STATEMENT OF BASIS AND PURPOSE, REGULATORY ANALYSIS AND SPECIFIC STATUTORY AUTHORITY

Alcohol and Other Drug Abuse Treatment rules of the Alcohol and Drug Abuse Division (ADAD) were originally adopted 5/18/76 by the Department of Health, with an effective date of 8/1/76. Subsequent revisions of these rules were adopted 4/15/81, effective 5/30/81; 4/17/85, effective 5/30/85; 5/21/86, effective 7/30/86; 3/16/88, effective 4/30/88; 1/18/89, effective 3/2/89; and, 3/18/92, effective 4/30/92.

These rule sections were rewritten and final adoption following publication at the 1/9/98 State Board of Human Services meeting, with an effective date of 3/1/98 (CSPR# 97-4-11-1). Statement of Basis and Purpose, Regulatory Analysis, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of External Affairs, Department of Human Services.

These rule sections were rewritten and final adoption following publication at the 5/7/99 State Board of Human Services meeting, with an effective date of 7/1/99 (CSPR# 99-2-10-1). Statement of Basis and Purpose, Regulatory Analysis, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of External Affairs, Department of Human Services.

Addition of sections 15.100 through 15.118 were adopted following publication at the 11/1/2002 State Board of Human Services meeting, with an effective date of 1/1/2003 (Rule# 02-6-19-1). Statement of Basis and Purpose, regulatory analysis, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Colorado Department of Human Services, Office of Performance Improvement, Boards and Commissions Division, State Board Administration.

15.100 MANAGED SERVICE ORGANIZATION (MSO) STANDARDS

15.110 Designation Authority

A. The Director of the Alcohol and Drug Abuse Division (ADAD) has the authority pursuant to 25-1-206, Colorado Revised Statutes, to designate a Designated Managed Service Organization (DMSO) responsible for service delivery to the residents of each of seven ADAD-defined geographic regions, which are described in the annual federal Substance Abuse Prevention and Treatment Block Grant application.

B. Once designated, each Designated Managed Service Organization shall receive an automatic renewal of designation annually if the Division determines that each is in substantial compliance with the intent of the designation statute, rules, and contract.

15.111 Role of Designated Managed Service Organizations

A. Each DMSO will oversee the prudent expenditure of ADAD funds in providing effective population-specific substance abuse treatment and related services to the priority populations identified in each ADAD contract.

B. Each DMSO will develop and monitor a network of ADAD-licensed subcontractor-providers to deliver a full continuum of care to priority populations in one or more of the seven ADAD-defined geographic regions of Colorado.

C. To the extent ADAD appropriations allow, each DMSO will ensure the delivery of effective population-specific services to priority populations, both individuals and families, in need of substance abuse treatment and related services.

15.112 Governance

Governance of each DMSO, an organization doing business in Colorado, shall ensure, provide for and maintain:

A. Organizational structures that clearly delineate staff positions and lines of authority and supervision;

B. Financial support for personnel, physical facilities, and operations;

C. Appropriate business facilities that meet all current, applicable local and state codes and ordinances;

D. Property liability insurance;

E. Professional and managed care liability insurance;

F. Required data that is accurate and submitted to ADAD or its authorized representatives within requested time frames;

G. Qualified and appropriately supervised staff;

H. Duties assigned to personnel, which are commensurate with their education, training, work experience, and professional licenses and certifications;

I. Compliance with federal and state statutes and rules promulgated thereunder, standards, policies, and procedures applicable to managed care organizations;

J. A written code of ethics that governs business and clinical conduct;

K. A written emergency plan and procedures that address provisions for dealing with medical or natural emergencies.

15.113 Revocation

A. Designation of a DMSO shall not be revoked if in substantial compliance with the applicable statute, rules, and contract terms. Grounds for revocation include one or more of the following:

1. Non-compliance with the applicable statute, these rules, or contract terms.

2. Non-compliance with reporting requirements, including applicable Healthcare Insurance Portability and Accountability Act (HIPAA) (45 CFR 104-191). This material may be obtained or examined during regular business hours by contacting the Colorado Department of Human Services, Alcohol and Drug Abuse Division (ADAD), Director of Treatment, 4055 S. Lowell Blvd., Denver, CO 80236, or at any state publications depository library. No editions or amendments are incorporated.

3. Non-compliance with Federal Confidentiality of Alcohol and Drug Abuse Patient Records Act (42 CFR 2.1). This material may be obtained or examined during regular business hours by contacting the Colorado Department of Human Services, Alcohol and Drug Abuse Division (ADAD), Director of Treatment, 4055 S. Lowell Blvd., Denver, CO 80236, or at any state publications depository library. No editions or amendments are incorporated.

4. Non-compliance with other applicable federal and state statutes, regulations, rules, standards, policies, procedures, and contracting requirements.

5. Negligence resulting in risk to MSO or subcontractor client and/or staff, and/or public health or

safety.

6. Failure to implement ADAD-imposed corrective actions.

7. Use of intentionally misleading or deceptive communications to the public or to ADAD.

8. Exercising undue influence on MSO or subcontractor clients to promote and sell services, goods, property, or drugs.

9. Acceptance of commissions, rebates, or other forms of remuneration for referring clients to particular agencies or individuals.

10. Failure to provide for adequate supervision of MSO staff providing treatment services.

11. Fraud, misrepresentation, or deception in application for ADAD designation.

12. Failure to provide MSO clients with information required by applicable state and federal statutes, rules, and regulations.

13. Failure to enforce state Fraudulent Insurance Act (10-1-127, C.R.S.).

14. Withholding from ADAD access to client records, client service data records, or fiscal records.

15. Illegal activities associated with the use, sale or distribution of alcohol and/or drugs of abuse on business premises or during business activities off premises.

B. Prior to starting a revocation process, ADAD shall provide a written notification to the DMSO of the facts or conduct that may warrant such action, and shall provide the DMSO the opportunity to submit written data, views and arguments with respect to such facts or conduct and shall give the DMSO a reasonable opportunity to comply with lawful requirements.

C. Where ADAD has reasonable grounds to believe and finds that the DMSO has been guilty of deliberate and willful violation or that the public health, safety, or welfare imperatively requires emergency action and incorporates such finding in its order, it may summarily suspend the license pending proceedings for suspension or revocation which shall be promptly instituted and determined.

D. Following such processes, if ADAD finds against the DMSO, it shall send a written notification to the DMSO of action to revoke designation. Except in cases of deliberate and willful violation or of substantial danger to the public health and safety, such notice shall be sent at least 10 working days before the date such action goes into effect and will include reasons for the action and rights to the appeal process specified in the State Administrative Procedure Act (24-4-101, et seq., CRS).

15.114 Reporting Requirements

A. Each DMSO must maintain a fiscal reporting system that complies with state and federal reporting requirements.

B. Each DMSO must maintain a client-services reporting system that complies with state and federal reporting requirements.

15.115 Service Provision

When any DMSO itself provides substance abuse treatment or a related service to any client, it must demonstrate compliance with all applicable ADAD Provider Treatment Standards and must be ADAD-licensed.

15.116 Monitoring and Quality Improvement

A. To determine MSO compliance with these standards, ADAD may request written documentation and may conduct on-site inspections.

B. Each DMSO must demonstrate ethical, legal, and solvent fiscal practices, and must maintain an ADAD-approved system for periodic review of its contracts, billing and coding procedures, billing records, contractual requirements, and legal requirements in order to identify any intentional or unintentional wrongdoing.

C. Each DMSO must maintain an ADAD-approved system for periodic review of its contractors to identify any intentional or unintentional wrongdoing and to ensure that they are exercising ethical, legal, and solvent fiscal practices.

D. Each DMSO must have a formal, substantive ADAD-approved clinical Quality Improvement process that includes periodic review of its contractors and that addresses current ADAD-specified content.

15.117 Complaints

Any complaints involving DMSOs or any of their subcontractors shall be investigated in accordance with ADAD complaint policies, applicable state and federal statutes, and rules.

15.118 Critical Incidents

Any critical incidents involving DMSOs or any of their subcontractors shall be investigated in accordance with ADAD critical incident policies, procedures, applicable state and federal statutes, and rules.

1.0 ADMINISTRATIVE PROCEDURES

A. The Alcohol and Drug Abuse Division (ADAD) is required by statute (Title 25, Article 1, Part 3, Colorado Revised Statutes) to establish minimum standards by which it licenses agencies and specifically designated sections of agencies to provide alcohol and other drug abuse/dependence treatment services and by which it monitors the provision of such services. ADAD licensure shall not authorize or endorse any other services provided by licensed agencies.

B. All agencies applying for ADAD licensure demonstrate compliance with core treatment standards, Sections 1.0 – 6.0.

1. Agencies applying for ADAD licensure to provide specialized treatment services to specific client populations, as delineated in Section 7.0 – 14.0, shall demonstrate compliance with all sections for which licensure is requested.

2. All agencies directly or indirectly funded by ADAD shall demonstrate compliance with Section 12.2, Involuntary Commitments.

3. In cases where standards governing treatment of specific client populations contradict core standards, the specific client population standards shall take precedence.

C. Recognized accreditation, such as that awarded by Joint Commission for Accreditation of Health Organizations (JCAHO) and Commission for Accreditation of Rehabilitation Facilities (CARF),

may be considered by ADAD as compliance with applicable sections of these standards.

D. Requests to waive specific standards shall be submitted in formats acceptable to ADAD. Requests shall document how undue financial hardship or inability to meet unique treatment needs will result if waiver requests are denied and how health, safety and welfare of clients and staff will not be put at risk if waiver requests are granted.

E. On-site inspections for ADAD licensure, complaint and critical incident investigations, and monitoring purposes shall be conducted by ADAD during normal treatment site business hours and, to the extent possible, with minimal impact on treatment service provision.

1.1 Initial Application and Licensing Process

A. Agencies initially applying for ADAD licensure to provide alcohol and other drug abuse/dependence treatment services shall submit completed ADAD license application forms, required documentation, and a $200 application fee.

B. Initial applications submitted to ADAD that are not completed according to instructions, do not include application fees, or lack required documentation shall be returned to applicant agencies with application fees (if submitted) and written notification of deficiencies.

C. ADAD shall review applications and conduct on-site inspections to determine applicant agency compliance with applicable sections of these standards. Applicant agencies found to be in compliance shall receive non-transferable ADAD licenses to provide alcohol and other drug abuse/dependence treatment services for 3 years from dates licenses are granted.

D. ADAD may provisionally license applicant agencies not able to 'demonstrate compliance if it is determined that health, safety, or welfare of clients or staff are not put at risk due to deficiencies or if applicant agencies' application reviews and on-site inspections demonstrate compliance with all applicable sections of these standards, but who have no active client records to inspect.

1. Provisional licenses shall be in force for not more than 90 consecutive days.

2. Applicant agencies found to be in full compliance at expiration of provisional licensure, shall receive non-transferable ADAD licensure for 3 years from dates provisional licenses are granted..

E. Applicant agencies unable to demonstrate compliance with applicable sections of these standards after applications are reviewed and on-site inspections are conducted, or at expiration of provisional licensure, shall receive written notification of deficiencies and that ADAD licensure is denied. Application fees shall not be returned.

F. Applicant agencies denied ADAD licensure may re-apply in accordance with Section 1.1, A.

1.2 ADAD License Expiration and Renewal

A. ADAD licenses shall expire 3 years from dates licenses are granted. Treatment providers may apply to renew licensure in accordance with Section 1.1, A.

B. Treatment providers may not be notified by ADAD in advance of ADAD license expiration and shall be solely responsible for monitoring license expiration dates.

C. Renewal applications submitted to ADAD that are not completed according to instructions, do not include application fees, lack required documentation, or are received by ADAD or are postmarked after license expiration dates shall be retumed with application fees (if submitted) and

written notification of deficiencies and that ADAD licensure has lapsed.

D. Treatment providers whose renewal applications are complete and received by ADAD or postmarked prior to expiration of existing ADAD licenses shall be considered licensed until ADAD has acted on their applications.

E. ADAD shall review applications and may conduct on-site inspections to determine treatment provider compliance with applicable sections of these standards. Treatment providers found to be in compliance shall receive non-transferable ADAD licenses to provide alcohol and other drug abuse/dependence treatment services for 3 years from dates licenses are granted.

F. ADAD may provisionally license renewing treatment providers not able to demonstrate compliance with applicable sections of these standards if it is determined that health, safety, or welfare of clients or staff are not put at risk due to deficiencies.

1. Provisional licenses shall be in force for not more than 90 consecutive days.

2. Treatment providers able to demonstrate compliance at expiration of provisional licenses shall be licensed by ADAD for 3 years from dates provisional licenses are granted.

G. Treatment providers whose licenses have lapsed or who are unable to demonstrate compliance with applicable sections of these standards at expiration of provisional licenses shall be so notified by certified mail. ADAD licensure may be re-applied for in accordance with Section 1.1, A.

1.3 Revocation, Denial, Suspension, or Modification of ADAD Licensure

A. ADAD may revoke, deny, suspend, or modify licensure based on the following:

1. Non-compliance with these standards;

2. Non-compliance with applicable state and federal statutes, and regulations;

3. Negligence resulting in risk to client and/or staff health or safety;

4. Failure to implement ADAD-imposed corrective actions;

5. Failure to submit required data in an accurate and timely manner to ADAD or its authorized representatives;

6. Use of misleading, deceptive, or false advertising;

7. Exercising undue influence on clients to promote and sell services, goods, property, or drugs in such a manner as to exploit clients for financial gain;

8. Failure to provide for available specialized services when indicated by client assessments;

9. Acceptance of commissions, rebates, or other forms of remuneration for referring clients to particular agencies or individuals;

10. Failure to provide for adequate supervision of staff providing treatment services;

11. Fraud, misrepresentation, or deception in applications for ADAD approval;

12. Failure to provide clients with information required by these standards and applicable state and federal statutes and regulations;

13. Commission of fraudulent insurance acts as defined in Section 10-1-127, C.R.S.;

14. Withholding treatment or administration records from ADAD;

15. Use or distribution of alcohol or illicit drugs, or unauthorized sale or distribution of prescription or over-the-counter drugs on treatment premises or during treatment activities off premises;

16. Failure to resist unlawful attempts to obtain client information.

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

1. Reasons for actions, citing applicable ADAD standards and state and federal statutes and regulations;

2. Rights of appeal in accordance with Administrative Procedures Act, Title 24, Article 4, Parts 1 and 2, Colorado Revised Statutes.

1.4 Adding Treatment Sites

A. Licensed providers adding treatment sites shall notify ADAD by completing and submitting applications to modify ADAD licensure within 10 working days of the start of service provision at such sites.

B. Failure to submit applications to modify ADAD licensure will result in additional sites not being included in agencies' ADAD licensure or listed in directories of ADAD-licensed treatment providers.

1.5 Selling or Closing Approved Treatment Agencies or Sites

A. ADAD shall be notified in writing within 10 working days of the sale or closure of ADAD-licensed treatment agencies or sites.

B. ADAD-licensed treatment agencies and/or sites being closed or sold shall observe all applicable ADAD policies and procedures.

1.6 Investigation of Critical Incidents and Complaints

A. Complaints against and critical incidents involving ADAD-licensed treatment providers shall be investigated by ADAD in accordance with critical incident and complaint investigation policies and procedures and applicable state and federal statutes and regulations.

B. ADAD shall have access to all persons and documents pertinent to critical incident and complaint investigations.

1.7 Definitions of Terms

ADAD — Alcohol and Drug Abuse Division.

ADAD Licensure — certified authorization by ADAD of agencies or specifically designated sections within agencies to provide alcohol and other drug abuse/dependence treatment services.

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

Admission Summary — a brief review of assessments and other relevant intake data, allowing efficient analysis of client status at treatment admission and providing a basis for individualized treatment planning.

AIDS — Acquired Immune Deficiency Syndrome.

Alcohol and Other Drug Abuse — use of alcohol and/or other psychoactive substances to the extent that personal health is substantially impaired or endangered and/or family, social or economic functioning is substantially disrupted and/or the diagnostic criteria for alcohol/other drug abuse described in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) are met.

Alcohol and Other Drug Abuse Treatment Services — therapeutic regimens provided to persons assessed as alcohol and/or other drug abusing or dependent, which may include interventions, detoxification, case management, and group and individual therapy of different intensities and frequencies carried out in modalities that provide minimum to maximum client restriction.

Alcohol and Other Drug Dependence — physical and/or psychological state produced by increasing ingestion of alcohol and/or other psychoactive substances over a period of time to the extent that negative physical and/or psychological effects occur when these substances are withdrawn and/or the criteria for alcohol and other drug dependence described in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) are met.

Approved Controlled Substances — drugs, including methadone and LAAM (levo-alpha-acetylmethadol), which are regulated and specifically approved for treating alcohol and other drug abuse by federal and state statutes, standards, rules and regulations.

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

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

Client — 1) person enrolled in alcohol and other drug abuse treatment, 2) in accordance with federal confidentiality regulations, any person who has contacted or has been contacted by a treatment provider for purposes of communicating alcohol and other drug abuse information, availability of treatment services, or for initial screening.

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

Client Record — all documentation of individual client treatment including client charts, shift logs, and attendance records.

Compliance — demonstration that these standards and applicable federal and state statutes, standards, and regulations are observed.

Continuing Care Planning — process addressing post-treatment issues such as additional treatment, relapse prevention, life skills, employability, education, training, socialization, and support systems.

Controlled Substances — all scheduled drugs as defined by Colorado Controlled Substance Act, Title 21, Article 22, Part 3, and Title 18, Article 18, Part 1, C.R.S.

Co-occurring Disorders — concurrent substance abuse and mental health problems as identified through a differential assessment and which can be verified by a professional, qualified to make mental

health diagnoses.

Court — 1) district court in the county in which individuals named in petitions filed in reliance on Section 12.2 and applicable statutes reside or are physically present, 2) In the City and County of Denver, “court” is the probate court, 3) for DUI and Title 16, Article 11.5, Part 1, C.R.S., offenders, “court” shall include county or municipal courts.

Credential — certificate, license, or academic degree that qualifies staff to independently provide treatment services within ADAD-approved treatment agencies.

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

C.R.S. - Colorado Revised Statutes.

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

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

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

Discharge Summary - a brief review of client treatment including assessment of client problems at admission, expected treatment outcomes, treatment plans and strategies, client status at discharge including treatment progress, and summaries of continuing care plans.

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

Dosing - dispensing or administering an approved controlled substance.

Federal Confidentiality Regulations - 42 C.F.R., Part 2 - Confidentiality of Alcohol and Drug Abuse Patient Records. Treatment standards referencing federal confidentiality regulations 42 C.F.R., Part 2, do not include amendments to or editions of said regulations later than October 1, 1995. Copies of these regulations are available from: Colorado Department of Human Services, Alcohol and Drug Abuse Division, 4055 S. Lowell Blvd., Bldg. KA, Denver, Colorado 80236.

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

Governance - overall management, oversight, administration, supervision, command, or control of agencies or specifically designated sections of agencies providing alcohol and other drug abuse treatment.

Guardian, Legal Guardian - person(s) or agency granted the rights and responsibilities of legal custody of another person in accordance with applicable state statutes.

HIV - Human Immunodeficiency Virus.

Intervention - short-term evaluation, information dissemination, and referral activities designed to immediately interrupt the progression of alcohol and other drug abuse.

Intoxicated - temporary state of substantially impaired mental and/or physical functioning as a result of alcohol and/or other drugs in the body.

LAAM - Levo-alpha-acetylmethadol; long-acting methadone.

Mental Health Treatment Services - a variety of services for preventing and treating mental illness that are provided in the least restrictive setting and include, but are not limited to, emergency services, medication management, assessment, clinical treatment services, case management, family support, and consumer advocacy.

Minor - individual under 18 years of age.

Monitor - 1) to supervise self-administration of medications prescribed for specific clients, 2) to assess whether treatment providers are meeting minimum treatment standards.

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

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

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

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

Qualified Service Organization Agreement (QSOA) - a written understanding between treatment providers and non-treatment service providers pursuant to which service providers acknowledge that in receiving, storing, processing, or otherwise handling any information about past and present clients, they are fully bound by the provisions of state and federal confidentiality rules and regulations.

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

Referral - process of linking clients to appropriate treatment and auxiliary services usually after screening and assessment and through case management.

Release of Information - signed client authorization to release specific treatment information to a specified person or agency.

Screening - an activity employing specific instruments and/or procedures to determine the presence of alcohol and other drug problems and appropriateness for treatment.

Split Dose - daily dose or take home dose of methadone, LAAM, or other approved controlled

substances that is divided into two or more smaller doses for purposes of improved client management.

Staff - all persons working in alcohol and other drug abuse treatment settings whether full-time, part-time, contracted, trainee, volunteer, or intern, and whether directly or indirectly involved in client treatment.

Standards - rules promulgated through Colorado Department of Human Services rule making process, including review by State Board of Human Services pursuant to Title 26, Article 1, Part 107(5)(g), C.R.S.

Substance Abuse - see Alcohol and Other Drug Abuse.

Supervision - group and/or individual evaluation of and guidance in treatment service provision conducted by qualified supervisory staff and occurring at a frequency and intensity set by agency policy and standards governing acquisition and retention of clinical credentials, but not less than 1 hour per month.

TB - tuberculosis

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

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

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

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

Treatment Staff - treatment agency personnel who are Colorado state certified or otherwise possess clinical credentials and experience with client populations served, or are counselor trainees and who independently or as co-counselors provide, but are not limited to: client screening, assessment, and placement; case management; treatment planning and review; client education; group, individual, and family therapy; continuing care planning; and, crisis intervention.

2.0 GOVERNANCE

A. Governance of the administration and provision of ADAD-approved alcohol and other drug abuse treatment services shall be the responsibility of legally established sole owners, partnerships or corporations, recognized by and allowed to do business in the state of Colorado.

B. Governance shall insure, provide for, and maintain:

1. Organizational structures that clearly delineate alcohol and other drug abuse/dependence treatment services and lines of authority and supervision;

2. Financial support for treatment agency personnel, physical facilities, and operations;

3. Physical facilities which meet all current and applicable local and state health, safety, building, plumbing and fire codes and ordinances;

4. Property liability insurance;

5. Professional liability (malpractice) insurance;

6. Accurate and timely submission of required data to ADAD or its authorized representatives;

7. Qualified and appropriately supervised staff;

8. Duties assigned to personnel which are commensurate with their education, training, work experience, and professional licenses and certifications;

9. Compliance with federal and state statutes, federal and state regulations, rules, standards, policies, and procedures applicable to providing alcohol and other drug abuse treatment services.

3.0 QUALITY IMPROVEMENT

A. Treatment providers shall develop and implement quality improvement systems including written policies and procedures and ongoing activities to:

1. Monitor and evaluate disposition of employee, client, and other grievances;

2. Monitor staff knowledge of and adherence to these standards and applicable ADAD policies and procedures and federal and state statutes and regulations, including federal regulation 42 C.F.R., Part 2, “Confidentiality of Alcohol and Drug Abuse Patient Records”, and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, C.R.S., governing testing for and reporting of TB, HIV/AIDS, hepatitis, and other infectious diseases;

3. Monitor and evaluate emergency procedures;

4. Evaluate treatment effectiveness;

5. Monitor and evaluate treatment practices, professional conduct, and staff qualifications, competence, and supervision.

B. Critical incidents (see “definitions”, Section 1.7) shall be reported to ADAD in accordance with ADAD policies and procedures governing critical incident reporting.

C. Reviews of quality improvement systems shall be conducted by treatment providers at least once during a 3-year ADAD licensure.

D. Evaluations of counselor performance shall be performed at least twice during a 3-year ADAD licensure.

E. ADAD shall review agency quality improvement systems at time of initial licensure and license renewal, at a minimum.

4.0 STAFF REQUIREMENTS

4.1 Background Investigations

A. Background investigations shall be required for all staff who have direct contact with clients or client records and shall include, at a minimum, name searches by Colorado Bureau of Investigation and Colorado Child Abuse Registry. ADAD shall have access to background investigation results.

B. Criteria shall be developed and implemented specifying convictions or complaints that make an applicant unacceptable for hiring or a staff person unacceptable for retention in terms of staff and client safety as well as appropriate counselor/client interactions.

4.2 Staff Qualifications and Competency

A. At least 50% of all treatment staff (See "Definitions", Section 1.7) shall posses Colorado addiction counselor certification at Levels II or III, current and in good standing.

B. Treatment staff possessing Colorado addiction counselor certification at Level I, current and in good standing or considered to be non-certified counselor trainees, shall not counsel independently and shall not comprise more than 25% of total treatment staff.

C. Treatment staff not included in Sections 4.2, A or B, shall possess clinical masters degrees and/or maintain Colorado licenses that are current and in good standing to practice medicine, psychiatry, clinical psychology, clinical social work, registered nursing, professional counseling, or marriage and family therapy.

D. Treatment agencies shall demonstrate that all treatment staff are qualified and competent to treat all client populations served and that relevant needs of culturally diverse clients, as well as clients with disabilities, are incorporated into planning and providing treatment, including effective and appropriate use of adjunctive resources.

E. Staff shall be current in methods of preventing and controlling infectious diseases and in universal precautions providing protection from possible infection when handling blood, other body fluids, and excreta.

F. Staff collecting urine, breath, and blood samples shall be knowledgeable of collection, handling, recording and storing procedures assuring sample viability for evidentiary and therapeutic purposes.

G. Treatment agencies administering and/or monitoring client medications shall maintain at least one staff person per shift who is currently qualified by certification and/or training to perform those functions in accordance with applicable ADAD policies and procedures and state and federal statutes, and regulations.

H. At least one residential treatment staff person per shift shall be currently certified in cardiopulmonary resuscitation and basic first aid.

I. All staff shall be knowledgeable of policies and procedures and federal and state statutes, standards, rules and regulations delineating actions, relationships, and affiliations which violate therapeutic boundaries between staff and clients or are considered conflicts of interest. Staff shall also be knowledgeable of corrective actions to be applied when such violations and conflicts occur.

5.0 CLIENT RECORDS

5.1 Client Record Content

A. Treatment documents shall include, if applicable:

1. Screening, assessments, and evaluations;

2. Admission summaries;

3. Treatment plans;

4. Treatment notes;

5. Treatment plan reviews;

6. Records of medication monitoring or administration;

7. Records of vital signs monitoring;

8. Continuing care plans (may be combined with discharge summaries);

9. Discharge summaries.

B. Client consents shall include:

1. Consent to treatment and follow-up;

2. Consent to release client information.

C. Client acknowledgments shall include:

1. Acknowledgment of protection afforded client records and client identity by federal confidentiality regulations and circumstances in which such regulations may be waived;

2. Acknowledgment of client rights and responsibilities;

3. Acknowledgment of chargeable fees and collection procedures;

4. Acknowledgment of risk factors associated with alcohol and other drug abuse for acquiring and transmitting HIV/AIDS, TB (see “Definitions”, Section 1.7), and other infectious diseases, and for pregnancy;

5. Acknowledgment of counselor credentials, appropriate therapeutic practices and boundaries, and agencies governing counselor conduct.

D. Other documents shall include:

1. Personal belongings inventories;

2. Court documents;

3. Copies of client data required by ADAD or its authorized representatives.

E. Client records shall be legible, accurate, current, complete, and stored in a secure and orderly manner. Organization of documents in client records shall be the same within each treatment setting.

5.2 Signatures

A. Counselor signatures shall be required on treatment documents listed in Section 5.1, B., with the exception of medication and vital signs monitoring reports which may be signed or initialed by other appropriate staff.

B. Credentialed counselors authorized by treatment agencies to counsel independently shall sign treatment documents with at least first initial, full last name, and State of Colorado addiction counselor credential, other professional credential, or academic degree.

C. Counselors not credentialed may sign treatment documents if countersigned by supervising credentialed counselors.

D. Signature stamps shall be permissible in lieu of written signatures if initialed by the counselors whose signatures they represent. Electronic signatures shall be permissible for computerized client records.

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

5.3 Client Record Retention, Disposal, and Confidentiality

A. Client records shall be retained for 5 years from date of client treatment discharge. Discharge summaries shall be retained for an additional 5 years.

B. Client records whose retention time has expired shall be disposed of in accordance with state and federal confidentiality rules and regulations.

C. Agencies commissioned by treatment providers to dispose of client records shall sign Qualified Service Organization Agreements (QSOA's).

D. Records of active and discharged clients shall be maintained in a manner which prevents unauthorized access in accordance with state and federal confidentiality rules and regulations.

E. Treatment providers shall assure that staff having access to clients or client records shall be knowledgeable of policies and procedures which protect client identity and treatment information from unauthorized disclosure in accordance with federal and state confidentiality rules and regulations.

F. Computerized client records shall comply with state and federal confidentiality rules and regulations and be maintained in a manner which reduces the risk of unauthorized access and destruction.

5.4 Client Access to Records

A. Clients shall have the right to view and obtain copies of their records.

B. Treatment providers shall deny access to information judged to be potentially damaging to clients and shall document such decisions in client records.

C. If decisions to deny access to information are challenged, treatment providers shall cooperate in providing the disputed information (with written client permission) to independent treatment professionals qualified to evaluate potential damage.

6.0 CLIENT CARE

6.1 Screening

A. ADAD-approved screening instruments (see “Definitions”, Section 1.7) and/or procedures shall be developed and applied to all potential clients.

B. Criminal justice system referrals for alcohol and other drug offenses, such as DUI/DWAI, BUI, or FUI, and controlled substance violations, may be exempt from screening if already diagnosed, assessed, or evaluated as having alcohol and other drug problems.

C. Clients shall be screened for past and present risk factors associated with alcohol and other drug abuse for acquiring and transmitting HIV/AIDS, TB, and other infectious diseases, and for pregnancy. Clients shall be apprised of risk factors considered to be significant and appropriate testing and pre/post-test counseling shall be offered on-site or through referral. Policies and procedures shall be developed and implemented for dealing with clients diagnosed with infectious diseases.

6.2 Admission, Assessment, and Client Placement

A. Admission criteria shall be developed and implemented to determine treatment eligibility and ineligibility. Relapses or leaving previous treatment against advice shall not be the sole reasons for treatment ineligibility. Restrictions, priorities, or special admission criteria shall be applied equally to all potential clients.

B. Agencies admitting offenders referred through Colorado's criminal justice system shall assure such referrals are in accordance with all applicable state and federal statutes and regulations.

C. Agencies admitting offenders referred through criminal justice systems in other states shall assure such referrals are in accordance with the Interstate Compact (Title 24, Article 60, Part 3, C.R.S.) and all other applicable state and federal statues and regulations.

D. Differential assessments (see “Definitions”, Section 1.7) shall be conducted using ADAD-approved assessment instruments and procedures and shall justify client placement, support treatment planning, and be updated during treatment as necessary.

E. Admission summaries (see “Definitions”, Section 1.7) shall be completed based on assessments and other relevant intake data.

F. Clients shall be placed in the least restrictive and most appropriate treatment modalities according to ADAD-approved client placement criteria.

G. Treatment facilities and services shall be reasonably accessible to all client populations served. Accessibility for disabled clients shall comply with the American Disabilities Act. Accessibility for other specific client populations shall be demonstrated by appropriate location of treatment sites and outreach activities.

6.3 Treatment Modalities

A. Social setting (non-hospital) residential detoxification - see Section 13.0, “Non-Hospital Detoxification”

B. Medically managed ambulatory and inpatient detoxification - see Section 10.0, “Medical Detoxification”

C. Opioid maintenance therapy - see Section 9.0, “Opioid Replacement Treatment and Supportive Services”

D. Outpatient Treatment

1. Outpatient treatment shall be conducted by appropriately credentialed counselors on a regularly scheduled basis with a frequency of less than 9 treatment contact hours per week.

2. Client/counselor ratios shall not regularly exceed 12 to 1 during group therapy sessions.

3. Procedures for responding to emergency situations shall be conspicuously posted in all outpatient sites.

4. Medical, psychological, psychiatric, laboratory, and toxicology services shall be available through consultation or referral when clinically indicated.

5. Emergency services shall be client accessible by telephone during non-business hours, either on-site or through referral.

E. Intensive Outpatient Treatment and Day Treatment (Partial Hospitalization)

1. Intensive outpatient and day treatment shall be conducted by appropriately credentialed counselors on a regularly scheduled basis with a minimum frequency of 9 treatment contact hours per week.

2. Client/counselor ratios shall not regularly exceed 12 to 1 during group therapy sessions.

3. Procedures for responding to emergency situations shall be conspicuously posted in all outpatient and day treatment sites.

4. Medical, psychological, laboratory, and toxicology services shall be available through consultation or referral when clinically indicated.

5. Emergency services shall be client accessible by telephone during non-business hours, either on-site or through referral.

F. Transitional Residential Treatment and Extended Residential Care (Low to Medium Intensity Residential Treatment)

1. Transitional residential treatment and extended residential care shall be conducted by appropriately credentialed counselors with a frequency of 5 – 10 contact hours per week.

2. Client/counselor ratios shall not regularly exceed 12 to 1 during group therapy, client/staff ratios shall not exceed 20 to 1 during night-time hours.

3. Procedures for responding to emergency situations shall be conspicuously posted in all residential sites.

4. Appropriate medical procedures including indicated laboratory and toxicology tests shall be available as needed through consultation and referral.

G. Intensive Residential Treatment (High Intensity Residential Treatment)

1. Intensive residential treatment shall be conducted by appropriately credentialed counselors in highly structured 24-hour, therapeutic environments.

2. Client/counselor ratios shall not regularly exceed 12 to 1 during group therapy, client/staff ratios shall not exceed 20 to 1 during night-time hours.

3. Procedures for responding to emergency situations shall be conspicuously posted in all residential sites.

4. Appropriate medical procedures including indicated laboratory and toxicology tests shall be available as needed.

H. Therapeutic Community (High Intensity Residential Treatment)

1. Treatment in therapeutic communities shall be conducted by appropriately credentialed

counselors and senior clients in highly structured 24-hour therapeutic environments.

2. Client/counselor ratios shall not regularly exceed 12 to 1 during scheduled therapeutic activities. Senior clients may be counted as part of counseling staff if specifically designated as such by treatment directors. Client/staff ratios shall not exceed 20 to 1 during night-time hours.

3. Procedures for responding to emergency situations shall be conspicuously posted in all residential and outpatient sites.

4. Appropriate medical procedures including indicated laboratory and toxicology tests shall be available as needed.

6.4 Treatment Planning and Review

A. Treatment planning (see "Definitions", Section 1.7) shall be required which results in an individualized treatment plan for each client, collaboratively developed and implemented by counselors and clients. Treatment plans shall not be required in cases where the sole expected outcomes are crisis intervention and referral.

B. Treatment plan reviews (see "Definitions", Section 1.7) shall be conducted at regular intervals during treatment based on completion dates for planned therapeutic activities and expected lengths of stay in treatment.

6.5 Treatment

A. A primary counselor or case manager shall be assigned to each client to assure performance, consistency, and coordination of treatment and auxiliary services.

B. Families/significant others shall be involved in client treatment when considered therapeutically appropriate and geographically possible.

C. Case management (see "Definitions", Section 1.7) services shall be provided to clients and their families/significant others as appropriate.

D. Treatment notes (see "Definitions", Section 1.7) shall be completed at regular intervals based on expected lengths of stay in treatment.

E. Medications shall be dispensed, administered, and monitored according to applicable state statutes and regulations and ADAD standards, policies, and procedures.

F. Urine, breath, and blood samples shall be collected and analyzed in accordance with applicable state statutes and regulations and ADAD standards, policies and procedures.

6.6 Treatment Discharge

A. Discharge criteria shall be developed and implemented which delineate grounds for client discharge from treatment.

B. Voluntary clients shall be discharged from treatment immediately at their request unless emergency commitments or emergency mental health holds are in effect.

C. Continuing care plans (see "Definitions", Section 1.7) shall be collaboratively developed by counselors and clients prior to treatment discharge.

D. Discharge summaries (see “Definitions”, Section 1.7) shall be completed following treatment discharge.

6.7 Physical Restraints and Seclusion

A. Treatment providers using physical restraints or seclusion shall develop and implement policies and procedures governing their use. Such policies and procedures shall be developed with medical and legal consultation, incorporate Section 6.7, B - H, and shall be maintained and staff-accessible in treatment facilities.

B. Restraints or seclusion shall not be used as discipline, punishment, or solely for the convenience of staff.

C. Restraints or seclusion shall be used only in extreme circumstances when it appears that clients or staff are at imminent risk for injury and other measures to reduce the risk have not proven sufficient.

D. Use of restraints or seclusion shall only be ordered by treatment directors, agency physicians, or other specifically designated treatment staff. Only staff who are qualified by experience or training in the use of restraints and seclusion shall implement such orders.

E. All orders, authorizations, monitoring, and justifications for initiating and continuing restraints or seclusion shall be documented in client records by agency physicians, treatment directors, or other specifically designated treatment staff.

F. Clients restrained or secluded shall be monitored at least every 15 minutes to determine physical status.

G. Treatment directors, agency physicians, or other specifically designated treatment staff shall be notified when use of restraints or seclusion has exceeded 1 hour and shall be required to authorize continued use. Verbal authorizations via telephone shall be documented and shall be countersigned by authorizing persons within 24 hours.

H. Authorized use of restraints or seclusion beyond 1 hour shall be re-evaluated at least ONCE every 4 hours thereafter and continued use shall require justifications and new orders by treatment agency physicians, treatment directors, or other specifically designated staff.

7.0 TREATING PERSONS CONVICTED OF MISDEMEANORS AND FELONIES

7.1 General Provisions

A. Alcohol/other drug treatment and adjunctive services shall be provided to persons convicted of misdemeanors and felonies (except persons convicted of Class 1 felonies), who are assessed as substance abusers, as provided by Title 16, Article 11.5, Part 1, Colorado Revised Statutes (C.R.S.) in accord with the current standardized offender assessment and placement protocol.

B. Programs providing these services shall develop and implement policies, procedures, and individualized treatment planning demonstrating recognition of issues and treatment needs unique to this client population.

C. Auxiliary services as clinically indicated shall be provided for on-site or through referrals and shall include:

1. Random urinalysis;

2. Naltrexone monitoring;

3. Disulfiram monitoring;

4. Methadone maintenance or LAAM;

5. Self-help programs;

6. Random breath testing;

7. Victim impact panel (if available);

8. Other medication.

D. Clients shall be engaged in therapeutic activities for a minimum of 9 months or as required by the referring criminal justice agency.

E. Services shall be based on the results of screening and differential assessments.

F. Level I DUI Education, Level II DUI Therapeutic Education, or Level II DUI Therapy shall not be provided unless there have also been arrests or convictions for DUI/DWAI.

7.2 Offender Education Services

A. Programs shall provide a specialized offender education program. The curriculum shall be written in manual format and be approved by the Department's Alcohol and Drug Abuse Division.

B. The following content/topics shall be presented at a minimum during offender education:

1. Drugs of abuse, physiological and psychological effects:

    a. alcohol;

    b. marijuana;

    c. stimulants.

2. Signs and symptoms of abuse and dependence;

3. Stress management and substance use;

4. Anger management and substance use;

5. Understanding behavioral triggers leading to substance abuse;

6. Driving and drugs;

7. Work place and legal issues.

C. Level I or Level II education cannot be substituted for offender education. Offender education can be substituted for Level I or Level II education if there is a DUI/DWAI/BUI/FUI offense concurrent with the felony, drug misdemeanor or drug petty offense.

7.3 Offender Treatment Services

A. Staff conducting offender therapy shall be required to have knowledge of and experience in working with offenders and be competent in group and individual therapy. These requirements are in addition to staff qualifications set forth in Section 4.2.

B. Programs admitting offenders referred by criminal justice agencies shall place offenders in accord with referral placement criteria.

8.0 EDUCATING AND TREATING DUI, DWAI, BUI AND FUI OFFENDERS

8.1 General Provisions

A. Alcohol and Drug Driving Safety (ADDS) education and treatment services shall be restricted to those convicted of receiving deferred prosecutions, sentences, or judgements for alcohol/other drug offenses related to driving (Title 42, Article 4, Part 13, C.R.S.), boating (Title 33, Article 13, Part 1, C.R.S.), or flying (Title 41, Article 2, Part 1, C.R.S.).

B. Driving Under the Influence (DUI), Driving While Ability Impaired (DWAI), Boating Under the Influence (BUI), and Flying Under the Influence (FUI) offenders who are admitted, educated, or treated shall have been screened, referred and placed in accord with current ADDS program screening, referral, and placement procedures.

C. The ADDS referral and placement criteria for substance abusing drivers is:

1. Level I education;
2. Level II education;
3. Level II education and weekly non-intensive outpatient treatment;
4. Intensive outpatient, followed by Level II education and non-intensive outpatient treatment;
5. Day treatment, followed by Level II education and weekly non-intensive outpatient treatment;
6. Low intensity residential treatment, followed by Level II education, intensive outpatient and/or weekly non-intensive outpatient treatment;
7. Transitional treatment, followed by Level II education, intensive outpatient and/or weekly non-intensive outpatient treatment;
8. Intensive residential treatment, followed by Level II education, intensive outpatient and/or weekly non-intensive outpatient treatment;
9. Hospital treatment, followed by Level II education, intensive outpatient and/or weekly non-intensive outpatient treatment;
10. Therapeutic community and Level II education;
11. No treatment.

D. Levels 2 through 10 above are Level II programs.

E. Programs providing DUI services shall develop and implement policies, procedures, and individualized treatment planning demonstrating recognition of issues and treatment needs unique to this client population.

F. Level I education, Level II therapeutic education, and Level II therapy shall be conducted in outpatient settings. Level II therapy may also be conducted in ADAD-approved residential settings.

G. Level I education, Level II therapeutic education, and Level II therapy shall not be combined, nor shall hours completed in one count as hours completed in another.

H. Programs providing Level I education, Level II therapeutic education, and Level II therapy shall report to sentencing courts, ADAD, probation departments, ADES, and when appropriate, Revenue Department Hearing Section, or Motor Vehicle Division, in a timely manner using reporting formats approved by ADAD. Reported client information shall include:

1. Enrollment;

2. Cooperation;

3. Attendance;

4. Treatment progress;

5. Education/treatment levels;

6. Fee payment;

7. Discharge status.

I. Programs furnishing non English education/treatment shall submit curricula and instructional materials, including handouts, to ADAD for approval and provide translation if requested.

J. Clients shall not be reported as finishing Level I education, Level II therapeutic education, or Level II therapy until all required sessions covering all required content/topics have been completed.

K. Programs shall furnish copies of ADAD-approved Discharge Referral Summaries (DRS) to clients within ten working days following client discharge from education/treatment.

L. Programs shall retain DRS's for 10 years and make them accessible to former clients upon request.

M. Adjunctive services shall be provided, either on-site or through referral, when clinically justified, either concurrently with or consecutively to Level II education and treatment. Such services shall include the following:

1. Random urine screens;

2. Disulfiram monitoring;

3. Naltrexone monitoring;

4. Opioid maintenance;

5. Self/mutual help programs;

6. Random breath testing;

7. Victim impact panel (if available);

8. Other medication.

N. Programs admitting DUI/SWAI, BUI, OR FUI offenders referred by criminal justice agencies shall place offenders in accord with agency referral placement criteria.

O. DUI/DWAI offenders shall not be educated or treated in groups with non-offenders or with non-driving offenders unless they need specialized services in accordance with Section 8.7.

8.2 Level I Education

A. Programs may apply for approval to conduct Level I education only or approval to conduct Level I education, Level II therapeutic education and Level II therapy.

B. Level I education shall be restricted to DUI/DWAI, BUI, or FUI offenders who have been screened, referred, or placed in this level of education in accord with current ADDS program clinical procedures.

C. Staff conducting Level I education shall be knowledgeable in all areas of Level I curricula, demonstrate instructional ability, and meet the staff qualifications set forth in Section 4.2. State of Colorado addiction counselor certification at CAC I may be substituted for these requirements.

D. Level I education shall be 12 hours of instruction, including client intakes and pre/post tests. No more than 6 hours shall be conducted in 1 calendar day.

E. Level I education shall not be conducted in residential settings.

F. An ADAD-approved pre/post test shall be administered to Level I education clients.

G. The following content/topics shall be presented at a minimum during Level I education:

1. Physiological effects of alcohol and other drugs, their effects on driving and their interactions;
2. High risk behavior patterns;
3. Psychological and sociological consequences of use/abuse of alcohol and/or other drugs;
4. Blood alcohol concentration and effects on driving performance;
5. Court penalties;
6. Motor Vehicle Division laws and penalties, including potential incongruence between court sentence and Motor Vehicle Division requirements;
7. Theories of addiction and common treatment approaches;
8. Availability of local treatment and self help programs;
9. Alternatives to drinking/drugging and driving;
10. Impact of impaired driving on victims.

H. The following content/topics may be presented to Level I/II education clients:

1. Understanding behavioral triggers leading to substance abuse;
2. Concepts of relapse and relapse prevention;

3. Stress management and substance use;

4. Anger management and substance use;

5. Decision making skills;

6. Feelings and self esteem (Level II);

7. Development of a personal change plan (Level II).

I. No more than 20 clients shall be present in a Level I education group.

J. Individual records shall be maintained for Level I education clients and shall include:

1. Pre/post test results;

2. Attendance and course completion data;

3. Descriptions of content/topics covered during each session;

4. Relevant reports, information releases, and records of communication;

5. Assessment data (if assessment is performed);

6. Client performance and progress;

7. Copies of DRS (following client discharge).

8.3 Level II Therapeutic Education

A. Programs applying for approval to conduct Level II therapeutic education must also apply for approval to conduct Level II therapy and meet the requirements of both.

B. Level II therapeutic education shall be restricted to DUI/DWAI, BUI, or FUI offenders who have been screened, referred, and placed in accord with the current ADDS program clinical procedures.

C. Staff conducting Level II therapeutic education shall be knowledgeable in the curriculum, demonstrate teaching ability, and be competent in group process. These requirements are in addition to the staff qualifications in Section 4.2.

D. The curriculum shall be written in manual format, use techniques which motivate the client, and be approved by ADAD.

E. The program shall adhere to the curriculum.

F. Level II therapeutic education shall be conducted in outpatient settings and shall range between 8 and 12 weeks and shall total 24 hours in duration. No more than 1 session shall be conducted per week without clinical justification.

G. Level II therapeutic education shall present all Level I education contents/topics and at least half of each Level II therapeutic education session shall consist of therapeutically oriented activities, emphasizing group process.

H. Attendance at Level II therapeutic education sessions shall not regularly exceed 12 clients.

I. An ADAD-approved pre/post test shall be administered to Level II therapeutic education clients.

J. Level II therapeutic education shall not be conducted concurrently with Level II therapy unless judged clinically appropriate. Such judgments shall be documented in client records. Total time in Level II therapeutic education and Level II therapy shall not be less than the minimum number of weeks required for Level II therapy.

K. Individual client records shall be maintained for Level II therapeutic education clients. In addition to the requirements in Section 5.0, records shall include:

1. Court documents regarding referral and classification;

2. Pre/post test results;

3. Attendance and completion data for all therapeutic education;

4. Assessment results (if performed);

5. Individual or individualized group treatment notes;

6. Client's progress in therapeutic education;

7. Relevant reports, information releases, and records of communication;

8. Copy of DRS (following client discharge).

8.4 Level II Therapy

A. Programs applying for approval to conduct Level II therapy must also apply for approval to conduct Level II therapeutic education and meet the requirements for both.

B. Level II therapy shall be restricted to DUI, DWAI, BUI, or FUI offenders who have been screened, referred, and placed in accord with the current ADDS program clinical procedures.

C. Clients whose blood alcohol content was between .150% and .199% and who have one offense for DUI, DWAI, BUI, or FUI shall complete a minimum of 42 hours of group and/or individual Level II therapy conducted over a period not less than 21 weeks (5 months).

D. Clients whose blood alcohol content was .20% or more and who have one offense for DUI, DWAI, BUI, or FUI shall complete a minimum of 52 hours of group and/or individual Level II therapy conducted over a period not less than 26 weeks (6 months).

E. Clients whose blood alcohol content was less than .20% and who have two or more offenses for DUI, DWAI, BUI, or FUI shall complete a minimum of 68 hours of group and/or individual Level II therapy conducted over a period not less than 34 weeks (8 months).

F. Clients whose blood alcohol content was .20% or more and who have two or more offenses for DUI, DWAI, BUI, or FUI shall complete a minimum of 86 hours of group and/or individual Level II therapy conducted over a period not less than 43 weeks (10 months).

G. Staff conducting Level II therapy shall be required to have knowledge of and experience in working with DUI/DWAI offenders and be competent in group process and individual therapy. These requirements are in addition to the staff qualifications in Section 4.2 of these rules.

H. The treatment program shall be written in manual format, incorporate treatment approaches which

have demonstrated effectiveness in the research literature and which are consistent with the client's readiness to change, and be approved by ADAD.

I. Level II therapy shall be conducted only after Level II therapeutic education has been completed unless clinically justified and documented in client records.

J. Level II therapy group sessions (except for intensive outpatient) shall not be less than 90 minutes of therapeutic contact, not including administrative procedures and breaks. Clients shall attend once or more each week unless less frequent contact is clinically justified and documented, but shall not attend less than one session per month. Attendance less than once per week shall require adjunctive treatment or collateral contact unless clinically justified and documented. Clients shall complete the minimum hours and weeks of group and/or individual Level II therapy required.

K. Attendance at Level II therapy sessions shall not regularly exceed 12 clients.

L. Level II therapy clients shall be assessed in accord with the requirements in Section 6.2.

M. A comprehensive treatment plan shall be developed using the results of the clinical assessment and shall be reviewed during the course of Level II therapy.

N. The treatment provided during the course of Level II therapy shall reflect the offender's progress toward change..

O. Individual client records shall be maintained for Level II therapy clients in accordance with applicable sections of these rules. Client records shall include:

1. Court documents regarding referral and placement;
2. Attendance and completion data for all therapy sessions;
3. Differential assessment documentation and results;
4. Revised treatment plans;
5. Individual or individualized group treatment notes which document progress in treatment;
6. Individual or individualized group treatment notes for every session;
7. Relevant reports, information releases, and records of communication;
8. Copy of DRS (following client discharge).

8.5 Level II Residential Therapy

A. Residential treatment programs may qualify to provide Level II therapy if:

1. They are ADAD-approved;
2. They provide at least 5 hours of scheduled, daily, multiple therapeutic activities;
3. They meet all the requirements in Sections 1.0 through 6.0, Section 8.1, and Section 8.4;
4. they are affiliated with ADAD approved outpatient DUI programs.

B. If, upon discharge from Level II residential therapy, the minimum number of weeks required for Level II

therapy has not been fulfilled, the clients shall be transferred to outpatient care, where the remaining education and therapy requirements shall be met.

8.6 Level II Intensive Outpatient Therapy

A. Intensive outpatient programs include intensive outpatient and day treatment.

B. Outpatient programs may qualify to provide intensive outpatient or day treatment services if:

1. They are ADAD approved for Level II; and,

2. They meet all requirements in Sections 1.0 through 6.0, Section 8.1, and Section 8.4.

C. The length of stay in Level II intensive outpatient or day treatment shall be four to six weeks.

D. Offenders placed in intensive outpatient treatment shall receive a minimum of 9 hours of treatment per week over not less than three calendar days per week.

E. Offenders placed in day treatment shall receive a minimum of 20 hours of treatment per week.

F. If, upon discharge from Level II intensive outpatient or day treatment, the minimum number of weeks required for Level II therapy has not been fulfilled, the client shall be transferred to outpatient care, where the remaining education and therapy requirements shall be met.

8.7 Specialized Services

A. Level II program clients requiring specialized services (e.g., therapy for other drug issues, mental health counseling, prenatal care, HIV/AIDS pre/post-test counseling, services for persons with disabilities) shall be referred to appropriate service providers.

B. Case management of specialized service provision, including reporting to referring courts or their representatives, shall be the responsibility of the admitting Level II programs.

C. Hours and weeks of specialized services may be included with, and reported as, hours of Level II therapy.

D. Level II programs not able to furnish or arrange for specialized services required by court-ordered clients shall refer these clients back to the ADES with letters describing the nature of the problems and suggestions for alternative services.

E. Level II programs shall assure that clients have access to court-ordered adjunctive treatment services specified in Section 8.1, M. and that these services are provided in compliance with ADAD rules, policies, and procedures, whether provided directly or through referral linkages.

9.0 OPIOD REPLACEMENT TREATMENT AND SUPPORTIVE SERVICES

9.1 General Provisions

A. Opioid replacement treatment and supportive services shall be provided to persons whose opioid addiction and subsequent related behaviors, as defined by the Diagnostic and Statistical Manual of Mental Disorders criteria, necessitate prescribed daily doses of methadone, LAAM (levo-alpha-acetylmethadol), or other approved controlled substances to prevent withdrawal symptoms, stabilize life styles, increase productivity and reduce risk of contracting and transmitting HIV/AIDS, TB and other life-threatening, infectious diseases. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, is available from the American Psychiatric

Association, 1400 K Street N.W., Washington, D.C. 20005; or, copies may be obtained from or examined at the Offices of the Alcohol and Drug Abuse Division, 4055 South Lowell Blvd., Denver, Colorado 80236; or, the material may be examined at any State Publication Depository Library. References to this manual do not include subsequent editions.

B. Programs providing these services shall develop policies, procedures, and individualized treatment planning demonstrating recognition of issues and treatment needs unique to this patient population and shall obtain Controlled Substance Licenses in compliance with Title 12, Article 22, Part 3, and Title 18, Article 18, Part 1, C.R.S.

C. Procedures for responding to emergency situations shall be conspicuously posted in all treatment sites.

D. This section of the treatment standards refers to consumers as patients due to the medical nature of this treatment.

9.2 Admission Criteria and Procedures

A. Persons shall be admitted as patients only if program physicians determine and document in patient records that such persons are currently physiologically dependent and were physiologically addicted to an opioid drug, continuously or episodically for most of the year immediately preceding admission.

B. In the case of persons for whom the exact date on which physiological dependence began cannot be ascertained, the admitting program physicians may, using reasonable clinical judgment, admit such persons to maintenance treatment if from the evidence presented, observed, and recorded in patient records, it is reasonable to conclude that there was physiological dependence at a time approximately one year before admission.

C. Decisions concerning admission to treatment shall be documented in patient records.

D. Programs that offer detoxification treatment shall follow all applicable federal laws, rules, and regulations regarding admission criteria.

9.3 Program Sponsor

A. Programs shall have sponsors who assume responsibility for the operation of the program and all the employees, including any practitioners, agents, or other persons providing services, and ensure that programs are in compliance with all applicable Colorado and Federal laws, rules, and regulations.

B. Program sponsors shall ensure that patients voluntarily choose to participate in programs, that all facts concerning the use of opioids used by programs are clearly and adequately explained, that all patients with full knowledge and understanding of its contents sign the “Consent to Methadone Treatment” Form FDA 2635, and that parents or legal guardians or responsible adults designated by the state authority (e.g., “emancipated minor” laws) sign for patients under the age of 18 the second part of Form FDA 2635.

C. Program sponsors shall ensure that patient-counselor ratios shall not regularly exceed 50:1.

9.4 Medical Evaluations, Physical Examinations and Laboratory Tests

A. Persons admitted or readmitted to programs after six month treatment lapses shall have a medical evaluations by program physicians or authorized licensed health care professional staff members under the supervision of a program physicians. Evaluations shall include at minimum the

following:

1. Medical histories which include required narcotic dependence chronology;

2. Evidence of current physiological dependence;

3. History or presence of the use of opioids;

4. Physical examination;

5. Appropriate laboratory tests.

B. Physical examinations shall be conducted, evaluated and documented in patient records at admission and every two years from date of admission. At minimum, physical examinations shall consist of:

1. Investigations of organ systems for possible infectious diseases and pulmonary, liver, and cardiac abnormalities;

2. Checks for dermatologic sequelae of addiction;

3. Vital signs (temperature, pulse, blood pressure and respiratory rate);

4. Examinations of patients' general appearance;

5. Inspections of head, ears, eyes, nose, throat (thyroid), chest (including heart, lungs and breasts), abdomen, extremities, and skin;

6. Neurological assessments;

7. Program physicians' overall medical evaluation of patients.

C. Laboratory tests shall be conducted and results shall be evaluated and documented in patient records within 30 calendar days of admission and shall include:

1. Serological test for syphilis;

2. Tuberculin skin test or other test for clinically active tuberculosis, when indicated;

3. Urinalysis for drug determination;

4. Complete blood count and differential;

5. Routine and microscopic urinalysis;

6. Liver function profile.

D. Other medical concerns shall be addressed by programs or referred to other medical facilities when appropriate as determined by program medical directors.

9.5 Medical Directors and Program Physicians

A. Programs shall have designated medical directors who assume responsibility for administering all medical services performed by programs.

B. Medical directors and other authorized program physicians shall be licensed to practice medicine in

Colorado as provided by Article 36, Title 12, C.R.S.

C. Medical directors are responsible for ensuring that programs are in compliance with all state and federal rules and regulations regarding medical treatment for opioid addiction.

D. Responsibilities of medical directors and other authorized program physicians include, but are not limited to, the following:

1. Ensuring that evidence of current physiologic dependence, history of addiction, or exceptions to criteria for admission are documented in patient records prior to dosing;

2. Ensuring that appropriate medical evaluations and physical examinations have been performed prior to initial dosing, (in emergency situations, initial dosing is allowed prior to physical examinations);

3. Ensuring that appropriate laboratory tests have been performed and reviewed, (initial dosing is allowed before the results of the laboratory tests are reviewed);

4. Documenting, signing or countersigning all medical orders which shall include initial methadone, LAAM, or other medication orders, and all subsequent medication order increases or decreases and all changes in frequency of take-home doses for privileges, emergency situations or special circumstances.

E. Medical directors and/or authorized program physicians shall review, sign, and date any resulting admission evaluations written by program health-care staff before initial doses may be administered to patients. When medical directors and/or authorized program physicians are not available on site to review, sign, and date evaluations for admission written by the program health-care staff, required physician reviews may be made by telephone and initial doses may be administered to patients on the physicians' verbal orders. In such cases, health-care staff shall document (including date and signature) in patient records that no physicians were available on site and that physician reviews were done by telephone.

F. Medical directors and/or program physicians shall review and counter-sign all telephone or other verbal authorizations within seventy-two hours of verbal approval.

9.6 Methadone Take-Homes

A. Program physicians shall review, approve and document in patient records all take-home doses along with written evaluation of patient responsibility in handling opioid drugs.

B. Take-home doses of methadone three times per week (Step Level I) may be approved after at least three (3) months of treatment during which compliance with the following minimum criteria has been demonstrated:

1. Last four (4) consecutive negative urine drug screen results;

2. No unexcused dose absences;

3. Adherence to program rules and take-home agreements;

4. Attending at least two (2) counseling sessions per month;

5. Following treatment plans;

6. Employed, attending school, homemaker (an individual who takes care of dependent(s) at

home), or considered unemployable for mental or physical reasons by program physicians;

7. Absence of known recent criminal activity, as defined by the program;

8. No abuse of alcohol;

9. Capable of handling take-home bottles and behaving in a responsible manner and maintaining a stable living environment.

C. Take-home doses two (2) times per week (Step Level II) may be approved after at least two (2) years of treatment during which compliance with the following minimum criteria has been demonstrated:

1. Six (6) months of consecutive negative urine drug screen results;

2. No unexcused dose absences;

3. Adherence to clinic rules and take-home agreements;

4. Attending at least one (1) counseling session per month;

5. Following treatment plans;

6. Employed, attending school, homemaker (an individual who takes care of dependent(s) at home), or considered unemployable for mental or physical reasons by program physicians;

7. Absence of known recent criminal activity;

8. No abuse of alcohol;

9. Capable of handling take-home bottles and behaving in a responsible manner and maintaining a stable living environment.

D. Take-home doses one (1) time per week (Step Level III) may be approved after three (3) years of treatment during which compliance with the following minimum criteria has been demonstrated:

1. Last twelve (12) months of consecutive negative urine drug screen results;

2. No unexcused dose absences;

3. Adherence to program rules and take-home agreements;

4. Attending at least one (1) counseling session per month;

5. Following treatment plans;

6. Employed, attending school, homemaker (an individual who takes care of dependent(s) at home), or considered unemployable for mental or physical reasons by program physicians;

7. Absence of known recent criminal activity;

8. No abuse of alcohol;

9. Capable of handling take-home bottles and behaving in a responsible manner and maintaining a stable living environment.

E. Take-home agreements shall be developed and implemented for patients approved for take-homes. Agreements shall be part of the treatment plan and specify the rationale for take-home step levels, doses, frequency of step level changes and consequences for violating conditions of the agreement.

F. Take-home methadone doses shall be dispensed in a medication container conforming to State and Federal Poison Prevention Packaging requirements, with the following labeling affixed:

1. Program name, address, and telephone number;

2. Patient names;

3. Drug type;

4. Quantity, if not a physician-authorized blind dose;

5. Directions for use.

G. Positive urine drug screens for patients at Step Level I shall result in a reduction of step level status to Daily Status for a period of thirty (30) calendar days.

1. If urine drug screen results are acceptable during this probationary period, patients may return to Step Level I.

2. Positive urine drug screen results during the probationary period shall result in patients having to re-earn step level privileges as defined in Section 9.6, B.

H. Positive urine drug screen results for patients at Step Level II shall result in a reduction of step level status from Step Level II to Step Level I for a period of thirty (30) calendar days.

1. If urine drug screen results are acceptable during this probationary period, patients may return to Step Level II.

2. Positive urine drug screen results during this probationary period shall result in a reduction of step level status from Step Level I to Daily Status for a period of thirty (30) calendar days. If urine drug screen results are acceptable during this second probationary period, patients may return to Step Level I for thirty (30) calendar days and then may return to Step Level II.

3. Positive urine drug screen during this second probationary period shall result in patients having to re-earn step level privileges as defined in Sections 9.6, B and C.

I. Positive urine drug screen results for patients at Step Level III shall result in a reduction of step level to Step Level II for a period of thirty (30) calendar days.

1. If urine drug screen results are acceptable during this probationary period, patients may return to Step Level III.

2. Positive urine drug screen results during this probationary period shall result in a reduction of step level status to Step Level I for a period of thirty (30) days. If urine drug screen results are acceptable during the second probationary period, patients may return to Step Level II for thirty (30) calendar days prior to resuming Step Level III.

3. Positive urine drug screen results during this second probationary period shall result in a reduction of step level status to Daily Status for a period of thirty (30) calendar days. If urine drug screen results are acceptable during this third probationary period, patients may return to Step Level I for thirty (30) calendar days, followed by Step Level II for thirty (30) calendar days prior to resuming Step Level III.

4. Positive urine drug screen results during this third probationary period shall result in patients having to re-earn step level privileges as defined in Sections 9.6, B, C, and D.

J. During a probationary period, urine drug screens shall be collected and analyzed on a random basis of two (2) times per month.

K. Unexcused absences or missed scheduled appointments for patients with step level privileges shall result in reductions of step level status for a period of ninety (90) calendar days. In order to resume step level status, there shall be three (3) consecutive months of urine drug screens that are acceptable and that have been analyzed on samples collected with a frequency of two (2) times each month.

L. Prior to dispensing take-home medications, programs shall submit and obtain ADAD approval for the following:

1. All doses in excess of 101 milligrams per daily dose;

2. Split doses;

3. Take-home medication provided during detoxification treatment of less than thirty (30) calendar days;

4. Take-home medication doses that exceed seven (7) calendar days;

5. Take-home medication doses that do not meet the criteria as defined in Section 9.6, B, C, and D;

6. Take-home medication doses for patients with unacceptable urine drug screen results within the last ninety (90) calendar days.

9.7 Prescribing, Dispensing, and Administering Methadone, LAAM, or Other Approved Controlled Substances

A. Program physicians shall prescribe doses and document same in patient records, including signature and date.

B. Standing orders for dispensing shall be approved by medical directors and ADAD.

C. Program physicians shall document justification for prescribing doses greater than one hundred (100) milligrams of methadone and one hundred forty (140) milligrams of LAAM.

D. Program physicians or designated licensed health-care professionals shall dispense and/or administer doses.

E. Exceptions to specific methadone dosing requirements shall require ADAD approval prior to dispensing and/or administering methadone doses. Dosing requirements ADAD will consider excepting are:

1. Initial daily methadone doses shall not exceed thirty (30) milligrams with a maximum of forty

(40) milligrams the first day;

2. Patients transferring from other methadone programs may initially be dosed at the dosage last received at the previous program.

F. Initial doses of LAAM shall be twenty (20) to forty (40) milligrams. Patients stabilized on methadone and crossing over to LAAM shall receive a starting dose of LAAM equal to 1.2 to 1.3 times their daily methadone dose, not to exceed one hundred twenty (120) milligrams.

G. Take-home doses of LAAM shall not be permitted.

9.8 Urinalysis - Collection, Screening, and Analysis

A. Programs shall develop and implement criteria and procedures establishing urine collection methods that minimize falsification.

B. Programs shall develop and implement criteria that establish treatment responses to:

1. Evidence of unauthorized drug use in urine screen analyses, including prescription medications not authorized by treatment program;

2. Lack of methadone in urine drug screen analyses for patients receiving methadone;

3. Lack of LAAM in urine drug screen analyses for patients receiving LAAM, if accepted laboratory analysis is available;

4. Lack of other approved controlled substances in urine drug screen analyses that patents are receiving, if accepted laboratory analysis is available.

C. Procedures for urine drug screen analysis shall be designed and implemented to ensure urine collection on a random, unannounced basis, and provide for scheduled urine collection from absent patients.

D. Urine drug screen analyses shall be recorded in patient records and occur with at least the following frequency:

1. One (1) urine drug screen analysis at admission;

2. Two (2) urine drug screen analyses every month thereafter for the first two (2) years in treatment;

3. One (1) urine drug screen analysis every month after two (2) years in treatment;

4. Two (2) urine drug screen analyses per month during a probationary period or a period where there has been a loss of take-home privileges.

E. Refusal to provide urine samples for drug screen analyses shall be considered a positive drug screen analyses results.

F. Urine drug screen analyses shall be for the presence of the following drugs:

1. Methadone;

2. LAAM or other approved controlled substances, if laboratory analyses are available;

3. Morphine;

4. Other opioids;

5. Cocaine and it's metabolite;

6. Amphetamines and barbiturates;

7. Benzodiazepines, amphetamines and barbiturates at admission to treatment;

8. Other drugs when clinically indicated.

G. Laboratories and/or on-site drug screen analysis procedures used by programs for urine drug screen analysis shall be approved by ADAD.

9.9 Cooperation, Data Submission, and Theft/Diversion

A. Treatment programs shall cooperate with ADAD in developing, implementing, updating, and adhering to, “Memorandum of Cooperation.”

B. Treatment programs shall submit to ADAD on a monthly basis the following:

1. Drug/Alcohol Coordinated Data System (DACODS) admission and discharge forms;

2. Summaries of critical incidents by type and frequency of incidents;

3. Other data as determined necessary by ADAD.

C. Agencies shall provide effective controls and procedures to guard against theft and diversion of methadone, LAAM, and other controlled substances.

D. Security controls and procedures shall be approved by ADAD.

E. Changes to previously approved security controls shall be approved by ADAD.

F. Accountability and record-keeping procedures shall be approved by ADAD.

10.0 MEDICAL DETOXIFICATION

10.1 General Provisions

A. Medical detoxification services shall be provided by licensed medical staff qualified to supervise withdrawal from alcohol and other drugs through use of medication and/or medical procedures in residential or outpatient settings which possess controlled substances licenses in compliance with Title 12, Article 22, Part 3, Colorado Revised Statutes (C.R.S.), Controlled Substances Act.

B. Procedures for responding to emergency situations shall be conspicuously posted in all settings and sites where medical detoxification services are provided.

C. Providers of these services shall develop and implement policies, procedures, and individualized treatment planning demonstrating recognition of issues and treatment needs unique to this client population.

10.2 Admission and Evaluation

A. Specific admission criteria shall be developed and implemented which detail for which drugs, including alcohol, medical detoxification is provided.

B. Informed consent to medical detoxification shall include:

1. medications to be used;

2. need to consult with primary care physicians.

C. Medical evaluations by authorized physicians or authorized health-care professionals under the supervision of authorized physicians shall be required and shall consist of, at minimum:

1. Medical histories including detailed chronologies of substance abuse;

2. Identification of current physical dependence including drug types;

3. Physical examinations to determine appropriateness for outpatient or inpatient medical detoxification;

4. Appropriate laboratory tests including pregnancy tests, and other evaluations as indicated.

D. Protocols for usual and customary detoxification from each drug delineated in admission criteria shall be developed in consultation with licensed physicians and other allied health-care professionals and shall be implemented in the form of individualized detoxification plans under direct supervision of program medical directors. Protocols shall include:

1. Levels and types of intoxication;

2. Tolerance levels;

3. Degrees of withdrawal;

4. Possible withdrawal and/or intoxication complications;

5. Other conditions affecting medical detoxification procedures;

6. Types of medications used;

7. Recommended dosage levels;

8. Frequency of visits (outpatient settings);

9. Procedures to follow in the event of detoxification complications;

10. Daily assessments including expected improvements as well as potential problems;

11. Expected duration of detoxification.

10.3 Clinical Staff

A. The following minimum clinical staff shall be provided:

1. One medical director;

2. One R.N. or L.P.N. with at least one year detoxification experience;

3. Clinicians certified by ADAD at levels which allow independent work.

B. Medical directors' responsibilities shall include, at minimum:

1. Quarterly reviews and revisions of drug detoxification categories and protocols;

2. Reviews of individual detoxification plans;

3. Reviews of individual prescriptions that deviate from standard detoxification protocols;

4. Five hours minimum of monthly supervision of and consultation with staff providing detoxification services;

5. Direct supervision of individual detoxification cases that deviate from standard protocols and/or experience complications;

6. Developing and implementing back up systems for physician coverage when medical directors are unavailable and/or for emergencies.

C. There shall be 24-hour access to clinical staff by telephone and accommodation for unscheduled visits for crises or problem situations.

10.4 Clinical Services

A. The following clinical services shall be provided in addition to medication dosing contacts:

1. Motivational counseling and support;

2. Continuous evaluation and clinical intervention.

B. There shall be a minimum of 1 daily clinical supportive services contact which shall be documented in client records.

10.5 Dispensing and Administration Procedures

A. There shall be procedures for dispensing medications per standard detoxification protocols which are in accordance with applicable state and federal statutes and for the following:

1. Individual prescriptions filled and dispensed by a registered pharmacist at a designated pharmacy location;

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

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

10.6 Discharge Planning

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

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

11.0 TREATING MINORS

11.1 General Provisions

A. Providers of alcohol and other drug abuse treatment services to minors shall develop and implement policies, procedures, and treatment planning demonstrating recognition of developmental and legal issues and treatment needs unique to this client population.

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

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

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

11.2 Admissions

A. Minors may voluntarily apply for admission to alcohol/other drug abuse treatment with or without parental or legal guardian consent.

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

11.3 Consents

A. Written information about minors' treatment, including dates/times of admission or discharge, shall not be disclosed to parents or legal guardians without minors' express written consent, in accordance with federal and state confidentiality regulations.

B. Policies governing whether programs shall treat minors with or without parental or legal guardian consent shall be developed and implemented.

C. If minors refuse to sign written consent to contact parents or legal guardians for permission to treat, and program policies require such consent, the following options shall be available.

1. Minors may be informed that they can be denied admission and referred to treatment programs not requiring parental or legal guardian consent to treat.

2. In acute care situations, minors may be informed that emergency guardianships can be sought through the county department of social services which has proper jurisdiction.

D. Parents or legal guardians shall be notified of minors' admission to treatment without minors' written consent if:

1. In the judgment of the treatment director or designated staff, minors do not have the capacity to rationally decide whether to consent to notification due to age or medical and/or mental conditions;

2. Disclosure is necessary to protect the lives or well being of minors or others;

3. Essential medical information is necessary for parents or legal guardians to make informed medical decisions on behalf of minors.

E. Parents or legal guardians who do not consent to minors' treatment shall not be billed for treatment services unless a parental fee is assessed by a court.

11.4 Assessment and Treatment

A. Treatment programs shall use differential assessment instruments and procedures designed specifically for minors.

B. In planning treatment, programs shall apply prevention, intervention, treatment, rehabilitative, and continuing care strategies developed expressly for minors, including, as appropriate:

1. Refusal skills and problem solving activities;
2. Recreational, social, and cultural activities as alternatives to alcohol/other drug use/abuse;
3. Peer support groups;
4. Corrective educational activities;
5. Employability training.

C. As appropriate or possible, treatment programs shall include the following persons, institutions, and agencies in treatment planning:

1. Minors;
2. Family;
3. Schools;
4. Mental health;
5. Vocational rehabilitation;
6. Social services;
7. Legal systems;
8. Civic and social groups.

D. Disulfiram shall not be administered to minors until behavioral controls as alternatives to disulfiram are implemented and have not proven sufficient.

E. Administering or monitoring prescription medications to minors shall be done with guidance from health care professionals qualified in pediatric medicine.

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

G. Programs shall comply with Section 14.0, Treating Women, of these standards when treating pregnant minors.

H. If minors wish to remain in treatment and parents or legal guardians demand minors be release to their custody, programs shall have the option to request investigations by county departments of social services to determine whether minors are neglected or dependent children.

11.5 Minors Sentenced to Treatment

A. Minors sentenced to treatment under adult alcohol/other drug criminal statutes or for purposes of completing court ordered substance abuse education or treatment shall be governed by the same standards as adults.

B. Minors shall be informed that non compliance with treatment programs to which they are sentenced shall be reported to referring courts and/or their agents.

C. Minors sentenced to treatment/education who are compliant but whose parents or legal guardians are non compliant, may be accepted into treatment or education as provided by Section 11.2.

11.6 Non-Acute Crisis Management

A. Minors with alcohol/other drug induced crises who do not require acute detoxification services for management of withdrawal symptoms or related physical and/or psychological problems, may be provided shelter in non acute care alcohol/other drug abuse residential or outpatient treatment programs for up to 8 hours.

B. Initial, cursory assessments shall be performed to determine the existence of medical and/or psychological conditions which may require hospitalization and/or acute detoxification services.

C. Beds, meals and other services normally associated with residential treatment shall not be required.

D. Periodic monitoring of vital signs shall be performed.

E. Parents or legal guardians may be notified if the criteria in Section 11.3, D, are met or with minors' permission. If no parents or legal guardians are available, programs shall have the option to contact county departments of social services to establish emergency guardianships.

F. Programs shall attempt follow-up contacts with minors and their families to determine the need for further alcohol/other drug treatment services.

12.0 EMERGENCY AND INVOLUNTARY COMMITMENTS

12.1 Emergency Commitments

A. Emergency commitment policies and procedures, based on and in compliance with Title 25, Article 1, Part 3 and Title 25, Article 1, Part 11, Colorado Revised Statutes (C.R.S.), and these standards shall be developed and implemented by ADAD licensed detoxification programs to:

1. Ascertain if grounds for commitment exist;

2. Assure that clients or their legal representatives receive copies of commitment forms and have received and comprehend written notifications of rights to challenge commitments through the courts;

3. Determine when grounds for emergency commitments no longer exist.

B. Detoxification directors shall designate, in writing, qualified staff to assume responsibility for accepting, evaluating, informing, and providing treatment to emergency commitment clients.

C. Applications for emergency commitments shall be prepared on forms approved by ADAD.

D. Daily evaluations for emergency commitment continuance shall take place and shall be documented.

E. If emergency commitment clients require treatment in other ADAD-approved detoxification programs, transfers may be managed by the programs which initially authorized the commitments.

F. When transferring clients, detoxification programs shall use transfer forms approved by ADAD and completed copies shall be given to transferring clients or their legal representatives and to detoxification programs to which clients are being transferred.

G. When minors are transferred, parents or legal guardians who have given permission for treatment shall receive copies of transfer forms.

H. When it is determined that grounds for emergency commitments no longer exist, clients shall be transferred to voluntary status and such transfers shall be communicated to clients and noted in client records.

12.2 Involuntary Commitments

A. All agencies directly or indirectly funded by ADAD shall accept involuntary commitment clients.

B. Involuntary commitment policies and procedures shall be developed and implemented based on and in compliance with Title 25, Article 1, Part 3 and Title 25, Article 1, Part 11, Colorado Revised Statutes (C.R.S.), and these standards.

C. ADAD shall be the legal custodian of persons involuntarily committed to treatment.

D. Passes shall be issued to involuntarily committed clients treated in residential settings only if they are directly related to clinical processes. Passes shall not be issued during initial 30 days of treatment except in extreme emergencies and with ADAD's prior approval.

E. The following client information shall be reported to ADAD:

1. Non-compliance with program requirements and/or court orders;

2. Failure to appear for admission to treatment;

3. Leaving treatment in violation of court orders;

4. Failure to return from passes;

5. Treatment status every 30 days.

F. Discharge summaries shall be submitted to ADAD, the referring source and to the provider of further treatment or aftercare.

G. Requests for early discharge and/or transfer to other treatment programs shall be submitted to ADAD for approval.

13.0 NON-HOSPITAL DETOXIFICATION

13.1 General Provisions

A. Providers of non-hospital detoxification services shall develop and implement policies, procedures, and treatment planning demonstrating recognition of issues and treatment needs unique to this client population.

B. Non-hospital detoxification services shall provide 24-hour supervised withdrawal from alcohol and/or

other drugs in a residential setting.

C. Client/staff ratios shall not exceed 10 to 1 and procedures for responding to periods of high client traffic and/or emergency situations shall be conspicuously posted.

D. Detoxification policies and procedures, including linkages with emergency medical and mental health services, shall be developed and implemented in accordance with federal, state, and ADAD standards, and in consultation with medical professionals qualified in alcohol and other drug abuse/dependence treatment and non-hospital detoxification.

E. Detoxification providers shall not be required to develop treatment plans but shall be required to develop and implement service plans for managing clients with medical conditions, suicidal ideation, pregnancy, psychiatric conditions, and other conditions which place clients at additional risk during detoxification.

F. Policies and procedures shall be developed and implemented for handling clients who pose a threat to themselves or others and shall include appropriate uses of law enforcement and emergency and involuntary commitments.

13.2 Admission and Monitoring

A. Clients admitted to detoxification services shall be intoxicated, under the influence, or in mild to moderate stages of withdrawal from alcohol and/or other drugs.

B. Detoxification admission procedures shall address at a minimum:

1. Degree of alcohol and other drug intoxication;

2. Initial vital signs;

3. Need for emergency medical and/or psychological services;

4. Current state of substance abuse including drug types and amounts;

5. Inventorying and securing personal belongings;

6. Substance abuse history and degree of personal and social dysfunction, as soon as clinically feasible following admission.

C. Detoxification monitoring procedures shall include:

1. Documentation of all monitoring activities in client records.

2. Vital signs taken at least every 2 hours until they remain in normal range for at least 4 hours, then taken every 8 hours thereafter until discharge;

3. Routine monitoring of physical and mental status.

D. There shall be documentation in client records that information is communicated to clients prior to discharge about:

1. Effects of alcohol and other drugs;

2. Risk factors associated with alcohol and other drug abuse for acquiring and transmitting HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome),

tuberculosis, and other infectious diseases, and for pregnancy;

3. Availability of testing and pre/post-test counseling for HIV/AIDS, TB, other infectious diseases, and pregnancy;

4. Availability of alcohol and other drug abuse treatment services.

E. Discharge policies and procedures shall be developed and implemented including:

1. Procedures which assure blood alcohol levels no greater than .04 prior to discharge and vital signs within normal range;

2. Procedures for dealing with clients leaving treatment while intoxicated and against staff recommendations, including clients signing releases of agency liability;

3. Circumstances under which clients will be discharged, other than completing detoxification or leaving against staff recommendations;

4. Assurances that clients have received information listed in Section D, 1-4, of these regulations and motivational counseling.

14.0 TREATING WOMEN

14.1 Assessment and Treatment

A. Providers of alcohol and other drug abuse treatment to women, pregnant women, and women with dependent children shall develop and implement policies, procedures, and individualized treatment planning demonstrating recognition of issues and treatment needs unique to these client populations.

B. Assessments shall be gender-sensitive, differential, and comprehensive. Assessments shall include age-appropriate evaluations of children whose mothers are enrolled in treatment when clinically indicated.

C. Treatment planning shall be based on comprehensive, differential assessments. Treatment plans shall include pre-natal care for pregnant women and self-sufficiency strategies addressing vocational/educational assessments/services and job training.

D. Therapeutic services and activities shall be gender-specific and shall address the following issues:

1. Alcohol/other drug abuse;

2. Emotional, physical and sexual abuse;

3. Relationships;

4. Mental health;

5. Parenting skills.

E. Women having a history of sexual abuse shall be offered the opportunity to be treated by counselors trained in sexual abuse issues; counselors shall be of the same gender as clients unless client preference and clinical assessment indicate otherwise.

F. Outreach and therapeutic interventions with dependent children, partners, and other family members

of women in treatment shall be provided when clinically indicated.

G. Directly or through referral linkages, women shall be provided information and services including:

1. Family planning and other reproductive health care;

2. Prevention of domestic violence and child abuse;

3. Life management skills encompassing budgeting, housing, and household management;

4. Nutrition;

5. Parenting training and child development;

6. Primary health care, including assessments for AIDS/HIV and other life-threatening infectious diseases;

7. Pediatric care for dependent children, including immunizations;

8. Transportation to treatment and/or auxiliary services;

9. Developmentally appropriate child care, including age- appropriate learning activities in a child-safe setting.

14.2 Pregnant Women

A. Pregnant women in any trimester shall be admitted within 48 hours or provided interim supportive services until admission is possible.

B. Written client consent shall be obtained to establish working relationships with identified medical professionals qualified in pre-natal care.

C. Pregnant methadone clients shall not be put at risk by being arbitrarily withdrawn from methadone and/or discharged from methadone maintenance programs. Assessments shall be performed by medical professionals qualified in addiction treatment and neonatal care and ADAD shall be notified prior to withdrawal and/or discharge.

D. Special Connections programs shall observe Sections 8.745 – 8.745.5, Colorado Department of Health Care Policy and Financing, Medical Assistance Staff Manual, Volume 8 (10 CCR 2505-10) when providing and billing for services.

E. Detoxification facilities shall coordinate additional treatment and auxiliary services for pregnant clients, including at least one follow-up outpatient contact.

F. Disulfiram, naltrexone, and other medications which may be contraindicated for pregnant women, shall not be administered without an assessment by medical professionals qualified in pre-natal care.