 14 and 25.

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 4-2010, f. & cert. ef. 3-4-10; MHS 15-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12

309-032-1510

Provider Policies

(1) Personnel Policies: All providers must develop and implement written personnel policies and procedures, compliant with these rules, including:

(a) Personnel Qualifications and Credentialing,

(b) Mandatory abuse reporting, compliant with ORS 430.735-430.768 and 407-045-0250 through 407-045-0360;

(c) Criminal Records Checks, compliant with ORS 181.533 through 181.575 and 407-007-0000 through 407-007-0370; and

(d) Fraud, waste and abuse in Federal Medicaid and Medicare programs compliant with OAR 410-120-1380 and 410-120-1510;

(2) Service Delivery Policies: All providers must develop and implement written policies and procedures, consistent with these rules, describing the provider’s approach to services and supports and the procedures for the delivery of services and supports.

(a) Policies must be available to individuals and family members upon request; and

(b) Service delivery policies and procedures must include, at a minimum:

(A) Entry and orientation;

(B) Fee agreements;

(C) Assessment, service planning, coordination and documentation;

(D) Person-directed services, including:

(i) Cultural competency;

(ii) Developmentally appropriate and age-appropriate service planning and delivery; and

(iii) Family involvement.

(E) Transfer and Continuity of Care;

(F) Trauma-informed Services, as defined in these rules;

(G) Confidentiality and compliance with HIPAA, Federal Confidentiality Regulations (42 CFR, Part 2), and State confidentiality regulations as specified in ORS 179.505 and 192.518 through 192.530;

(H) Compliance with Title 2 of the Americans with Disabilities Act of 1990 (ADA);

(I) Grievances and Appeals;

(J) Individual Rights;

(K) Quality Assessment and Performance Improvement;

(L) Crisis Prevention and Response, and Incident Reporting;

(M) Services to Young Adults in Transition, when applicable; and

(N) Urinalysis testing to ensure validity of urine specimens collected by staff authorized to collect urine samples, when applicable.

(3) Residential Program Policies: In addition to the personnel and service delivery policies required of all providers, residential program providers

must develop and implement written policies and procedures for the following:

(a) Medical Protocols and Medical Emergencies;

(b) Medication Administration, Storage and Disposal;

(c) Facility standards for Alcohol and Other Drug Residential Treatment Programs, including the standards under these rules;

(d) General Safety and Emergency Procedures; and

(e) Emergency Safety Interventions in ITS Programs.

(f) Alcohol and Other Drug Residential Treatment programs must establish written policies that prohibit:

(A) Physical or other forms of aversive action to discipline an individual;

(B) Seclusion, personal restraint, mechanical restraint and chemical restraint;

(C) Withholding shelter, regular meals, clothing or aids to physical functioning; and

(D) Discipline of one individual by another.

(4) Behavior Support Policies: Applicable providers, as specified below, must develop behavior support policies including:

(a) ITS and ICTS Services: policies consistent with 309-032-1540(8) of these rules.

(b) ECS Services: policies consistent with 309-032-1540(8) of these rules.

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270

Hist.: MHS 4-2010, f. & cert. ef. 3-4-10; MHS 15-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12

309-032-1515

Individual Rights

(1) In addition to all applicable statutory and constitutional rights, every individual receiving services has the right to:

(a) Choose from available services and supports, those that are consistent with the ISSP and provided in the most integrated setting in the community and under conditions that are least restrictive to the individual's liberty, that are least intrusive to the individual and that provide for the greatest degree of independence;

(b) Be treated with dignity and respect;

(c) Participate in the development of a written ISSP, receive services consistent with that plan and participate in periodic review and reassessment of service and support needs, assist in the development of the plan, and to receive a copy of the written ISSP;

(d) Have all services explained, including expected outcomes and possible risks;

(e) Confidentiality, and the right to consent to disclosure in accordance with ORS 107.154, 179.505, 179.507, 192.515, 192.507, 42 CFR Part 2 and 45 CFR Part 205.50.

(f) Give informed consent in writing prior to the start of services, except in a medical emergency or as otherwise permitted by law. Minor children may give informed consent to services in the following circumstances:

(A) Under age 18 and lawfully married;

(B) Age 16 or older and legally emancipated by the court; or

(C) Age 14 or older for outpatient services only. For purposes of informed consent, outpatient service does not include service provided in residential programs or in day or partial hospitalization programs;

(g) Inspect their Individual Service Record in accordance with ORS 179.505;

(h) Not participate in experimentation;

(i) Receive medication specific to the individual's diagnosed clinical needs;

(j) Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety;

(k) Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation;

(l) Have religious freedom;

(m) Be free from seclusion and restraint, except as regulated in OAR 309-032-1540(9).

(n) Be informed at the start of services, and periodically thereafter, of the rights guaranteed by this rule;

(o) Be informed of the policies and procedures, service agreements and fees applicable to the services provided, and to have a custodial parent, guardian, or representative, assist with understanding any information presented;

(p) Have family involvement in service planning and delivery;

(q) Make a declaration for mental health treatment, when legally an adult;

(r) File grievances, including appealing decisions resulting from the grievance;

(s) Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules;

(t) Exercise all rights set forth in ORS 426.385 if the individual is committed to the Authority; and

(u) Exercise all rights described in this rule without any form of reprisal or punishment.

(2) In addition to the rights specified in (1) of this rule, every individual receiving residential services has the right to:

(a) A safe, secure and sanitary living environment;

(b) A humane service environment that affords reasonable protection from harm, reasonable privacy and daily access to fresh air and the outdoors;

(c) Keep and use personal clothing and belongings, and to have an adequate amount of private, secure storage space. Reasonable restriction of the time and place of use, of certain classes of property may be implemented if necessary to prevent the individual or others from harm, provided that notice of this restriction is given to individuals and their families, if applicable, upon entry to the program, documented, and reviewed periodically;

(d) Express sexual orientation, gender identity and gender presentation;

(e) Have access to and participate in social, religious and community activities;

(f) Private and uncensored communications by mail, telephone and visitation, subject to the following restrictions:

(A) This right may be restricted only if the provider documents in the individual's record that there is a court order to the contrary, or that in the absence of this restriction, significant physical or clinical harm will result to the individual or others. The nature of the harm must be specified in reasonable detail, and any restriction of the right to communicate must be no broader than necessary to prevent this harm; and

(B) The individual and his or her guardian, if applicable, must be given specific written notice of each restriction of the individual's right to private and uncensored communication. The provider must ensure that correspondence can be conveniently received and mailed, that telephones are reasonably accessible and allow for confidential communication, and that space is available for visits. Reasonable times for the use of telephones and visits may be established in writing by the provider;

(g) Communicate privately with public or private rights protection programs or rights advocates, clergy, and legal or medical professionals;

(h) Have access to and receive available and applicable educational services in the most integrated setting in the community;

(i) Participate regularly in indoor and outdoor recreation;

(j) Not be required to perform labor;

(k) Have access to adequate food and shelter; and

(l) A reasonable accommodation if, due to a disability, the housing and services are not sufficiently accessible.

(3) Notification of Rights: The provider must give to the individual and, if appropriate, the guardian, a document that describes the applicable individual's rights as follows:

(a) Information given to the individual must be in written form or, upon request, in an alternative format or language appropriate to the individual's need;

(b) The rights, and how to exercise them, must be explained to the individual, and if appropriate, to her or his guardian; and

(c) Individual rights must be posted in writing in a common area.

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 4-2010, f. & cert. ef. 3-4-10; MHS 15-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12

309-032-1520

Personnel

(1) Licensing and Credentialing: All program staff must meet applicable credentialing or licensing standards, including those outlined in these rules, for the following:

(a) Alcohol and Other Drug Treatment Staff;

(b) CESIS;

(c) Clinical Supervisor;

(d) LMP;

(e) Medical Director;

(f) Peer Support Specialist;

(g) Problem Gambling Treatment Staff;

(h) QMHA; and

(i) QMHP.

(2) Specific Program Staff Competencies: At minimum, competencies for the following specified program staff must include:

(a) Program Administrators or Program Directors must demonstrate competence in leadership, program planning and budgeting, fiscal management, supervision of program staff, personnel management, program staff performance assessment, data collection, reporting, program evaluation, quality assurance, and developing and coordinating community resources;

(b) Clinical Supervisors in addictions and mental health programs must demonstrate competence in leadership, wellness, oversight and evaluation of services, staff development, individual service and support planning, case management and coordination, utilization of community resources, group, family and individual therapy or counseling, documentation and rationale for services to promote intended outcomes and implementation of all provider policies. In addition:

(A) Clinical Supervisors in alcohol and other drug treatment programs must be certified or licensed by a health or allied provider agency, as defined in these rules, to provide addiction treatment, and have one of the following qualifications:

(i) Five years of paid full-time experience in the field of alcohol and other drug counseling; or

(ii) A Bachelor's degree and four years of paid full-time experience in the social services field, with a minimum of two years of direct alcohol and other drug counseling experience; or

(iii) A Master's degree and three years of paid full-time experience in the social services field with a minimum of two years of direct alcohol and other drug counseling experience;

(B) Clinical Supervisors in mental health programs must meet QMHP requirements and have completed two years of post-graduate clinical experience in a mental health treatment setting; and

(C) Clinical Supervisors in problem gambling treatment programs must meet the requirements for clinical supervisors in either mental health or alcohol and other drug treatment programs, and have completed 10 hours of gambling specific training within two years of designation as a problem gambling services supervisor.

(c) Alcohol and other drug treatment staff must:

(A) Be certified or licensed by a health or allied provider agency, as defined in these rules, to provide addiction treatment within two years of the first hire date and must make application for certification no later than six months following that date. The two years is not renewable if the person ends employment with a provider and becomes re-employed with another provider.

(B) Demonstrate competence in treatment of substance-use disorders including individual assessment and individual, group, family and other counseling techniques, program policies and procedures for service delivery and documentation, and identification, implementation and coordination of services identified to facilitate intended outcomes.

(d) Problem gambling treatment staff must demonstrate competence in treatment of problem gambling including individual assessment and individual, group, family and other counseling techniques, program policies and procedures for service delivery and documentation, and identification, implementation and coordination of services identified to facilitate intended outcomes.

(e) QMHAs must demonstrate the ability to communicate effectively, understand mental health assessment, treatment and service terminology and apply each of these concepts, implement skills development strategies, and identify, implement and coordinate the services and supports identified in an ISSP.

(f) QMHPs must demonstrate the ability to conduct an assessment, including identifying precipitating events, gathering histories of mental and physical health, alcohol and other drug use, past mental health services and criminal justice contacts, assessing family, cultural, social and work relationships, and conducting a mental status examination, complete a five-axis DSM diagnosis, write and supervise the implementation of a ISSP and provide individual, family or group therapy within the scope of their training.

(g) Peer support specialists must demonstrate knowledge of approaches to support others in recovery and resiliency, and demonstrate efforts at self-directed recovery.

(3) Recovering Staff: Program staff, contractors, volunteers and interns recovering from a substance-use disorder, providing treatment services or peer support services in alcohol and other drug treatment programs, must be able to document continuous abstinence under independent living conditions or recovery housing for the immediate past two years.

(4) Personnel Documentation: Providers must maintain personnel records for each program staff that contains all of the following documentation:

(a) An employment application;

(b) Where required, verification of a criminal records check consistent with OAR 407-007-0200 through 407-007-0370;

(c) A current job description that includes applicable competencies;

(d) Copies of relevant licensure or certification, diploma, or certified transcripts from an accredited college, indicating that the program staff meets applicable qualifications;

(e) Periodic performance appraisals;

(f) Staff orientation and development activities;

(g) Program staff incident reports;

(h) Disciplinary documentation;

(i) Reference checks;

(j) Emergency contact information; and

(k) Information from subsection (6) of this rule, if applicable.

(5) For providers utilizing contractors, interns or volunteers, providers must maintain the following documentation, as applicable:

(a) A contract, or written agreement, if applicable;

(b) A signed confidentiality agreement;

(c) Service-specific orientation documentation; and

(d) For subject individuals, verification of a criminal records check consistent with OAR 407-007-0200 through 407-007-0370.

(6) Program Specific Personnel Documentation: In addition to general program staff documentation requirements, providers must maintain additional documentation as applicable.

(a) For all program staff and volunteers providing residential services to children or adults:

(A) Results of a Tuberculosis screening as per OAR 333-071-0057.

(7) Training: Providers must ensure that program staff receives training applicable to the specific population for whom services are planned, delivered, or supervised as follows:

(a) Orientation training: The program must document appropriate orientation training for each program staff, or person providing services, within 30 days of the hire date. At minimum, orientation training for all program staff must include, but not be limited to,

(A) A review of individual crisis response procedures;

(B) A review of emergency procedures;

(C) A review of program policies and procedures;

(D) A review of rights for individuals receiving services and supports; and

(E) Mandatory abuse reporting procedures;

(F) For ICTS, ITS and Enhanced Care Services, positive behavior support training consistent with 309-032-1540(8).

(8) Supervision: Persons providing services to individuals in accordance with this rule must receive supervision by a qualified Clinical Supervisor, as defined in these rules, related to the development, implementation and outcome of services.

(a) Clinical supervision must be provided to assist program staff and volunteers to increase their skills, improve quality of services to individuals, and supervise program staff and volunteers' compliance with program policies and procedures, including:

(A) Documentation of supervision for each person supervised, of no less than two hours per month. The two hours must include one hour of face-to-face contact for each person supervised, or a proportional level of supervision for part-time program staff.

(B) Documentation of quarterly supervision for program staff holding a health or allied provider license.

(b) Medical supervision must be secured, when required, through a current written agreement, job description, or similar type of binding arrangement between a LMP and the provider, which describes the LMP’s responsibility in reviewing and approving the assessment and services and supports

identified in the ISSP for each individual receiving mental health services for one or more continuous years.

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 4-2010, f. & cert. ef. 3-4-10; MHS 15-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12

309-032-1525

Entry and Assessment

(1) Entry Process: The program must utilize a written entry procedure to ensure the following:

(a) Individuals must be considered for entry without regard to race, ethnicity, gender, gender identity, gender presentation, sexual orientation, religion, creed, national origin, age, except when program eligibility is restricted to children, adults or older adults, familial status, marital status, source of income, and disability.

(b) Individuals must receive services in the most timely manner feasible consistent with the presenting circumstances.

(c) For individuals receiving services funded by the SAPT Block Grant, entry of pregnant women to services must occur no later than 48 hours from the date of first contact, and no less than 14 days after the date of first contact for individuals using substances intravenously. If services are not available within the required timeframe, the provider must document the reason and provide interim referral and informational services as defined in these rules, within 48 hours.

(d) Written informed consent for services must be obtained from the individual or guardian, if applicable, prior to the start of services. If such consent is not obtained, the reason must be documented and further attempts to obtain informed consent must be made as appropriate.

(e) The provider must establish an Individual Service Record for each individual on the date of entry.

(f) The provider must report the entry of all individuals on the mandated state data system.

(g) In accordance with ORS 179.505 and HIPAA, an authorization for the release of information must be obtained for any confidential information concerning the individual being considered for, or receiving, services.

(h) Orientation: At the time of entry, the program must give to the individual and guardian if applicable, written program orientation information. The written information must be in the individual's primary language and must include:

(A) The program's philosophical approach to providing services and supports;

(B) A description of individual rights consistent with these rules;

(C) An overview of services available including any related fees when applicable; and

(D) Policies concerning grievances and confidentiality.

(2) Entry Priority:

(a) Entry of adults and older adults, in community-based mental health programs, whose services are not funded by Medicaid, must be prioritized in the following order:

(A) Individuals who, in accordance with the assessment of professionals in the field of mental health, are at immediate risk of hospitalization for the treatment of mental health conditions or are in need of continuing services to avoid hospitalization or pose a hazard to the health and safety of themselves, including the potential for suicide;

(B) Individuals who, because of the nature of their diagnosis, their geographic location or their family income, are least capable of obtaining assistance from the private sector; and

(C) Individuals who, in accordance with the assessment of professionals in the field of mental health, are experiencing mental health conditions but will not require hospitalization in the foreseeable future.

(b) Entry of children in community-based mental health services, whose services are not funded by Medicaid, must be prioritized in the following order:

(A) Children who are at immediate risk of psychiatric hospitalization or removal from home due to emotional and mental health conditions;

(B) Children who have severe mental health conditions;

(C) Children who exhibit behavior which indicates high risk of developing conditions of a severe or persistent nature; and

(D) Any other child who is experiencing mental health conditions which significantly affect the child's ability to function in everyday life but not requiring hospitalization or removal from home in the near future.

(c) Entry of individuals whose services are funded by the SAPT Block Grant, must be prioritized in the following order:

(A) Women who are pregnant and using substances intravenously;

(B) Women who are pregnant;

(C) Individuals who are using substances intravenously; and

(D) Women with dependent children.

(3) Assessment:

(a) When an individual is admitted for services, an assessment must be completed prior to development of the ISSP, or provisional ISSP, if applicable.

(b) When an assessment cannot be completed at entry, a provisional assessment, as defined in these rules, must document the immediate medical appropriateness of services. If services are continued, an

assessment must be completed within a timeframe that reflects the level and complexity of services and supports to be provided.

(c) The assessment must be completed by qualified program staff as follows:

(A) A QMHP in mental health programs. A QMHA may assist in the gathering and compiling of information to be included in the assessment.

(B) Supervisory or treatment staff in alcohol and other drug treatment programs, and

(C) Supervisory or treatment staff in problem gambling treatment programs.

(d) Each assessment must include:

(A) Sufficient biopsychosocial information and documentation to support the presence of a DSM diagnosis that is the medically appropriate reason for services.

(B) Screening for the presence of substance use, problem gambling, mental health conditions, and chronic medical conditions.

(C) Screening for the presence of symptoms related to psychological and physical trauma.

(D) Suicide potential must be assessed and individual service records must contain follow-up actions and referrals when an individual reports symptoms indicating risk of suicide.

(E) In addition, for children age zero to five, diagnosis must be informed by treatment guidelines included in the Health Services Commission prioritized list of paired conditions and treatments, and must include:

(i) Direct observation of child, parent, family and interaction;

(ii) Neurodevelopment considerations; and

(iii) Parental and family biopsychosocial functioning within the context of the home, community and culture.

(F) Subsections (3)(d)(A), (3)(d)(B), (3)(d)(C) and (3)(d)(D) of this rule, apply to alcohol and other drug assessments, which must be consistent with the dimensions described in the ASAM PPC-2R, and must document a diagnosis and level of care determination consistent with the DSM and ASAM PPC-2R.

(e) When the assessment process determines the presence of co-occurring substance use and mental health disorders, all providers must document referral for further assessment, planning and intervention from an appropriate professional, either with the same provider or with a collaborative community provider.

(f) Providers must document updates to the assessment consistent with the timelines specified in the ISSP, and when there are changes related to the biopsychosocial information in the assessment.

(g) In addition to periodic assessment updates, any individual continuing to receive mental health services for one or more continuous years, must receive an annual assessment by a QMHP, that has documented approval by an LMP.

(h) The requirements in OAR 309-032-1525(3)(d)(A) and 309-032-1525(3)(g) are minimum requirements to meet Medicaid auditing standards and may result in financial findings when not met. The requirements in OAR 309-032-1525(3)(d)(B) through 309-032-1525(3)(f) are quality standards and may result in limitations, or revocation of, certification when not met. Failure to maintain certification may result in exclusion or limited participation in the Medicaid program.

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 4-2010, f. & cert. ef. 3-4-10; MHS 15-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12

309-032-1530

Individual Service and Support Planning and Coordination

(1) Individual Services and Supports: The provider must deliver or coordinate, for each individual, appropriate services and supports to collaboratively facilitate intended service outcomes as identified by the individual, and family, when applicable.

(a) Qualified program staff must facilitate a planning process, resulting in an ISSP that reflects the assessment and the level of care to be provided.

(b) A provisional ISSP, including applicable crisis services, must be completed prior to the start of services. For mental health services, a QMHP, who is also a licensed health care professional, must recommend the services and supports by signing the provisional ISSP.

(c) If services are continued, an ISSP must be completed within a timeframe that reflects:

(A) The type and level of services and supports to be provided;

(B) A complete assessment; and

(C) Engagement and agreement of the individual, and family if applicable, in the development of the ISSP.

(d) Individuals, and family members, as applicable, must collaboratively participate in the development of the ISSP.

(e) Providers must fully inform the individual and guardian when applicable, of the proposed services and supports, in developmentally and culturally appropriate language, obtain informed consent for all proposed services, and give the individual and guardian when applicable, a written copy of the ISSP.

(f) Providers must collaborate with community partners to coordinate or deliver services and supports identified in the ISSP.

(g) Providers must request authorization to exchange information with any applicable physical health care providers or Fully Capitated Health Plans, for the individual, to collaborate in promoting regular and adequate health care.

(h) When there are barriers to services due to culture, gender, language, illiteracy, or disability, the provider must take measures to address or overcome those barriers including:

(A) Providing supports including, but not limited to, the provision of interpreters to provide translation services, at no additional cost to the individual.

(2) Individual Service and Support Plan (ISSP):

(a) The ISSP must document the specific services and supports to be provided, arranged or coordinated to assist the individual and his or her family, if applicable, to achieve intended outcomes.

(b) At minimum, each ISSP must include:

(A) Measurable or observable intended outcomes;

(B) Specific services and supports to be provided;

(C) Applicable service and support delivery details including frequency and duration of each service; and

(D) Timelines for review of progress and ISSP updates must be consistent with the level of care provided and the needs of the individual. For ITS programs, the interdisciplinary team must conduct a review of progress and transfer criteria at least every 30 days from the date of entry and must document members present, progress and changes made. For Psychiatric Day Treatment Services, the review must be conducted every 30 days and the LMP must participate in the review at least every 90 days.

(c) For ICTS programs, the ISSP must include:

(A) Identification of strengths and needs;

(B) A service coordination section that summarizes service planning in all relevant life domains by the participating team members; and

(d) For ICTS and ITS programs, the ISSP must include:

(A) Proactive safety and crisis planning; and

(B) A behavior support plan, consistent with OAR 309-032-1540(8) of these rules.

(e) A QMHP, who is also a licensed health care professional, must recommend the services and supports by signing the ISSP for each individual receiving mental health services within five days of the development of the ISSP;

(f) A LMP must approve updates to the ISSP at least annually for each individual receiving mental health services for one or more continuous years.

(g) The requirements in OAR 309-032-1530(2)(a) through 309-032-1530(2)(e) are minimum requirements to meet both Medicaid auditing and quality standards and may result in financial findings or limitations or both, or revocation of certification when not met. Failure to maintain certification may result in exclusion or limited participation in the Medicaid program.

(3) Individual Service Notes:

(a) A written individual service note must be recorded each time a service is provided.

(b) Individual Service Notes must document the:

(A) Specific service provided;

(B) Duration of the service provided;

(C) Date on which the service was provided;

(D) Location of service; and

(E) Date of authentication and name, signature, and credentials, of the person who provided the service.

(c) Individual service notes must also include:

(A) Periodic reviews of progress toward intended outcomes, consistent with timelines documented in the ISSP;

(B) Any significant events or changes in the individual's life circumstances, including mental status, treatment response and recovery status; and

(C) Any decisions to transfer an individual from service.

(d) The requirements in OAR 309-032-1530(3)(a) and 309-032-1530(3)(b)(A) through 309-032-1530(3)(b)(E) are minimum requirements to meet Medicaid auditing standards and may result in financial findings when not met. The requirements in 309-032-1530(3)(c)(A) through 309-032-1530(3)(c)(C) are quality standards and may result in limitations, or revocation of, certification when not met. Failure to maintain certification may result in exclusion or limited participation in the Medicaid program.

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 4-2010, f. & cert. ef. 3-4-10; MHS 15-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12

309-032-1535

Individual Service Record

(1) Documentation Standards: Documentation must be appropriate in quality and quantity to meet professional standards applicable to the provider and any additional standards for documentation in the provider's policies and any pertinent contracts.

(2) General Requirements for Individual Service Record: All providers must develop and maintain an Individual Service Record for each individual upon entry. The record must, at a minimum, include:

(a) Identifying information, or documentation of attempts to obtain the information, including:

(A) The individual's name, address, telephone number, date of birth, gender, and for adults, marital status and military status;

(B) Name, address, and telephone number of the parent or legal guardian, primary care giver or emergency contact;

(C) Contact information for medical and dental providers;

(b) Informed Consent for Service, including medications, or documentation specifying why the provider could not obtain consent by the individual or guardian as applicable;

(c) Written refusal of any services and supports offered, including medications;

(d) A signed fee agreement, when applicable;

(e) Assessment or provisional assessment and updates to the assessment;

(f) An ISSP or provisional ISSP, including any applicable behavior support or crisis intervention planning;

(g) Individual service notes;

(h) A Transfer Summary, when required;

(i) Other plans as made available, such as, but not limited to recovery plans, wellness action plans, education plans, and advance directives for physical and mental health care; and

(j) Applicable signed consents for release of information.

(3) Medical Service Records: When medical services are provided, the following documents must be part of the Individual Service Record as applicable:

(a) Medication Administration Records as per these rules;

(b) Laboratory reports; and

(c) LMP orders for medication, protocols or procedures.

(4) Documentation in Residential Programs: In addition to the requirements for Individual Service Records in subsection 309-032-1535(2), PRTS and

Alcohol and Other Drug Residential Treatment providers must include the following documentation in the Individual Service Record:

(a) A personal belongings inventory created upon entry and updated whenever an item of significant value is added or removed, or on the date of transfer;

(b) Documentation indicating that the individual and guardian, as applicable, were provided with the required orientation information upon entry;

(c) Background information including strengths and interests, all available previous mental health or substance use assessments, previous living arrangements, service history, behavior support considerations, education service plans if applicable, and family and other support resources;

(d) Medical information including a brief history of any health conditions, documentation from a LMP or other qualified health care professional of the individual's current physical health, and a written record of any prescribed or recommended medications, services, dietary specifications, and aids to physical functioning;

(e) Copies of documents relating to guardianship or any other legal considerations, as applicable;

(f) A copy of the individual’s most recent ISSP, if applicable, or in the case of an emergency or crisis-respite entry, a summary of current addictions or mental health services and any applicable behavior support plans;

(g) Documentation of the individual’s ability to evacuate the home consistent with the program’s evacuation plan developed in accordance with the Oregon Structural Specialty Code and Oregon Fire Code;

(h) Documentation of any safety risks; and

(i) Incident reports, when required, including:

(A) The date of the incident, the persons involved, the details of the incident, and the quality and performance actions taken to initiate investigation of the incident and correct any identified deficiencies; and

(B) Any child abuse reports made by the provider to law enforcement or to the DHS Children, Adults and Families Division, documenting the date of the incident, the persons involved and, if known, the outcome of the reports.

(5) Additional documentation in ITS Programs: In addition to OAR 309-032-1535(2), 309-032-1535(3) and 309-032-1535(4), ITS providers must include the following documentation in the Individual Service Record:

(a) Level of Service Intensity Determination;

(b) Names and contact information of the members of the interdisciplinary team;

(c) Documentation by the interdisciplinary team that the child's ISSP has been reviewed, the services provided are medically appropriate for the specific level of care, and changes in the plan recommended by the interdisciplinary team, as indicated by the child's service and support needs, have been implemented;

(d) Emergency safety intervention records, in a separate section or in a separate format, documenting each incident of personal restraint or seclusion, signed and dated by the qualified program staff directing the intervention and, if required, by the psychiatrist or clinical supervisor authorizing the intervention; and

(e) A copy of the written transition instructions provided to the child and family on the date of transfer.

(6) Additional documentation in ICTS Programs: In addition to OAR 309-032-1535(2), ICTS providers must include the following documentation in the Individual Service Record:

(a) Level of Service Intensity Determination; and

(b) Names and contact information of the members of the child and family team.

(7) PSRB and JPSRB Documentation: When the individual is under the jurisdiction of the PSRB or JPSRB, providers must include the following additional documentation in the Individual Service Record:

(a) Monthly reports to the PSRB or JPSRB;

(b) Interim reports, as applicable;

(c) The PSRB Initial Evaluation; and

(d) For PSRB and JPSRB services, a copy of the Conditional Order of Release.

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 4-2010, f. & cert. ef. 3-4-10; MHS 15-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12

309-032-1540

Program Specific Service Standards

In addition to individualized service and support planning and coordination, providers of each of the following program-specific service areas must ensure the following requirements listed for that service are met.

(1) Co-Occurring Mental Health and Substance Use Disorders (COD):

(a) Providers approved and designated to provide services and supports for individuals diagnosed with COD must:

(A) Provide concurrent service and support planning and delivery for substance use and mental health diagnosis, including integrated assessment, ISSP and individual service record

(2) Outpatient Mental Health Services to Children, Adults and Older Adults:

(a) Crisis services must be provided directly or through linkage to a local crisis services provider and must include the following:

(A) 24 hours, seven days per week telephone or face-to-face screening to determine an individual's need for immediate community mental health services; and

(B) 24 hour, seven days per week capability to conduct, by or under the supervision of a QMHP, a provisional assessment resulting in a provisional ISSP that includes the crisis services necessary to assist the individual and family to stabilize and transition to the appropriate level of care.

(b) Individual, family and group therapy provided by a QMHP;

(c) Psychiatric services including medication management as applicable, provided by a LMP who is either an employee of the provider or is a contracted provider; and

(d) Available case management services including the following:

(A) Assistance in applying for benefits to which the individual may be entitled. Program staff must assist individuals in gaining access to, and maintaining, resources such as Social Security benefits, general assistance, food stamps, vocational rehabilitation, and housing. When needed, program staff must arrange transportation or accompany individuals to help them apply for benefits;

(B) Assistance with completion of a declaration for mental health treatment with the individual's participation and informed consent;

(C) Referral and coordination to help individuals gain access to services and supports identified in the ISSP;

(D) When an individual receives residential services, program staff must collaborate with the residential program and family to coordinate services;

(E) When an individual resides in an Adult Foster Home, program staff must assist in the development of a Personal Care Plan. Program staff must also evaluate the appropriateness of services in relation to the individual’s assessed need and review the Personal Care Plan every 180 days;

(F) When an individual is admitted to a hospital or non-hospital facility, program staff must make contact in person or by telephone with the

individual within one working day of entry and P must be actively involved with transition planning from the hospital or non-hospital facility;

(G) If an individual is receiving treatment in a state funded long-term care psychiatric facility, program staff must, from the point of entry, be actively involved with transitioning the individual from long term care;

(H) When significant health and safety concerns are identified, program staff must assure that necessary services or actions occur to address the identified health and safety needs for the individual; and

(I) For children and youth, program staff must create linkages to and ongoing communication with other involved child-serving providers and agencies such as child welfare, education, primary care and juvenile justice, and make referrals for additional services and supports as indicated.

(e) Skills training as indicated;

(f) Peer delivered supports, as indicated; and

(g) Older adult services, including preventative mental health services, when applicable.

(3) Enhanced Care Services:

(a) Enhanced care services must be provided in DHS' SPD licensed facilities that have a multipurpose room, an area providing an environment with low stimulation, an accessible outdoor space with a covered area, a refrigerator, a microwave conveniently located for program activities, space for interdisciplinary meetings, space for mental health treatment and space for storage of records. A minimum of one private room is required in facilities opened after January 1, 1994.

(b) Services must include:

(A) 12 hours per week of mental health services available during evening and weekend shifts provided or arranged for by the contracted mental health provider;

(B) Weekly interdisciplinary team meetings to develop the ISSP, review the behavior support plan and to coordinate care planning with the SPD licensed provider staff and related professionals, including a QMHP, prescriber, SPD direct care staff, SPD case manager, SPD facility RN and SPD facility administrator; and

(C) A crisis service staffed by a QMHP or the local CMHP available to the provider and facility direct care staff 24-hours per day.

(c) ECOS services must be delivered according to the individual's needs and do not require the services listed under OAR 309-032-1540(3)(b)(A) and 309-032-1540(3)(b)(B) of this rule.

(d) Behavior support services must be consistent with OAR 309-032-1540(8) of these rules.

(4) Psychiatric Security Review Board and Juvenile Psychiatric Security Review Board: Services and supports must include all appropriate services determined necessary to assist the individual in maintaining community placement and which are consistent with Conditional Release Orders and the Agreement to Conditional Release.

(a) Providers of PSRB and JPSRB services acting through the designated Qualified Person, must submit reports to the PSRB or JPSRB as follows:

(A) Orders for Evaluation: For individuals under the jurisdiction of the PSRB or the JPSRB, providers must take the following action upon receipt of an Order for Evaluation:

(i) Within 15 days of receipt of the Order, schedule an interview with the individual for the purpose of initiating or conducting the evaluation;

(ii) Appoint a QMHP to conduct the evaluation and to provide an evaluation report to the PSRB or JPSRB;

(iii) Within 30 days of the evaluation interview, submit the evaluation report to the PSRB or JPSRB responding to the questions asked in the Order for Evaluation; and

(iv) If supervision by the provider is recommended, notify the PSRB or JPSRB of the name of the person designated to serve as the individual's

Qualified Person, who must be primarily responsible for delivering or arranging for the delivery of services and the submission of reports under these rules.

(B) Monthly reports consistent with PSRB or JPSRB reporting requirements as specified in the Conditional Release Order that summarize the individual's adherence to Conditional Release requirements and general progress; and

(C) Interim reports, including immediate reports by phone, if necessary, to ensure the public or individual's safety including:

(i) At the time of any significant change in the individual's health, legal, employment or other status which may affect compliance with Conditional Release orders;

(ii) Upon noting major symptoms requiring psychiatric stabilization or hospitalization;

(iii) Upon noting any other major change in the individual's ISSP;

(iv) Upon learning of any violations of the Conditional Release Order; and

(v) At any other time when, in the opinion of the Qualified Person, such an interim report is needed to assist the individual.

(b) JPSRB providers must submit copies of all monthly reports and interim reports to both the JPSRB and the Division.

(5) Intensive Community-Based Treatment and Support Services (ICTS) for Children: ICTS services may be delivered at a clinic, facility, home, school, other provider or allied agency location or other setting as identified by the child and family team. In addition to services specified by the ISSP and the standards for outpatient mental health services, ICTS services must include:

(a) Care coordination provided by a QMHP or a QMHA supervised by a QMHP;

(b) A child and family team, as defined in these rules;

(c) Service coordination as specified in the ISSP, to be developed by the child and family team;

(d) Review of progress at child and family team meetings to occur at a frequency documented in the ISSP;

(e) Family support and respite care, as indicated;

(f) Proactive safety and crisis planning that utilizes professional and natural supports to provide 24 hours, seven days per week flexible response and is reflective of strategies to avert potential crisis without placement disruptions; and

(g) Behavior support planning, consistent with OAR 309-032-1540(8) of these rules.

(6) Intensive Treatment Services (ITS) for Children:

(a) ITS Providers must meet the following general requirements:

(A) Maintain the organizational capacity and interdisciplinary treatment capability to deliver clinically and developmentally appropriate services in the medically appropriate amount, intensity and duration for each child specific to the child's diagnosis, level of functioning and the acuity and severity of the child's psychiatric symptoms;

(B) Maintain 24 hour, seven days per week treatment responsibility for children in the program;

(C) Non-residential programs must maintain on-call capability at all times to respond directly or by referral to the treatment needs of children, including crises, 24 hours per day and seven days per week;

(D) Inform the Division and the legal guardian within twenty-four hours of reportable incidents;

(E) Maintain linkages with primary care physicians, CMHPs and MHOs and the child's parent or guardian to coordinate necessary continuing care resources for the child; and

(F) Maintain linkages with the applicable education service district or school district to coordinate and provide the necessary educational services for the children and integrate education services in all phases of assessment, service and support planning, active treatment and transition planning.

(b) General staffing requirements: ITS providers must have the clinical leadership and sufficient QMHP, QMHA and other program staff to meet the 24-hour, seven days per week treatment needs of children and must establish policies, procedures and contracts to assure:

(A) Availability of psychiatric services to meet the following requirements;

(i) Provide medical oversight of the clinical aspects of care in nationally accredited sub-acute and psychiatric residential treatment facilities and provide 24-hour, seven days per week psychiatric on-call coverage; or consult on clinical care and treatment in psychiatric day treatment; and

(ii) Assess each child's medication and treatment needs, prescribe medicine or otherwise assure that case management and consultation services are provided to obtain prescriptions, and prescribe therapeutic modalities to achieve the child's individual service and support plan goals.

(B) There must be at least one program staff who has completed First Aid and CPR training on duty at all times.

(c) ITS providers must ensure that the following services and supports are available and accessible through direct service, contract or by referral:

(A) Active psychiatric treatment and education services must be functionally integrated in a therapeutic environment designed of reflect and promote achievement of the intended outcomes of each child’s ISSP;

(B) When treatment services interrupt the child's day to day educational environment, the program must provide or make arrangements for the continuity of the child's education;

(C) Family therapy must be provided by a QMHP. The family therapist to child ratio must be at least one family therapist for each 12 children;

(D) Psychiatric services;

(E) Individual, group and family therapies provided by a QMHP. There must be no less than one family therapist available for each 12 children;

(F) Medication evaluation, management and monitoring;

(G) Pre-vocational or vocational rehabilitation;

(H) Therapies supporting speech, language and hearing rehabilitation;

(I) Individual and group psychosocial skills development;

(J) Activity and recreational therapies;

(K) Nutrition;

(L) Physical health care services or coordination;

(M) Recreational and social activities consistent with individual strengths and interests;

(N) Educational services coordination and advocacy; and

(O) Behavior support services, consistent with OAR 309-032-1540(8) of these rules.

(7) Program Specific Requirements for ITS Providers: In addition to the general requirements for all ITS providers listed in OAR 309-032-1540(6), the following program-specific requirements must be met:

(a) Psychiatric Residential Treatment Facilities (PRTF):

(A) Children must either have or be screened for an Individual Education Plan, Personal Education Plan, or an Individual Family Service Plan;

(B) Psychiatric Residential Treatment Facilities must maintain one or more linkages with acute care hospitals or MHOs to coordinate necessary inpatient care;

(C) Psychiatric residential clinical care and treatment must be under the direction of a psychiatrist and delivered by an interdisciplinary team of board-certified or board-eligible child and adolescent psychiatrists, registered nurses, psychologists, other qualified mental health

professionals, and other relevant program staff. A psychiatrist must be available to the unit 24-hours per day, seven days per week; and

(D) Psychiatric Residential Treatment Facilities must be staffed at a clinical staffing ratio of not less than one program staff for three children during the day and evening shifts. At least one program staff for every three program staff members during the day and evening shifts must be a QMHP or QMHA. For overnight program staff there must be a staffing ratio of at least one program staff for six children; at least one of the overnight program staff must be a QMHA. For units that by this ratio have only one overnight program staff, there must be additional program staff immediately available within the facility or on the premises. At least one QMHP must be on site or on call at all times. At least one program staff with designated clinical leadership responsibilities must be on site at all times.

(b) SCIP and SAIP: Programs providing SCIP and SAIP Services must meet the requirements for PRTFs listed in 7(a) of this subsection. They must also establish policies and practices to meet the following:

(A) The staffing model must allow for the child's frequent contact with the child psychiatrist a minimum of one hour per week;

(B) Psychiatric nursing staff must be provided in the program 24 hours per day;

(C) A psychologist, psychiatric social worker, rehabilitation therapist and psychologist with documented training in forensic evaluations must be available 24 hours per day as appropriate; and

(D) Program staff with specialized training in SCIP or SAIP must be available 24 hours per day;

(E) The program must provide all medically appropriate psychiatric services necessary to meet the child's psychiatric care needs;

(F) The program must provide secure psychiatric treatment services in a manner that ensures public safety to youth who are under the care and custody of the Oregon Youth Authority, court ordered for the purpose of psychiatric evaluation, or admitted by the authority of the JPSRB; and

(G) The program must not rely on external entities such as law enforcement or acute hospital care to assist in the management of the SCIP or SAIP setting.

(c) Sub-Acute Psychiatric Care: In addition to the services provided as indicated by the assessment and specified in the ISSP, Sub-Acute Psychiatric Care providers must:

(A) Provide psychiatric nursing staffing at least 16 hours per day;

(B) Provide nursing supervision and monitoring and psychiatric supervision at least one to three times per week; and

(C) Work actively with the child and family team and multi-disciplinary community partners, to plan for the long-term emotional, behavioral, physical and social needs of the child to be met in the most integrated setting in the community.

(d) Psychiatric Day Treatment Services (PDTS):

(A) PDTS must be provided to children who remain at home with a parent, guardian or foster parent by qualified mental health professionals and qualified mental health associates in consultation with a psychiatrist;

(B) An education program must be provided and children must either have or be screened for an Individual Education Plan, Personal Education Plan or Individual Family Service Plan; and

(C) Psychiatric Day Treatment programs must be staffed at a clinical staffing ratio of at least one QMHP or QMHA for three children.

(8) Behavior Support Services: Behavior support services must be proactive, recovery-oriented, individualized, and designed to facilitate positive alternatives to challenging behavior, as well as to assist the individual in developing adaptive and functional living skills. Behavior support services are required in ITS, ICTS and ECS Services. Providers of these services must:

(a) Develop and implement individual behavior support strategies, based on a functional or other clinically appropriate assessment of challenging behavior;

(b) Document the behavior support strategies and measures for tracking progress as a behavior support plan in the ISSP;

(c) Establish a framework which assures individualized positive behavior support practices throughout the program and articulates a rationale consistent with the philosophies supported by the Division, including the Division's Trauma-informed Services Policy;

(d) Obtain informed consent from the parent or guardian, when applicable, in the use of behavior support strategies and communicate both verbally and in writing the information to the individual and guardian in the individual's primary language and in a developmentally appropriate manner;

(e) Establish outcome-based tracking methods to measure the effectiveness of behavior support strategies in:

(A) Reducing or eliminating the use of emergency safety interventions ; and

(B) Increasing positive behavior.

(f) Require all program staff to receive annual training in Collaborative Problem Solving, Positive Behavior Support or other Evidence-based Practice to promote positive behavior support; and

(g) Review and update behavior support policies, procedures, and practices annually.

(9) Emergency Safety Interventions in ITS Programs: Providers of ITS services must:

(a) Adopt policies and procedures for Emergency safety interventions as part of a Crisis Prevention and Intervention Policy. The policy must be consistent with the provider's trauma-informed services policies and procedures.

(b) Inform the individual and his or her parent or guardian of the provider's policy regarding the use of personal restraint and seclusion during an emergency safety situation by both furnishing a written copy of the policy and providing an explanation in the individual's primary language that is developmentally appropriate.

(c) Obtain a written acknowledgment from the parent or guardian that he or she has been informed of the provider’s policies and procedures regarding the use of personal restraint and seclusion.

(d) Prohibit the use of mechanical restraint and chemical restraint as defined in these rules.

(e) Establish an Emergency Safety Interventions Committee or designate this function to an already established Quality Assessment and Performance Improvement Committee. Committee membership must minimally include a program staff with designated clinical leadership responsibilities, the person responsible for staff training in crisis intervention procedures and other clinical personnel not directly responsible for authorizing the use of emergency safety interventions. The committee must:

(A) Monitor the use of emergency safety interventions to assure that individuals are safeguarded and their rights are always protected;

(B) Meet at least monthly and must report in writing to the provider's Quality Assessment and Performance Improvement Committee at least quarterly regarding the committee's activities, findings and recommendations;

(C) Analyze emergency safety interventions to determine opportunities to prevent their use, increase the use of alternatives, improve the quality of care and safety of individuals receiving services and recommend whether follow up action is needed;

(D) Review and update emergency safety interventions policies and procedures annually;

(E) Conduct individual and aggregate review of all incidents of personal restraint and seclusion; and

(F) Report the aggregate number of personal restraints and incidents of seclusion to the Division within 30 days of the end of each calendar quarter.

(f) Providers must meet the following general conditions of personal restraint and seclusion:

(A) Personal restraint and seclusion must only be used in an emergency safety situation to prevent immediate injury to an individual who is in danger of physically harming him or herself or others in situations such as the occurrence of, or serious threat of violence, personal injury or attempted suicide;

(B) Any use of personal restraint or seclusion must respect the dignity and civil rights of the individual;

(C) The use of personal restraint or seclusion must be directly related to the immediate risk related to the behavior of the individual and must not be used as punishment, discipline, or for the convenience of staff;

(D) Personal restraint or seclusion must only be used for the length of time necessary for the individual to resume self-control and prevent harm to the individual or others, even if the order for seclusion or personal restraint has not expired, and must under no circumstances, exceed 4 hours for individuals ages 18 to 21, 2 hours for individuals ages 9 to 17, or 1 hour for individuals under age 9;

(E) An order for personal restraint or seclusion must not be written as a standing order or on an as needed basis;

(F) Personal restraint and seclusion must not be used simultaneously;

(G) Providers must notify the individual's parent or guardian of any incident of seclusion or personal restraint as soon as possible;

(H) If incidents of personal restraint or seclusion used with an individual cumulatively exceed five interventions over a period of five days, or a single episode of one hour within 24 hours, the psychiatrist, or designee, must convene, by phone or in person, program staff with designated clinical leadership responsibilities to:

(i) Discuss the emergency safety situation that required the intervention, including the precipitating factors that led up to the intervention and any alternative strategies that might have prevented the use of the personal restraint or seclusion;

(ii) Discuss the procedures, if any, to be implemented to prevent any recurrence of the use of personal restraint or seclusion;

(iii) Discuss the outcome of the intervention including any injuries that may have resulted; and

(iv) Review the individual's ISSP, making the necessary revisions, and document the discussion and any resulting changes to the individual's ISSP in the Individual Service Record.

(g) Personal Restraint:

(A) Each personal restraint must require an immediate documented order by a physician, licensed practitioner, or, in accordance with OAR 309-034-0400 through 309-034-0490, a licensed CESIS;

(B) The order must include:

(i) Name of the person authorized to order the personal restraint;

(ii) Date and time the order was obtained; and

(iii) Length of time for which the intervention was authorized.

(C) Each personal restraint must be conducted by program staff that have completed and use a Division-approved crisis intervention training. If in the event of an emergency a non Division-approved crisis intervention technique is used, the provider's on-call administrator must immediately review the intervention and document the review in an incident report to be provided to the Division within 24 hours;

(D) At least one program staff trained in the use of emergency safety interventions must be physically present, continually assessing and monitoring the physical and psychological well-being of the individual and the safe use of the personal restraint throughout the duration of the personal restraint;

(E) Within one hour of the initiation of a personal restraint, a psychiatrist, licensed practitioner, or CESIS must conduct a face-to-face assessment of the physical and psychological well being of the individual;

(F) A designated program staff with clinical leadership responsibilities must review all personal restraint documentation prior to the end of the shift in which the intervention occurred; and

(G) Each incident of personal restraint must be documented in the individual service record. The documentation must specify:

(i) Behavior support strategies and less restrictive interventions attempted prior to the personal restraint;

(ii) Required authorization;

(iii) Events precipitating the personal restraint;

(iv) Length of time the personal restraint was used;

(v) Assessment of appropriateness of the personal restraint based on threat of harm to self or others;

(vi) Assessment of physical injury; and

(vii) Individuals response to the emergency safety intervention.

(h) Seclusion: Providers must be approved by the Division for the use of seclusion.

(A) Authorization for seclusion must be obtained by a psychiatrist, licensed practitioner or CESIS prior to, or immediately after the initiation of seclusion. Written orders for seclusion must be completed for each instance of seclusion and must include:

(i) Name of the person authorized to order seclusion;

(ii) Date and time the order was obtained; and

(iii) Length of time for which the intervention was authorized.

(B) Program staff trained in the use of emergency safety interventions must be physically present continually assessing and monitoring the physical and psychological well-being of the individual throughout the duration of the seclusion;

(C) Visual monitoring of the individual in seclusion must occur continuously and be documented at least every fifteen minutes or more often as clinically indicated;

(D) Within one hour of the initiation of seclusion a psychiatrist or CESIS must conduct a face-to-face assessment of the physical and psychological well being of the individual;

(E) The individual must have regular meals, bathing, and use of the bathroom during seclusion and the provision of these must be documented in the individual service record; and

(F) Each incident of seclusion must be documented in the individual service record. The documentation must specify:

(i) The behavior support strategies and less restrictive interventions attempted prior to the use of seclusion;

(ii) The required authorization for the use of seclusion;

(iii) The events precipitating the use of seclusion;

(iv) The length of time seclusion was used;

(v) An assessment of the appropriateness of seclusion based on threat of harm to self or others;

(vi) An assessment of physical injury to the individual, if any; and

(vii) The individual's response to the emergency safety intervention.

(i) Any room specifically designated for the use of seclusion or time out must be approved by the Division.

(j) If the use of seclusion occurs in a room with a locking door, the program must be authorized by the Division for this purpose and must meet the following requirements:

(A) A facility or program seeking authorization for the use of seclusion must submit a written application to the Division;

(B) Application must include a comprehensive plan for the need for and use of seclusion of children in the program and copies of the facility's policies and procedures for the utilization and monitoring of seclusion including a statistical analysis of the facility's actual use of seclusion, physical space,

staff training, staff authorization, record keeping and quality assessment practices;

(C) The Division must review the application and, after a determination that the written application is complete and satisfies all applicable requirements, must provide for a review of the facility by authorized Division staff;

(D) The Division must have access to all records including individual service records, the physical plant of the facility, the employees of the facility, the professional credentials and training records for all program staff, and must have the opportunity to fully observe the treatment and seclusion practices employed by the facility;

(E) After the review, the Deputy Director of the Division or their designee must approve or disapprove the facility's application and upon approval must certify the facility based on the determination of the facility's compliance with all applicable requirements for the seclusion of children;

(F) If disapproved, the facility must be provided with specific recommendations and have the right of appeal to the Division; and

(G) Certification of a facility must be effective for a maximum of three years and may be renewed thereafter upon approval of a renewal application.

(k) Structural and physical requirements for seclusion: An ITS provider seeking this certification under these rules must have available at least one room that meets the following specifications and requirements:

(A) The room must be of adequate size to permit three adults to move freely and allows for one adult to lie down. Any newly constructed room must be no less than 64 square feet;

(B) The room must not be isolated from regular program staff of the facility, and must be equipped with adequate locking devices on all doors and windows;

(C) The door must open outward and contain a port of shatterproof glass or plastic through which the entire room may be viewed from outside;

(D) The room must contain no protruding, exposed, or sharp objects;

(E) The room must contain no furniture. A fireproof mattress or mat must be available for comfort;

(F) Any windows must be made of unbreakable or shatterproof glass or plastic. Non-shatterproof glass must be protected by adequate climb-proof screening;

(G) There must be no exposed pipes or electrical wiring in the room. Electrical outlets must be permanently capped or covered with a metal shield secured by tamper-proof screws. Ceiling and wall lights must be recessed and covered with safety glass or unbreakable plastic. Any cover, cap or shield must be secured by tamper-proof screws;

(H) The room must meet State Fire Marshal fire, safety, and health standards. If sprinklers are installed, they must be recessed and covered with fine mesh screening. If pop-down type, sprinklers must have breakaway strength of under 80 pounds. In lieu of sprinklers, combined smoke and heat detector must be used with similar protective design or installation;

(I) The room must be ventilated, kept at a temperature no less than 64°F and no more than 85°F. Heating and cooling vents must be secure and out of reach;

(J) The room must be designed and equipped in a manner that would not allow a child to climb off the ground;

(K) Walls, floor and ceiling must be solidly and smoothly constructed, to be cleaned easily, and have no rough or jagged portions; and

(L) Adequate and safe bathrooms must be available.

(10) Outpatient Problem Gambling Treatment Services: These services include group, individual and family treatment consistent with the following requirements:

(a) The first offered service appointment must be five business days or less from the date of request for services;

(b) Service sessions must address the challenges of the individual as they relate, directly or indirectly, to the problem gambling behavior;

(c) Telephone counseling: Providers may provide telephone counseling when person-to-person contact would involve an unwise delay, as follows:

(A) Individual must be currently enrolled in the problem gambling treatment program;

(B) Phone counseling must be provided by a qualified provider within their scope of practice;

(C) Individual service notes must follow the same criteria as face-to-face counseling and identify the session was conducted by phone and the clinical rationale for the phone session;

(D) Telephone counseling must meet HIPAA and 42 CFR standards for privacy; and

(E) There must be an agreement of informed consent for phone counseling that is discussed with the individual and documented in the individual's service record.

(d) Family Counseling: Family counseling includes face-to-face or non face-to-face service sessions between a program staff member delivering the service and a family member whose life has been negatively impacted by gambling.

(A) Service sessions must address the problems of the family member as they relate directly or indirectly to the problem gambling behavior; and

(B) Services to the family must be offered even if the individual identified as a problem gambler is unwilling, or unavailable to accept services.

(e) 24-hour crisis response accomplished through agreement with other crisis services, on-call program staff or other arrangement acceptable to the Division.

(11) Residential Problem Gambling Treatment Services: Providers of this service must comply with OAR 309-032-1545 of these rules.

(a) When problem gambling treatment services are provided in a psychiatric health facility, providers must have Division approved written

policies and procedures for operating this service, and must be licensed in accordance with OAR 309-035-0100 through OAR 309-035-0460.

(b) When problem gambling treatment services are provided in an alcohol and other drug residential treatment facility providers of this service must have Division approved written policies and procedures for operating this service and have a current license issued by the Division in accordance with OAR 415-012-0000 through 415-012-0090.

(c) Providers must coordinate services and make appropriate referrals to other formal and informal service systems to insure continuity of care, including, but not limited to, mental health, self-help support groups, financial consultants, legal advice, medical, crisis management, cultural issues, housing and vocational. All referral and follow-up actions must be documented in the individual service record.

(12) Alcohol and Other Drug Treatment and Recovery Services:

(a) Interim Referral and Information Services: Pregnant women or other individuals using substances intravenously, whose services are funded by the SAPT Block Grant, must receive interim referrals and information prior to entry, to reduce the adverse health effects of alcohol and other drug use, promote the health of the individual, and reduce the risk of transmission of disease. At a minimum, interim referral and informational services must include:

(A) Counseling and education about blood borne pathogens including Hepatitis, HIV, STDs and Tuberculosis (TB); the risks of needle and paraphernalia sharing and the likelihood of transmission to sexual partners and infants;

(B) Counseling and education about steps that can decrease the likelihood of Hepatitis, HIV, STD, and TB transmission;

(C) Referral for Hepatitis, HIV, STD and TB testing, vaccine or care services if necessary; and

(D) For pregnant women, counseling on the likelihood of blood borne pathogen transmission as well as the effects of alcohol, tobacco and other drug use on the fetus and referral for prenatal care.

(b) Culturally Specific Services: Programs approved and designated as culturally specific programs must meet the following criteria:

(A) Serve a majority of individuals representing the culturally specific population; and

(B) Governing Board: Develop and maintain a governing or advisory board that must:

(i) Have a majority representation of the culturally specific group being served;

(ii) Receive training concerning the significance of culturally relevant services and supports;

(iii) Include at least 20% representation of individuals, as defined in these rules, or family members of individuals; and

(iv) Meet at least quarterly.

(C) Maintain accessibility to culturally specific populations including:

(i) The physical location of the program must be within close proximity to the culturally specific populations;

(ii) Where available, public transportation must be within close proximity to the program; and

(iii) Hours of service, telephone contact, and other accessibility issues must be appropriate for the population; and

(D) The physical facility within which the culturally specific services are delivered must be psychologically comfortable for the group including:

(i) Materials displayed must be culturally relevant;

(ii) Mass media programming (radio, television, etc.) must be sensitive to cultural background; and

(iii) Other cultural differences must be considered and accommodated when possible, such as the need or desire to bring family members to the facility, play areas for small children and related accommodations.

(c) Adolescent Treatment Services: Programs approved to provide adolescent alcohol and other drug treatment services or those with adolescent-designated service funding must meet the following standards:

(A) Residential programs providing services to individuals defined as children for purposes of this rule must, in addition to the applicable requirements of this rule, be licensed by DHS' Children, Adults and Families Division in cooperation with the Division.

(B) Development of ISSPs and case management services must include participation of parents, other family members, schools, children's services agencies, and juvenile corrections, as appropriate;

(C) Services, or appropriate referrals, must include:

(i) Family service;

(ii) Recreation and leisure time consistent with the individual's interests;

(iii) Community and social skills training;

(iv) Academic education services or referral; and

(v) Smoking cessation service.

(D) Continuing care services must be of appropriate duration, consistent with ASAM PPC-2R criteria, and designed to maximize recovery opportunities. The services must include:

(i) Reintegration services and coordination with family and schools;

(ii) Youth dominated self-help groups where available;

(iii) Linkage to emancipation services when appropriate; and

(iv) Linkage to physical or sexual abuse counseling and support services when appropriate.

(E) There must be a sufficient number of qualified program staff to ensure a ratio of at least one treatment staff per eight adolescents at all times.

(F) Program staff coverage must be provided 24 hours per day, seven days per week.

(d) Women's Treatment Services: Programs approved and designated to provide alcohol and other drug treatment services primarily to women must meet the following standards:

(A) The Assessment must contain an evaluation that identifies and assesses needs specific to women's issues in service such as social isolation, self-reliance, parenting issues, domestic violence, women’s physical health, housing and financial considerations;

(B) The Individual Service and Support Plan must address all areas identified in (12)(d)(A) of this subsection as well as alcohol and other drug use and any other applicable service coordination details;

(C) The program must provide or coordinate services and supports that meet the special access needs of women such as childcare, mental health services, and transportation, as indicated;

(D) The program must provide, or coordinate, the following services and supports unless clinically contraindicated:

(i) Gender-specific services and supports;

(ii) Family services, including therapeutic services for children in the custody of women in treatment;

(iii) Reintegration with family;

(iv) Peer delivered supports;

(v) Smoking cessation;

(vi) Housing; and

(vii) Transportation.

(E) Individual Service and Support Planning and treatment must include the participation of family and other agencies as appropriate, such as social service, child welfare, or corrections agencies;

(F) Referral Services: The program must coordinate services with the following, if indicated:

(i) Agencies providing services to women who have experienced physical abuse, sexual abuse or other types of domestic violence; and

(ii) Parenting training; and

(G) Continuing care treatment services must be consistent with the ASAM PPC-2R and must include referrals to female dominated support groups where available; and

(H) Programs that receive SAPT Block Grant funding must provide or coordinate the following services for pregnant women and women with dependent children, including women who are attempting to regain custody of their children:

(i) Primary medical care for women, including referral for prenatal care and, while the women are receiving such services, child care;

(ii) Primary pediatric care, including immunizations for their children;

(iii) Gender specific substance abuse treatment and other therapeutic interventions for women which may include, but are not limited to:

(I) Relationship issues;

(II) Sexual and physical abuse;

(III) Parenting; and

(IV) Access to child care while the women are receiving these services; and

(iv) Therapeutic interventions for children in the custody of women in treatment which may include, but are not limited to:

(I) Their developmental needs; and

(II) Any issues concerning sexual and physical abuse, and neglect; and

(III) Sufficient case management and transportation to ensure that women and their children have access to services.

(e) Specialized Alcohol and Other Drug Community-based Programs for Individuals in the Criminal Justice System: These services and supports are for individuals who are under the supervision of a probation officer or on parole or post-prison supervision or participating in a drug treatment court program or otherwise under the direct supervision of the court.

(A) Services and supports must incorporate interventions and strategies that target criminogenic risk factors and include:

(i) Cognitive behavioral interventions;

(ii) Motivational interventions;

(iii) Relapse prevention; and

(iv) Healthy relationships education;

(B) Providers must demonstrate coordination of services with criminal justice partners through written protocols, program staff activities, and individual record documentation;

(C) Program Directors or clinical supervisors must have experience in community-based offender treatment programs and have specific training and experience applying effective, evidence-based clinical strategies and services for individuals receiving community-based alcohol and other drug treatment services to individuals in the criminal justice system;

(D) Within the first six months of hire, program staff must receive training on effective principles of evidenced-based practices for individuals with criminogenic risk factors; and

(E) Within six months of hire, program staff must have documented knowledge, skills, and abilities demonstrating treatment strategies for individuals with criminogenic risk factors.

(f) DUII Alcohol and Other Drug Rehabilitation Programs: In addition to the general standards for alcohol and other drug treatment programs, those programs approved to provide DUII rehabilitation services must meet the following standards:

(A) DUII rehabilitation programs must assess individuals referred for treatment by the evaluation specialist. Placement, continued stay and transfer of individuals must be based on the criteria described in the ASAM PPC-2R, subject to the following additional terms and conditions:

(i) Abstinence: Individuals must demonstrate continuous abstinence for a minimum of 90 days prior to completion as documented by urinalysis tests and other evidence;

(ii) Treatment Completion: Only DUII rehabilitation programs may certify treatment completion;

(iii) Residential Treatment: Using the ASAM PPC-2R, the DUII program's assessment may indicate that the individual requires treatment in a residential program. It is the responsibility of the DUII program to:

(I) Monitor the case carefully while the individual is in residential treatment;

(II) Provide or monitor outpatient and follow-up services when the individual is transferred from the residential program; and

(III) Verify completion of residential treatment and follow-up outpatient treatment.

(iv) Urinalysis Testing: A minimum of one urinalysis sample per month must be collected during the period of service deemed necessary by an individual's DUII rehabilitation program:

(I) Using the process defined in these rules, the samples must be tested for at least five controlled drugs;

(II) At least one of the samples is to be collected and tested in the first two weeks of the program and at least one is to be collected and tested in the last two weeks of the program;

(III) If the first sample is positive, two or more samples must be collected and tested, including one sample within the last two weeks before completion; and

(IV) Programs may use methods of testing for the presence of alcohol and other drugs in the individual's body other than urinalysis tests if they have obtained the prior review and approval of such methods by the Division.

(v) Reporting: The program must report:

(I) To the Division on forms prescribed by the Division;

(II) To the evaluation specialist within 30 days from the date of the referral by the specialist. Subsequent reports must be provided within 30 days of completion or within 10 days of the time that the individual enters noncompliant status; and

(III) To the appropriate evaluation specialist, case manager, court, or other agency as required when requested concerning individual cooperation, attendance, treatment progress, utilized modalities, and fee payment.

(vi) Certifying Completion: The program must send a numbered Certificate of Completion to the Department of Motor Vehicles to verify the completion of convicted individuals. Payment for treatment may be considered in determining completion. A certificate of completion must not be issued until the individual has satisfied the abstinence requirements of 309-032-1540(f)(A)(i).

(vii) Records: The DUII rehabilitation program must maintain in the permanent Individual Service Record, urinalysis results and all information necessary to determine whether the program is being, or has been, successfully completed.

(viii) Separation of Evaluation and Rehabilitation Functions: Without the approval of the Director , no agency or person may provide DUII rehabilitation to an individual who has also been referred by a Judge to the same agency or person for a DUII evaluation. Failure to comply with this rule will be considered a violation of ORS chapter 813. If the Director finds such a violation, the Director may deny, suspend, revoke, or refuse to renew a letter of approval.

(13) Medical Protocols in Alcohol and Other Drug Treatment Programs: Medical protocols must be approved by a medical director under contract with a program or written reciprocal agreement with a medical practitioner under managed care. The protocols must:

(a) Require, but not be limited to a medical history, as described in the Assessment;

(b) Designate those medical symptoms that, when found, require further investigation, physical examinations, service, or laboratory testing;

(c) Require that individuals admitted to the program who are currently injecting or intravenously using a drug, or have injected or intravenously used a drug within the past 30 days, or who are at risk of withdrawal from a drug, or who may be pregnant, must be referred for a physical examination and appropriate lab testing within 30 days of entry to the program. This requirement may be waived by the medical director if these services have been received within the past 90 days and documentation is provided;

(d) Require pregnant women be referred for prenatal care within two weeks of entry to the program;

(e) Require that the program provide HIV and AIDS, TB, sexually transmitted disease, Hepatitis and other infectious disease information and risk assessment, including any needed referral, within 30 days of entry; and

(f) Specify the steps for follow up and coordination with physical health care providers in the event the individual is found to have an infectious disease or other major medical problem.

(14) Administration of Medications: The following guidelines must be followed in policies on administration of medications in all programs:

(a) Medications prescribed for one individual must not be administered to or self-administered by another individual or program staff;

(b) When an individual self-administers medication in a residential program, self-administration must be approved in writing by a physician and closely monitored by the residential program staff;

(c) No unused, outdated, or recalled drugs must be kept in a program. On a monthly basis any unused, outdated, or recalled drugs must be disposed of in a manner that assures they cannot be retrieved;

(d) Disposal of prescription drugs in a residential program: A written record of all disposals of drugs must be maintained in the program and must include:

(A) A description of the drug, including the amount;

(B) The individual for whom the medication was prescribed;

(C) The reason for disposal; and

(D) The method of disposal.

(e) Storage of Prescription Drugs in residential programs: All prescription drugs stored in the residential program must be kept in a locked stationary container. Medications requiring refrigeration must be stored in a refrigerator using a locked container; and

(f) Written documentation of medications prescribed for the individual by a LMP must be maintained in the Individual Service Record. Documentation for each medication prescribed must include the following:

(A) A copy or detailed written description of the signed prescription order;

(B) The name of the medication prescribed;

(C) The prescribed dosage and method of administration;

(D) The date medications were prescribed, reviewed, or renewed;

(E) The date, the signature and credentials of program staff administering or prescribing medications; and

(F) Medication records which contain:

(i) Observed side effects including laboratory findings; and

(ii) Medication allergies and adverse reaction.

(15) Building Requirements for Alcohol and Other Drug Programs: Each alcohol and other drug treatment program must provide facilities that:

(a) Comply with all applicable state and local building, electrical, plumbing, fire, safety, and zoning codes;

(b) Maintain up-to-date documentation verifying that they meet applicable local business license, zoning and building codes and federal, state and local fire and safety regulations. It is the responsibility of the program to check with local government to make sure all applicable local codes have been met;

(c) Provide space for services including but not limited to intake, assessment, counseling and telephone conversations that assures the privacy and confidentiality of individuals and is furnished in an adequate and comfortable fashion including plumbing, sanitation, heating, and cooling;

(d) Provide rest rooms for individuals, visitors, and staff that are accessible to persons with disabilities pursuant to Title II of the Americans with Disabilities Act if the program receives any public funds or Title III of the Act if no public funds are received;

(e) Adopt and implement emergency policies and procedures, including an evacuation plan and emergency plan in case of fire, explosion, accident, death or other emergency. The policies and procedures and emergency plans must be current and posted in a conspicuous area; and

(f) Tobacco Use: Outpatient programs must not allow tobacco use in program facilities and on program grounds. Effective July 1, 2012, residential programs must not allow tobacco use in program facilities and on program grounds.

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 4-2010, f. & cert. ef. 3-4-10; MHS 15-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12

309-032-1545

Facility Standards for Alcohol and Other Drug Residential Treatment Programs

(1) Building Requirements: In addition to the building requirements for outpatient Alcohol and Other Drug treatment programs, residential programs must meet the following standards:

(a) Prior to construction of a new building or major alteration of or addition to an existing building:

(A) One set of plans and specifications must be submitted to the State Fire Marshal for approval;

(B) Plans must be in accordance with the State of Oregon Structural Specialty Code and Fire and Life Safety Regulations;

(C) Plans for construction containing 4,000 square feet or more must be prepared and bear the stamp of an Oregon licensed architect or engineer; and

(D) The water supply, sewage, and garbage disposal system must be approved by the agency having jurisdiction.

(2) Interiors: All rooms used by individuals must have floors, walls, and ceilings that meet the interior finish requirements of the State of Oregon Structural Specialty Code and Fire and Life Safety Regulations:

(a) A separate dining room or area must be provided for exclusive use of individuals, program staff, and invited guests, and must:

(A) Seat at least one-half of the individuals at a time with a minimum of 15 square feet per occupant; and

(B) Be provided with adequate ventilation.

(b) A separate living room or lounge area must be provided for the exclusive use of individuals, program staff, and invited guests and must:

(A) Provide a minimum of 15 square feet per occupant; and

(B) Be provided with adequate ventilation.

(c) Bedrooms must be provided for all individuals and must:

(A) Be separate from the dining, living, multi-purpose, laundry, kitchen, and storage areas;

(B) Be an outside room with a window that can be opened, and is at least the minimum required by the State Fire Marshal;

(C) Have a ceiling height of at least seven feet, six inches;

(D) Provide a minimum of 60 square feet per individual, with at least three feet between beds;

(E) Provide permanently wired light fixtures located and maintained to give light to all parts of the room; and

(F) Provide a curtain or window shade at each window to assure privacy.

(d) Bathrooms must be provided and conveniently located in each building containing a bedroom and must:

(A) Provide a minimum of one toilet and one hand-washing sink for each eight individuals, and one bathtub or shower for each ten individuals;

(B) Provide one hand-washing sink convenient to every room containing a toilet;

(C) Provide permanently wired light fixtures located and maintained to give adequate light to all parts of the room;

(D) Provide arrangements for personal privacy for individuals;

(E) Provide a privacy screen at each window;

(F) Provide a mirror; and

(G) Be provided with adequate ventilation.

(e) A supply of hot and cold water installed and maintained in compliance with rules of, the Authority , Health Services, Office of Public Health Systems, must be distributed to taps conveniently located throughout the residential program;

(f) All plumbing must comply with applicable codes;

(g) Laundry facilities, when provided, must be separate from:

(A) Resident living areas, including bedrooms;

(B) Kitchen and dining areas; and

(C) Areas used for the storage of unrefrigerated perishable foods.

(h) Storage areas must be provided appropriate to the size of the residential program. Separate storage areas must be provided for:

(A) Food, kitchen supplies, and utensils;

(B) Clean linens;

(C) Soiled linens and clothing;

(D) Cleaning compounds and equipment; and

(E) Poisons, chemicals, insecticides, and other toxic materials, which must be properly labeled, stored in the original container, and kept in a locked storage area.

(i) Furniture must be provided for each individual and must include:

(A) A bed with a frame and a clean mattress and pillow;

(B) A private dresser or similar storage area for personal belongings which is readily accessible to the individual; and

(C) Access to a closet or similar storage area for clothing and

(j) Linens must be provided for each individual and must include:

(A) Sheets and pillowcases;

(B) Blankets, appropriate in number and type for the season and the individual's comfort; and

(C) Towel and washcloth.

(3) Food Service and Storage: The residential program must meet the requirements of the State of Oregon Sanitary Code for Eating and Drinking Establishments relating to the preparation, storage, and serving of food. At minimum:

(a) Menus must be prepared in advance to provide a sufficient variety of foods served in adequate amounts for each resident at each meal;

(b) Records of menus as served must be filed and maintained in the residential program records for at least 30 days;

(c) All modified or special diets must be ordered by a physician;

(d) At least three meals must be provided daily;

(e) Supplies of staple foods for a minimum of one week and of perishable foods for a minimum of a two-day period must be maintained on the premises;

(f) Food must be stored and served at proper temperature;

(g) All utensils, including dishes, glassware, and silverware used in the serving or preparation of drink or food for individuals must be effectively washed, rinsed, sanitized, and stored after each individual use to prevent contamination in accordance with Health Division standards; and

(h) Raw milk and home-canned vegetables, meats, and fish must not be served or stored in a residential program.

(4) Safety: The residential program must meet the following safety requirements:

(a) At no time must the number of individuals served exceed the approved capacity;

(b) A written emergency plan must be developed and posted next to the telephone used by program staff and must include:

(A) Instructions for the program staff or designated resident in the event of fire, explosion, accident, death, or other emergency and the telephone numbers of the local fire department, law enforcement agencies, hospital

emergency rooms, and the residential program's designated physician and on-call back-up program staff;

(B) The telephone number of the administrator or clinical supervisor and other persons to be contacted in case of emergency; and

(C) Instructions for the evacuation of individuals and program staff in the event of fire, explosion, or other emergency.

(c) The residential program must provide fire safety equipment appropriate to the number of individuals served, and meeting the requirements of the State of Oregon Structural Specialty Code and Fire and Life Safety Regulations:

(A) Fire detection and protection equipment must be inspected as required by the State Fire Marshal;

(B) All flammable and combustible materials must be properly labeled and stored in the original container in accordance with the rules of the State Fire Marshal; and

(C) The residential program must conduct unannounced fire evacuation drills at least monthly. At least once every three months the monthly drill must occur between 10 p.m. and 6 a.m. Written documentation of the dates and times of the drills, time elapsed to evacuate, and program staff conducting the drills must be maintained.

(d) At least one program staff who is trained in First Aid and CPR must be onsite at all times; and

(e) In Residential Transition programs, at least one individual, designated by the administrator as being capable of managing emergencies and other situations that require immediate attention, must be onsite at all times when there is no onsite program staff coverage.

(5) Sanitation: The residential program must meet the following sanitation requirements:

(a) All floors, walls, ceilings, window, furniture, and equipment must be kept in good repair, clean, neat, orderly, and free from odors;

(b) Each bathtub, shower, hand-washing sink, and toilet must be kept clean and free from odors;

(c) The water supply in the residential program must meet the requirements of the rules of the Health Division governing domestic water supplies;

(d) Soiled linens and clothing must be stored in an area separate from kitchens, dining areas, clean linens and clothing and unrefrigerated food;

(e) All measures necessary to prevent the entry into the program of mosquitoes and other insects must be taken;

(f) All measures necessary to control rodents must be taken;

(g) The grounds of the program must be kept orderly and free of litter, unused articles, and refuse;

(h) Garbage and refuse receptacles must be clean, durable, water-tight, insect- and rodent proof and kept covered with a tight-fitting lid;

(i) All garbage solid waste must be disposed of at least weekly and in compliance with the rules of the Department of Environmental Quality; and

(j) Sewage and liquid waste must be collected, treated and disposed of in compliance with the rules of the Department of Environmental Quality.

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 4-2010, f. & cert. ef. 3-4-10; MHS 15-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12

309-032-1550

Service Conclusion, Transfer, and Continuity of Care

(1) Planned Transfer: Providers must meet the following requirements for planned transfer:

(a) Decisions to transfer individuals must be documented in a transfer summary. The documentation must include the reason for transfer;

(b) For alcohol and other drug treatment services, planned transfer must be consistent with ASAM criteria established in the assessment;

(c) For ITS programs, planned transfer must be consistent with the transfer criteria established by the interdisciplinary team and documented in the ISSP. In addition:

(A) Providers must not conclude services unless the interdisciplinary team, in consultation with the child's parent or guardian and the next provider, agree that the child requires a more or less restrictive level of care; and

(B) If the determination is made to admit the child to acute care, the provider must not conclude services during the acute care stay unless the interdisciplinary team, in consultation with the child's parent or guardian and the next provider, agree that the child requires a more or less restrictive level of care following the acute care stay; and

(d) For DUII Alcohol and Other Drug Rehabilitation Programs, the balance, if any, of fees charged not paid by the individual.

(2) Transfer Process and Continuity of Care: Prior to transfer, providers must:

(a) When applicable, coordinate and provide appropriate referrals for medical care and medication management. The transferring provider must assist the individual to identify the medical provider who will provide continuing care and to arrange an initial appointment with that provider;

(b) Coordinate recovery and ongoing support services for individuals and their families including identifying resources and facilitating linkage to other service systems necessary to sustain recovery, including peer delivered services.;

(c) Complete a Transfer Summary;

(d) When services are concluded due to the absence of the individual, the provider must document outreach efforts made to re-engage the individual, or document the reason why such efforts were not made;

(e) If the individual is under the jurisdiction of the PSRB or JPSRB, the provider must notify the PSRB or JPSRB immediately and provide a copy of the Transfer Summary within 30 days;

(f) The provider must report all instances of Transfer on the mandated state data system; and

(g) Transfer in ITS programs: At a minimum, the provider's interdisciplinary team must:

(A) Integrate transfer planning into ongoing treatment planning and documentation from the time of entry, and specify the transfer criteria that must indicate resolution of the symptoms and behaviors that justified the entry;

(B) Review and, if needed, modify the transfer criteria in the ISSP every 30 days;

(C) Notify the child's parent or guardian, and the provider to which the child must be transitioned of the anticipated transfer dates at the time of entry, and when the ISSP is changed;

(D) Include the parent, guardian and provider to which the child must be transitioned in transfer planning and reflect their needs and desires to the extent clinically indicated;

(E) Finalize the transition plan prior to transfer and identify in the plan the continuum of services and the type and frequency of follow-up contacts recommended by the provider to assist in the child's successful transition to the next appropriate level of care;

(F) Assure that appropriate medical care and medication management must be provided to individuals who leave through a planned transfer. The last service provider’s interdisciplinary team must identify the medical personnel who will provide continuing care and must arrange an initial appointment with that provider;

(G) Coordinate appropriate education services with applicable school district personnel; and

(H) Give written transition instructions to the child's parent or guardian and the next provider if applicable, on the date of transfer.

(3) Transfer Summary:

(a) A Transfer Summary must include:

(A) The date and reason for the transfer;

(B) A summary statement that describes the effectiveness of services in assisting the individual and his or her family to achieve intended outcomes identified in the ISSP;

(C) Where appropriate, a plan for personal wellness and resilience, including relapse prevention; and

(D) Identification of resources to assist the individual and family, if applicable, in accessing recovery and resiliency services and supports.

(b) If the transfer is to services with another provider, all documentation contained in the Individual Service Record requested by the receiving provider must be furnished, compliant with applicable confidentiality policies and procedures, within 14 days of receipt of a written request for the documentation.

(c) A complete transfer summary must be sent to the receiving provider within 30 days of the transfer.

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 4-2010, f. & cert. ef. 3-4-10; MHS 15-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12

309-032-1555

Quality Assessment and Performance Improvement

(1) Quality Assessment and Performance Improvement Process: Providers must develop and implement a structured and ongoing process to assess, monitor, and improve the quality and effectiveness of services provided to individuals and their families.

(2) Quality Improvement Committee: The Quality Improvement Committee must oversee and advise the Quality Assessment and Performance Improvement process:

(a) The Quality Improvement Committee must include representatives of individuals served and their families; and

(b) The Quality Improvement Committee must meet at least quarterly to:

(A) Identify indicators of quality including:

(i) Access to services;

(ii) Outcomes of services;

(iii) Systems integration and coordination of services; and

(iv) Utilization of services.

(B) Review incident reports, emergency safety intervention documentation, grievances and other documentation as applicable;

(C) Identify measurable and time-specific performance objectives and strategies to meet the objectives and measure progress;

(D) Recommend policy and operational changes necessary to achieve performance objectives; and

(E) Reassess and, if necessary, revise objectives and methods to measure performance on an ongoing basis to ensure sustainability of improvements.

(3) Performance Improvement Plan: The quality assessment and performance improvement process must be documented in a Performance Improvement Plan including:

(a) Performance objectives aimed at improving services; and

(b) Strategies designed to meet the performance objectives and measure progress.

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 4-2010, f. & cert. ef. 3-4-10; MHS 15-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12

309-032-1560

Grievances and Appeals

(1) Any individual receiving services, or the parent or guardian of the individual receiving services, may file a grievance with the provider, the individual's managed care plan or the Division.

(2) For individuals whose services are funded by Medicaid, grievance and appeal procedures outlined in OAR 410-141-0260 through 410-141-0266, must be followed.

(3) For individuals whose services are not funded by Medicaid, providers must:

(a) Notify each individual, or guardian, of the grievance procedures by reviewing a written copy of the policy upon entry;

(b) Assist individuals and parents or guardians, as applicable, to understand and complete the grievance process; and notify them of the results and basis for the decision;

(c) Encourage and facilitate resolution of the grievance at the lowest possible level;

(d) Complete an investigation of any grievance within 30 calendar days;

(e) Implement a procedure for accepting, processing and responding to grievances including specific timelines for each;

(f) Designate a program staff person to receive and process the grievance;

(g) Document any action taken on a substantiated grievance within a timely manner; and

(h) Document receipt, investigation and action taken in response to the grievance.

(4) Grievance Process Notice. The provider must have a Grievance Process Notice, which must be posted in a conspicuous place stating the telephone number of:

(a) The Division;

(b) The CMHP;

(c) Disability Rights Oregon; and

(d) The applicable managed care organization.

(5) Expedited Grievances: In circumstances where the matter of the grievance is likely to cause harm to the individual before the grievance procedures outlined in these rules are completed, the individual, or guardian of the individual, may request an expedited review. The program administrator must review and respond in writing to the grievance within 48 hours of receipt of the grievance. The written response must include information about the appeal process.

(6) Retaliation: A grievant, witness or staff member of a provider must not be subject to retaliation by a provider for making a report or being interviewed about a grievance or being a witness. Retaliation may include, but is not limited to, dismissal or harassment, reduction in services, wages or benefits, or basing service or a performance review on the action.

(7) Immunity: The grievant is immune from any civil or criminal liability with respect to the making or content of a grievance made in good faith.

(8) Appeals: Individuals and their legal guardians, as applicable, must have the right to appeal entry, transfer and grievance decisions as follows:

(a) If the individual or guardian, if applicable, is not satisfied with the decision, the individual or guardian may file an appeal in writing within ten working days of the date of the program administrator's response to the grievance or notification of denial for services as applicable. The appeal must be submitted to the CMHP Director in the county where the provider is located or to the Division as applicable;

(b) If requested, program staff must be available to assist the individual;

(c) The CMHP Director or Division, must provide a written response within ten working days of the receipt of the appeal; and

(d) If the individual or guardian, if applicable, is not satisfied with the appeal decision, he or she may file a second appeal in writing within ten working days of the date of the written response to the Director.

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 4-2010, f. & cert. ef. 3-4-10; MHS 15-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12

309-032-1565

Variances

(1) Criteria for a Variance: Variances may be granted to a LMHA, CMHP or provider holding a certificate directly with the Division, by the Division:

(a) If there is a lack of resources to implement the standards required in these rules; or

(b) If implementation of the proposed alternative services, methods, concepts or procedures would result in improved outcomes for the individual.

(2) Application for a Variance:

(a) CMHPs and other providers may submit their variance request directly to the Division;

(b) Providers who hold Certificates of Approval jointly with CMHP's and the Division must submit their variance requests to the CMHP. The CMHP must then submit the variance request, along with the CMHP's written recommendation;

(c) The LMHA, CMHP or provider requesting a variance must submit a written application to the Deputy Director; and

(d) Variance requests must contain the following:

(A) The section of the rule from which the variance is sought;

(B) The reason for the proposed variance;

(C) The alternative practice, service, method, concept or procedure proposed;

(D) When the variance directly affects services provided, a description of the individual's opinion and participation in requesting the variance;

(E) A proposal for the duration of the variance; and

(F) A plan and timetable for compliance with the section of the rule for which the variance applies.

(3) Division Review and Notification: The Deputy Director of the Division must approve or deny the request for a variance and must notify the LMHA, CMHP or provider in writing of the decision to approve or deny the requested variance, within 30 days of receipt of the variance. The written notification must include the specific alternative practice, service, method, concept or procedure that is approved and the duration of the approval.

(4) Appeal Application: Appeal of the denial of a variance request must be made in writing to the Director of the Division, whose decision will be final and must be provided in writing within 30 days of receipt of the appeal.

(5) Written Approval: The LMHA, CMHP or provider may implement a variance only after written approval from the Division.

(6) Duration of Variance: It is the responsibility of the LMHA, CMHP or the provider to submit a request to extend a variance in writing prior to a variance expiring. Extension must be approved in writing by the Division.

(7) Granting a variance for one request does not set a precedent that must be followed by the Division when evaluating subsequent requests for variance.

Stat. Auth.: ORS 161.390, 413.042, 409.410, 409.420, 426.490 - 426.500, 428.205 - 428.270, 430.640 & 443.450
Stats. Implemented: ORS 109.675, 161.390 - 161.400, 179.505, 409.010, 409.430 - 409.435, 426.380 - 426.395, 426.490 - 426.500, 430.010, 430.205 - 430.210, 430.240 - 430.640, 430.850 - 430.955, 443.400 - 443.460, 443.991, 461.549, 743A.168, 813.010 - 813.052 & 813.200 - 813.270
Hist.: MHS 4-2010, f. & cert. ef. 3-4-10; MHS 15-2011(Temp), f. 12-29-11, cert. ef. 1-1-12 thru 6-29-12

The official copy of an Oregon Administrative Rule is contained in the Administrative Order filed at the Archives Division, 800 Summer St. NE, Salem, Oregon 97310. Any discrepancies with the published version are satisfied in favor of the Administrative Order. The Oregon Administrative Rules and the Oregon Bulletin are copyrighted by the Oregon Secretary of State. Terms and Conditions of Use

BOATING UNDER THE INFLUENCE OF INTOXICANTS (BUII)

Operating a boat/vessel while under the influence of alcohol or drugs is a crime in the State of Oregon. The legal consequences for those convicted of breaking this law are severe.

In Oregon, a boat/vessel operator with a BAC of 0.08 or more is considered to be under the influence. Any operator convicted of boating under the influence will be subject to the following penalties:

- Fines of up to $5,000 and/or up to a year in jail,
- Must complete a boating safety education class,
- Loss of boat/vessel operation privileges for one year, and
- Have boat/vessel registrations suspended for up to three years.

The law also applies to non-motorized craft such as rafts, kayaks, and canoes.

Occasionally an individual may present themselves for a screening because they were charged with a BUII. In some counties the court will handle the BUII the same as a DUII. The court will refer the individual to an ADES and then the ADES will refer the individual to a DUII program and monitor the alcohol and drug treatment for the court.

For treatment purposes, the BUII should not be handled in the same manner as a DUII. The individual should be enrolled in an outpatient service and not in the DUII service. The individual may be served using funds available through state assistance agreements. If appropriate, the treatment provider can bill OHP for chemical dependency services.

The treatment provider should utilize the placement, continued stay, and discharge criteria, based on the criteria described in the ASAM PPC-2R. The more stringent DUII guidelines for treatment completion may also be followed. The DUII Treatment Completion Certificate will not be required since the individual's driver license has not been suspended for a DUII.

REFERRAL GUIDE

1. Referral to DUII Information Program: Refer an individual to a DUII Information program only when the individual exhibits none of the indicators listed on the ADES Screening and Referral Report.

2. Referral to DUII Rehabilitation Program: refer an individual to a DUII rehabilitation program (treatment) when the individual exhibits any of the indicators listed on the ADES Screening and Referral Report.

3. Referral to Residential Treatment: The ADES does not refer to a residential treatment program. Referrals to residential care should be made only by an outpatient DUII rehabilitation program; utilizing the placement, continued stay, and discharge criteria based on the criteria described in the ASAM PPC-2R.

   The following referral procedure should be followed:

   A. Refer the individual to an approved DUII rehabilitation program with the recommendation that consideration be given to placement in residential treatment

   B. The DUII rehabilitation program will complete an alcohol and drug assessment to determine if the criteria is met for a referral to residential treatment

   C. If the decision is that the individual would best be treated in a residential treatment setting, the rehabilitation program will make the necessary referral and will track the individual's progress while in the residential facility. Progress reports will come from the residential program to the rehabilitation program and forward to the ADES.

   D. Following termination from the residential program, the individual will return to the DUII outpatient rehabilitation program for treatment planning and continued treatment. ONLY DUII approved outpatient programs can issue the DUII Treatment Completion Certificate.

4. Out of State Referrals of Individuals Arrested of DUII in Oregon: Individuals who were arrested in Oregon but reside in another state or have since moved to another stated may be referred to a program near the individual's residence that can provide the appropriate services. Remember the court must also approve of an individual moving out of state. The ADES should send the referral to the out-of-state provider with the requirements which must be met. The individual must still meet the requirements for the State of Oregon. The ADES will monitor the individual's treatment progress and ensure that the requirements have been met. Compliance and non-compliance of treatment will be reported to the court by the ADES. Upon successful completion, the ADES will be responsible for sending the DUII Treatment Completion Certificate to the out-of-state program when documentation of successful completion has been received by the ADES. The DUII Treatment Completion Certificate is **NOT** mailed out with the initial referral. The ADES should fill in all fields except the name of the person signing the certificate, the person's signature, and the signing individual's job title. Place a copy of the DUII Treatment Completion Certificate in the individual's file before mailing the certificate to the provider. If the provider misplaces the DUII Treatment Completion Certificate, **DO NOT** re-issue. Simply make a copy of the certificate in the individual's file and send it to the out-of-state program. The ADES never signs the DUII Treatment Completion Certificate.

5. Persons Arrested in Another State: An individual who was arrested in another state and who requests a referral to an Oregon program is not listed on the ADES Monthly Report. The individual is responsible for paying for treatment based on the treatment agencies sliding fee scale. The individual must meet the alcohol and drug treatment requirements of completion from the state in which the arrest occurred.

6. Referrals of Clients Who Are Already in Treatment at the Time of Screening:

   A. When an individual with a DUII presents for a screening and is already participating in a program not approved by the Oregon Health Authority Addictions and Mental Health

Division, the ADES must refer the client to an approved DUII rehabilitation program. The DUII rehabilitation program will see the individual as soon as possible and will consult with the “non-DUII” treatment program. The DUII rehabilitation program, following its consultation, will determine whether it will immediately take over treatment responsibilities or wait. It is expected that, in most cases, the DUII rehabilitation program will assume responsibility very quickly. The exceptions would be where the individual is participating in or just entering residential treatment, or where the individual has entered an especially crucial stage of therapy in the “non DUII” program.

B. When an individual with a DUII presents for a screening and has apparently completed treatment since the DUII arrest, the individual must be referred to a program approved to provide DUII services.

The DUII program will conduct a face-to-face assessment with the individual and review documentation of treatment by the “non-DUII” treatment program. The documentation will include the initial alcohol and drug assessment, the treatment summary, the aftercare or discharge plans, and random UA results. Utilizing the criteria described in the ASAM PPC-2R, the DUII program will determine whether additional education or treatment is appropriate for the individual.

In cases where the individual’s clinical needs have been met and administrative rule requirements for discharge have been satisfied, the DUII program will notify the ADES that DUII treatment is complete and sign the DUII Treatment Completion Certificate for individuals convicted of DUII in the State of Oregon. If the clinical and administrative rule requirements have not been met, the DUII program will not sign the DUII Treatment Completion Certificate. The DUII program will provide the individual with the required services and sign the DUII Treatment Completion Certificate only when all requirements have been met.

C. When an individual with a DUII, although referred by an ADES to an approved DUII program, instead enters a “non-DUII” program, the ADES and the “non-DUII” program should work together to involve the individual in a DUII program as soon as possible.

If a treatment program discovers an individual is enrolled in a “non-DUII” program, the ADES should be notified immediately. The ADES will initially need to coordinate with the DUII and the “non-DUII” programs to ensure the individual is referred properly.

In most cases, the individual will be expected to enter treatment at the approved DUII program unless there is an overriding reason to remain at the “non-DUII” program, such as a need for residential treatment.

If the individual remains in the “non-DUII” program, the “non-DUII” program and the ADES should, working together, inform the individual that referral to a DUII program will be forthcoming.

Ultimately, the DUII program will have to make the determination whether the clinical and administrative rule requirements have been met.

D. When an individual with a DUII presents for a screening and wants to enter a “non-DUII,” or when the ADES believes a “non-DUII” program appears to be the best resource (such as a residential program), the ADES will refer the individual to an approved DUII program.

If there was an overriding reason for treatment with a “non-DUII” provider, the DUII program would coordinate the process and would ultimately determine whether continuing services would be required of the individual following discharge from the “non-DUII” program. The DUII program is responsible for providing the DUII Treatment Completion Certificate when all requirements have been met.

7. Referrals of Individuals who Require Restricted Driver License (RDL) Monitoring: Any individual with a DUII who needs a hardship license should be referred to a RDL-approved DUII program for DUII treatment.

   The RDL program is a monitoring program for individuals who are not likely to reoffend and who wish to drive while their driver license is suspended for DUII. These individuals must obtain what Oregon DMV calls a “Mental Health Recommendation.” The Mental Health Recommendation and RDL program are separate from the DUII services to obtain the DUII Treatment Completion Certificate. The individual must also be approved for the RDL by the court and DMV.

   Individuals are enrolled in the RDL program only during the DUII suspension and must attend classes to prevent reoffending. The individual is restricted to specific routes and times of driving.

   Just to be certain that the individual with a DUII is properly aware of hardship license issues, screeners are asked to do the following:

   A. During the screening, ask the individual if they will be seeking a restricted driver license. If so, refer the individual to a program approved to make REL recommendations.

   B. If not, explain to the individual that if at a later time they decide to seek a RDL, it will be necessary to enroll in a program approved to make such recommendations.

   C. Make a brief note in every new individual’s file that RDL information has been discussed.

OREGON HEALTH AUTHORITY, ADDICTIONS AND MENTAL HEALTH DIVISION: ADDICTION SERVICES

DIVISION 55

RECOMMENDATIONS FOR RESTRICTED LICENSE FOR DRIVING UNDER THE INFLUENCE OF INTOXICANTS AND OTHER RELATED SUSPENSIONS AND/OR REVOCATIONS

415-055-0000

Purpose

The purpose of these rules is to prescribe standards and procedures for approval of outpatient alcoholism and drug-dependence treatment programs which make recommendations to the Division of Motor Vehicles (DMV) regarding persons seeking a restricted operator's license.

Stat. Auth.: ORS 409.410 & 409.420
Stats. Implemented: ORS 813.500, 813.510 & 813.520
Hist.: MHD 20-1983, f. & ef. 10-12-83; ADAP 3-1993, f. & cert. ef. 12-6-93, Renumbered from 309-055-0000; ADAP 3-1997, f. & cert. ef. 12-18-97; ADS 2-2008, f. & cert. ef. 11-13-08

415-055-0005

Definitions

As used in these rules:

(1) "Assistant Director" means the Assistant Director of the Addictions and Mental Health Division of the Oregon Health Authority.

(2) "Client" means a person receiving services under these rules, and who has signed a consent form which complies with Section 2.35 of the federal confidentiality regulations (42 CFR Part 2).

(3) "Community Mental Health Program" OR “CMHP” means the organization of all services for persons with mental or emotional disturbances, drug abuse problems, and alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a Local Mental Health Authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Addictions and Mental Health Division.

(4) "Court" means the last convicting court unless specifically noted.

(5) "DMV" means the Driver and Motor Vehicle Services Branch of the Department of Transportation.

(6) "Division" means the Addictions and Mental Health Division of the Oregon Health Authority.

(7) "Drug-dependent person" means a person who has lost the ability to control the use of controlled substances or other substances with abuse potential, or who uses such substances to the extent that the person's health or that of others is substantially impaired or endangered or the person's social or economic function is substantially disrupted. A drug-dependent person may be physically dependent, a condition in which the body requires a continuing supply of a drug or controlled substance to avoid characteristic withdrawal symptoms, or psychologically dependent, a condition characterized by an overwhelming mental desire for continued use of a drug or controlled substance.

(8) " Driving under the influence of intoxicants (DUII) Information Program" means a short-term (12-20 hours in duration), didactic, alcohol and driving education program which meets the minimum curriculum, instructor, and hourly standards established in OAR 415-054-0005 through 415-054-0040, Standards for DUII Information Programs.

(9) "DUII Rehabilitation Program" means programs of treatment and therapeutically oriented education services that meet the minimum standards established by the Division.

(11) "Restricted license" means a hardship or probationary license issued by the D MV.

Stat. Auth.: ORS 409.410 & 409.420
Stats. Implemented: ORS 813.500, 813.510 & 813.520
Hist.: MHD 20-1983, f. & ef. 10-12-83; ADAP 3-1993, f. & cert. ef. 12-6-93; Renumbered from 309-055-0005; ADAP 3-1997, f. & cert. ef. 12-18-97; ADS 2-2008, f. & cert. ef. 11-13-08

415-055-0010

Application for Program Approval

(1) New programs seeking Division approval to make recommendations to DMV regarding restricted driving licenses shall:

(a) Comply with applicable rules including OAR 415-012-0000 through 415-012-0090 and 415-051-0000 through 415-051-0150;

(b) Be currently holding a two-year DUII Rehabilitation Program Letter of Approval; and

(c) Have maintained a DUII Rehabilitation Program Letter of Approval from the Division for four continuous years prior to making application.

(2) The application must be accompanied by documentation that the application has been reviewed by the local alcoholism and drug planning committee and the CMHP.

Stat. Auth.: ORS 409.410 & 409.420
Stats. Implemented: ORS 813.500, 813.510 & 813.520
Hist.: MHD 20-1983, f. & ef. 10-12-83; ADAP 3-1993, f. & cert. ef. 12-6-93, Renumbered from 309-055-0010; ADAP 3-1997, f. & cert. ef. 12-18-97; ADS 2-2008, f. & cert. ef. 11-13-08

415-055-0015

Standards for Assessment Services

(1) Assessment Procedure: An approved program shall develop and implement a written procedure for assessing and evaluating each client's

treatment needs and extent of the client's alcohol abuse or drug-dependent problem in accordance with the requirements of 415-051-0030. Facts upon which the clinical conclusion is based shall be documented in the client's chart. Recent prior assessments by another program may be honored or disregarded by the program in which the client is presently enrolled.

(2) Determinations: Based on the assessment, one of the following four determinations shall be made and recorded in the client's record:

(a) The client does not have an alcohol or other drug abuse problem: The program shall obtain from the client a written consent to release information and shall notify the last convicting court and DMV, in writing, of its determination and recommend that the client, at a minimum, participate in a DUII information program which has been approved by the Division

(b) The client's participation in the assessment has been too limited to make a determination: The program shall make no recommendations to DMV for a restricted license until a complete assessment has occurred.

(c) The client has an alcohol or drug abuse problem:

(A) After obtaining from the client a written consent to release information, the program shall notify the court, if requested by the court, in writing, that the client has an alcohol or other drug problem, and that the client has agreed to accept the treatment plan and participate in treatment; and

(B) The program must follow the requirements of OAR 415-055-0020 in making recommendations for a restricted license.

(d) The client will not participate in selecting an adequate plan, or the client will not agree to follow a plan proposed by the program:

(A) The facts upon which this conclusion is based shall be documented in the client record; and

(B) Upon request by the court and after obtaining a written consent to release information, the facts upon which this conclusion is based shall be specified in a written report to the court; and

(C) The program shall make no recommendation to DMV for a restricted driver's license.

Stat. Auth.: ORS 409.410 & 409.420
Stats. Implemented: ORS 813.500, 813.510 & 813.520
Hist.: MHD 20-1983, f. & ef. 10-12-83; ADAP 3-1993, f. & cert. ef. 12-6-93, Renumbered from 309-055-0015; ADAP 3-1997, f. & cert. ef. 12-18-97; ADS 2-2008, f. & cert. ef. 11-13-08

415-055-0020

Recommendations for Restricted License

(1) First Offense: When the court or DMV requires a recommendation for a restricted license for a client convicted of a first offense, the treatment provider shall obtain client consent to comply with the following documentation procedures and shall:

(a) Send a written recommendation to DMV regarding the issuance of a restricted license;

(b) Complete evaluation of the client as described in OAR 415-051-0000 through 415-051-0030;

(c) Send a copy of the recommendation to the court;

(d) Document the minimum period of cooperative participation required of the client and, when appropriate, participation in a program of antabuse or urinalysis monitoring;

(e) Document enrollment by the client in a DUII information or rehabilitation program unless there is written documentation that the client has completed a similar program within the last 12 months. If the current incident followed completion of an information program, the client shall be evaluated and could be required to participate in more intense treatment;

(f) Obtain written commitment from the client stating that the client will remain abstinent from alcohol and illicit drugs throughout the entire period of the restricted license; and

(g) Obtain written agreement that the client understands the program will withdraw its recommendation if the client fails to continue in treatment or moves from the county.

(2) Second Offense: When the court or DMV requires a recommendation for a restricted license for a client who has a second conviction or a first conviction with previous participation in an alcohol rehabilitation or diversion program, the treatment provider shall, in addition to the requirements in section (1)(a) through (g) of this rule:

(a) Ensure that a recommendation for a restricted license is not provided until a 90-day waiting period has elapsed.

(A) This 90-day period begins on the effective date of the license suspension for driving under the influence of intoxicants; and

(B) If the applicant is suspended by the court on the date of conviction, and the court notifies DMV of this court-ordered suspension, the 90-day waiting period will begin on the conviction date.

(b) Document required cooperative participation in the treatment plan for a minimum of the first 8 contact hours or 30 days, whichever is greater, unless an earlier recommendation is justified by the client's occupation and approved by the program director. The client record must clearly document this justification.

(c) Document follow-up when a client has completed treatment, but is still driving on a restricted license:

(A) The program must document contact with the client at least once a month for the first 18 months; and

(B) Document contact no less than once every 90 days thereafter while the person is driving on the recommendation of that treatment program.

(3) Third or More Offense: When the court or DMV requires a recommendation for a restricted license for a client who has a third or subsequent suspension for DUII, the treatment provider shall, in addition to the requirements in section (1)(a) through (g) of this rule:

(a) Ensure that a recommendation for a restricted license is not provided until a one-year waiting period has elapsed.

(A) This one-year waiting period begins on the effective date of the license suspension for driving under the influence of intoxicants.

(B) If the applicant is suspended by the court on the date of conviction, and the court notifies DMV of this court-ordered suspension, the one-year waiting period will begin on the conviction date.

(b) Document cooperative participation in the treatment plan for a minimum of the first 24 contact hours or 90 days, whichever is greater.

Stat. Auth.: ORS 409.410 & 409.420
Stats. Implemented: ORS 813.500, 813.510 & 813.520
Hist.: MHD 20-1983, f. & ef. 10-12-83; ADAP 3-1993, f. & cert. ef. 12-6-93, Renumbered from 309-055-0020; ADAP 3-1997, f. & cert. ef. 12-18-97; ADS 2-2008, f. & cert. ef. 11-13-08

415-055-0025

Withdrawal of Recommendation for Restricted License

(1) The program shall notify the court, when requested, and shall withdraw its recommendation to the DMV if the program becomes aware of any of the following:

(a) The client fails to demonstrate progress in the planned course of treatment or follow-up care to which the client agreed;

(b) The client moves from the treatment area. The client and DMV must be notified that a new letter of recommendation must be secured from the new location treatment provider. Both the client and DMV must be notified of the date upon which the current letter of recommendation expires;

(c) The client uses alcohol or drugs; or

(d) The client violates any of the conditions which apply to restricted licenses which have been established by the DMV. Such conditions are contained in OAR 735-064-0005 through 735-064-0237.

(2) The basis upon which the program withdraws its recommendations are to be entered into the client's record and shall identify and document specifically which of the conditions enumerated in sections (1)(a)-(d) of this rule were applicable.

(3) The program must notify the client of the program's decision, and the basis upon which the withdrawal was made. The client may appeal the revocation decision to withdraw the letter of recommendation as provided under OAR 415-055-0030 of these rules.

(4) If the program receives notice from the DMV of a violation of restricted license, the program will review the case to consider withdrawal of the recommendation, and document the review in the client's record.

Stat. Auth.: ORS 409.410 & 409.420
Stats. Implemented: ORS 813.500, 813.510 & 813.520
Hist.: MHD 20-1983, f. & ef. 10-12-83; ADAP 3-1993, f. & cert. ef. 12-6-93, Renumbered from 309-055-0025; ADAP 3-1997, f. & cert. ef. 12-18-97; ADS 2-2008, f. & cert. ef. 11-13-08

415-055-0030

Appeal Process

(1) The program shall establish a procedure for clients to appeal licensing recommendations made by the program or to register complaints. The program is responsible for explaining the appeal process to clients and applicants. A written copy of the process must be available for clients.

(2) The appeal process may be quite informal at the preliminary stage but should be simple, expedient, and readily accessible. For example, the program could plan for review of the client's file by a member of the staff who had no previous contact with the client and provide an opportunity for the client to meet with that staff member.

(a) The appeal process for licensing recommendations shall be conducted as provided for under OAR 735-064-0110.

(b) The appeal process for registering complaints shall be conducted as provided for under OAR 415-012-0080.

(3) The appeal process shall include but not be limited to recourse to the staff supervisor, program director, and CMHP director. Complaints which are unresolved may be referred to the Division for review.

Stat. Auth.: ORS 409.410 & 409.420
Stats. Implemented: ORS 813.500, 813.510 & 813.520
Hist.: MHD 20-1983, f. & ef. 10-12-83; ADAP 3-1993, f. & cert. ef. 12-6-93, Renumbered from 309-055-0030; ADAP 3-1997, f. & cert. ef. 12-18-97; ADS 2-2008, f. & cert. ef. 11-13-08

415-055-0035

Variances

Requirements and standards for requesting and granting variances or exceptions are found in OAR 415-012-0090.

Stat. Auth.: ORS 409.410 & 409.420
Stats. Implemented: ORS 813.500, 813.510 & 813.520
Hist.: MHD 20-1983, f. & ef. 10-12-83; ADAP 3-1993, f. & cert. ef. 12-6-93, Renumbered from 309-055-0035; ADAP 3-1997, f. & cert. ef. 12-18-97; ADS 2-2008, f. & cert. ef. 11-13-08

The official copy of an Oregon Administrative Rule is contained in the Administrative Order filed at the Archives Division, 800 Summer St. NE, Salem, Oregon 97310. Any discrepancies with the published version are satisfied in favor of the Administrative Order. The Oregon Administrative Rules and the Oregon Bulletin are copyrighted by the Oregon Secretary of State. Terms and Conditions of Use

COURT MONITORING

Once the referral has been made, whether to a DUII program in the State of Oregon or to an out-of-state provider, you will be monitoring the progress of the individual's alcohol and drug treatment to keep the Court appraised of the compliance or non-compliance. Status reports should be available for the Court when the Court makes a request. The Court may require you to appear in court to provide the status update. Or the Court may have a form for you to fill out. Unless otherwise stipulated by the Court, the ADES also serves as the case manager for the duration of the individual's period of responsibility to the Court. A Sample letter is located on the following page. Use you letterhead when using the sample letter.

Individuals with a Diversion Agreement with the court should be diligently monitored. The individual usually has one year to meet all of the requirements of the Diversion or the Diversion will be revoked and the individual will be convicted of the DUII. You may no longer have contact with the individual. If you have contact you should inform the individual of the possibility of being convicted of a DUII. A Sample letter follows the Court Status Report. Utilize your letterhead for the sample letter.

SOBER DIVERSION

Effective June 23, 2011, individuals who enter into a diversion agreement with the court are to remain abstinent from alcohol and drugs throughout the diversion period. Work with the court and all providers to agree on the community's expectations of sober diversion compliance. Set clear notification procedures with providers and the court(s).

Court Status Report

Date: _____

To: *(Judge)*

_____
_____
_____
_____

From: *(ADES)*

_____
_____
_____
_____

RE: *(Individual)*

_____
_____
_____
_____

The individual above was referred to this office for a DUII Evaluation and Screening:

- ☐ has not contacted this office
- ☐ has made an appointment on _____, but failed to appear
- ☐ has made an appointment with a treatment program, but is not currently in treatment
- ☐ is currently in treatment
- ☐ is currently in aftercare
- ☐ has completed a DUII information program
- ☐ has completed a DUII information program, but has not met financial obligations to the treatment program
- ☐ has completed treatment and needs no further treatment or aftercare
- ☐ has completed treatment and needs no further treatment or aftercare but has not met financial obligations to the treatment program
- ☐ other:

Date enrolled: _____ Date completed: _____

☐ is being reported "non-compliant" for the following reason(s):

_____

LETTER TO DEFENDANT

DEFENDANT'S NAME

ADDRESS

CITY STATE ZIP

Date: _____

Dear _____ ;

This is to inform you that our records show that you have not cooperated fully with the terms and conditions of your diversion agreement with the _____ Court. As you know, your cooperation is necessary to satisfy those terms and conditions. Our records indicate the following problem(s):

☐ Failure to appear for alcohol screening

☐ Failure to contact treatment agency
(Agency referred to: _____)

☐ Not attending information/rehabilitation sessions
(Date last attended: _____)

☐ Failure to pay information/rehabilitation costs

☐ Failure to pay alcohol and drug screening fee

☐ Other: _____
_____

Please take the following action(s) before: _____

☐ Pay outstanding fees or costs to: _____

☐ Contact information/rehabilitation agency and attend all sessions.

☐ Contact this office immediately.

☐ Other: _____

If you do not cooperate, the court will be informed and you may face the possibility of being prosecuted for DUII.

Sincerely;

Alcohol and Drug Evaluation and Screening Specialist

DUII TREATMENT COMPLETION CERTIFICATES (DTCC)

All individuals arrested for DUII in the State of Oregon whose arrest occurred on or after January 1, 1988 – and who were subsequently convicted – must prove completion of DUII treatment before their privilege to drive is reinstated. An individual who has a Diversion Agreement with the court or whose arrest occurred in another state do not need proof of completion of DUII treatment to reinstate their privilege to drive and a DTCC will not be issued.

Proof of completion is handled through the DTCC (form # 735-6821) which DUII providers and ADESs have access by ordering through AMH. The DTCC is a four-part controlled document with the Seal of Oregon in the upper left hand corner. A control number is in the upper right area of the form.

In most cases, it will be the DUII program who will issue the DTCC. The DUII program will fill out the DTCC for an individual convicted of DUII in the State of Oregon. The DTCC is distributed per the instructions listed on the certificate.

Only one DTCC is issued per person with the most recent Oregon DUII arrest and convicted information entered in the correct fields of the DTCC. Each ADES will track each DTCC for when and for whom it was issued. The DTCC is not sent until successful completion documentation has been received by the ADES.

Before sending a DTCC to an out of state provider, please refer to the "Referral Guide" section number 4. The ADES will mail the DTCC to the out-of-state treatment programs of individuals who have been convicted of DUII in the State of Oregon. When the ADES receives documentation of successful completion of all requirements, the ADES informs the court and sends the DTCC to the out-of-state program. The ADES fills out the entire DTCC except the name of the person signing for the treatment program, the signature for the treatment program, and the job title of the person signing. Before mailing the DTCC to the out-of-state program, the ADES will make a copy and place it in the individual's file. **The ADES does not sign the DTCC.** The ADES should inform the individual that the privilege to drive will not be reinstated until the DTCC is received and all of DMV's requirements have been met.

Programs may issue non-compliance notices for individuals who have failed to meet treatment requirements. This would include those individuals who have failed to comply with signed fee agreements. Programs may also refuse to issue the DTCC if the individual has not complied with the fee agreement. Individuals are required to pay for treatment services as a condition of their diversion agreement or probation.

The DTCC will be issued for those individuals who may have had a Diversion Agreement when referred but subsequently were convicted as they would have successfully completed and were in need of no further treatment or aftercare. The only instance would be if the court were to require the individual to complete the DUII program an additional time.

While it is important that individuals be held accountable in paying for treatment, it is inappropriate to use payment issues as a means of extending or increasing treatment requirements. Programs should not, for instance, increase treatment requirements, require additional urinalysis tests, or increase the length of time in treatment based solely on the individual's failure to pay. Programs should not use failure to make payments as a reason for scheduling "exit interviews" more than 30-days after the last counseling contact. All individuals should be closed and a CPMS form completed within 30-days of the last treatment contact.

It should be noted that should an individual declare bankruptcy, the DTCC will be issued by the treatment program as the debt would be discharged. Debt incurred after the bankruptcy is filed may not be affected by the discharge. Consult with your legal counsel if you have questions on this issue.

The DTCC is the program's statement that the convicted individual does not require further treatment or aftercare, has met their financial obligations to the program, and has met the abstinence requirement. The program cannot be compelled to make a statement of clinical results that is not in accord with evidence and knowledge available to the program. AMH continues to support programs that refuse to issues a DTCC to an individual who has not, in the opinion of the treatment program, successfully completed treatment.

RENEWAL OF ADES CERTIFICATION – RECERTIFICATION POLICY

1. The certified ADES has the responsibility to keep the Addictions and Mental Health Division apprised of any change in their job status that affects either where the ADES is working (moving to a different county) or for whom the ADES is working (a different agency). Unless the ADES provides the information in a timely manner, AMH cannot be responsible for maintaining communication with them. Notating the changes on the ADES Monthly Report will not be accepted.

2. The ADES must provide the Addictions and Mental Health Division with the site address where the DUII records are maintained. A Post Office Box may be used for correspondence but not as the site address.

3. When an ADES is no longer performing screenings for the court, the ADES must notify the Addictions and Mental Health Division to discuss the federal regulations governing the maintenance or disposition of the DUII records.

4. At least 90-days prior to the expiration date of the certification, the ADES is responsible for contacting the Addictions and Mental Health Division to request a recertification review. If the ADES does not notify the Addictions and Mental Health Division of the need for a recertification review and the ADES Certification lapses, the ADES must cease conducting screenings and attend the next ADES training to gain recertification. If the ADES has requested a review 90-days before the expiration date of the certificate and the Addictions and Mental Health Division is remiss in conducting the review before the deadline, the certificate will not lapse.

5. Any ADES who has not conducted 12 screenings during the year prior to the recertification date will be dropped from the list of Certified ADESs unless an exception is requested and granted. It will be necessary to attend the next ADES training to be recertified.

6. The change of information form is to be used to notify the Addictions and Mental Health Division of changes in status or the need for a recertification review. Mail or fax the form to the DUII Information Specialist.

Request for Recertification

Use this form to notify the Oregon Health Authority Addictions and Mental Health Division of changes in status or need for recertification and changes in address.

PLEASE PRINT OR TYPE ALL INFORMATION

Name: _____

Date current ADES/AMES certification was issued: _____

Date current ADES/AMES certification expires: _____

Check all that apply:

☐ Effective date of change: _____

☐ Please schedule a site review on or about: _____

☐ I intend to (or have already) quit doing screenings. Please contact me regarding disposition of client records.

Return the completed form to:

Addictions and Mental Health Division
DUII Information Specialist
500 Summer Street NE E86
Salem, Oregon 97301-1118

Or fax to: 503-378-8467

Change of Information Notification

Person filling out this form: _____

Effective date of changes: _____

	ADES
ADES NAME:	
AGENCY NAME:	
COURT DESIGNATION(S):	
	SITE INFORMATION
ADDRESS:	
CITY:	
STATE, ZIP:	
	MAILING ADDRESS
ADDRESS:	
CITY:	
STATE, ZIP:	
	PHONE, FAX, E-MAIL
PHONE/EXTENSION:	
FAX:	
E-MAIL:	

Return the completed form to:

Addictions and Mental Health Division
DUII Information Specialist
500 Summer Street NE E86
Salem, Oregon 97301-1118

Or fax to: 503-378-8467

RESOURCES

Your access to AMH: Driving Under the Influence of Intoxicants (DUII): Information for Providers (This is not for the DUII Offender)

http://www.oregon.gov/OHA/amh/duii/providers/index.shtml

For DUII Offenders with closed court cases and out-of-state treatment providers: DUII Info for the Public; Driving Under the Influence of Intoxicants (DUII)
http://www.oregon.gov/OHA/amh/duii/

California:

http://www.adp.ca.gov/Criminal_Justice/DUI/pdf/DUI_dir.pdf

Known as: Driving Under-the-Influence Program Directory of Service Providers

Oregon:

http://www.oregon.gov/OHA/amh/publications/provider-directory.pdf

Known as: Oregon Alcohol and Other Drug Services Directory

Washington:

http://www.dshs.wa.gov/pdf/dbhr/directory/April2011Directory.pdf

Known as: Directory of Certified Chemical Dependency Services in Washington State

SAMHSA: http://findtreatment.samhsa.gov/

Known as: Substance Abuse Treatment Facility Locator

DMV: http://www.odot.state.or.us/forms/dmv/6665.pdf

Known as: Guide to Oregon Driving Records and Standard Conviction Abbreviation Manual

Oregon Transportation Safety Impaired Driving Program:
http://www.oregon.gov/ODOT/TS/docs/DUII/2008_DUII_Statistics.pdf

Known as: Transportation Safety Division DATA Book for Oregon Counties

National Organization of State Impaired Driving Programs:
http://www3.flhsmv.gov/ddl/dui/

42 CFR Part 2; Confidentiality of Alcohol and Drug Abuse Patient Records:

http://www.gpo.gov/fdsys/pkg/CFR-2002-title42-vol1/pdf/CFR-2002-title42-vol1-chapI.pdf

DRIVING-UNDER-THE-INFLUENCE PROGRAM

DIRECTORY OF SERVICE PROVIDERS

2012 EDITION

State of California
Department of Alcohol and Drug Programs
Driving-Under-the-Influence Program
1700 K Street, 5th Floor
Sacramento, CA 95811

Oregon Alcohol & Other Drug Services Directory

Revised March 2012

Addictions and Mental Health Division

If you need this directory in an alternate format, please call (503) 945-5763 (voice) or (503) 947-5330 (TTY)

"Assisting People to Become Independent, Healthy and Safe" An Equal Opportunity Employer

Washington State Department of Social & Health Services

DBHR Division of Behavioral Health and Recovery

DIRECTORY OF CERTIFIED CHEMICAL DEPENDENCY SERVICES IN WASHINGTON STATE

April 1, 2011

Division of Behavioral Health and Recovery (DBHR)
P.O. Box 45330 (MS: 45330), Olympia, WA 98504-5330 Main Line: 360-725-3700 or TOLL FREE 1-877-301-4557 Fax: 360-586-0343/586-0341

To Access Treatment or Crisis Intervention, call:

Alcohol Drug Help Line
Monday – Sunday, 8 a.m. to 10 p.m.
1-800-562-1240 Toll Free (from within Washington State)
206-722-3700 (from Seattle or Out of State)

TeenLine
1-877-345-8336

To order information, contact:

Washington State Alcohol/Drug Clearinghouse
1-800-662-9111 Toll Free (from within Washington State) 206-725-9696 (From Seattle or Out of State) or FAX 206-760-0589 E-Mail: clearinghouse@adhl.org
Website: http://clearinghouse.adhl.org/
(more information is contained in Appendix B)

This directory is located on the DBHR Website at:

http://www.dshs.wa.gov/dbhr/dadirectory.shtml

SAMHSA
Substance Abuse & Mental Health Services Administration
U.S. Department of Health and Human Services

Substance Abuse Treatment
FACILITY LOCATOR

Looking for drug treatment programs and alcohol abuse treatment programs?

Find the right drug abuse treatment program or alcohol abuse treatment program with the
Substance Abuse Treatment Facility Locator
Sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA)

CLICK HERE
to enter the drug abuse and alcoholism Treatment Facility Locator

Please note that we have upgraded to a new version of the Treatment Facility Locator. If you have bookmarked pages from the old version, you will probably need to re-do your bookmarks. As always, if you have questions about, or problems using the locator, you are welcome to use the comments page.

This searchable directory of drug and alcohol treatment programs shows the location of facilities around the country that treat alcoholism, alcohol abuse and drug abuse problems.

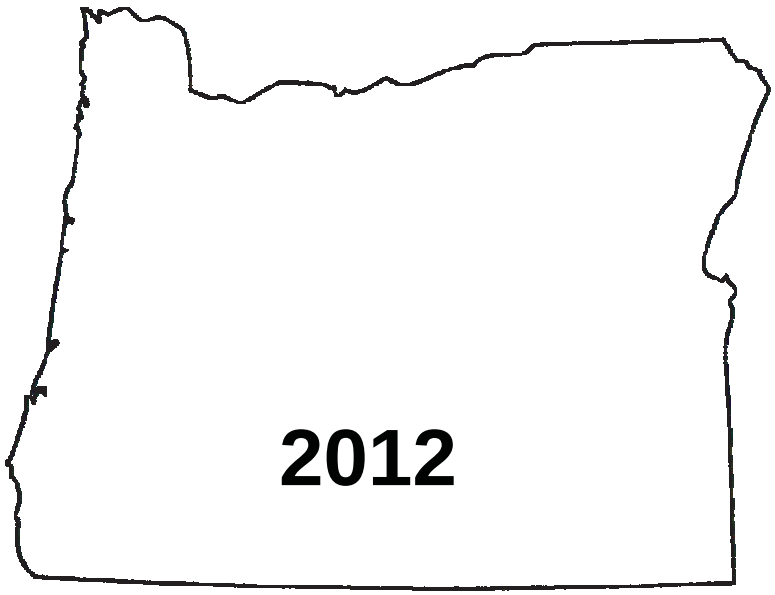
The Locator includes more than 11,000 addiction treatment programs, including residential treatment centers, outpatient treatment programs, and hospital inpatient programs for drug addiction and alcoholism. Listings include treatment programs for marijuana, cocaine, and heroin addiction, as well as drug and alcohol treatment programs for adolescents, and adults.

SAMHSA endeavors to keep the Locator current. All information in the Locator is completely updated each year, based on facility responses to SAMHSA's National Survey of Substance Abuse Treatment Services. The most recent complete update occurred on May 03, 2011 based on data collected as of March 31, 2010 in the National Survey of Substance Abuse Treatment Services. New facilities are added monthly. Updates to facility names, addresses, telephone numbers and services are made weekly, if facilities inform SAMHSA of changes. The last weekly update was done on April 09, 2012.

GUIDE TO OREGON DRIVING RECORDS

&

STANDARD CONVICTION ABBREVIATION MANUAL



DUII DATA BOOK
for Oregon Counties

1999 – 2008

Drive Sober. Save Lives.

Transportation Safety
Oregon Department of Transportation

National Organization of State Impaired Driving Programs

State Coordinator Logon

State Impaired Driving Programs Compendium Compiled by Florida Department of Highway Safety & Motor Vehicles

©2004 Florida Department of Highway Safety & Motor Vehicles

Coordinator	Phone	State Information
Cheryl Plato-Bryant/ Marty Ramsay	334-954-5127/ 334-954-5118	Alabama
Anthony E. Piper	907-264-0735	Alaska
Jay McGahee	602-364-2595	Arizona
Terrell M. Rose	501-686-9858 or 501-686-9667	Arkansas
JosÃ© M. GonzÃ¡lez	916-324-5908	California
Christine Flavia	303-866-7400	Colorado
Betsy Graziano	860-262-6104	Connecticut
M. Kimberly Brown	202-727-3500	District of Columbia
Lisa Shaw	302-672-7639	Delaware
Vanessa Christian	850-617-2505	Florida
Kecia Bivins	678-413-8685	Georgia
Leflie Kiyabu	808-534-6400	Hawaii
Pharis P. Stanger	208-334-4944	Idaho
Robert Johnson	217-785-9449	Illinois
Lisa White	317-232-1313	Indiana
Barbara Ledvina	515-242-5036	Iowa
Norraine Wingfield	1-800-416-2522	Kansas
Lee Etta Cummings	502-564-9208, ext. 4550	Kentucky
Tom Dumas	225-342-1085	Louisiana
Susan H. Long	207-626-8600	Maine

Eugenia Conolly	410-402-8600	Maryland
Gary Larareo	508-984-0623	Massachusetts
Joyce Washburn	517-335-5247	Michigan
Shawn Dunford	651-201-7591	Minnesota
Bill Henderson	662-325-3423 or 1-800-678-2534	Mississippi
Steve Deets	573-522-4020	Missouri
Lorelle Demont	406-444-7411	Montana
Julie M. Scott / Deb Minardi	402-471-3526 / 402-471-3525	Nebraska
Sean McDonald	775-684-4773	Nevada
Patti Fowler / Jay Apicelli	603- 271-6107 / 603-524-6651	New Hampshire
Andrea G.A. Connor	609-588-7318	New Jersey
Franklin Garcia	1-800-541-7952 or 505-827-2098	New Mexico
Michael Kibler / Madeline Rodriguez DeBenitez	518-473-7174	New York
Lynn B. Jones / Judy Beavers	919- 733-0566/0567 EXT. 219	North Carolina
Kris Storbeck	701-328-8982	North Dakota
Rosland Hawkins	614-644-9141	Ohio
Ray Caesar	405-522-3870 or 405-522-5840	Oklahoma
Jim Bradshaw	503-945-5814	Oregon
Troy Love	717-783-1902 / 717-787-6853	Pennsylvania
Susan Capoverde	401-462-0826 or 401-462-0819	Rhode Island
Shehenia Mitchell	803-896-1240	South Carolina
Gib Sudbeck	605 773-3123	South Dakota
Ellen Abbott	615-253-7837	Tennessee

Celeste Lunceford Havis	800-832-9623 or 512-834-6628 x2910	Texas
Dave Felt	801-538-3939 or 801-538-4233 or 801-538-4379	Utah
Richard W. Keane	802-651-1574	Vermont
Debra D. Gardner / Angela D. Coleman	804-786-5895	Virginia
Glenn Baldwin	360-725-3704	Washington
Gary J. Koontz	304-558-2276	West Virginia
Phillip Rangsuebsin	608-264-7143 or 608-261-8202	Wisconsin
Korn Schmidt	307-777-3365	Wyoming
DUI Program - "Back on Track"	1-888-814-5831	Canada-Ontario

Title 42—Public Health

(This book contains parts 1 to 399)

Part

CHAPTER I—Public Health Service, Department of Health and Human Services 3
CHAPTERS II—III [Reserved]

Title 42—Public Health

CHAPTER I—PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUBCHAPTER A—GENERAL PROVISIONS

PART 1 [RESERVED]

PART 2—CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

Subpart A—Introduction

Sec.
2.1 Statutory authority for confidentiality of drug abuse patient records.
2.2 Statutory authority for confidentiality of alcohol abuse patient records.
2.3 Purpose and effect.
2.4 Criminal penalty for violation.
2.5 Reports of violations.

Subpart B—General Provisions

2.11 Definitions.
2.12 Applicability.
2.13 Confidentiality restrictions.
2.14 Minor patients.
2.15 Incompetent and deceased patients.
2.16 Security for written records.
2.17 Undercover agents and informants.
2.18 Restrictions on the use of identification cards.
2.19 Disposition of records by discontinued programs.
2.20 Relationship to State laws.
2.21 Relationship to Federal statutes protecting research subjects against compulsory disclosure of their identity.

2.22 Notice to patients of Federal confidentiality requirements.
2.23 Patient access and restrictions on use.

Subpart C—Disclosures With Patient's Consent

2.31 Form of written consent.
2.32 Prohibition on re-disclosure
2.33 Disclosures permitted with written consent.
2.34 Disclosures to prevent multiple enrollments in detoxification and maintenance treatment programs.
2.35 Disclosures to elements of the criminal justice system which have referred patients.

Subpart D—Disclosures Without Patient Consent

2.51 Medical emergencies.
2.52 Research activities.
2.53 Audit and evaluation activities.

Subpart E—Court Orders Authorizing Disclosure and Use

2.61 Legal effect of order.
2.62 Order not applicable to records disclosed without consent to researchers, auditors and evaluators.
2.63 Confidential communications.
2.64 Procedures and criteria for orders authorizing disclosures for noncriminal purposes.
2.65 Procedures and criteria for orders authorizing disclosure and use of records to criminally investigate or prosecute patients.
2.66 Procedures and criteria for orders authorizing disclosure and use of records to investigate or prosecute a program or the person holding the records.
2.67 Orders authorizing the use of undercover agents and informants to criminally investigate employees or agents of a program.

AUTHORITY: Sec. 408 of Pub. L. 92–255, 86 Stat. 79, as amended by sec. 303 (a), (b) of Pub L. 93–282, 83 Stat. 137, 138; sec. 4(c)(5)(A) of Pub. L. 94–237, 90 Stat. 244; sec. 111(c)(3) of Pub. L. 94–581, 90 Stat. 2852; sec. 509 of Pub. L. 96–88, 93 Stat. 695; sec. 973(d) of Pub. L. 97–35, 95 Stat. 598; and transferred to sec. 527 of the Public Health Service

Act by sec. 2(b)(16)(B) of Pub. L. 98–24, 97 Stat. 182 and as amended by sec. 106 of Pub. L. 99–401, 100 Stat. 907 (42 U.S.C. 290ee–3) and sec. 333 of Pub. L. 91–616, 84 Stat. 1853, as amended by sec. 122(a) of Pub. L. 93–282, 88 Stat. 131; and sec. 111(c)(4) of Pub. L. 94–581, 90 Stat. 2852 and transferred to sec. 523 of the Public Health Service Act by sec. 2(b)(13) of Pub. L. 98–24, 97 Stat. 181 and as amended by sec. 106 of Pub. L. 99–401, 100 Stat. 907 (42 U.S.C. 290dd–3), as amended by sec. 131 of Pub. L. 102–321, 106 Stat. 368, (42 U.S.C. 290dd–2).

SOURCE: 52 FR 21809, June 9, 1987, unless otherwise noted.

Subpart A—Introduction

§ 2.1 Statutory authority for confidentiality of drug abuse patient records.

The restrictions of these regulations upon the disclosure and use of drug abuse patient records were initially authorized by section 408 of the Drug Abuse Prevention, Treatment, and Rehabilitation Act (21 U.S.C. 1175). That section as amended was transferred by Pub. L. 98–24 to section 527 of the Public Health Service Act which is codified at 42 U.S.C. 290ee–3. The amended statutory authority is set forth below:

§ 290EE–3. CONFIDENTIALITY OF PATIENT RECORDS.

(a) *Disclosure authorization*

Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e) of this section, be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

(b) *Purposes and circumstances of disclosure affecting consenting patient and patient regardless of consent*

(1) The content of any record referred to in subsection (a) of this section may be disclosed in accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to subsection (g) of this section.

(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefore. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(c) *Prohibition against use of record in making criminal charges or investigation of patient*

Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) of this section may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

(d) *Continuing prohibition against disclosure irrespective of status as patient*

The prohibitions of this section continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

(e) *Armed Forces and Veterans' Administration; interchange of records; report of suspected child abuse and neglect to State or local authorities*

The prohibitions of this section do not apply to any interchange of records—

(1) within the Armed Forces or within those components of the Veterans' Administration furnishing health care to veterans, or

(2) between such components and the Armed Forces.

The prohibitions of this section do not apply to the reporting under State law of incidents of suspected child abuse and neglect to the appropriate State or local authorities.

(f) *Penalty for first and subsequent offenses*

Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

(g) *Regulations; interagency consultations; definitions, safeguards, and procedures, including procedures and criteria for issuance and scope of orders*

Except as provided in subsection (h) of this section, the Secretary, after consultation with the Administrator of Veterans' Affairs and the heads of other Federal departments and agencies substantially affected thereby, shall prescribe regulations to carry out the purposes of this section. These regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders under subsection (b)(2)(C) of this section, as in the judgment of the Secretary are necessary or proper to effectuate the purposes of this section, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

(Subsection (h) was superseded by section 111(c)(3) of Pub. L. 94–581 The responsibility of the Administrator of Veterans' Affairs to write regulations to provide for confidentiality of drug abuse patient records under Title 38 was moved from 21 U.S.C. 1175 to 38 U.S.C. 4134.)

§ 2.2 Statutory authority for confidentiality of alcohol abuse patient records.

The restrictions of these regulations upon the disclosure and use of alcohol abuse patient records were initially authorized by section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (42 U.S.C. 4582). The section as amended was transferred by Pub. L. 98–24 to section 523 of the Public Health Service Act which is codified at 42 U.S.C. 290dd–3. The amended statutory authority is set forth below:

§ 290DD–3. CONFIDENTIALITY OF PATIENT RECORDS

(a) *Disclosure authorization*

Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to alcoholism or alcohol abuse education, training, treatment, rehabilitation, or research, which is conducted, regulated, or

directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e) of this section, be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

(b) *Purposes and circumstances of disclosure affecting consenting patient and patient regardless of consent*

(1) The content of any record referred to in subsection (a) of this section may be disclosed in accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to subsection (g) of this section.

(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefore. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(c) *Prohibition against use of record in making criminal charges or investigation of patient*

Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) of this section may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

(d) *Continuing prohibition against disclosure irrespective of status as patient*

The prohibitions of this section continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

(e) *Armed Forces and Veterans' Administration; interchange of record of suspected child abuse and neglect to State or local authorities*

The prohibitions of this section do not apply to any interchange of records—

(1) within the Armed Forces or within those components of the Veterans' Administration furnishing health care to veterans, or

(2) between such components and the Armed Forces.

The prohibitions of this section do not apply to the reporting under State law of incidents of suspected child abuse and neglect to the appropriate State or local authorities.

(f) *Penalty for first and subsequent offenses*

Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

(g) *Regulations of Secretary; definitions, safeguards, and procedures, including procedures and criteria for issuance and scope of orders*

Except as provided in subsection (h) of this section, the Secretary shall prescribe regulations to carry out the purposes of this section. These regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders under subsection(b)(2)(C) of this section, as in the judgment of the Secretary are necessary or proper to effectuate the purposes of this section, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

(Subsection (h) was superseded by section 111(c)(4) of Pub. L. 94–581. The responsibility of the Administrator of Veterans' Affairs to write regulations to provide for confidentiality of alcohol abuse patient records under Title 38 was moved from 42 U.S.C. 4582 to 38 U.S.C. 4134.)

§ 2.3 Purpose and effect.

(a) *Purpose.* Under the statutory provision quoted in §§ 2.1 and 2.2, these regulations impose restrictions upon the disclosure and use of alcohol an drug abuse patient records which are maintained in connection with the performance of any federally assisted alcohol and drug abuse program. The regulations specify:

(1) Definitions, applicability, and general restrictions in subpart B (definitions applicable to § 2.34 only appear in that section);

(2) Disclosures which may be made with written patient consent and the form of the written consent in subpart C;

(3) Disclosures which may be made without written patient consent or an authorizing court order in subpart D; and

(4) Disclosures and uses of patient records which may be made with an authorizing court order and the procedures and criteria for the entry and scope of those orders in subpart E.

(b) *Effect.* (1) These regulations prohibit the disclosure and use of patient records unless certain circumstances exist. If any circumstances exists under which disclosure is permitted, that circumstance acts to remove the prohibition on disclosure but it does not compel disclosure. Thus, the regulations do not require disclosure under any circumstances.

(2) These regulations are not intended to direct the manner in which substantive functions such as research, treatment, and evaluation are carried out. They are intended to insure that an alcohol or drug abuse patient in a federally assisted alcohol or drug abuse program is not made more vulnerable by reason of the availability of his or her patient record than an individual who has an alcohol or drug problem and who does not seek treatment.

(3) Because there is a criminal penalty (a fine—see 42 U.S.C. 290ee–3(f), 42 U.S.C. 290dd–3(f) and 42 CFR 2.4) for violating the regulations, they are to be construed strictly in favor of the potential violator in the same manner as a criminal statute (see *M. Kraus & Brothers* v. *United States,* 327 U.S. 614, 621–22, 66 S. Ct. 705, 707–08 (1946)).

§ 2.4 Criminal penalty for violation.

Under 42 U.S.C. 290ee–3(f) and 42 U.S.C. 290dd–3(f), any person who violates any provision of those statutes or these regulations shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

§ 2.5 Reports of violations.

(a) The report of any violation of these regulations may be directed to the United States Attorney for the judicial district in which the violation occurs.

(b) The report of any violation of these regulations by a methadone program may be directed to the Regional Offices of the Food and Drug Administration.

Subpart B—General Provisions

§ 2.11 Definitions.

For purposes of these regulations:

Alcohol abuse means the use of an alcoholic beverage which impairs the physical, mental, emotional, or social well-being of the user.

Drug abuse means the use of a psychoactive substance for other than medicinal purposes which impairs the physical, mental, emotional, or social well-being of the user.

Diagnosis means any reference to an individual's alcohol or drug abuse or to a condition which is identified as having been caused by that abuse which is made for the purpose of treatment or referral for treatment.

Disclose or disclosure means a communication of patient indentifying information, the affirmative verification of another person's communication of patient identifying information, or the communication of any information from the record of a patient who has been identified.

Informant means an individual:

(a) Who is a patient or employee of a program or who becomes a patient or employee of a program at the request of a law enforcement agency or official: and

(b) Who at the request of a law enforcement agency or official observes one or more patients or employees of the program for the purpose of reporting the information obtained to the law enforcement agency or official.

Patient means any individual who has applied for or been given diagnosis or treatment for alcohol or drug abuse at a federally assisted program and includes any individual who, after arrest on a criminal charge, is identified as an alcohol or drug abuser in order to determine that individual's eligibility to participate in a program.

Patient identifying information means the name, address, social security number, fingerprints, photograph, or similar information by which the identity of a patient can be determined with reasonable accuracy and speed either directly or by reference to other publicly available information. The term does not include a number assigned to a patient by a program, if that number does not consist of, or contain numbers (such as a social security, or driver's license number) which could be used to identify a patient with reasonable accuracy and speed from sources external to the program.

Person means an individual, partnership, corporation, Federal, State or local government agency, or any other legal entity.

Program means:

(a) An individual or entity (other than a general medical care facility) who holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment; or

(b) An identified unit within a general medical facility which holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment; or

(c) Medical personnel or other staff in a general medical care facility whose primary function is the provision of alcohol or drug abuse diagnosis, treatment or referral for treatment and who are identified as such providers. (See § 2.12(e)(1) for examples.)

Program director means:

(a) In the case of a program which is an individual, that individual:

(b) In the case of a program which is an organization, the individual designated as director, managing director, or otherwise vested with authority to act as chief executive of the organization.

Qualified service organization means a person which:

(a) Provides services to a program, such as data processing, bill collecting, dosage preparation, laboratory analyses, or legal, medical, accounting, or other professional services, or services to prevent or treat child abuse or neglect, including training on nutrition and child care and individual and group therapy, and

(b) Has entered into a written agreement with a program under which that person:

(1) Acknowledges that in receiving, storing, processing or otherwise dealing with any patient records from the programs, it is fully bound by these regulations; and

(2) If necessary, will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by these regulations.

Records means any information, whether recorded or not, relating to a patient received or acquired by a federally assisted alcohol or drug program.

Third party payer means a person who pays, or agrees to pay, for diagnosis or treatment furnished to a patient on the basis of a contractual relationship with the patient or a member of his family or on the basis of the patient's eligibility for Federal, State, or local governmental benefits.

Treatment means the management and care of a patient suffering from alcohol or drug abuse, a condition which is identified as having been

caused by that abuse, or both, in order to reduce or eliminate the adverse effects upon the patient.

Undercover agent means an officer of any Federal, State, or local law enforcement agency who enrolls in or becomes an employee of a program for the purpose of investigating a suspected violation of law or who pursues that purpose after enrolling or becoming employed for other purposes.

[52 FR 21809, June 9, 1987, as amended by 60 FR 22297, May 5, 1995]

§ 2.12 Applicability.

(a) *General*—(1) *Restrictions on disclosure.* The restrictions on disclosure in these regulations apply to any information, whether or not recorded, which:

(i) Would identify a patient as an alcohol or drug abuser either directly, by reference to other publicly available information, or through verification of such an identification by another person; and

(ii) Is drug abuse information obtained by a federally assisted drug abuse program after March 20, 1972, or is alcohol abuse information obtained by a federally assisted alcohol abuse program after May 13, 1974 (or if obtained before the pertinent date, is maintained by a federally assisted alcohol or drug abuse program after that date as part of an ongoing treatment episode which extends past that date) for the purpose of treating alcohol or drug abuse, making a diagnosis for that treatment, or making a referral for that treatment.

(2) *Restriction on use.* The restriction on use of information to initiate or substantiate any criminal charges against a patient or to conduct any criminal investigation of a patient (42 U.S.C. 290ee–3(c), 42 U.S.C. 290dd–3(c)) applies to any information, whether or not recorded which is drug abuse information obtained by a federally assisted drug abuse program after March 20, 1972, or is alcohol abuse information obtained by a federally assisted alcohol abuse program after May 13, 1974 (or if obtained before the pertinent date, is maintained by a federally assisted alcohol or drug abuse program after that date as part of an ongoing treatment episode which extends past that date), for the purpose of treating alcohol or drug abuse, making a diagnosis for the treatment, or making a referral for the treatment.

(b) *Federal assistance.* An alcohol abuse or drug abuse program is considered to be federally assisted if:

(1) It is conducted in whole or in part, whether directly or by contract or otherwise by any department or agency of the United States (but see paragraphs (c)(1) and (c)(2) of this section relating to the Veterans' Administration and the Armed Forces);

(2) It is being carried out under a license, certification, registration, or other authorization granted by any department or agency of the United States including but not limited to:

(i) Certification of provider status under the Medicare program;

(ii) Authorization to conduct methadone maintenance treatment (see 21 CFR 291.505); or

(iii) Registration to dispense a substance under the Controlled Substances Act to the extent the controlled substance is used in the treatment of alcohol or drug abuse;

(3) It is supported by funds provided by any department or agency of the United States by being:

(i) A recipient of Federal financial assistance in any form, including financial assistance which does not directly pay for the alcohol or drug abuse diagnosis, treatment, or referral activities; or

(ii) Conducted by a State or local government unit which, through general or special revenue sharing or other forms of assistance, receives Federal funds which could be (but are not necessarily) spent for the alcohol or drug abuse program; or

(4) It is assisted by the Internal Revenue Service of the Department of the Treasury through the allowance of income tax deductions for contributions to the program or through the granting of tax exempt status to the program.

(c) *Exceptions*—(1) *Veterans' Administration.* These regulations do not apply to information on alcohol and drug abuse patients maintained in connection with the Veterans' Administration provisions of hospital care, nursing home care, domiciliary care, and medical services under title 38, United States Code. Those records are governed by 38 U.S.C. 4132 and regulations issued under that authority by the Administrator of Veterans' Affairs.

(2) *Armed Forces.* These regulations apply to any information described in paragraph (a) of this section which was obtained by any component of the Armed Forces during a period when the patient was subject to the Uniform Code of Military Justice except:

(i) Any interchange of that information within the Armed Forces; and

(ii) Any interchange of that information between the Armed Forces and those components of the Veterans Administration furnishing health care to veterans.

(3) *Communication within a program or between a program and an entity having direct administrative control over that program.* The restrictions on disclosure in these regulations do not apply to communications of information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of alcohol or drug abuse if the communications are

(i) Within a program or

(ii) Between a program and an entity that has direct administrative control over the program.

(4) *Qualified Service Organizations.*

The restrictions on disclosure in these regulations do not apply to communications between a program and a qualified service organization of information needed by the organization to provide services to the program.

(5) *Crimes on program premises or against program personnel.* The restrictions on disclosure and use in these regulations do not apply to communications from program personnel to law enforcement officers which—

(i) Are directly related to a patient's commission of a crime on the premises of the program or against program personnel or to a threat to commit such a crime; and

(ii) Are limited to the circumstances of the incident, including the patient status of the individual committing or threatening to commit the crime, that individual's name and address, and that individual's last known whereabouts.

(6) *Reports of suspected child abuse and neglect.* The restrictions on disclosure and use in these regulations do not apply to the reporting under State law of incidents of suspected child abuse and neglect to the appropriate State or local authorities. However, the restrictions continue to apply to the original alcohol or drug abuse patient records maintained by the program including their disclosure and use for civil or criminal proceedings which may arise out of the report of suspected child abuse and neglect.

(d) *Applicability to recipients of information*—(1) *Restriction on use of information.* The restriction on the use of any information subject to these regulations to initiate or substantiate any criminal charges against a patient or to conduct any criminal investigation of a patient applies to any person

who obtains that information from a federally assisted alcohol or drug abuse program, regardless of the status of the person obtaining the information or of whether the information was obtained in accordance with these regulations. This restriction on use bars, among other things, the introduction of that information as evidence in a criminal proceeding and any other use of the information to investigate or prosecute a patient with respect to a suspected crime. Information obtained by undercover agents or informants (see § 2.17) or through patient access (see § 2.23) is subject to the restriction on use.

(2) *Restrictions on disclosures—Third party payers, administrative entities, and others.* The restrictions on disclosure in these regulations apply to:

(i) Third party payers with regard to records disclosed to them by federally assisted alcohol or drug abuse programs;

(ii) Entities having direct administrative control over programs with regard to information communicated to them by the program under 2.12(c)(3); and

(iii) Persons who receive patient records directly from a federally assisted alcohol or drug abuse program and who are notified of the restrictions on re-disclosure of the records in accordance with § 2.32 of these regulations.

(e) *Explanation of applicability*—(1) *Coverage.* These regulations cover any information (including information on referral and intake) about alcohol and drug abuse patients obtained by a program (as the terms ‘‘patient’’ and ‘‘program’’ are defined in § 2.11) if the program is federally assisted in any manner described in § 2.12(b). Coverage includes, but is not limited to, those treatment or rehabilitation programs, employee assistance programs, programs within general hospitals, school-based programs, and private practitioners who hold themselves out as providing, and provide alcohol or drug abuse diagnosis, treatment, or referral for treatment. However, these regulations would not apply, for example, to emergency room personnel who refer a patient to the intensive care unit for an apparent overdose, unless the primary function of such personnel is the provision of alcohol or drug abuse diagnosis, treatment or referral and they are identified as providing such services or the emergency room has promoted itself to the community as a provider of such services.

(2) *Federal assistance to program required.* If a patient’s alcohol or drug abuse diagnosis, treatment, or referral for treatment is not provided by a program which is federally conducted, regulated or supported in a manner which constitutes Federal assistance under § 2.12(b), that patient’s record

is not covered by these regulations. Thus, it is possible for an individual patient to benefit from Federal support and not be covered by the confidentiality regulations because the program in which the patient is enrolled is not federally assisted as defined in § 2.12(b). For example, if a Federal court placed an individual in a private for-profit program and made a payment to the program on behalf of that individual, that patient's record would not be covered by these regulations unless the program itself received Federal assistance as defined by § 2.12(b).

(3) *Information to which restrictions are applicable.* Whether a restriction is on use or disclosure affects the type of information which may be available. The restrictions on disclosure apply to any information which would identify a patient as an alcohol or drug abuser. The restriction on use of information to bring criminal charges against a patient for a crime applies to any information obtained by the program for the purpose of diagnosis, treatment, or referral for treatment of alcohol or drug abuse. (Note that restrictions on use and disclosure apply to recipients of information under § 2.12(d).)

(4) *How type of diagnosis affects coverage.* These regulations cover any record of a diagnosis identifying a patient as an alcohol or drug abuser which is prepared in connection with the treatment or referral for treatment of alcohol or drug abuse. A diagnosis prepared for the purpose of treatment or referral for treatment but which is not so used is covered by these regulations. The following are not covered by these regulations:

(i) Diagnosis which is made solely for the purpose of providing evidence for use by law enforcement authorities; or

(ii) A diagnosis of drug overdose or alcohol intoxication which clearly shows that the individual involved is not an alcohol or drug abuser (e.g., involuntary ingestion of alcohol or drugs or reaction to a prescribed dosage of one or more drugs).

[52 FR 21809, June 9, 1987; 52 FR 42061, Nov. 2, 1987, as amended at 60 FR 22297, May 5, 1995]

§ 2.13 Confidentiality restrictions.

(a) *General.* The patient records to which these regulations apply may be disclosed or used only as permitted by these regulations and may not otherwise be disclosed or used in any civil, criminal, administrative, or legislative proceedings conducted by any Federal, State, or local authority.

Any disclosure made under these regulations must be limited to that information which is necessary to carry out the purpose of the disclosure.

(b) *Unconditional compliance required.* The restrictions on disclosure and use in these regulations apply whether the holder of the information believes that the person seeking the information already has it, has other means of obtaining it, is a law enforcement or other official, has obtained a subpoena, or asserts any other justification for a disclosure or use which is not permitted by these regulations.

(c) *Acknowledging the presence of patients: Responding to requests.* (1) The presence of an identified patient in a facility or component of a facility which is publicly identified as a place where only alcohol or drug abuse diagnosis, treatment, or referral is provided may be acknowledged only if the patient's written consent is obtained in accordance with subpart C of these regulations or if an authorizing court order is entered in accordance with subpart E of these regulations. The regulations permit acknowledgement of the presence of an identified patient in a facility or part of a facility if the facility is not publicly identified as only an alcohol or drug abuse diagnosis, treatment or referral facility, and if the acknowledgement does not reveal that the patient is an alcohol or drug abuser.

(2) Any answer to a request for a disclosure of patient records which is not permissible under these regulations must be made in a way that will not affirmatively reveal that an identified individual has been, or is being diagnosed or treated for alcohol or drug abuse. An inquiring party may be given a copy of these regulations and advised that they restrict the disclosure of alcohol or drug abuse patient records, but may not be told affirmatively that the regulations restrict the disclosure of the records of an identified patient. The regulations do not restrict a disclosure that an identified individual is not and never has been a patient.

§ 2.14 Minor patients.

(a) *Definition of minor.* As used in these regulations the term ''minor'' means a person who has not attained the age of majority specified in the applicable State law, or if no age of majority is specified in the applicable State law, the age of eighteen years.

(b) *State law not requiring parental consent to treatment.* If a minor patient acting alone has the legal capacity under the applicable State law to apply for and obtain alcohol or drug abuse treatment, any written consent for disclosure authorized under subpart C of these regulations may be given only by the minor patient. This restriction includes, but is not limited

to, any disclosure of patient identifying information to the parent or guardian of a minor patient for the purpose of obtaining financial reimbursement. These regulations do not prohibit a program from refusing to provide treatment until the minor patient consents to the disclosure necessary to obtain reimbursement, but refusal to provide treatment may be prohibited under a State or local law requiring the program to furnish the service irrespective of ability to pay.

(c) *State law requiring parental consent to treatment.* (1) Where State law requires consent of a parent, guardian, or other person for a minor to obtain alcohol or drug abuse treatment, any written consent for disclosure authorized under subpart C of these regulations must be given by both the minor and his or her parent, guardian, or other person authorized under State law to act in the minor's behalf.

(2) Where State law requires parental consent to treatment the fact of a minor's application for treatment may be communicated to the minor's parent, guardian, or other person authorized under State law to act in the minor's behalf only if:

(i) The minor has given written consent to the disclosure in accordance with subpart C of these regulations or

(ii) The minor lacks the capacity to make a rational choice regarding such consent as judged by the program director under paragraph (d) of this section.

(d) *Minor applicant for services lacks capacity for rational choice.* Facts relevant to reducing a threat to the life or physical well being of the applicant or any other individual may be disclosed to the parent, guardian, or other person authorized under State law to act in the minor's behalf if the program director judges that:

(1) A minor applicant for services lacks capacity because of extreme youth or mental or physical condition to make a rational decision on whether to consent to a disclosure under subpart C of these regulations to his or her parent, guardian, or other person authorized under State law to act in the minor's behalf, and

(2) The applicant's situation poses a substantial threat to the life or physical well being of the applicant or any other individual which may be reduced by communicating relevant facts to the minor's parent, guardian, or other person authorized under State law to act in the minor's behalf.

§ 2.15 Incompetent and deceased patients.

(a) *Incompetent patients other than minors*—(1) *Adjudication of incompetence.* In the case of a patient who has been adjudicated as lacking the capacity, for any reason other than insufficient age, to manage his or her own affairs, any consent which is required under these regulations may be given by the guardian or other person authorized under State law to act in the patient's behalf.

(2) *No adjudication of incompetency.* For any period for which the program director determines that a patient, other than a minor or one who has been adjudicated incompetent, suffers from a medical condition that prevents knowing or effective action on his or her own behalf, the program director may exercise the right of the patient to consent to a disclosure under subpart C of these regulations for the sole purpose of obtaining payment for services from a third party payer.

(b) *Deceased patients*—(1) *Vital statistics.* These regulations do not restrict the disclosure of patient identifying information relating to the cause of death of a patient under laws requiring the collection of death or other vital statistics or permitting inquiry into the cause of death.

(2) *Consent by personal representative.* Any other disclosure of information identifying a deceased patient as an alcohol or drug abuser is subject to these regulations. If a written consent to the disclosure is required, that consent may be given by an executor, administrator, or other personal representative appointed under applicable State law. If there is no such appointment the consent may be given by the patient's spouse or, if none, by any responsible member of the patient's family.

§ 2.16 Security for written records.

(a) Written records which are subject to these regulations must be maintained in a secure room, locked file cabinet, safe or other similar container when not in use; and

(b) Each program shall adopt in writing procedures which regulate and control access to and use of written records which are subject to these regulations.

§ 2.17 Undercover agents and informants.

(a) *Restrictions on placement.* Except as specifically authorized by a court order granted under § 2.67 of these regulations, no program may knowingly employ, or enroll as a patient, any undercover gent or informant.

(b) *Restriction on use of information.* No information obtained by an undercover agent or informant, whether or not that undercover agent or informant is placed in a program pursuant to an authorizing court order, may be used to criminally investigate or prosecute any patient.

[52 FR 21809, June 9, 1987; 52 FR 42061, Nov. 2, 1987]

§ 2.18 Restrictions on the use of identification Cards.

No person may require any patient t carry on his or her person while away from the program premises any card or other object which would identify the patient as an alcohol or drug abuser. This section does not prohibit a person from requiring patients to use or carry cards or other identification objects on the premises of a program.

§ 2.19 Disposition of records by discontinued programs.

(a) *General.* If a program discontinues operations or is taken over or acquired by another program, it must purge patient identifying information from its records or destroy the records unless—

(1) The patient who is the subject of the records gives written consent (meeting the requirements of § 2.31) to a transfer of the records to the acquiring program or to any other program designated in the consent (the manner of obtaining this consent must minimize the likelihood of a disclosure of patient identifying information to a third party); or

(2) There is a legal requirement that the records be kept for a period specified by law which does not expire until after the discontinuation or acquisition of the program.

(b) *Procedure where retention period required by law.* If paragraph (a)(2) of this section applies, the records must be:

(1) Sealed in envelopes or other containers labeled as follows: ‘‘Records of [insert name of program] required to be maintained under [insert citation to statute, regulation, court order or other legal authority requiring that records be kept] until a date not later than [insert appropriate date]’’; and

(2) Held under the restrictions of these regulations by a responsible person who must, as soon as practicable after the end of the retention period specified on the label, destroy the records.

§ 2.20 Relationship to State laws.

The statutes authorizing these regulations (42 U.S.C. 290ee–3 and 42 U.S.C. 290dd–3) do not preempt the field of law which they cover to the exclusion of all State laws in that field. If a disclosure permitted under these regulations is prohibited under State law, neither these regulations nor the authorizing statutes may be construed to authorize any violation of that State law. However, no State law may either authorize or compel any disclosure prohibited by these regulations.

§ 2.21 Relationship to Federal statutes protecting research subjects against compulsory disclosure of their identity.

(a) *Research privilege description.* There may be concurrent coverage of patient identifying information by these regulations and by administrative action taken under: Section 303(a) of the Public Health Service Act (42 U.S.C. 242a(a) and the implementing regulations at 42 CFR part 2a); or section 502(c) of the Controlled Substances Act (21 U.S.C. 872(c) and the implementing regulations at 21 CFR 1316.21). These ‘‘research privilege’’ statutes confer on the Secretary of Health and Human Services and on the Attorney General, respectively, the power to authorize researchers conducting certain types of research to withhold from all persons not connected with the research the names and other identifying information concerning individuals who are the subjects of the research.

(b) *Effect of concurrent coverage.* These regulations restrict the disclosure and use of information about patients, while administrative action taken under the research privilege statutes and implementing regulations protects a person engaged in applicable research from being compelled to disclose any identifying characteristics of the individuals who are the subjects of that research. The issuance under subpart E of these regulations of a court order authorizing a disclosure of information about a patient does not affect an exercise of authority under these research privilege statutes. However, the research privilege granted under 21 CFR 291.505(g) to treatment programs using methadone for maintenance treatment does not protect from compulsory disclosure any information which is permitted to be disclosed under those regulations. Thus, if a court

order entered in accordance with subpart E of these regulations authorizes a methadone maintenance treatment program to disclose certain the research privilege under 21 CFR 291.505(g) as a defense to a subpoena for that information.

§ 2.22 Notice to patients of Federal confidentiality requirements.

(a) *Notice required.* At the time of admission or as soon thereafter as the patient is capable of rational communication, each program shall:

(1) Communicate to the patient that Federal law and regulations protect the confidentiality of alcohol and drug abuse patient records; and (2) Give to the patient a summary in writing of the Federal law and regulations.

(b) *Required elements of written summary.* The written summary of the Federal law and regulations must include:

(1) A general description of the limited circumstances under which a program may acknowledge that an individual is present at a facility or disclose outside the program information identifying a patient as an alcohol or drug abuser.

(2) A statement that violation of the Federal law and regulations by a program is a crime and that suspected violations may be reported to appropriate authorities in accordance with these regulations.

(3) A statement that information related to a patient's commission of a crime on the premises of the program or against personnel of the program is not protected.

(4) A statement that reports of suspected child abuse and neglect made under State law to appropriate State or local authorities are not protected.

(5) A citation to the Federal law and regulations.

(c) *Program options.* The program may devise its own notice or may use the sample notice in paragraph (d) to comply with the requirement to provide the patient with a summary in writing of the Federal law and regulations. In addition, the program may include in the written summary information concerning State law and any program policy not inconsistent with State and Federal law on the subject of confidentiality of alcohol and drug abuse patient records.

(d) *Sample notice.*

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser *Unless:*

(1) The patient consents in writing:

(2) The disclosure is allowed by a court order; or

(3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation. Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities

(See 42 U.S.C. 290dd–3 and 42 U.S.C. 290ee– for Federal laws and 42 CFR part 2 for Federal
regulations.)

(Approved by the Office of Management an Budget under control number 0930–0099)

§ 2.23 Patient access and restrictions on use.

(a) *Patient access not prohibited.* These regulations do not prohibit a program from giving a patient access to his or her own records, including the opportunity to inspect and copy any records that the program maintains about the patient. The program is not required to obtain a patient's written consent or other authorization under these regulations in order to provide such access to the patient.

(b) *Restriction on use of information.* Information obtained by patient access to his or her patient record is subject to the restriction on use of his information to initiate or substantiate any criminal charges against the

patient or to conduct any criminal investigation of the patient as provided for under § 2.12(d)(1).

Subpart C—Disclosures With Patient's Consent

§ 2.31 Form of written consent.

(a) *Required elements.* A written consent to a disclosure under these regulations must include:

(1) The specific name or general designation of the program or person permitted to make the disclosure.

(2) The name or title of the individual or the name of the organization to which disclosure is to be made.

(3) The name of the patient.

(4) The purpose of the disclosure.

(5) How much and what kind of information is to be disclosed.

(6) The signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under § 2.14; or, when required for a patient who is incompetent or deceased, the signature of a person authorized to sign under § 2.15 in lieu of the patient.

(7) The date on which the consent is signed.

(8) A statement that the consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer.

(9) The date, event, or condition upon which the consent will expire if not revoked before. This date, event, or condition must insure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.

(b) *Sample consent form.* The following form complies with paragraph (a) of this section, but other elements may be added.

1. I (name of patient) ☐ Request ☐Authorize:

2. (name or general designation of program which is to make the disclosure)

_____

3. To disclose: (kind and amount of information to be disclosed)

_____

4. To: (name or title of the person or organization to which disclosure is to be made)

_____

5. For (purpose of the disclosure)

_____

6. Date (on which this consent is signed)

_____

7. Signature of patient

_____

8. Signature of parent or guardian (where required)

_____

9. Signature of person authorized to sign in lieu of the patient (where required)

_____

10. This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon: (specific date, event, or condition)

(c) *Expired, deficient, or false consent.* A disclosure may not be made on the basis of a consent which:

(1) Has expired;

(2) On its face substantially fails to conform to any of the requirements set forth in paragraph (a) of this section;

(3) Is known to have been revoked; or

(4) Is known, or through a reasonable effort could be known, by the person holding the records to be materially false.

(Approved by the Office of Management and Budget under control number 0930–0099)

§ 2.32 Prohibition on re-disclosure.

Notice to accompany disclosure. Each disclosure made with the patient's written consent must be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

[52 FR 21809, June 9, 1987; 52 FR 41997, Nov. 2, 1987]

§ 2.33 Disclosures permitted with written consent.

If a patient consents to a disclosure of his or her records under § 2.31, a program may disclose those records in accordance with that consent to any individual or organization named in the consent, except that disclosures to central registries and in connection with criminal justice referrals must meet the requirements of §§ 2.34 and 2.35, respectively.

§ 2.34 Disclosures to prevent multiple enrollments in detoxification and maintenance treatment programs.

(a) *Definitions.* For purposes of this section:

Central registry means an organization which obtains from two or more member programs patient identifying information about individuals applying for maintenance treatment or detoxification treatment for the purpose of avoiding an individual's concurrent enrollment in more than one program.

Detoxification treatment means the dispensing of a narcotic drug in decreasing doses to an individual in order to reduce or eliminate adverse physiological or psychological effects incident to withdrawal from the sustained use of a narcotic drug.

Maintenance treatment means the dispensing of a narcotic drug in the treatment of an individual for dependence upon heroin or other morphine-like drugs.

Member program means a detoxification treatment or maintenance treatment program which reports patient identifying information to a central registry and which is in the same State as that central registry or is not more than 125 miles from any border of the State in which the central registry is located.

(b) *Restrictions on disclosure.* A program may disclose patient records to a central registry or to any detoxification or maintenance treatment program not more than 200 miles away for the purpose of preventing the multiple enrollment of a patient only if:

(1) The disclosure is made when:

(i) The patient is accepted for treatment;

(ii) The type or dosage of the drug is changed; or

(iii) The treatment is interrupted, resumed or terminated.

(2) The disclosure is limited to:

(i) Patient identifying information;

(ii) Type and dosage of the drug; and

(iii) Relevant dates.

(3) The disclosure is made with the patient's written consent meeting the requirements of § 2.31, except that:

(i) The consent must list the name and address of each central registry and each known detoxification or maintenance treatment program to which a disclosure will be made; and

(ii) The consent may authorize a disclosure to any detoxification or maintenance treatment program established within 200 miles of the program after the consent is given without naming any such program.

(c) *Use of information limited to prevention of multiple enrollments.* A central registry and any detoxification or maintenance treatment program to which information is disclosed to prevent multiple enrollments may not re-disclose or use patient identifying information for any purpose other than the prevention of multiple enrollments unless authorized by a court order under subpart E of these regulations.

(d) *Permitted disclosure by a central registry to prevent a multiple enrollment.* When a member program asks a central registry if an identified patient is enrolled in another member program and the registry determines that the patient is so enrolled, the registry may disclose—

(1) The name, address, and telephone number of the member program(s) in which the patient is already enrolled to the inquiring member program; and

(2) The name, address, and telephone number of the inquiring member program to the member program(s) in which the patient is already enrolled. The member programs may communicate as necessary to verify that no error has been made and to prevent or eliminate any multiple enrollment.

(e) *Permitted disclosure by a detoxification or maintenance treatment program to prevent a multiple enrollment.* A detoxification or maintenance treatment program which has received a disclosure under this section and has determined that the patient is already enrolled may communicate as necessary with the program making the disclosure to verify that no error has been made and to prevent or eliminate any multiple enrollment.

§ 2.35 Disclosures to elements of the criminal justice system which have referred patients.

(a) A program may disclose information about a patient to those persons within the criminal justice system which have made participation in the program a condition of the disposition of any criminal proceedings against the patient or of the patient's parole or other release from custody if:

(1) The disclosure is made only to those individuals within the criminal justice system who have a need for the information in connection with their duty to monitor the patient's progress (e.g., a prosecuting attorney who is withholding charges against the patient, a court granting pretrial or post-trial release, probation or parole officers responsible for supervision of the patient); and

(2) The patient has signed a written consent meeting the requirements of § 2.31 (except paragraph (a)(8) which is inconsistent with the revocation provisions of paragraph (c) of this section) and the requirements of paragraphs (b) and (c) of this section.

(b) *Duration of consent.* The written consent must state the period during which it remains in effect. This period must be reasonable, taking into account:

(1) The anticipated length of the treatment;

(2) The type of criminal proceeding involved, the need for the information in connection with the final disposition of that proceeding, and when the final disposition will occur; and

(3) Such other factors as the program, the patient, and the person(s) who will receive the disclosure consider pertinent.

(c) *Revocation of consent.* The written consent must state that it is revocable upon the passage of a specified amount of time or the occurrence of a specified, ascertainable event. The time or occurrence upon which consent becomes revocable may be no later than the final disposition of the conditional release or other action in connection with which consent was given.

(d) *Restrictions on re-disclosure and use.* A person who receives patient information under this section may re-disclose and use it only to carry out that person's official duties with regard to the patient's conditional release or other action in connection with which the consent was given.

Subpart D—Disclosures Without Patient Consent

§ 2.51 Medical emergencies.

(a) *General Rule.* Under the procedures required by paragraph (c) of this section, patient identifying information may be disclosed to medical personnel who have a need for information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention.

(b) *Special Rule.* Patient identifying information may be disclosed to medical personnel of the Food and Drug Administration (FDA) who assert a reason to believe that the health of any individual may be threatened by an error in the manufacture, labeling, or sale of a product under FDA jurisdiction, and that the information will be used for the exclusive purpose of notifying patients or their physicians of potential dangers.

(c) *Procedures.* Immediately following disclosure, the program shall document the disclosure in the patient's records, setting forth in writing:

(1) The name of the medical personnel to whom disclosure was made and their affiliation with any health care facility;

(2) The name of the individual making the disclosure;

(3) The date and time of the disclosure; and

(4) The nature of the emergency (or error, if the report was to FDA).

(Approved by the Office of Management and Budget under control number 0930–0099)

§ 2.52 Research activities.

(a) Patient identifying information may be disclosed for the purpose of conducting scientific research if the program director makes a determination that the recipient of the patient identifying information:

(1) Is qualified to conduct the research;

(2) Has a research protocol under which the patient identifying information:

(i) Will be maintained in accordance with the security requirements of § 2.16 of these regulations (or more stringent requirements); and

(ii) Will not be re-disclosed except as permitted under paragraph (b) of this section; and

(3) Has provided a satisfactory written statement that a group of three or more individuals who are independent of the research project has reviewed the protocol and determined that:

(i) The rights and welfare of patients will be adequately protected; and

(ii) The risks in disclosing patient identifying information are outweighed by the potential benefits of the research.

(b) A person conducting research may disclose patient identifying information obtained under paragraph (a) of this section only back to the program from which that information was obtained and may not identify any individual patient in any report of that research or otherwise disclose patient identities.

[52 FR 21809, June 9, 1987, as amended at 52 FR 41997, Nov. 2, 1987]

§ 2.53 Audit and evaluation activities.

(a) *Records not copied or removed.* If patient records are not copied or removed, patient identifying information may be disclosed in the course of a review of records on program premises to any person who agrees in writing to comply with the limitations on re-disclosure and use in paragraph (d) of this section and who:

(1) Performs the audit or evaluation activity on behalf of:

(i) Any Federal, State, or local governmental agency which provide financial assistance to the program or is authorized by law to regulate its activities; or

(ii) Any private person which provides financial assistance to the program, which is a third party payer covering patients in the program, or which is a quality improvement organization performing a utilization or quality control review; or

(2) Is determined by the program director to be qualified to conduct the audit or evaluation activities.

(b) *Copying or removal of records.* Records containing patient identifying information may be copied or removed from program premises by any person who:

(1) Agrees in writing to:

(i) Maintain the patient identifying information in accordance with the security requirements provided in § 2.16 of these regulations (or more stringent requirements);

(ii) Destroy all the patient identifying information upon completion of the audit or evaluation; and

(iii) Comply with the limitations on disclosure and use in paragraph (d) of this section; and

(2) Performs the audit or evaluation activity on behalf of:

(i) Any Federal, State, or local governmental agency which provides financial assistance to the program or is authorized by law to regulate its activities; or

(ii) Any private person which provides financial assistance to the program, which is a third part payer covering patients in the program, or which is a quality improvement organization performing a utilization or quality control review.

(c) *Medicare or Medicaid audit or evaluation.*

(1) For purposes of Medicare or Medicaid audit or evaluation under this section, audit or evaluation includes a civil or administrative investigation of the program by any Federal, State, or local agency responsible for oversight of the Medicare or Medicaid program and includes administrative enforcement, against the program by the agency, of any remedy authorized by law to be imposed as a result of the findings of the investigation.

(2) Consistent with the definition of program in § 2.11, program includes an employee of, or provider of medical services under, the program when the employee or provider is the subject of a civil investigation or administrative remedy, as those terms are used in paragraph (c)(1) of this section.

(3) If a disclosure to a person is authorized under this section for a Medicare or Medicaid audit or evaluation, including a civil investigation or administrative remedy, as those terms are used in paragraph (c)(1) of this section, then a quality improvement organization which obtains the information under paragraph (a) or (b) may disclose the information to that person but only for purposes of Medicare or Medicaid audit or evaluation.

(4) The provisions of this paragraph do not authorize the agency, the program, or any other person to disclose or use patient identifying information obtained during the audit or evaluation for any purposes other than those necessary to complete the Medicare or Medicaid audit or evaluation activity as specified in this paragraph.

(d) *Limitations on disclosure and use.* Except as provided in paragraph (c) of this section, patient identifying information disclosed under this section may be disclosed only back to the program from which it was obtained and used only to carry out an audit or evaluation purpose or to investigate or prosecute criminal or other activities, as authorized by a court order entered under § 2.66 of these regulations.

Subpart E—Court Orders

Authorizing Disclosure and Use

§ 2.61 Legal effect of order.

(a) *Effect.* An order of a court of competent jurisdiction entered under this subpart is a unique kind of court order Its only purpose is to authorize a disclosure or use of patient information which would otherwise be prohibited by 42 U.S.C. 290ee–3, 42 U.S.C. 290dd–3 and these regulations. Such an order does not compel disclosure. A subpoena or a similar legal mandate must be issued in order to compel disclosure. This mandate may be entered at the same time as and accompany an authorizing court order entered under these regulations.

(b) *Examples.* (1) A person holding records subject to these regulations receives a subpoena for those records: a response to the subpoena is not permitted under the regulations unless an authorizing court order is entered. The person may not disclose the records in response to the subpoena unless a court of competent jurisdiction enters an authorizing order under these regulations.

(2) An authorizing court order is entered under these regulations, but the person authorized does not want to make the disclosure. If there is no subpoena or other compulsory process or a subpoena for the records has expired or been quashed, that person may refuse to make the disclosure. Upon the entry of a valid subpoena or other compulsory process the person authorized to disclose must disclose, unless there is a valid legal defense to the process other than the confidentiality restrictions of these regulations.

[52 FR 21809, June 9, 1987; 52 FR 42061, Nov. 2, 1987]

§ 2.62 Order not applicable to records disclosed without consent to researchers, auditors and evaluators.

A court order under these regulations may not authorize qualified personnel, who have received patient identifying information without consent for the purpose of conducting research, audit or evaluation, to disclose that information or use it to conduct any criminal investigation or prosecution of a patient. However, a court order under § 2.66 may

authorize disclosure and use of records to investigate or prosecute qualified personnel holding the records.

§ 2.63 Confidential communications.

(a) A court order under these regulations may authorize disclosure of confidential communications made by a patient to a program in the course of diagnosis, treatment, or referral for treatment only if:

(1) The disclosure is necessary to protect against an existing threat to life or of serious bodily injury, including circumstances which constitute suspected child abuse and neglect and verbal threats against third parties;

(2) The disclosure is necessary in connection with investigation or prosecution of an extremely serious crime, such as one which directly threatens loss of life or serious bodily injury, including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, or child abuse and neglect; or

(3) The disclosure is in connection with litigation or an administrative proceeding in which the patient offers testimony or other evidence pertaining to the content of the confidential communications.

(b) [Reserved]

§ 2.64 Procedures and criteria for orders authorizing disclosures for noncriminal purposes.

(a) *Application.* An order authorizing the disclosure of patient records for purposes other than criminal investigation or prosecution may be applied for by any person having a legally recognized interest in the disclosure which is sought. The application may be filed separately or as part of a pending civil action in which it appears that the patient records are needed to provide evidence. An application must use a fictitious name, such as John Doe, to refer to any patient and may not contain or otherwise disclose any patient identifying information unless the patient is the applicant or has given a written consent (meeting the requirements of these regulations) to disclosure or the court has ordered the record of the proceeding sealed from public scrutiny.

(b) *Notice.* The patient and the person holding the records from whom disclosure is sought must be given:

(1) Adequate notice in a manner which will not disclose patient identifying information to other persons; and

(2) An opportunity to file a written response to the application, or to appear in person, for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order.

(c) *Review of evidence: Conduct of hearing.* Any oral argument, review of evidence, or hearing on the application must be held in the judge's chambers or in some manner which ensures that patient identifying information is not disclosed to anyone other than a party to the proceeding, the patient, or the person holding the record, unless the patient requests an open hearing in a manner which meets the written consent requirements of these regulations. The proceeding may include an examination by the judge of the patient records referred to in the application.

(d) *Criteria for entry of order.* An order under this section may be entered only if the court determines that good cause exists. To make this determination the court must find that:

(1) Other ways of obtaining the information are not available or would not be effective; and

(2) The public interest and need for the disclosure outweigh the potential injury to the patient, the physician-patient relationship and the treatment services.

(e) *Content of order.* An order authorizing a disclosure must:

(1) Limit disclosure to those parts of the patient's record which are essential to fulfill the objective of the order;

(2) Limit disclosure to those persons whose need for information is the basis for the order; and

(3) Include such other measures as are necessary to limit disclosure for the protection of the patient, the physician- patient relationship and the treatment services; for example, sealing from public scrutiny the record of any proceeding for which disclosure of a patient's record has been ordered.

§ 2.65 Procedures and criteria for order authorizing disclosure and us of records to criminally investigate or prosecute patients.

(a) *Application.* An order authorizing the disclosure or use of patient records to criminally investigate or prosecute a patient may be applied for by the person holding the records or by any person conducting investigative or prosecutorial activities with respect to the enforcement of criminal laws. The application may be filed separately, as part of an application for a subpoena or other compulsory process, or in a pending criminal action. An application must use a fictitious name such as John Doe, to refer to any patient and may not contain or otherwise disclose

patient identifying information unless the court has ordered the record of the proceeding sealed from public scrutiny.

(b) *Notice and hearing.* Unless an order under § 2.66 is sought with an order under this section, the person holding the records must be given:

(1) Adequate notice (in a manner which will not disclose patient identifying information to third parties) of an application by a person performing a law enforcement function;

(2) An opportunity to appear and be heard for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order; and

(3) An opportunity to be represented by counsel independent of counsel for an applicant who is a person performing a law enforcement function.

(c) *Review of evidence: Conduct of hearings.* Any oral argument, review of evidence, or hearing on the application shall be held in the judge's chambers or in some other manner which ensures that patient identifying information is not disclosed to anyone other than a party to the proceedings, the patient, or the person holding the records. The proceeding may include an examination by the judge of the patient records referred to in the application.

(d) *Criteria.* A court may authorize the disclosure and use of patient records for the purpose of conducting a criminal investigation or prosecution of a patient only if the court finds that all of the following criteria are met:

(1) The crime involved is extremely serious, such as one which causes or directly threatens loss of life or serious bodily injury including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, and child abuse and neglect.

(2) There is a reasonable likelihood that the records will disclose information of substantial value in the investigation or prosecution.

(3) Other ways of obtaining the information are not available or would not be effective.

(4) The potential injury to the patient, to the physician-patient relationship and to the ability of the program to provide services to other patients is outweighed by the public interest and the need for the disclosure.

(5) If the applicant is a person performing a law enforcement function that:

(i) The person holding the records has been afforded the opportunity to be represented by independent counsel; and

(ii) Any person holding the records which is an entity within Federal, State, or local government has in fact been represented by counsel independent of the applicant.

(e) *Content of order.* Any order authorizing a disclosure or use of patient records under this section must:

(1) Limit disclosure and use to those parts of the patient's record which are essential to fulfill the objective of the order;

(2) Limit disclosure to those law enforcement and prosecutorial officials who are responsible for, or are conducting, the investigation or prosecution, and limit their use of the records to investigation and prosecution of extremely serious crime or suspected crime specified in the application; and

(3) Include such other measures as are necessary to limit disclosure and use to the fulfillment of only that public interest and need found by the court.

[52 FR 21809, June 9, 1987; 52 FR 42061, Nov. 2,1987]

§ 2.66 Procedures and criteria for orders authorizing disclosure and use of records to investigate or prosecute a program or the person holding the records.

(a) *Application.* (1) An order authorizing the disclosure or use of patient records to criminally or administratively investigate or prosecute a program or the person holding the records (or employees or agents of that program or person) may be applied for by any administrative, regulatory, supervisory, investigative, law enforcement, or prosecutorial agency having jurisdiction over the program's or person's activities.

(2) The application may be filed separately or as part of a pending civil or criminal action against a program or the person holding the records (or agents or employees of the program or person) in which it appears that the patient records are needed to provide material evidence. The application must use a fictitious name, such as John Doe, to refer to any patient and may not contain or otherwise disclose any patient identifying information unless the court has ordered the record of the proceeding sealed from public scrutiny or the patient has given a written consent (meeting the requirements of § 2.31 of these regulations) to that disclosure.

(b) *Notice not required.* An application under this section may, in the discretion of the court, be granted without notice. Although no express notice is required to the program, to the person holding the records, or to

any patient whose records are to be disclosed, upon implementation of an order so granted any of the above persons must be afforded an opportunity to seek revocation or amendment of that order, limited to the presentation of evidence on the statutory and regulatory criteria for the issuance of the court order.

(c) *Requirements for order.* An order under this section must be entered in accordance with, and comply with the requirements of, paragraphs (d) and (e) of § 2.64 of these regulations.

(d) *Limitations on disclosure and use of patient identifying information:*

(1) An order entered under this section must require the deletion of patient identifying information from any documents made available to the public.

(2) No information obtained under this section may be used to conduct any investigation or prosecution of a patient, or be used as the basis for an application for an order under § 2.65 of these regulations.

§ 2.67 Orders authorizing the use of undercover agents and informants to criminally investigate employees or agents of a program.

(a) *Application.* A court order authorizing the placement of an undercover agent or informant in a program as an employee or patient may be applied for by any law enforcement or prosecutorial agency which has reason to believe that employees or agents of the program are engaged in criminal misconduct.

(b) *Notice.* The program director must be given adequate notice of the application and an opportunity to appear and be heard (for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order), unless the application asserts a belief that:

(1) The program director is involved in the criminal activities to be investigated by the undercover agent or informant; or

(2) The program director will intentionally or unintentionally disclose the proposed placement of an undercover agent or informant to the employees or agents who are suspected of criminal activities.

(c) *Criteria.* An order under this section may be entered only if the court determines that good cause exists. To make this determination the court must find:

(1) There is reason to believe that an employee or agent of the program is engaged in criminal activity;

(2) Other ways of obtaining evidence of this criminal activity are not available or would not be effective; and

(3) The public interest and need for the placement of an undercover agent or informant in the program outweigh the potential injury to patients of the program, physician-patient relationships and the treatment services.

(d) *Content of order.* An order authorizing the placement of an undercover agent or informant in a program must:

(1) Specifically authorize the placement of an undercover agent or an informant;

(2) Limit the total period of the placement to six months;

(3) Prohibit the undercover agent or informant from disclosing any patient identifying information obtained from the placement except as necessary to criminally investigate or prosecute employees or agents of the program; and

(4) Include any other measures which are appropriate to limit any potential disruption of the program by the placement and any potential for a real or apparent breach of patient confidentiality; for example, sealing from public scrutiny the record of any proceeding for which disclosure of a patient's record has been ordered.

(e) *Limitation on use of information.* No information obtained by an undercover agent or informant placed under this section may be used to criminally investigate or prosecute any patient or as the basis for an application for an order under § 2.65 of these regulations.

APPENDIX

Acronyms
Forms
Blood Alcohol Concentration as a Function of Drinks Consumed and Time Taken to Consume

ACRONYMS

AA	Alcoholics Anonymous
ADES	Alcohol and Drug Evaluation and Screening Specialist
AMH	Addictions and Mental Health Division
ASAP	Alcohol Safety Action Program Projects
BAC	Blood Alcohol Concentration
BUII	Boating Under the Influence of Intoxicants
CPMS	Client Process Monitoring System
DMV	Driver & Motor Vehicle Services
DT's	Delirium Tremens
DUI	Driving Under the Influence
DUII	Driving Under the Influence of Intoxicants
DUIL	Driving Under the Influence of Liquor
DWI	Driving While Intoxicated
DWUI	Driving While Under the Influence
HSRI	Highway Safety Research Institute
OAR	Oregon Administrative Rule
OHA	Oregon Health Authority
OHP	Oregon Health Plan
OMVI	Operating Motor Vehicle While Intoxicated
ORS	Oregon Revised Statutes
OUI	Operating Under the Influence
OWI	Operating While intoxicated
RDL	Restricted Driver License
SAMHSA	Substance Abuse and Mental Health Services Administration
UA	Urinalysis Test

Oregon Health Authority

ADES Monthly Report

Please enter complete information. Incomplete forms may be returned.

Name of ADES: _____ Month of _____ , 20 _____

Agency: _____ County: _____

Address: _____ Phone: _____

_____ Email: _____

NOTE: ADES must submit a report each month, **even if no interviews were done**. Failure to report regularly may jeopardize certification.

NOTE: Individuals who were simultaneously charged with DUII and Marijuana possession must be referred to an approved DUII program.

Date of interview	Name of individual	Date of birth	List one: Oregon driver license number, reference number, customer service number or ID number	SID number	DUII Diversion	DUII Conviction	Marijuana Diversion	MIP — 2nd offense	DUII BAC	Indicate info or tx "I" / "T" No Referral "NR"	TCU/Risk Score	Check RDL	Name of treatment provider (No numbers)	Out–of–state State referred to
1.					☐	☐	☐	☐				☐		
2.					☐	☐	☐	☐				☐		
3.					☐	☐	☐	☐				☐		
4.					☐	☐	☐	☐				☐		
5.					☐	☐	☐	☐				☐		
6.					☐	☐	☐	☐				☐		
7.					☐	☐	☐	☐				☐		
8.					☐	☐	☐	☐				☐		
9.					☐	☐	☐	☐				☐		
10.					☐	☐	☐	☐				☐		
11.					☐	☐	☐	☐				☐		
12.					☐	☐	☐	☐				☐		

OHA 8050 ADES Monthly Report

This form is available online and downloadable in MSWord and Pdf.

Line Item	Action
Name of ADES	Your name
Month of….,20	Place the name of the month with the last two digits of the year
County	County which you are designated by the court A Monthly report is submitted every month for each county you have court designation, each county is a separate report
Agency	Name of the ADES's agency
Phone	Phone number for ADES's agency
Address	Mailing address for ADES's agency
E-mail	ADES's e-mail address
Date of Interview	The day of the interview, such as: 3rd, 10th
Name of individual	Name of the individual being screened and referred
Date of Birth	mm/dd/yyyy of the individual being screened and referred
Oregon driver license number	The number that corresponds with the individual's Oregon driving record NOTE: do not put the Social Security #, docket #, or any other state's license number
SID number	Department of Corrections State Identification (number) available from the court, if individual has been booked, there will be a SID
DUII Diversion	Check this box if the individual has been granted a DUII Diversion Agreement by the court NOTE: this may be revoked by the court at a later date
DUII Conviction	Check this box if individual has been convicted of the DUII
Marijuana Diversion	Check this box if the individual has been charged with less than 2 oz. of Marijuana
MIP 2nd offence	Check this box if the individual has been charged as a Minor in Possession
DUII BAC	The Blood alcohol content (breath or blood) taken at the time of arrest process
Indicate info or tx or no referral for MJ Diversion	Indicate the individual is being referred to a DUII Info program or a DUII Treatment (Rehab) program NR for no referral for Marijuana Diversion
TCU/Risk Score	The score of the screening tool(s)

OHA 8050 ADES Monthly Report, cont.

Line Item	Action
RDL Needed	Check this box if the individual needs to work with a Restricted Driver License program
Name of Treatment Provider	The name of the alcohol and drug program where the ADES has referred the individual, do not use the CPMS numbers
The State Referred to if Out of State	If the individual has been referred to an out of state program, what is the state abbreviation, such as: CA, FL, NE

NOTE:

- Submit one report for each screener, do not group screeners form one agency on one report
- Submit a separate report for each month, this includes the months that you do no screenings
- If you have more than 12 screenings, use a second monthly report, reports with more than 12 clients per page will be returned for correction
- Submit a separate report for each county of designation, every month
- Submit reports by the 10th of the following month, do not accumulate reports
- Failure to report monthly as required can jeopardize renewal of your ADES certification
- Do not use this report to list screenings for assault, domestic violence, resisting arrest, theft, etc. charges which the court may request a screening
- Oregon residents should be referred to DUII Providers in the State of Oregon, not neighboring states

TCU Drug Screen II

Instruction Page

The following questions ask about your drug use (including alcohol) in the past 12 months. Please answer them by marking only one circle for each question. If you do not feel comfortable giving an answer to a particular question, you may skip it and move on to the next question.

Also, alcohol is a drug. Your answers to questions about drug use need to include alcohol use, such as drinking beer.

The example below shows how to mark the circles

\	*Yes*	*No*
1. I like ice cream.	○	●

U FORMS/TCUDS/TCUDS2-V3 (5/06)
© Copyright 2006 TCU Institute of Behavioral Research, Fort Worth, Texas. All rights reserved.

TCU Drug Screen II

Instrucciones

Estas preguntas son sobre su uso de drogas (incluyendo alcohol) durante los últimos 12 meses. Si alguna pregunta le hace sentir incómodo, puede no contestarla y pasar a la próxima pregunta.

El alcohol es una droga. Al responder incluya su uso de alcohol, tal como tomar cerveza, en sus respuestas sobre el uso de drogas.

El ejemplo siguiente le muestra como marcar los círculos.

\	***Sí***	***No***
1. Me gusta el helado.	○	●

TCU FORMS/TCUDS/TCUDS2 SPANISH (5/03)
© Copyright 2003 TCU Institute of Behavioral Research, Fort Worth, Texas. All rights reserved

Scoring for the TCU Drug Screen II

Page 1 of the TCU Drug Screen is scored as follows:

1. Give 1-point to each "yes" response to 1-9 (Questions 4 and 6 are worth one point each if a respondent answers "yes" to any portion).

2. The total score can range from 0 to 9; score values of 3 or greater indicate relatively severe drug-related problems, and correspond approximately to DSM drug dependence diagnosis.

3. Responses to Question 10 indicate which drug (or drugs) the respondent feels is primarily responsible for his or her drug related problems.

The TCU Drug Screen II was developed as part of NIJ Grant 1999-MU-MU-K008, *Assessment of a Drug Screening Instrument*.

The TCU Drug Screen II may be used for personal, educational, research, and/or information purposes. Permission is hereby granted to reproduce and distribute copies of the form for nonprofit educational and nonprofit library purposes, provided that copies are distributed at or below costs and that credit for author, source, and copyright are included on each copy. No material may be copied, downloaded, stored in a retrieval system, or redistributed for any commercial purpose without the express written permission of Texas Christian University.

For more information on the TCU Drug Screen II, please contact:

Institute of Behavioral Research
Texas Christian University
TCU Box 298740
Fort Worth, TX 76129
817-257-7226
817-257-7290 FAX
Email: ibr@tcu.edu
Web site: www.ibr.tcu.edu

OHA 8051i TCU Drug Screen II

Instruction page and Scoring for the TCU Drug Screen II
This form is available online and downloadable in MSWord and Pdf.

The TCU Drug Screen II Instruction page has the instructions in English followed by the instructions in Spanish and is meant for use by the individual needing a referral to a state certified DUII provider. This page can be placed in a sleeve protector or laminated. Do not provide the Scoring Sheet to the individual taking the TCU Drug Screen II.

The Scoring for the TCU Drug Screen II is for use by the ADES and not to be provided to the individual taking the TCU Drug Screen II. This page can be placed in a sleeve protector or laminated. Do not provide the Scoring Sheet to the individual taking the TCU Drug Screen II.

The TCUDS Instructions and Scoring Sheet are meant to be reused. Suggestion: Place in separate sleeve protectors or laminate separately for extended use.

TCU DRUG SCREEN II

During the last 12 months(before being locked up, if applicable):

	Yes	No
1. Did you use larger amounts of drugs or use them for a longer time than you planned or intended?	☐	☐
2. Did you try to cut down on your drug use but were unable to do it?	☐	☐
3. Did you spend a lot of time getting drugs, using them, or recovering from their use?	☐	☐
4. Did you get so high or sick from drugs that it:		
a. kept you from doing work, going to school, or caring for children?	☐	☐
b. caused an accident or put you or others in danger?	☐	☐
5. Did you spend less time at work, school, or with friends so that you could use drugs?	☐	☐
6. Did your drug use cause:		
a. emotional or psychological problems?	☐	☐
b. problems with family, friends, work or police?	☐	☐
c. physical health or medical problems?	☐	☐
7. Did you increase the amount of a drug you were taking so that you could get the same effects as before?	☐	☐
8. Did you ever keep taking a drug to avoid withdrawal symptoms or keep from getting sick?	☐	☐
9. Did you get sick or have withdrawal symptoms when you quit or missed taking a drug?	☐	☐

10. Which drug caused the most serious problem? [CHOOSE ONE]

☐ *None* ☐ *Alcohol* ☐ *Marijuana/Hashish*
☐ *Hallucinogens/LSD/PCP/psychedelics/mushrooms*
☐ *Inhalants* ☐ *Crack/Freebase*
☐ *Heroin and cocaine (mixed together as speedball)*
☐ *Cocaine (by itself)* ☐ *Heroin (by itself)*
☐ *Street Methadone (non-prescription)*
☐ *Other opiates/opium/morphine/demerol* ☐ *Methamphetamines*
☐ *Amphetamines (other uppers)*
☐ *Tranquilizers/barbiturates/sedatives (downers)*

11. How often did you use each type of drug during the last 12 months?

DRUG USE IN LAST 12 MONTHS

	Never	Only a few times	1 – 3 times a month	1 – 5 times a week	About every day
a. Alcohol	☐	☐	☐	☐	☐
b. Marijuana/hashish	☐	☐	☐	☐	☐
c. Hallucinogens/LSD/PCP psychedelics/mushrooms.....	☐	☐	☐	☐	☐
d. Inhalants	☐	☐	☐	☐	☐
e. Crack/freebase	☐	☐	☐	☐	☐
f. Heroin and cocaine (mixed together as speedball)	☐	☐	☐	☐	☐
g. Cocaine (by itself)	☐	☐	☐	☐	☐
h. Heroin (by itself)	☐	☐	☐	☐	☐
i. Street Methadone (non-prescription)	☐	☐	☐	☐	☐
j. Other opiates/opium/morphine/Demerol	☐	☐	☐	☐	☐
k. Methamphetamines	☐	☐	☐	☐	☐
l. Amphetamines (other uppers)	☐	☐	☐	☐	☐
m. Tranquilizers/barbiturates/sdatives downers)	☐	☐	☐	☐	☐
n. Other: *(specify)* _____	☐	☐	☐	☐	☐

12. During the last 12 months, how often did you inject drugs with a needle?

☐ *Never* ☐ *Only a few times* ☐ *1-3 times per month*
☐ *1-5 times per week* ☐ *Daily*

13. How serious do you think your drug problems are?

☐ *Not at all* ☐ *Slightly* ☐ *Moderately* ☐ *Considerably* ☐ *Extremely*

14. How many times before now have you ever been in a drug treatment program?
[DO NOT INCLUDE AA/NA/CA MEETINGS]

☐ *Never* ☐ *1 time* ☐ *2 times* ☐ *3 times* ☐ *4 or more times*

15. How important is it for you to get drug treatment now?

☐ *Not at all* ☐ *Slightly* ☐ *Moderately* ☐ *Considerably* ☐ *Extremely*

Texas Christian University Drug Screen II - English

This form is available online and downloadable in MSWord and Pdf. Have the individual to be screened place a check mark in the appropriate square for each question. This can be completed online by the individual.

Texas Christian University Drug Screen II - Spanish

This form is available online and downloadable in Pdf. Have the individual to be screened place a check mark in the appropriate square for each question. This can be completed online by the individual.

ADDICTIONS AND MENTAL HEALTH DIVISION
Addictions Policy and Program Development

Oregon Health Authority

ADES Screening and Referral Report

Name: Date of birth:

Street address: Home phone:

Mailing address: *(if different than above)* Cell phone:

Oregon driver license number: *(AKA: reference number, customer service number or identification number)*

SID number: Law enforcement agency and report number:

Court and case number: Incident date: Adjudication date:

Petition term. date:

Adjudication:
- ☐ DUII diversion
- ☐ DUII conviction
- ☐ Marijuana diversion

Referral criteria:

BAC: _____ ☐ Breath ☐ Blood ☐ Refused TCU/risk score: _____

Indicators:

- ☐ BAC over .15
- ☐ Self-admission of problems involving alcohol and/or other drugs
- ☐ Previous alcohol and/or other drug arrest
- ☐ Prior diagnosis or treatment for alcohol and/or other drugs
- ☐ Personality changes
- ☐ Passed out on more than one occasion
- ☐ Regular pattern of use
- ☐ Concern of others regarding alcohol and/or other drug use
- ☐ Symptoms of withdrawal
- ☐ Blackout on more than one occasion
- ☐ Unsuccessful attempts to quit or cut back
- ☐ Alcohol and/or other drug related problems
  - ☐ Health, including cirrhosis or fatty liver ☐ Psychological ☐ Social
  - ☐ Employment/school ☐ Family

DUII diversion or conviction:

- Anyone exhibiting any of the indicators listed above must be referred to a DUII treatment program for an assessment and treatment.
- Anyone whose screening reveals none of the indicators listed above should be referred to a DUII information program.

Marijuana diversion:

- Anyone exhibiting any of the indicators listed above must be referred to a treatment program for an assessment and consideration for treatment.
- If no indicators are found, then the client should be reported to the court as screening completed – no referral made.

Individual's name:_____

Barriers to successful treatment: *(if checked, provide details in screening summary)*

☐ Not fluent in English, primary language: _____

☐ Housing instability ☐ Employment instability ☐ Income instability

☐ Transportation issues ☐ Health issues ☐ Mental health issues

☐ Recent hospitalizations ☐ Lack of family support

Other pending court matters: _____

Prior/pending substance abuse related arrests		*Prior/pending substance abuse related treatment*	
Year:	**Charge:**	**Type:**	**Year:**

Screening summary, additional recommendations and description of any special needs:

DUII referral category: ☐ Treatment program ☐ Information program ☐ Restricted driver license

Marijuana diversion referral category: ☐ Treatment program ☐ No referral necessary

Initial referral:	**Re-referral:**
Agency:	Agency:
Street address:	Street address:
City/state/ZIP code:	City/state/ZIP code:
Phone number:	Phone number:
Contact person:	Contact person:

Printed name of ADES:		Signature of ADES:	
Agency:			
Address:			
Phone:	Email:	Date of interview:	Date of referral:

Individual's name:_____

OHA 8052 ADES Screening and Referral Report

This form is available online and downloadable in MSWord and Pdf.

Line Item	Action
Name	Name of the individual being screened and referred
Date of birth	mm/dd/yyyy of the individual being screened and referred
Street address	Site address of the individual being screened and referred
Home phone	Home phone number of the individual being screened and referred
Mailing address	Address where mail is delivered for the individual being screened and referred
Cell phone	Cell phone number of the individual being screened
Oregon driver license number	The number that corresponds with the individual's Oregon driving record NOTE: do not put the Social Security #, docket #, or any other state's license number
SID number	Department of Corrections State Identification (number) available from the court, if individual has been booked, there will be a SID
Law enforcement agency and report number	Name of the arresting law enforcement agency, such as: Polk County Sheriff's Office The agency's corresponding report number, such as: 11-998523
Court and case number	Name of the court and the case (docket) number
Incident date	mm/dd/yyyy of the date arrested
Adjudication date	mm/dd/yyyy of the court's judgment
Adjudication	The court's decision regarding the arrest DUII diversion (1 year court agreement) DUII conviction (court ordered DUII) Marijuana diversion (Possession of less than 2 oz. of marijuana)
Petition term. date	Diversion termination date
Referral criteria	Fill-in Blood Alcohol Content Breath or Blood: method to determine BAC Refused: individual refused to be tested Fill-in TCU (Texas Christian University)/Risk Score

OHA 8052 ADES Screening and Referral Report, cont.

Line Item	Action
Indicators	Check all indicators that apply to the individual
Barriers to successful treatment	List primary language if not fluent in English Check all barriers that apply to the individual List any other pending court related issues
Prior/pending substance abuse related arrests	List the year of the arrest and the charge
Prior/pending substance abuse related treatment	List the type of substance abuse treatment and the year of the treatment episode
Screening summary, additional recommendations and description of any special needs:	Provide information you would like the treatment provider to have knowledge of
DUII referral category	Check if recommending treatment and education Check if the individual will be applying for a restricted driver license
Marijuana diversion referral category	Check if recommending treatment or no referral necessary
Initial referral	Provide the name of the agency with address, phone number and contact individual of agency the individual is to contact for alcohol and drug services
Re-referral	If the individual needs to be to referred to another program, provide the name of the agency with address, phone number and contact individual of agency the individual is to contact for alcohol and drug services

OHA 8052 ADES Screening and Referral Report, cont.

Line Item	Action
Printed name of ADES	Print your name
Signature of ADES	Sign your name
Agency	Name of your agency
Address	Address of your agency
Phone	Phone number to contact you
Email	Your e-mail address
Date of interview	Date the screening occurred
Date of referral	Date the referral was made to treatment provider
Individual's name	This is located in the footer, place the name of the individual in the footer on page 1 and 2 in case the pages are separated

Alcohol and Drug Treatment Status Check

(Attach signed release of information form.)

Date: _____

To: *(Treatment agency)*

_____
_____
_____
_____

From: *(ADES)*

_____
_____
_____
_____

RE: *(Individual)*

_____
_____
_____
_____

The individual above has been ordered to have a DUII Evaluation and Screening done in my office. The individual reports that he/she has completed or is currently participating in your alcohol/drug treatment program.

Please complete the form below and return it to me within seven business days.

Thank you for your assistance.

To be completed by the treatment agency

The individual above:

- ☐ has made an appointment, but is not currently in treatment
- ☐ is currently in treatment
- ☐ is currently in aftercare
- ☐ has completed a DUII information program
- ☐ has completed treatment and needs no further treatment or aftercare

other: _____

Date enrolled: _____ Date completed: _____

Treatment summary:

Return to evaluator indicated above.

Counselor: *(please print)* _____ Phone: _____

Signature: _____ Date: _____

OHA 8053 Alcohol and Drug Treatment Status Check

This form is available online and downloadable in MSWord and Pdf.
This form is available only online.

Line Item	Action
Date	Date of inquiry
To	List the name of the treatment program, the name of the contact individual, the agency address, and agency phone
From	List your name, the name of your agency, your agency address, and your agency phone
Individual	List the name of the individual screened, the individual's address, and the individual's phone
To be completed by the treatment agency	The treatment provider will check the status of the individual
Date enrolled	The treatment provider will list the enrollment date in the program
Date completed	The treatment provider will list the completion date in the program
Treatment summary	The treatment provider will include any pertinent information for the ADES regarding the individual's status in the treatment program
Counselor	The printed name of the counselor who is signing the form
Phone	The phone number for the counselor
Signature	The signed name of the counselor filling out the form
Date	The date form OHA 8053 was filled out

ADES Screening Cover Sheet

Personal Information

Name: Date of birth: Gender: ☐ M ☐ F

Street address:

Mailing address:(if different)

Phone number: Cell phone number: Email address:

Emergency contact name: Phone number: Cell phone number:

Collateral information

1. Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

2. Parental status: Number of dependents living with individual: _____

Number of dependents not living with individual: _____

3. Living arrangement with: ☐ Alone ☐ With roommate(s) ☐ Significant other ☐ With parents

4. Primary Language: ☐ English ☐ Spanish ☐ Russian ☐ Vietnamese

☐ Other: _____

5. Interpreter requested: ☐ Yes ☐ No

6. Education: High School diploma/GED: ☐ Yes ☐ No

Highest year in school completed: Vocational school: ☐ Yes ☐ No

College courses taken: ☐ Yes ☐ No AA/AS degree: ☐ Yes ☐ No

BA/BS: ☐ Yes ☐ No Graduate degree: ☐ Yes ☐ No

Currently in school: ☐ Yes ☐ No Area of study: _____

7. Employment status/history Currently employed: ☐ Yes ☐ No

Number of hours: _____ Type of work: _____

History of frequent job changes: ☐ Yes ☐ No

Justification for phone interview: _____

OHA 8056 ADES Screening Coversheet

This form is available online and downloadable in MSWord and Pdf.
This form is available only online.

Line Item	Action to be taken
Name	Name of the individual being screened and referred
Date of Birth	mm/dd/yyyy of the individual being screened and referred
Gender	Check “M” for male and “F” for female
Street address	Address of the individual being screened and referred
Mailing address	Address where the individual being screened and referred receives mail
Phone number	House phone number of the individual being screened and referred
Cell phone number	Cell phone number of the individual being screened and referred
Email address	Email address of the individual being screened and referred
Emergency contact name	A person who would be available to help the individual being screened and referred in an emergency
Phone number	Phone number of the person who would be available to help the individual being screened and referred
Cell phone number	Cell phone number of the person who would be available to help the individual being screened and referred
Marital status	Check the most appropriate box for the individual being screened and referred
Parental status	Provide the most appropriate quantity of dependents for the individual being screened and referred
Living arrangement with	Check the most appropriate box for the individual being screened and referred
Primary Language	Check the most appropriate box for the individual being screened and referred
Interpreter requested	Check if an interpreter is needed for the individual being screened and referred
Education	Check the most appropriate boxes for the individual being screened and referred
Area of study	What is the major course study for the individual being screened and referred

OHA 8056 ADES Screening Coversheet, cont.

Line Item	Action
Employment status/history	Check the most appropriate box for the individual being screened and referred Indicate the number of hours worked per week and the type of work performed
History of frequent job changes	Check the most appropriate box for the individual being screened and referred
Justification for phone interview	Explain why the individual being screened and referred is unable to meet face to face for the evaluation and screening

OFFICE OF MENTAL HEALTH AND ADDICTION SERVICES

DUII Treatment Completion Certificate

124087

INSTRUCTIONS:

DUII TREATMENT PROVIDER -

1. When you have notified the court evaluator that the client has completed DUII treatment requirements, **including payment of fees,** please fill out this Completion Certificate. Leave no blanks. The Certificate must be signed by the Program Director or designee.
2. **Mail the original (WHITE copy) of the form to:** Driver and Motor Vehicle Services (DMV), Driver Suspension Unit, 1905 Lana Ave. NE, Salem OR 97314.
3. Give or mail the CANARY and PINK copies to the client.
4. Retain the GOLDENROD copy for your client file.

CLIENT - To have your driving privilege reinstated, you must do the following:

1. Check the form and make sure that it is complete. Take it back to the DUII Treatment Provider if there are any blanks. Do not write on this form.
2. Take the CANARY copy to a DMV office.
3. Keep the PINK copy for your personal files.

Name (print last, first, middle)	
ODL / ID / CUSTOMER NUMBER	**DATE OF BIRTH (month, day, year)**
DUII ARREST DATE (month, day, year)	CONVICTION DATE (month, day, year)

COURT TYPE: ☐ DISTRICT ☐ MUNICIPAL ☐ CIRCUIT ☐ JUSTICE ☐ JUVENILE

COURT LOCATION (city and county)

TREATMENT PROGRAM

DATE TREATMENT STARTED (month, day, year)	DATE TREATMENT COMPLETED (month, day, year)
NAME OF PROGRAM	
ADDRESS (building number and street)	
CITY, STATE, ZIP	
PRINTED NAME OF PROGRAM DIRECTOR OR DESIGNEE	PHONE NUMBER
SIGNATURE X	TITLE

735-6821 (2/04)

SEND ONLY THIS COPY TO DMV

735-6821 DUII Treatment Completion Certificate

Form 735-6821 is a four-part carbonless controlled document and is not available online or downloadable. The unsigned form 735-6821 is not faxed. Form 735-6821 is only issued for an individual convicted of a DUII in the State of Oregon. Form 735-6821 is not issued for individuals with Diversion Agreements or with DUIIs in other states. If the Diversion Agreement is revoked, the individual will be convicted and will need form 735-6821. The ADES fills in most of the information except the printed name of program director or designee, signature, and title of person signing form 735-6821 before mailing. A copy is made of form 735-6821 and the copy is placed in the individual's file before form 735-6821 is mailed to the out of state treatment provider.

Line Item	Action to be taken
Name	Name of the individual convicted of a DUII in the State of Oregon.
Oregon driver license number	The number that corresponds with the individual's Oregon driving record NOTE: do not put the Social Security #, docket #, or any other state's license number
Date of Birth	mm/dd/yyyy of the individual convicted of a DUII in the State of Oregon
DUII Arrest Date	mm/dd/yyyy date of arrest
Conviction Date	mm/dd/yyyy date of conviction
Court Type	Check the appropriate court
Court Location	The City and County where the arrest occurred
Date Treatment Started	mm/dd/yyyy date of enroll in alcohol and drug program
Date Treatment Completed	mm/dd/yyyy date of completion in alcohol and drug program Completion: see requirements
Name of Program	Name of the out of state alcohol and drug program
Address	Site address of out of state alcohol and drug program
Cit, State, Zip	City, State and zip of out of state alcohol and drug program
Printed Name of Program Director or Designee	The person who is signing form 735-6821 will print their name
Phone Number	Phone number of the out of state alcohol and drug program

735-6821 DUII Treatment Completion Certificate, cont.

Line Item	Action to be taken
Signature	Signature of the printed name
Title	The job title of the person who is signing form 735-6821
Completion requirements	
DUII Rehab (alcohol and drug treatment)	Has met the alcohol and drug treatment recommendations and is in need of no further alcohol and drug treatment or aftercare Has met the financial obligations to the alcohol and drug program Individual demonstrates a minimum of 90 days of abstinence prior to service end date Documentation will be by at least one random Urinalysis tests per month showing 90-days of abstinence This is not to say that 90 days is all that is required, only that there must be a 90-day demonstration of continuous abstinence during the last 90 days of the program If a urinalysis sample is positive, the 90-days will begin with the next clean UA The individual may also be placed at a higher level of care with further requirements to obtain the DUII Treatment Completion Certificate.

735-6821 DUII Treatment Completion Certificate, cont.

Line Item	Action to be taken
DUII Info (alcohol and drug education)	The alcohol and drug education program will be of not less than 12 hours of alcohol and drug education with weekly contact of not less than 4 consecutive weeks and include at least one random UA Required Content/Topics of Education Curriculum: Victim's panel A pre-and post-test that has been approved by the Division History, use, and definition of alcohol Alcohol as a drug Physiological effects of alcohol Other drugs – legal and illegal – and their effects on driving when used separately and/or in combination with alcohol Psychological and sociological consequences of abuse of alcohol or drugs to include the effect on families Blood alcohol concentration and effects on driving performance Court penalties Motor Vehicles Division laws and penalties Alcoholism as a problem and a disease (one hour minimum); and Alternatives to drinking and driving "A minimum of one urinalysis sample shall be observed and collected during the first two weeks of a client's DUII information program." If the urinalysis sample is positive, the individual must be referred to a DUII rehab program for assessment and further treatment

Blood Alcohol Concentration as a Function of Drinks Consumed and Time Taken to Consume

Female 100 lbs.

HOURS

NUMBER OF DRINKS	0	1	2	3	4	5	6	7	8	9	10
1	.045	.029	.013	.000	.000	.000	.000	.000	.000	.000	.000
2	.090	.074	.058	.042	.026	.010	.000	.000	.000	.000	.000
3	.135	.119	.103	.087	.071	.055	.039	.023	.007	.000	.000
4	.180	.164	.148	.132	.116	.100	.084	.068	.052	.036	.020
5	.225	.209	.193	.177	.161	.145	.129	.113	.097	.081	.065
6	.270	.254	.238	.222	.206	.190	.174	.158	.142	.126	.110
7	.315	.299	.283	.267	.251	.235	.219	.203	.187	.171	.155
8	.360	.344	.328	.312	.296	.280	.264	.248	.232	.216	.200
9	.405	.389	.373	.357	.341	.325	.309	.293	.277	.261	.245
10	.450	.434	.418	.402	.386	.370	.354	.338	.322	.306	.290
11	.495	.479	.463	.447	.431	.415	.399	.383	.367	.351	.335
12	.540	.524	.508	.492	.476	.460	.444	.428	.412	.396	.380
13	.585	.569	.553	.537	.521	.505	.489	.473	.457	.441	.425
14	.630	.614	.598	.582	.566	.550	.534	.518	.502	.486	.470
15	.675	.659	.643	.627	.611	.595	.579	.563	.547	.531	.515
16	.720	.704	.688	.672	.656	.640	.624	.608	.592	.576	.560
17	.765	.749	.733	.717	.701	.685	.669	.653	.637	.621	.605
18	.810	.794	.778	.762	.746	.730	.714	.698	.682	.666	.650
19	.855	.839	.823	.807	.791	.775	.759	.743	.727	.711	.695
20	.900	.884	.868	.852	.836	.820	.804	.788	.772	.756	.740
21	.945	.929	.913	.897	.881	.865	.849	.833	.817	.801	.785
22	.990	.974	.958	.942	.926	.910	.894	.878	.862	.846	.830
23	.*35	.*19	.*03	.987	.971	.955	.939	.923	.907	.891	.875
24	.*80	.*64	.*48	.*32	.*16	.*00	.984	.968	.852	.936	.920
25	.*25	.*09	.*93	.*77	.*61	.*45	.*29	.*13	.997	.981	.965

Blood Alcohol Concentration as a Function of Drinks Consumed and Time Taken to Consume

Female 110 lbs.

HOURS

NUMBER OF DRINKS	0	1	2	3	4	5	6	7	8	9	10
1	.040	.024	.008	.000	.000	.000	.000	.000	.000	.000	.000
2	.080	.064	.048	.032	.016	.000	.000	.000	.000	.000	.000
3	.120	.104	.088	.072	.056	.040	.024	.008	.000	.000	.000
4	.160	.144	.128	.112	.096	.080	.064	.048	.032	.016	.000
5	.200	.184	.168	.152	.136	.120	.104	.088	.072	.056	.040
6	.240	.224	.208	.192	.176	.160	.144	.128	.112	.096	.080
7	.280	.264	.248	.232	.216	.200	.184	.168	.152	.136	.120
8	.320	.304	.288	.272	.256	.240	.224	.208	.192	.176	.160
9	.360	.344	.328	.312	.296	.280	.264	.249	.232	.216	.200
10	.400	.384	.368	.352	.336	.320	.304	.288	.272	.256	.240
11	.440	.424	.408	.392	.376	.360	.344	.328	.312	.296	.280
12	.480	.464	.448	.432	.416	.400	.384	.368	.352	.336	.320
13	.520	.504	.488	.472	.456	.440	.424	.408	.392	.376	.360
14	.560	.544	.528	.512	.496	.480	.464	.448	.432	.416	.400
15	.600	.584	.568	.552	.536	.520	.504	.488	.472	.456	.440
16	.640	.624	.608	.592	.576	.560	.544	.528	.512	.496	.480
17	.680	.664	.648	.632	.616	.600	.584	.568	.552	.536	.520
18	.720	.704	.688	.672	.656	.640	.624	.608	.592	.576	.560
19	.760	.744	.728	.712	.696	.680	.664	.648	.632	.616	.600
20	.800	.784	.768	.752	.736	.720	.704	.688	.672	.656	.640
21	.840	.824	.808	.792	.776	.760	.744	.728	.712	.696	.680
22	.880	.864	.848	.832	.816	.800	.784	.768	.752	.736	.720
23	.920	.904	.888	.872	.856	.840	.824	.808	.792	.776	.760
24	.960	.944	.928	.912	.896	.880	.864	.848	.832	.816	.800
25	.*00	.984	.968	.952	.936	.920	.904	.888	.872	.856	.840

Blood Alcohol Concentration as a Function of Drinks Consumed and Time Taken to Consume

Female 120 lbs.

HOURS

NUMBER OF DRINKS	0	1	2	3	4	5	6	7	8	9	10
1	.037	.021	.005	.000	.000	.000	.000	.000	.000	.000	.000
2	.074	.058	.042	.026	.010	.000	.000	.000	.000	.000	.000
3	.111	.095	.079	.063	.047	.031	.015	.000	.000	.000	.000
4	.148	.132	.116	.100	.084	.068	.052	.036	.020	.004	.000
5	.185	.169	.153	.137	.121	.105	.089	.073	.057	.041	.025
6	.222	.206	.190	.174	.158	.142	.126	.110	.094	.078	.062
7	.259	.243	.227	.211	.195	.179	.163	.147	.131	.115	.099
8	.296	.280	264	.248	.232	.216	.200	.184	.168	.152	.136
9	.333	.317	.301	.285	.269	.253	.237	.221	.205	.189	.173
10	.370	.354	.338	.322	.306	.290	.274	.258	.242	.226	.210
11	.407	.391	.375	.359	.343	.327	.311	.295	.279	.263	.247
12	.444	.428	.412	.396	.380	.364	.348	.332	.316	.300	.284
13	.481	.465	.449	.433	.417	.401	.385	.369	.353	.337	.321
14	.518	.502	.486	.470	.454	.438	.422	.406	.390	.374	.358
15	.555	.539	.523	.507	.491	.475	.459	.443	.427	.411	.395
16	.592	.576	.560	.544	.528	.512	.495	.480	.464	.448	.432
17	.629	.613	.597	.581	.565	.549	.533	.517	.501	.485	.469
18	.666	.650	.634	.618	.602	.586	.570	.554	.538	.522	.506
19	.703	.687	.671	.655	.639	.623	.607	.591	.575	.559	.543
20	.740	.724	.708	.692	.676	.660	.644	.628	.612	.596	.580
21	.777	.761	.745	.729	.713	.697	.681	.665	.649	.633	.617
22	.814	.798	.782	.766	.750	.734	.718	.702	.686	.670	.654
23	.851	.835	.819	.803	.787	.771	.755	.739	.723	.707	.691
24	.889	.872	.856	.840	.824	.808	.792	.776	.760	.744	.728
25	.925	.809	.893	.877	.861	.845	.829	.813	.797	.781	.765

Blood Alcohol Concentration as a Function of Drinks Consumed and Time Taken to Consume

Female 130 lbs.

HOURS

NUMBER OF DRINKS	0	1	2	3	4	5	6	7	8	9	10
1	.034	.018	.002	.000	.000	.000	.000	.000	.000	.000	.000
2	.068	.052	.036	.020	.004	.000	.000	.000	.000	.000	.000
3	.102	.086	.070	.054	.038	.022	.006	.000	.000	.000	.000
4	.136	.120	.104	.088	.072	.056	.040	.024	.008	.000	.000
5	.170	.154	.138	.122	.106	.090	.074	.058	.042	.026	.010
6	.204	.188	.172	.156	.140	.124	.108	.092	.076	.060	.044
7	.238	.222	.206	.190	.174	.158	.142	.126	.110	.094	.078
8	.272	.256	.240	.224	.208	.192	.176	.160	.144	.128	.112
9	.306	.290	.274	.258	.242	.226	.210	.194	.178	.162	.146
10	.340	.324	.308	.292	.276	.260	.244	.229	.212	.196	.182
11	.374	.358	.342	.326	.310	.294	.278	.262	.246	.230	.214
12	.408	.392	.376	.360	.344	.328	.312	.296	.280	.264	.248
13	.442	.426	.410	.394	.378	.362	.346	.330	.314	.298	.282
14	.476	.460	.444	.428	.412	.396	.380	.364	.348	.332	.316
15	.510	.494	.478	.462	.446	.430	.414	.398	.382	.366	.350
16	.544	.528	.512	.496	.480	.464	.448	.432	.416	.400	.384
17	.578	.562	.546	.530	.514	.498	.432	.466	.450	.434	.418
18	.612	.596	.580	.564	.548	.532	.516	.500	.484	.468	.452
19	.646	.630	.614	.598	.582	.566	.550	.534	.518	.502	.486
20	.680	.664	.648	.632	.615	.600	.584	.568	.552	.536	.520
21	.714	.698	.682	.666	.650	.634	.612	.602	.586	.570	.554
22	.748	.732	.716	.700	.684	.668	.652	.636	.620	.604	.598
23	.782	.766	.750	.734	.718	.702	.686	.670	.654	.638	.622
24	.816	.800	.784	.768	.752	.736	.720	.704	.688	.672	.565
25	.850	.834	.818	.802	.786	.770	.754	.738	.722	.706	.690

Blood Alcohol Concentration as a Function of Drinks Consumed and Time Taken to Consume

Female 140 lbs.

HOURS

NUMBER OF DRINKS	0	1	2	3	4	5	6	7	8	9	10
1	.032	.016	.000	.000	.000	.000	.000	.000	.000	.000	.000
2	.064	.048	.032	.016	.000	.000	.000	.000	.000	.000	.000
3	.096	.080	.064	.048	.032	.016	.000	.000	.000	.000	.000
4	.128	.112	.096	.080	.064	.048	.032	.016	.000	.000	.000
5	.160	.144	.128	.112	.096	.080	.064	.048	.032	.016	.000
6	.192	.176	.160	.144	.128	.112	.096	.080	.064	.048	.032
7	.224	.208	.192	.176	.160	.144	.128	.112	.096	.080	.064
8	.256	.240	.224	.208	.192	.176	.160	.144	.128	.112	.096
9	.288	.272	.256	.240	.224	.208	.192	.176	.160	.144	.128
10	.320	.304	.288	.272	.256	.240	.224	.208	.192	.176	.160
11	.352	.336	.320	.304	.288	.272	.256	.240	.224	.208	.192
12	.384	.368	.352	.336	.320	.304	.288	.272	.256	.240	.224
13	.416	.400	.384	.368	.352	.336	.320	.304	.288	.272	.256
14	.448	.432	.416	.400	.384	.368	.352	.336	.320	.304	.288
15	.480	.464	.448	.432	.416	.400	.384	.368	.352	.336	.320
16	.512	.496	.480	.464	.448	.432	.416	.400	.384	.368	.352
17	.544	.528	.512	.496	.480	.464	.443	.432	.416	.400	.384
18	.576	.560	.544	.528	.512	.496	.480	.464	.448	.432	.416
19	.608	.592	.576	.560	.544	.528	.512	.496	.480	.464	.448
20	.640	.624	.608	.592	.576	.560	.544	.528	.512	.496	.480
21	.672	.656	.640	.624	.608	.592	.576	.560	.544	.528	.512
22	.704	.688	.672	.656	.640	.624	.608	.592	.576	.560	.544
23	.736	.720	.704	.688	.672	.656	.640	.624	.609	.592	.576
24	.768	.752	.736	.720	.704	.688	.672	.656	.640	.624	.608
25	.800	.784	.768	.752	.736	.720	.704	.688	.672	.656	.640

Blood Alcohol Concentration as a Function of Drinks Consumed and Time Taken to Consume

Female 150 lbs.

HOURS

NUMBER OF DRINKS	0	1	2	3	4	5	6	7	8	9	10
1	.030	.014	.000	.000	.000	.000	.000	.000	.000	.000	.000
2	.060	.044	.028	.012	.000	.000	.000	.000	.000	.000	.000
3	.090	.074	.058	.042	.026	.010	.000	.000	.000	.000	.000
4	.120	.104	.088	.072	.056	.040	.024	.008	.000	.000	.000
5	.150	.134	.118	.102	.086	.070	.054	.038	.022	.006	.000
6	.180	.164	.148	.132	.116	.100	.084	.068	.052	.036	.020
7	.210	.194	.178	.162	.146	.130	.114	.098	.082	.066	.050
8	.240	.224	.208	.192	.176	.160	.144	.128	.112	.096	.080
9	.270	.254	.238	.222	.206	.190	.174	.153	.142	.126	.110
10	.300	.284	.268	.252	.236	.220	.204	.188	.172	.156	.140
11	.330	.314	.298	.282	.266	.250	.234	.218	.202	.186	.170
12	.360	.344	.328	.312	.296	.280	.264	.248	.232	.216	.200
13	.390	.374	.358	.342	.326	.310	.294	.278	.262	.246	.230
14	.420	.404	.388	.372	.356	.340	.324	.308	.292	.276	.260
15	.450	.434	.418	.402	.386	.370	.354	.338	.322	.306	.290
16	.480	.464	.448	.432	.416	.400	.394	.368	.352	.336	.320
17	.510	.494	.478	.462	.446	.430	.414	.398	.382	.366	.350
18	.540	.324	.508	.492	.476	.460	.444	.428	.412	.396	.380
19	.570	.554	.538	.522	.506	.490	.474	.458	.442	.426	.410
20	.600	.584	.568	.552	.536	.520	.504	.488	.472	.456	.440
21	.630	.614	.598	.582	.566	.550	.534	.518	.502	.486	.470
22	.660	.644	.628	.612	.596	.580	.564	.548	.532	.516	.500
23	.690	.674	.658	.642	.626	.610	.594	.578	.562	.546	.530
24	.720	.704	.688	.672	.656	.640	.624	.608	.592	.576	.560
25	.750	.734	.718	.702	.686	.670	.664	.638	.622	.606	.590

Blood Alcohol Concentration as a Function of Drinks Consumed and Time Taken to Consume

Female 160 lbs.

HOURS

NUMBER OF DRINKS	0	1	2	3	4	5	6	7	8	9	10
1	.028	.012	.000	.000	.000	.000	.000	.000	.000	.000	.000
2	.056	.040	.024	.008	.000	.000	.000	.000	.000	.000	.000
3	.084	.068	.052	.036	.020	.004	.000	.000	.000	.000	.000
4	.112	.096	.080	.064	.048	.032	.016	.000	.000	.000	.000
5	.140	.124	.108	.092	.076	.060	.044	.028	.012	.000	.000
6	.168	.152	.136	.120	.104	.088	.072	.056	.040	.024	.008
7	.196	.180	.164	.148	.132	.116	.100	.084	.068	.052	.036
8	.224	.208	.192	.176	.160	.144	.128	.112	.096	.080	.064
9	.252	.236	.220	.204	.188	.172	.156	.140	.124	.108	.092
10	.280	.264	.248	.232	.216	.200	.184	.168	.152	.136	.120
11	.308	.292	.276	.260	.244	.228	.212	.196	.180	.164	.148
12	.336	.320	.304	.288	.272	.256	.240	.224	.208	.192	.176
13	.364	.348	.332	.316	.300	.284	.268	.252	.236	.220	.204
14	.392	.376	.360	.344	.328	.312	.296	.280	.264	.248	.232
15	.420	.404	.388	.372	.356	.340	.324	.308	.292	.276	.260
16	.448	.432	.416	.400	.384	.368	.352	.336	.320	.304	.288
17	.476	.460	.444	.428	.412	.396	.380	.364	.348	.332	.316
18	.504	.488	.472	.456	.440	.424	.408	.392	.376	.360	.344
19	.532	.516	.500	.484	.469	.452	.436	.420	.404	.388	.372
20	.560	.544	.528	.512	.496	.480	.464	.448	.432	.416	.400
21	.588	.572	.556	.540	.524	.508	.492	.476	.460	.444	.428
22	.616	.600	.584	.568	.552	.536	.520	.504	.488	.472	.456
23	.644	.628	.612	.596	.580	.564	.548	.532	.516	.500	.484
24	.672	.656	.640	.624	.608	.592	.576	.560	.544	.528	.512
25	.700	.684	.668	.652	.636	.620	.604	.588	.572	.556	.540

Blood Alcohol Concentration as a Function of Drinks Consumed and Time Taken to Consume

Female 170 lbs.

HOURS

NUMBER OF DRINKS	0	1	2	3	4	5	6	7	8	9	10
1	.026	.010	.000	.000	.000	.000	.000	.000	.000	.000	.000
2	.052	.036	.020	.004	.000	.000	.000	.000	.000	.000	.000
3	.078	.062	.046	.030	.014	.000	.000	.000	.000	.000	.000
4	.104	.088	.072	.056	.040	.024	.008	.000	.000	.000	.000
5	.130	.114	.098	.082	.066	.050	.034	.018	.002	.000	.000
6	.156	.140	.124	.108	.092	.076	.060	.044	.028	.012	.000
7	.182	.166	.150	.134	.118	.102	.086	.070	.054	.038	.022
8	.208	.192	.176	.160	.144	.128	.112	.096	.080	.064	.048
9	.234	.218	.202	.186	.170	.154	.138	.122	.106	.090	.074
10	.260	.244	.228	.212	.196	.180	.164	.148	.132	.116	.100
11	.286	.270	.254	.239	.222	.206	.190	.174	.158	.142	.126
12	.312	.296	.280	.264	.248	.232	.216	.200	.184	.168	.152
13	.338	.322	.306	.290	.274	.258	.242	.226	.210	.194	.178
14	.364	.348	.332	.316	.300	.284	.268	.252	.236	.220	.204
15	.390	.374	.358	.342	.326	.310	.294	.278	.268	.246	.230
16	.416	.400	.384	.368	.352	.336	.320	.304	.288	.272	.256
17	.442	.426	.410	.394	.378	.362	.346	.330	.314	.298	.282
18	.468	.452	.436	.420	.404	.388	.372	.356	.340	.324	.308
19	.494	.478	.462	.446	.430	.414	.398	.382	.366	.350	.334
20	.520	.504	.488	.472	.456	.440	.424	.408	.392	.376	.360
21	.546	.530	.514	.498	.482	.466	.450	.434	.418	.402	.386
22	.572	.556	.540	.524	.508	.492	.476	.460	.444	.428	.412
23	.598	.582	.566	.550	.534	.518	.502	.486	.470	.454	.438
24	.624	.608	.592	.576	.560	.544	.528	.512	.496	.480	.464
25	.650	.634	.618	.602	.586	.570	.554	.538	.522	.506	.490

Blood Alcohol Concentration as a Function of Drinks Consumed and Time Taken to Consume

Female 180 lbs.

HOURS

NUMBER OF DRINKS	0	1	2	3	4	5	6	7	8	9	10
1	.025	.009	.000	.000	.000	.000	.000	.000	.000	.000	.000
2	.050	.034	.018	.002	.000	.000	.000	.000	.000	.000	.000
3	.075	.059	.043	.027	.011	.000	.000	.000	.000	.000	.000
4	.100	.084	.068	.052	.036	.020	.004	.000	.000	.000	.000
5	.125	.109	.093	.077	.061	.045	.029	.013	.000	.000	.000
6	.150	.134	.118	.102	.086	.070	.054	.038	.022	.006	.000
7	.175	.159	.143	.127	.111	.095	.079	.063	.047	.031	.015
8	.200	.184	.168	.152	.136	.120	.104	.088	.072	.056	.040
9	.225	.209	.193	.177	.161	.145	.129	.113	.097	.081	.065
10	.250	.234	.218	.202	.186	.170	.154	.138	.122	.106	.090
11	.275	.259	.243	.227	.211	.195	.179	.163	.147	.131	.115
12	.300	.284	.268	.252	.236	.220	.204	.188	.172	.156	.140
13	.325	.309	.293	.277	.261	.245	.229	.213	.197	.181	.165
14	.350	.334	.318	.302	.386	.270	.254	.238	.222	.206	.190
15	.375	.359	.343	.327	.311	.295	.279	.263	.247	.231	.215
16	.400	.384	.368	.352	.336	.320	.304	.288	.272	.256	.240
17	.425	.409	.393	.377	.361	.345	.329	.313	.297	.281	.265
18	.450	.434	.418	.402	.386	.370	.354	.338	.322	.306	.290
19	.475	.459	.443	.427	.411	.395	.379	.363	.347	.331	.315
20	.500	.484	.468	.452	.436	.420	.404	.388	.372	.356	.340
21	.525	.509	.493	.477	.461	.445	.429	.413	.397	.381	.365
22	.550	.534	.518	.502	.486	.470	.454	.438	.422	.406	.390
23	.575	.559	.543	.527	.511	.495	.479	.463	.447	.431	.415
24	.600	.584	.568	.552	.536	.520	.504	.488	.472	.456	.440
25	.625	.609	.593	.577	.561	.545	.529	.513	.497	.481	.465

Blood Alcohol Concentration as a Function of Drinks Consumed and Time Taken to Consume

Male 120 lbs.

HOURS

NUMBER OF DRINKS	0	1	2	3	4	5	6	7	8	9	10
1	.031	.015	.000	.000	.000	.000	.000	.000	.000	.000	.000
2	.062	.046	.030	.014	.000	.000	.000	.000	.000	.000	.000
3	.093	.077	.061	.045	.029	.013	.000	.000	.000	.000	.000
4	.124	.108	.092	.076	.060	.044	.028	.012	.000	.000	.000
5	.155	.139	.123	.107	.091	.075	.059	.043	.027	.011	.000
6	.186	.170	.154	.138	.122	.106	.090	.074	.058	.042	.026
7	.217	.201	.185	.169	.153	.137	.121	.105	.089	.073	.057
8	.248	.232	.216	.200	.184	.168	.152	.136	.120	.104	.088
9	.279	.263	.247	.231	.215	.199	.183	.167	.151	.135	.119
10	.310	.294	.278	.262	.246	.230	.214	.198	.182	.166	.150
11	.341	.325	.309	.293	.277	.261	.245	.229	.213	.197	.181
12	.372	.356	.340	.324	.308	.292	.276	.260	.244	.228	.212
13	.403	.387	.371	.355	.339	.323	.307	.291	.275	.259	.243
14	.434	.418	.402	.386	.370	.354	.338	.322	.306	.290	.274
15	.465	.449	.433	.417	.401	.385	.369	.353	.337	.321	.305
16	.496	.480	.464	.448	.432	.416	.400	.384	.368	.352	.336
17	.527	.511	.495	.479	.463	.447	.431	.415	.399	.383	.367
18	.558	.542	.526	.510	.494	.478	.462	.446	.430	.414	.398
19	.589	.573	.557	.541	.525	.509	.493	.477	.461	.445	.429
20	.620	.604	.588	.572	.556	.540	.524	.508	.492	.476	.460
21	.651	.635	.619	.603	.587	.571	.555	.539	.523	.507	.491
22	.682	.666	.650	.634	.618	.602	.586	.570	.554	.538	.522
23	.713	.697	.681	.665	.649	.633	.617	.601	.585	.569	.553
24	.744	.728	.712	.696	.680	.664	.648	.632	.616	.600	.584
25	.775	.759	.743	.727	.711	.695	.679	.663	.647	.631	.615

Blood Alcohol Concentration as a Function of Drinks Consumed and Time Taken to Consume

Male 130 lbs.

HOURS

NUMBER OF DRINKS	0	1	2	3	4	5	6	7	8	9	10
1	.028	.012	.000	.000	.000	.000	.000	.000	.000	.000	.000
2	.056	.040	.024	.008	.000	.000	.000	.000	.000	.000	.000
3	.084	.068	.052	.036	.020	.004	.000	.000	.000	.000	.000
4	.112	.096	.080	.064	.048	.032	.016	.000	.000	.000	.000
5	.140	.124	.108	.092	.076	.060	.044	.028	.012	.000	.000
6	.168	.152	.136	.120	.104	.088	.072	.056	.040	.024	.008
7	.196	.180	.164	.148	.132	.116	.100	.084	.068	.052	.036
8	.224	.208	.192	.176	.160	.144	.128	.112	.096	.080	.064
9	.252	.236	.220	.204	.188	.172	.156	.140	.124	.108	.092
10	.280	.264	.243	.232	.216	.200	.184	.168	.152	.136	.120
11	.308	.292	.276	.260	.244	.228	.212	.196	.180	.164	.148
12	.336	.320	.304	.288	.272	.256	.240	.224	.208	.192	.176
13	.364	.348	.332	.316	.300	.284	.268	.252	.236	.220	.204
14	.392	.376	.360	.344	.328	.312	.296	.280	.264	.248	.232
15	.420	.404	.388	.372	.356	.340	.324	.308	.292	.276	.260
16	.448	.432	.416	.400	.384	.368	.352	.336	.320	.304	.288
17	.476	.460	.444	.428	.412	.396	.380	.364	.348	.332	.316
18	.504	.488	.472	.456	.440	.424	.408	.392	.376	.360	.344
19	.532	.516	.500	.484	.468	.452	.436	.420	.404	.388	.372
20	.560	.544	.528	.512	.496	.480	.464	.448	.432	.416	.400
21	.588	.572	.556	.540	.524	.508	.492	.476	.460	.444	.428
22	.616	.600	.584	.568	.552	.536	.520	.504	.488	.472	.456
23	.644	.629	.612	.596	.580	.564	.548	.532	.516	.500	.484
24	.672	.656	.640	.624	.608	.592	.576	.560	.544	.528	.512
25	.700	.684	.668	.652	.636	.620	.604	.588	.572	.556	.540

Blood Alcohol Concentration as a Function of Drinks Consumed and Time Taken to Consume

Male 140 lbs.

HOURS

NUMBER OF DRINKS	0	1	2	3	4	5	6	7	8	9	10
1	.026	.010	.000	.000	.000	.000	.000	.000	.000	.000	.000
2	.052	.036	.020	.004	.000	.000	.000	.000	.000	.000	.000
3	.078	.062	.046	.030	.014	.000	.000	.000	.000	.000	.000
4	.104	.088	.072	.056	.040	.024	.008	.000	.000	.000	.000
5	.130	.114	.098	.082	.066	.050	.034	.018	.002	.000	.000
6	.156	.140	.124	.108	.092	.076	.060	.044	.028	.012	.000
7	.182	.166	.150	.134	.118	.102	.086	.070	.054	.038	.022
8	.208	.192	.176	.160	.144	.128	.112	.096	.080	.064	.048
9	.234	.218	.202	.186	.170	.154	.138	.122	.106	.090	.074
10	.260	.244	.228	.212	.196	.180	.164	.148	.132	.116	.100
11	.286	.270	.254	.238	.222	.206	.190	.174	.158	.142	.126
12	.312	.296	.280	.264	.248	.232	.216	.200	.184	.168	.152
13	.338	.322	.306	.290	.274	.258	.242	.225	.210	.194	.178
14	.364	.348	.332	.316	.300	.284	.268	.252	.236	.220	.204
15	.390	.374	.358	.342	.326	.310	.294	.278	.262	.246	.230
16	.415	.400	.384	.368	.352	.336	.320	.304	.288	.272	.256
17	.442	.426	.410	.394	.378	.362	.346	.330	.314	.298	.282
18	.468	.452	.436	.420	.404	.388	.372	.356	.340	.324	.308
19	.494	.478	.462	.446	.430	.414	.398	.382	.366	.350	.334
20	.520	.504	.488	.472	.456	.440	.424	.403	.392	.376	.360
21	.546	.530	.514	.498	.482	.466	.450	.434	.418	.402	.386
22	.572	.556	.540	.524	.508	.492	.476	.460	.444	.428	.412
23	.598	.582	.566	.550	.534	.518	.502	.486	.470	.454	.438
24	.624	.608	.592	.576	.560	.544	.528	.512	.496	.480	.464
25	.650	.634	.613	.602	.586	.570	.554	.538	.522	.506	.490

Blood Alcohol Concentration as a Function of Drinks Consumed and Time Taken to Consume

Male 150 lbs.

HOURS

NUMBER OF DRINKS	0	1	2	3	4	5	6	7	8	9	10
1	.025	.009	.000	.000	.000	.000	.000	.000	.000	.000	.000
2	.050	.034	.018	.002	.000	.000	.000	.000	.000	.000	.000
3	.075	.059	.043	.027	.011	.000	.000	.000	.000	.000	.000
4	.100	.084	.068	.052	.036	.020	.004	.000	.000	.000	.000
5	.125	.109	.093	.077	.061	.045	.029	.013	.000	.000	.000
6	.150	.134	.118	.102	.086	.070	.054	.038	.022	.006	.000
7	.175	.159	.143	.127	.111	.095	.079	.063	.047	.031	.015
8	.200	.184	.168	.152	.136	.120	.104	.088	.072	.056	.040
9	.225	.209	.193	.177	.161	.145	.129	.113	.097	.081	.065
10	.250	.234	.218	.202	.186	.170	.154	.138	.122	.106	.090
11	.275	.259	.243	.227	.211	.195	.179	.163	.147	.131	.115
12	.300	.284	.268	.252	.236	.220	.204	.188	.172	.156	.140
13	.325	.309	.293	.277	.261	.245	.229	.213	.197	.181	.165
14	.350	.334	.318	.302	.286	.270	.254	.238	.222	.206	.190
15	.375	.359	.343	.327	.311	.295	.279	.263	.247	.231	.215
16	.400	.384	.368	.352	.336	.320	.304	.288	.272	.256	.240
17	.425	.409	.393	.377	.361	.345	.329	.313	.297	.281	.265
18	.450	.434	.418	.402	.386	.370	.354	.338	.322	.306	.290
19	.475	.459	.443	.427	.411	.395	.379	.363	.347	.331	.315
20	.500	.484	.468	.452	.436	.420	.404	.388	.372	.356	.340
21	.525	.509	.493	.477	.461	.445	.429	.413	.397	.381	.365
22	.550	.534	.518	.502	.486	.470	.454	.438	.422	.406	.390
23	.575	.559	.543	.527	.511	.495	.479	.463	.447	.431	.415
24	.600	.584	.568	.552	.536	.520	.504	.488	.472	.456	.440
25	.625	.609	.593	.577	.561	.545	.529	.513	.497	.481	.465

Blood Alcohol Concentration as a Function of Drinks Consumed and Time Taken to Consume

Male 160 lbs.

HOURS

NUMBER OF DRINKS	0	1	2	3	4	5	6	7	8	9	10
1	.023	.007	.000	.000	.000	.000	.000	.000	.000	.000	.000
2	.046	.030	.014	.000	.000	.000	.000	.000	.000	.000	.000
3	.069	.053	.037	.021	.005	.000	.000	.000	.000	.000	.000
4	.092	.076	.060	.044	.028	.012	.000	.000	.000	.000	.000
5	.115	.099	.083	.067	.051	.035	.019	.003	.000	.000	.000
6	.138	.122	.106	.090	.074	.058	.042	.026	.010	.000	.000
7	.161	.145	.129	.113	.097	.081	.065	.049	.033	.017	.001
8	.184	.168	.152	.136	.120	.104	.088	.072	.056	.040	.024
9	.207	.191	.175	.159	.143	.127	.111	.095	.079	.063	.047
10	.230	.214	.198	.182	.166	.150	.134	.118	.102	.086	.070
11	.253	.237	.221	.205	.189	.173	.157	.141	.125	.109	.093
12	.276	.260	.244	.228	.212	.196	.180	.164	.148	.132	.116
13	.299	.283	.267	.251	.235	.219	.203	.187	.171	.155	.139
14	.322	.306	.290	.274	.258	.242	.226	.210	.194	.178	.162
15	.345	.329	.313	.297	.281	.265	.249	.233	.217	.201	.185
16	.368	.352	.336	.320	.304	.288	.272	.256	.240	.224	.208
17	.391	.375	.359	.343	.327	.311	.295	.279	.263	.247	.231
18	.414	.398	.382	.366	.350	.334	.318	.302	.286	.270	.254
19	.437	.421	.405	.389	.373	.357	.341	.325	.309	.293	.277
20	.460	.444	.428	.412	.396	.380	.364	.348	.332	.316	.300
21	.483	.467	.451	.435	.419	.403	.387	.371	.355	.339	.323
22	.506	.490	.474	.453	.442	.426	.410	.394	.378	.362	.346
23	.529	.513	.497	.481	.465	.449	.433	.417	.401	.385	.369
24	.552	.536	.520	.504	.488	.472	.456	.440	.424	.408	.392
25	.575	.559	.543	.527	.511	495	.479	.463	.447	.431	.415

Blood Alcohol Concentration as a Function of Drinks Consumed and Time Taken to Consume

Male 170 lbs.

HOURS

NUMBER OF DRINKS	0	1	2	3	4	5	6	7	8	9	10
1	.022	.006	.000	.000	.000	.000	.000	.000	.000	.000	.000
2	.044	.028	.012	.000	.000	.000	.000	.000	.000	.000	.000
3	.066	.050	.034	.018	.002	.000	.000	.000	.000	.000	.000
4	.088	.072	.056	.040	.024	.008	.000	.000	.000	.000	.000
5	.110	.094	.078	.062	.046	.030	.014	.000	.000	.000	.000
6	.132	.116	.100	.084	.068	.052	.036	.020	.004	.000	.000
7	.154	.138	.122	.106	.090	.074	.058	.042	.026	.010	.000
8	.176	.160	.144	.128	.112	.096	.080	.064	.048	.032	.016
9	.198	.182	.166	.150	.134	.118	.102	.086	.070	.054	.038
10	.220	.204	.188	.172	.156	.140	.124	.108	.092	.076	.060
11	.242	.226	.210	.194	.178	.162	.146	.130	.114	.098	.082
12	.264	.248	.232	.216	.200	.184	.168	.152	.136	.120	.104
13	.286	.270	.254	.238	.222	.206	.190	.174	.158	.142	.126
14	.308	.292	.276	.260	.244	.228	.212	.195	.180	.164	.148
15	.330	.314	.298	.282	.266	.250	.234	.218	.202	.186	.170
16	.352	.336	.320	.304	.288	.272	.256	.240	.224	.208	.192
17	.374	.358	.342	.326	.310	.294	.278	.262	.246	.230	.214
18	.396	.380	.364	.348	.332	.316	.300	.284	.268	.252	.236
19	.418	.402	.386	.370	.354	.338	.322	.306	.290	.274	.258
20	.440	.424	.408	.392	.376	.360	.344	.328	.312	.296	.280
21	.462	.446	.430	.414	.398	.382	.366	.350	.334	.318	.302
22	.484	.468	.452	.436	.420	.404	.388	.372	.356	.340	.324
23	.506	.490	.474	.458	.442	.426	.410	.394	.378	.362	.346
24	.528	.512	.496	.480	.464	.448	.432	.416	.400	.384	.368
25	.550	.534	.518	.502	.486	.470	.454	.438	.422	.406	.390

Blood Alcohol Concentration as a Function of Drinks Consumed and Time Taken to Consume

Male 180 lbs.

HOURS

NUMBER OF DRINKS	0	1	2	3	4	5	6	7	8	9	10
1	.020	.004	.000	.000	.000	.000	.000	.000	.000	.000	.000
2	.040	.024	.008	.000	.000	.000	.000	.000	.000	.000	.000
3	.060	.044	.028	.012	.000	.000	.000	.000	.000	.000	.000
4	.080	.064	.048	.032	.016	.000	.000	.000	.000	.000	.000
5	.100	.084	.068	.052	.036	.020	.004	.000	.000	.000	.000
6	.120	.104	.088	.072	.056	.040	.024	.008	.000	.000	.000
7	.140	.124	.108	.092	.076	.060	.044	.028	.012	.000	.000
8	.160	.144	.128	.112	.096	.080	.064	.048	.032	.016	.000
9	.180	.164	.148	.132	.116	.100	.084	.068	.052	.036	.020
10	.200	.184	.168	.152	.136	.120	.104	.088	.072	.056	.040
11	.220	.204	.188	.172	.156	.140	.124	.108	.092	.076	.060
12	.240	.224	.208	.192	.176	.160	.144	.128	.112	.096	.080
13	.260	.244	.228	.212	.196	.180	.164	.148	.132	.116	.100
14	.280	.264	.248	.232	.216	.200	.184	.168	.152	.136	.120
15	.300	.284	.268	.252	.236	.220	.204	.188	.172	.156	.140
16	.320	.304	.288	.272	.256	.240	.224	.208	.192	.176	.160
17	.340	.324	.308	.292	.276	.260	.244	.228	.212	.196	.180
18	.360	.344	.328	.312	.296	.280	.264	.248	.232	.216	.200
19	.380	.364	.343	.332	.316	.300	.284	.268	.252	.236	.220
20	.400	.384	.368	.352	.336	.320	.304	.288	.272	.256	.240
21	.420	.404	.388	.372	.356	.340	.324	.308	.292	.276	.260
22	.440	.424	.408	.392	.376	.360	.344	.328	.312	.296	.280
23	.460	.444	.428	.412	.396	.380	.364	.348	.332	.316	.300
24	.480	.464	.448	.432	.416	.400	.384	.368	.352	.336	.320
25	.500	.484	.468	.452	.436	.420	.404	.388	.372	.356	.340

Blood Alcohol Concentration as a Function of Drinks Consumed and Time Taken to Consume

Male 190 lbs.

HOURS

NUMBER OF DRINKS	0	1	2	3	4	5	6	7	8	9	10
1	.019	.003	.000	.000	.000	.000	.000	.000	.000	.000	.000
2	.038	.022	.006	.000	.000	.000	.000	.000	.000	.000	.000
3	.057	.041	.025	.009	.000	.000	.000	.000	.000	.000	.000
4	.076	.060	.044	.028	.012	.000	.000	.000	.000	.000	.000
5	.095	.079	.063	.047	.031	.015	.000	.000	.000	.000	.000
6	.114	.098	.082	.066	.050	.034	.018	.002	.000	.000	.000
7	.133	.117	.101	.085	.069	.053	.037	.021	.005	.000	.000
8	.152	.136	.120	.104	.088	.072	.056	.040	.024	.008	.000
9	.171	.155	.139	.123	.107	.091	.075	.059	.043	.027	.011
10	.190	.174	.158	.142	.126	.110	.094	.078	.062	.046	.030
11	.209	.193	.177	.161	.145	.129	.113	.097	.081	.065	.049
12	.228	.212	.196	.180	.164	.148	.132	.116	.100	.084	.068
13	.247	.231	.215	.199	.183	.167	.151	.135	.119	.103	.087
14	.266	.250	.234	.218	.202	.186	.170	.154	.138	.122	.106
15	.285	.269	.253	.237	.221	.205	.189	.173	.157	.141	.125
16	.304	.288	.272	.256	.240	.224	.208	.192	.176	.160	.144
17	.323	.307	.291	.275	.259	.243	.227	.211	.195	.179	.163
18	.342	.326	.310	.294	.278	.262	.246	.230	.214	.198	.182
19	.361	.345	.329	.313	.297	.281	.265	.249	.233	.217	.201
20	.380	.364	.348	.332	.316	.300	.284	.268	.252	.236	.220
21	.399	.383	.367	.351	.335	.319	.303	.287	.271	.255	.239
22	.418	.402	.386	.370	.354	.338	.322	.306	.290	.274	.258
23	.437	.421	.405	.389	.373	.357	.341	.325	.309	.293	.277
24	.456	.440	.424	.408	.392	.376	.360	.344	.329	.312	.296
25	.475	.459	.443	.427	.411	.395	.379	.363	.347	.331	.315

Blood Alcohol Concentration as a Function of Drinks Consumed and Time Taken to Consume

Male 200 lbs.

HOURS

NUMBER OF DRINKS	0	1	2	3	4	5	6	7	8	9	10
1	.018	.002	.000	.000	.000	.000	.000	.000	.000	.000	.000
2	.036	.020	.004	.000	.000	.000	.000	.000	.000	.000	.000
3	.054	.038	.022	.006	.000	.000	.000	.000	.000	.000	.000
4	.072	.056	.040	.024	.008	.000	.000	.000	.000	.000	.000
5	.090	.074	.058	.042	.026	.010	.000	.000	.000	.000	.000
6	.108	.092	.076	.060	.044	.028	.012	.000	.000	.000	.000
7	.126	.110	.094	.078	.062	.046	.030	.014	.000	.000	.000
8	.144	.128	.112	.096	.080	.064	.048	.032	.016	.000	.000
9	.162	.146	.130	.114	.096	.082	.066	.050	.034	.018	.002
10	.180	.164	.148	.132	.116	.100	.084	.068	.052	.036	.020
11	.198	.182	.166	.150	.134	.118	.102	.086	.070	.054	.038
12	.216	.200	.184	.168	.152	.136	.120	.104	.088	.072	.056
13	.234	.218	.202	.186	.170	.154	.138	.122	.106	.090	.074
14	.252	.236	.220	.204	.188	.172	.156	.140	.124	.108	.092
15	.270	.254	.238	.222	.206	.190	.174	.158	.142	.126	.110
16	.288	.272	.256	.240	.224	.208	.182	.176	.160	.144	.128
17	.306	.290	.274	.258	.242	.226	.210	.194	.178	.162	.146
18	.324	.308	.292	.276	.260	.244	.228	.212	.196	.180	.164
19	.342	.326	.310	.294	.278	.262	.246	.230	.214	.198	.182
20	.360	.344	.328	.312	.296	.280	.264	.248	.232	.216	.200
21	.378	.362	.346	.330	.314	.298	.282	.266	.250	.234	.218
22	.396	.380	.364	.348	.332	.316	.300	.284	.268	.252	.236
23	.414	.398	.382	.366	.350	.334	.318	.302	.286	.270	.254
24	.432	.416	.400	.384	.368	.352	.336	.320	.304	.288	.272
25	.450	.434	.418	.402	.386	.370	.354	.338	.322	.306	.290

Oregon
Health
Authority