

# **State of West Virginia**

## **DUI SAFETY AND TREATMENT PROGRAM STANDARDS FOR EDUCATIONAL CURRICULUM, TREATMENT SERVICES AND QUALITY ASSURANCE**



**ADMINISTERED BY  
WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES  
BUREAU FOR BEHAVIORAL HEALTH AND HEALTH FACILITIES**

**PREPARED IN COOPERATION WITH:  
WEST VIRGINIA DEPARTMENT OF TRANSPORTATION  
DIVISION OF MOTOR VEHICLES**

**Earl Ray Tomblin, Governor**

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**DUI SAFETY AND TREATMENT PROGRAM  
STANDARDS FOR EDUCATIONAL CURRICULUM, TREATMENT SERVICES,  
AND QUALITY ASSURANCE**

**Introduction**

Through a partnership between the Department of Health and Human Resources, Bureau for Behavioral Health and Health Facilities (BBHBF), the Department of Transportation, Division of Motor Vehicles and approved program providers, the DUI Safety and Treatment Program coordinates the delivery of services to individuals found in violation of West Virginia driving under the influence (DUI) statutes.

The DUI Safety and Treatment program coordinates the individual's participation in referral, evaluation, education and treatment services provided by approved providers. Those services are made available through private pay and the Department of Health and Human Resources Safety and Treatment Fund for indigent West Virginia residents meeting certain requirements.

**Purpose**

The purpose of this document is to provide uniform standards for the administration and operation of the DUI Safety and Treatment Program as mandated by West Virginia Code § 17C-5A-3.

*“Safety and treatment program; reissuance of license (a) The Department of Health and Human Resources, Division of Alcoholism and Drug Abuse shall administer a comprehensive safety and treatment program for persons whose licenses have been revoked under the provisions of this article or section seven, article five of this chapter or subsection (6), section five, article three, chapter seventeen-b of this code and shall also establish the minimum qualifications for mental health facilities, day report centers, community correction centers or other public agencies or private entities conducting the safety and treatment program...”*

Furthermore, in accordance with requirements of and authority provided in West Virginia Code § 17C-5A-3 the West Virginia Department of Health and Human Resources proposed and filed West Virginia Legislative Rule Title 64 Series 98, Safety and Treatment Program for the purposes of establishing a comprehensive safety and treatment program for persons found in initial and subsequent violation of WV Code §17C-5-1 et seq. and §17C-5a-1 et seq.

## Definitions:

- A. **BBHHF** refers to the West Virginia Department of Health and Human Resources, Bureau for Behavioral Health and Health Facilities.
- B. **Committee** refers to the DUI Safety and Treatment Advisory Committee, referenced in these standards.
- C. **DMV** refers to the West Virginia Department of Transportation, Division of Motor Vehicles.
- D. **Driver's Safety Rehabilitation Fund** refers to the legislatively mandated state revenue account created for the purposes of recording and expending funds for the DUI Safety and Treatment Program. This fund shall be directed and controlled by the Secretary of the Department of Health and Human Resources.
- E. **DUI Enrollment/Evaluation/Assessment** refers to the provider's initial evaluation session used to determine the severity and scope of the participant's abuse/addiction, as well as the determination of the intensity of treatment services required.
- F. **DUI Offender** refers to anyone arrested for driving under the influence of alcohol and/or other drugs or permitting another individual to drive while under the influence, per Chapter 17C-5-2 of the State Code.
- G. **Prevention and Education Component (Level I)**: refers to the mandatory 19 hours of educational instruction and corresponding counseling session.
- H. **Intervention and Treatment Component (Level II)** refers to intervention and/or treatment services which are recommended beyond the 19 hours Educational Component which may include individual/group modalities. These services may include planned, therapeutic, interventions. The goal of the interventions is to move the participant from use/abuse into recovery.
- I. **Intensive Care Component (Level III)**: refers to the treatment services which are recommended beyond the 19 hours Educational Component and Prescribed Intervention/Treatment Component. These services may consist of day treatment, intensive outpatient, medically monitored/managed inpatient residential, and aftercare services. A period of detoxification may also be required prior to involvement in intensive modalities.
- J. **MOU** refers to a Memorandum of Understanding which describes the bilateral agreement between the Provider and Bureau for Behavioral Health and Health Facilities or Division of Motor Vehicles and Bureau for Behavioral Health and Health Facilities which serves to document the terms and conditions of the agreement.
- K. **Provider** refers to any individual, government, or governmental subdivision, agency, corporation, partnership, firm, business trust, estate, organization, or association acting individually or as a group which is approved to operate the DUI Safety and Treatment Program.

- L. **Service** refers to the DUI Safety and Treatment programming as referenced in Chapter 17C-5A-3 of the West Virginia State Code and as referenced in Title 91, Legislative Rules, Series 15, entitled Safety and Treatment Program.
- M. **Site Review** refers to the process of conducting interviews, record reviews, or physical observations at a designated program location to assess compliance with federal and state standards as applicable to the DUI Safety and Treatment Program.
- N. **Staff** refers to individuals and supervisors providing services as indicated in these Standards.
- O. **Treatment** refers to any specific modality or intervention provided for the purposes of changing Substance Abuse or Misuse behavior. Treatment may include assessment; diagnostic impression; treatment planning; individual and/or group counseling, education; and discharge planning. It may also include medical, psychiatric and psychological assessment, evaluation, treatment, and related services.
- P. **Driving Record:** refers to a log of the motorists' past offenses, including speeding tickets, moving violations, DUIs, and other incidents related to his or her driving career

### **Program Participation**

Admission of participants to the DUI Safety and Treatment Program shall be made available, but not limited to, individuals who have been arrested for violation of Chapter 17, Section 5.2 and related sections of the West Virginia State Code and who are subject to loss of driving privileges.

### **Applicability**

This rule is applicable to all individuals found in violation of West Virginia driving under the influence (DUI) statutes. In situations where an out of state resident is found in violation of WV Statues, the State of WV may waive the requirements of this document so that the individual may participate in a local program administered within their state of residency. Individuals interested in pursuing this option need to contact the West Virginia State program at 1-877-215-2522, regarding clarification as to whether or not their state's requirements will suffice and any steps necessary for submitting verification to the DUI Safety and Treatment Program.

For all in state residents found in violation of another states DUI statutes, the WV DUI Safety and Treatment Program may serve as a substitute for that states program. Individuals interested in possibly participating in the WV DUI Safety and Treatment Program as a replacement to the program administered in the state

where they were found in violation of statute shall maintain all responsibility for verifying all criteria prior to their enrollment in West Virginia's program.

### **Program Overview**

The West Virginia Department of Health and Human Resources administers the DUI Safety and Treatment Program through its Bureau for Behavioral Health and Health Facilities (BBHFF). The BBHFF approves and monitors all DUI Safety and Treatment Programs, operating in West Virginia establishes regulations, approves participant fees and fee schedules, and provides DUI information and technical assistance.

The objectives of the program are to: (1) reduce the number of repeat DUI offenses by persons who complete a state-approved DUI program; and (2) provide participants an opportunity to address problems related to the use of alcohol and/or other drugs.

All approved providers must demonstrate sound administrative, fiscal, and operational capabilities to operate the program; provide program facilities that are clean, safe, and free of alcohol or illicit drug use; and adhere to all applicable statutes and regulations.

### **The Memorandum of Understanding (MOU) Agreement**

#### **MOU Overview**

For the purposes of providing the DUI Safety and Treatment Program, the Bureau for Behavioral Health and Health Facilities establishes Memorandums of Understanding (MOU) with approved providers. In order to become an approved provider and obtain a MOU, prospective providers for the DUI Safety and Treatment Program must submit applications which reflect the ability to adequately provide the DUI Safety and Treatment Program to the BBHFF for review.

The awarding of an MOU does not obligate BBHFF to utilize the provider on an exclusive or other basis. Any decision rendered by BBHFF specific to review of proposals/applications, renewals, or denial of MOUs shall be considered final.

#### **Provider Eligibility**

An MOU may be established with any provider, including a governmental subdivision or agency, corporation, partnership, firm, organization, or association acting individually or as a group which submits an approved application to BBHFF and can meet all applicable standards.

## **MOU Document**

MOUs will be negotiated and approved on an annual basis to all newly approved providers and approved providers seeking a renewal. Each DUI Safety and Treatment Program MOU shall encompass one State Fiscal Year (July 1 through June 30). The option of solicitation/announcement for annual Request for Proposal (RFP) shall remain at the discretion of the BBHFF and announced by BBHFF as necessary.

## **MOU Criteria for Prospective Providers**

Any organization wishing to establish a MOU with BBHFF to administer the DUI Safety and Treatment Program must:

1. Demonstrate need
2. Provide a DUI Coordinator and other qualified staff
3. Ensure that they meet or can meet by the start of the MOU, all standards as contained herein
4. Agree to provide for all of the following Safety and Treatment program levels of Referral:
  - A. Initial Assessment
  - B. Prevention and Education Component (Level I)
  - C. Intervention/Treatment Component (Level II)
  - D. Intensive Care Component (Level III).

*The first three services (Initial Assessment, Level I and Level II) must be made available DIRECTLY from the provider. The Intensive Care Component may be either offered directly or through subcontract/referral; however those services must still be provided in accordance with these requirements and shall be subject to review and approval by BBHFF.*

5. Maintain partnering agreements with Behavioral Health Providers to insure all levels of services are provided
6. Submit a detailed proposal to BBHFF for providing the DUI Safety and Treatment Program at least sixty (30) days prior to the beginning of the new State Fiscal Year

## **Processing New Applications and MOU's**

When accepting applications/MOU's for processing, the documents must:

- Meet any deadlines or timeframes indicated
- Be complete in order to be accepted for processing
- Include the designated provider named in the document and shall not be transferable or assignable to other organizations.
- Document an organizations ability to comply with the standards

Accepting an application/MOU for processing does not preclude a subsequent request for additional information and has no bearing on whether or not the MOU will be granted.

### **Additional Information**

BBHFF may, at its discretion, request that a prospective provider submit revised or additional documents or written statements of fact relevant to the application as it deems necessary to determine whether the MOU should be approved. The failure of a Provider to submit such documents or statements within the allotted time, without good cause or without a written consent for extension of time, shall be deemed to be a waiver by the provider of any opportunity to present such documents or facts for consideration by BBHFF in granting or denying the agreement.

### **Rejection of Application/MOU**

Any application/MOU deemed not to be in compliance with the standards set forth herein, shall be returned to the provider within 30 days following its receipt with a statement of the reason(s) for not approving the application or accepting the MOU and include the time frame in which the provider can resubmit the amended contract.

### **Verification of Submitted Information**

BBHFF may verify data and any related information furnished or claims inferred by the provider. Submission of an application/MOU carries implied consent to permit inquiry into the data furnished.

### **Site Reviews of Prospective Provider**

Whereas, any organization seeking approval to administer the DUI Safety and Treatment Program (potential provider) must possess or be able to demonstrate the ability to meet all standards as referenced herein prior to the approval of an MOU, BBHFF may conduct an on- site review to assess those qualifications prior to executing a MOU. In general, BBHFF will contact the prospective provider and arrange for a convenient time for the initial site review. While onsite, BBHFF and/or its representatives shall perform procedures as deemed necessary to make a determination as to whether or not a prospective provider meets or can meet all applicable standards.

If it is determined that a prospective provider does not meet the applicable standards they will be provided written documentation of the reasons they were deemed to be in noncompliance and permitted fourteen (14) calendar days to remedy the issue causing the noncompliance. If the prospective provider is unable or unwilling to remedy the noncompliance within the fourteen (14) days, the application for MOU shall be automatically denied. A prospective provider whose application was denied

in a prior period may reapply for any subsequent MOU agreement period pursuant to applicable Standards.

### **Withdrawal of Application/ MOU**

After an application/ MOU has been submitted for processing, the provider may withdraw the MOU with a written request.

### **Denial of MOU**

In the event that a Provider fails to file a proper MOU form and/or a provider fails to meet the conditions where applicable, BBHHF shall deny the application for a MOU in writing, and shall be considered final.

### **MOU Renewal Process**

Renewals shall be administered in accordance with the terms and conditions of this document and original MOU. The BBHHF shall notify each current provider in writing of the renewal requirements for the subsequent year at least thirty (30) days prior to the end of the State Fiscal year.

Any provider wishing to renew their MOU must respond to the BBHHF within thirty (30) days of the fiscal year end with a statement of their intent to renew and any additional information as mandated by the renewal requirements. The decision to renew any MOU is the responsibility of the BBHHF, West Virginia DUI Safety and Treatment Program and shall be considered final.

Inferred approval shall not be considered a guarantee until the completion, signature and filing of a valid MOU.

### **MOU Extensions for Existing Providers**

In the event that BBHHF is unable to process an MOU prior to the expiration date, the existing MOU shall be automatically extended and continue in effect until notification of BBHHF's decision. However, this extension shall in no case exceed the original expiration date by ninety (90) calendar days. It is the responsibility of providers to request an extension for services.

### **MOU Suspension/Revocation**

At the discretion of BBHHF, suspension or revocation of a provider MOU may occur when there is sufficient evidence to suggest that the Provider has:

- a. Knowingly falsified any information required under these standards

- b. Permitted unqualified staff members to perform any aspects of the DUI Safety and Treatment Program
- c. Interfered with or obstructed a site review or investigation
- d. Concealed or attempted to conceal its true ownership
- e. Failed to adhere to the DUI Safety and Treatment Program Standards
- f. Violated standards, as such that a delay in action could result in harm to participants, staff members, or the public

### **Removal of MOU Suspension**

The provider shall have thirty (30) days from receipt of the notice of suspension in which to file a written Plan of Correction. The plan of correction shall be reviewed by the State DUI Program Coordinator to determine the necessity for further action.

If such a determination is made to conduct further investigation, BBHFF may request additional individuals to serve as onsite review team members. The results of the investigation shall be reviewed by BBHFF and a final decision regarding the suspension of MOU shall be determined and served with written notification to the affected provider(s).

### **General Provider Standards and Requirements**

#### **Standards for Providers**

Providers shall document compliance of all DUI Safety and Treatment Program Standards including but not limited to:

- a. WV State Code § 17C-5A-3 and related State Code and Legislative provisions referenced herein
- b. Circuit Court rules
- c. Ordinances
- d. Orders, including zoning, health, welfare and safety
- e. Title 91, Legislative Rules, Division of Motor Vehicles, Series 15, entitled Safety and Treatment Program;
- f. Federal Confidentiality Regulations, 42 CFR Part II and HIPAA regulations
- g. Site conduciveness for the provision of DUI Safety and Treatment programming
- h. 64-CSR-98
- i. All other standards or future revisions of such standards

## **Documentation of Policies and Procedures**

Each Provider shall maintain a written document which describes all current policies and procedures related to the provision of DUI Safety and Treatment programming. All Provider staff shall be familiar with these policies and procedures.

## **Appointment of Provider DUI Coordinator**

Each provider shall designate one individual as a DUI Coordinator, to supervise the administration and performance of the DUI Safety and Treatment Program. The DUI Coordinator shall be responsible for ensuring provider compliance with all applicable performance and program standards, as well as working collaboratively with the State DUI Safety and Treatment Program Coordinator and Division of Motor Vehicles.

This individual shall meet ALL criteria and qualifications as established by these standards and participate in a minimum of 6 hours of continuing education specific to clinical supervision biannually.

## **Meeting Attendance**

Each provider's DUI Coordinator or a qualified designated clinical staff person shall attend DUI Coordinator meetings two times a year and at other times as requested by BBHFF. Failure to attend meetings shall be reviewed on an individualized basis. Absence from two consecutive meetings may result in the provider's MOU being placed on provisional status.

## **Notification of Transfer of Ownership**

The provider shall notify BBHFF in writing a minimum of ninety (30) days prior to any changes in ownership or location of service delivery. Any such changes may subject the provider organization to potential review and failure to promptly notify BBHFF could lead to a delay in that process and hence a possible suspension of the MOU.

## **Indigent Status Determination Policy**

Each provider must evidence proof of compliance with existing BBHFF policy and procedures governing indigent status determination for safety and education. Additionally, providers must apply such standards, procedures and guidelines uniformly for intervention, treatment and/or intensive treatment components as may be warranted due to offense category, BAC levels and/or as a result of the individual assessment completed that guides program involvement and intensity.

## **Participant Screening**

Each provider must be capable of processing or accessing the capability to process drug screens, and the documentation of Blood Alcohol Concentration (BAC). The provider shall conduct initial alcohol and other drug screening of participants during the assessment process and at any time a participant is suspected of being under the influence of alcohol or drugs. This includes the obligation of the provider to test for any suspected illegal drug usage during the entire period of the program whether or not the participant is using while on site.

Any positive results on tests performed (BAC reading above .000 or a positive urine screen), shall result in the participant's IMMEDIATE withdrawal from the Educational Component and/or Intervention Treatment Component and reassessment of the participants needs.

Participants are required to sign an "Agreement of Understanding" (Appendix D) as part of the DUI Safety and Treatment program. Refusal by any participant to submit to a breathalyzer test or to provide a urine screen, when requested, shall result in the participant's IMMEDIATE withdrawal from the Educational Component and/or Intervention Treatment Component and reassessment of the participants needs.

## **Appeals Process**

Each Provider shall establish an appeals process for the participants in the DUI Safety and Treatment Program which provides a mechanism to resolve participant complaints against the Provider and/or related services of the Provider, regarding the DUI Safety and Treatment Program.

This process must be made available to all participants and is LIMITED to disagreement with his/her evaluation/assessment, individualized treatment plan and/or related services. At a minimum each provider's appeals process must ensure:

### **For Evaluation/Assessment Appeals:**

- a. Participants shall be encouraged to discuss the evaluation/assessment findings and recommended treatment plan with the assessor at any time during the assessment process to provide additional information or clarification.
- b. If disagreement still exists, the participant should be informed of their right to appeal the evaluation/assessment findings to the director of the provider facility or designee in writing within 5 working days of receipt of the evaluation/assessment finding and treatment plan.

- c. If the director or designee determines, based on a review of the case file, that the evaluation/assessment findings and treatment plan are substantially correct, the participant shall be given written notification that the client may undergo another assessment at another facility at his or her own expense.
- d. If the participant chooses to undergo an alternate assessment, the participant shall be informed that the director or designee will review the results of the alternate assessment and provide the assessment finding and treatment plan recommendation within 5 working days after receiving the information.
- e. Each provider shall have procedures for obtaining releases and forwarding of initial assessment finding and treatment plan recommendations, as well as any other relevant clinical information, to the alternate assessment facility with references to DUI Safety and Treatment Program Standards.
- f. Appeals shall be processed according to written agency procedures that will result in a timely, complete, and impartial review and decision.

#### **Appeals During Treatment:**

- a. Participants who believe that the treatment plan is inappropriate and refuse to consent or withdraw consent to treatment may request the counselor or case manager review and consider an amendment to the treatment plan.
- b. If after review by the counselor or case manager conflict still exists, the participant shall be notified of their right to appeal to the treatment agency director or designee in writing within 5 working days of the client requested review.
- c. If upon appeal the director or designee determines that the treatment plan is appropriate and a revision is not warranted, the participant shall be given written justification for the decision and notice that continued failure to comply with the treatment plan will result in a determination of noncompliance and removal from the program with forfeiture of any fees paid.

#### **Documentation of Program and Participant Evaluation/Outcome**

Each Provider will conduct program evaluations to measure knowledge outcomes of the DUI Safety and Treatment Program and Consumer Perception of Services. Pre and Post tests will be administered at the beginning and end of each Level of Service.

## **DUI Safety and Treatment Program Administrative Compliance**

*The following records shall be maintained for a minimum of five (5) years:*

a. Provider operating records supporting the DUI Safety and Treatment program, to include:

- 1) Service records
- 2) Class attendance records
- 3) Documentation of program evaluation and outcome measures
- 4) Financial, billing and accounting records
- 5) Documentation of consumer perception of services, as indicated
- 6) Provider issued policies and procedures
- 7) Clinical Records
- 8) Referral Evaluation and Status Evaluation Reports

b. Personnel Records of Staff Members to include:

- 1) Copies of staff qualifications and staff member information
- 2) Documentation of educational experience including degrees awarded
- 3) Documentation of employment history
- 4) Documentation of staff members' training requirements and on-going training/continuing education specific to all components of the DUI Safety and Treatment Program, including all related licenses and/or certifications

c. Participant Records for each participant to include:

- 1) Name, address, age, date of birth, sex, and driver's license number
- 2) Court documents related to DUI, as available
- 3) Consent for release of information form(s)
- 4) Pre and post test results
- 5) Attendance and completion data
- 6) Notes on results of the exit interview
- 7) A copy of the DUI offender's personal action plan
- 8) A copy of the intake, psychosocial/biomedical assessment form
- 9) A copy of the offender's referral evaluation report and status report referred to as Revised 400 SE Form
- 10) DMV file number
- 11) Copies of all collateral information obtained, and copies of any referrals to additional alcohol/drug treatment services as required
- 12) Individual Initial and Master Treatment Plan, as applicable
- 13) Termination/Discharge Summary in accordance with behavioral health care provider licensure standards

## **Confidentiality**

Each Provider shall establish written policies that protect the confidentiality of program participants and their records. The policies and procedures established shall be in accordance with 42 CFR Part II, "Confidentiality of Alcohol and Drug Abuse Patient Records," as well as the Health Insurance Portability and Accountability Act (HIPAA).

## **Records Security and Access**

Records retained by the Provider which contain participant information shall be stored in a secure area, preventing unauthorized access. Additionally those records should be filed systematically, and be made available for inspection and review by BBHFF and its representatives.

## **Informed Consent for Release of Information Forms**

Prior to conducting any facet of the DUI Safety and Treatment Program, the Provider shall require participants to consent to the release of information referencing the outcome of services to BBHFF, including completion or non-completion of program requirements, as well as related Judicial systems as necessary.

Additionally, as a condition of admission to the DUI Safety and Treatment Program, individuals will be required to sign a consent form for the Provider to release information to the appropriate judicial officials as related to the individual's progress in the program. Such forms shall comply with 42CFR, Part II. Should any standard herein conflict with 42CFR Part II, the Federal regulations shall prevail.

## **Service Payment and Fee Submission**

Fees associated with receipt of the DUI Safety and Treatment program as outlined herein are the responsibility of the participant unless or in the event that a determination of indigent status has been made.

Each provider shall submit to BBHFF a portion of the fee for the Educational Component of the program made payable to the Driver's Rehabilitation Fund, in the amount as agreed in cooperation with BBHFF, as per Chapter 17C-5A-3 of the state code.

## **Treatment Service Standards**

### **Scheduling Appointments**

Provider will ensure that initial appointments for individuals who are referred for enrollment in the DUI Safety and Treatment Program are scheduled in a timely manner. Providers will schedule the initial assessment/evaluation session no later

than five (5) business days from the day the DUI Offender inquired and enrollment shall occur within three weeks once enrollment fee is paid in full.

### **Administrative Procedures**

When a participant arrives for their initial assessment/ evaluation session the following administrative services must be performed prior to the performance of the actual assessment/evaluation:

- a. The provider will determine indigent status as requested by the participant
- b. The provider will discuss the mandate of alcohol/drug free attendance and the participant's requirement to submit to a breathalyzer test and/or urine screen at any time requested by program staff
- c. The provider will discuss the attendance policy and define "excused absences"
- d. The provider will present a written schedule of all fees and payment terms applicable to the participant
- e. The provider will review the "Agreement of Understanding" (Appendix D) with the participant and obtain their signature

### **Treatment and Evaluation Standards**

When performing the evaluation/assessment or any treatment services, the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria shall be required for diagnosis, and the American Society of Addiction Medicine (ASAM) shall be required for placement, continuing stay, and discharge.

It is the responsibility of the provider to ensure that all intensive outpatient, day treatment, non-medical detoxification, ambulatory detoxification, medically monitored residential, and medically managed residential treatment programs meet all applicable criteria prior to referral of participants.

### **Evaluation/Assessment Process**

The assessment provided during the evaluation session shall accomplish the following:

1. Assess the participant's involvement with alcohol and/or other drugs using, at a minimum, assessment instrument(s) as indicated in these Standards
2. Provide documentation of each participant's involvement with alcohol and/or other drugs, which includes all of the following information:
  - a. A written test of each participant, using at a minimum an assessment instrument approved by BBHFF
  - b. The participant's blood alcohol level at the time of arrest for any alcohol-related offenses
  - c. A history of alcohol/drug related offenses

3. Complete a diagnostic interview with each participant which gathers at a minimum:
  - 1) A history of the participant's involvement with alcohol and other drugs including the frequency of use, volume, and type of substance used
  - 2) The participant's statement concerning his or her current physical condition
  - 3) Sociological data describing the participant's most recent living situation, e.g. family, environment, employment, and school
  
4. Develop a written assessment that, at a minimum, incorporates the following:
  - 1) The participant's raw score and/or percentile score from an approved assessment instrument such as: Michigan Alcohol Screen Test (MAST), Drug Abuse Screening Test (DAST), Numerical Drinking Profile (NDP) and the McAndrews Scale of the Minnesota Multiphasic Personality Inventory (MMPI).
  - 2) The participant's own assessment of his or her involvement with alcohol and/or other drugs
  - 3) The qualified substance abuse professional's evaluation of the information required by these Standards, and a diagnostic statement specifically describing the participant's involvement with alcohol and other drugs, and the signs and symptoms leading to that assessment, and use of the current edition of the DSM
  
5. Inform the participant of the results of the assessment during the session or immediately thereafter

### **Collateral Information for Assessment**

Collateral information for the evaluation/assessment process shall be obtained independently from significant others, including but not limited to the DUI offender's spouse, family member, or employer. Contradictions between any information provided by the DUI offender and information obtained from collateral sources shall be clearly noted on the assessment form and shall be documented in the clinical record.

### **Withdrawn Participants**

Participants who are withdrawn or removed from any component of the program due to refusal to submit to testing or a positive alcohol/drug screening shall be required to:

1. Be re-assessed for more intensive treatment than initially prescribed; and
2. Participate in the Educational Component at a future date with ALL classes being repeated

## **Assessment Results**

Based on the results of the assessment the evaluator will recommend one of the following levels of referral:

**Prevention and Educational Component (Level I)** – If a participant is evaluated as not having a significant substance abuse problem they are referred to Level I for an informational and educational component intended to create an awareness of the misuse of alcohol and other drugs, particularly as the use relates to the operation of a motor vehicle.

Level I shall consist of a total of 19 hours; 18 hours of prescribed classes and 1 post-instruction counseling session to determine if the participant has a need for further services. If it is determined that additional activities are required, those activities must be completed prior to completion of Level I.

**Intervention and Treatment Component (Level II)** – If a participant is evaluated as having a potential, probable, early stage or middle stage substance abuse problem they are referred to Level II for individual or group outpatient counseling on a frequency correspondent to the determined need. As part of this level participants shall be required to attend meetings of Alcoholics Anonymous, Narcotics Anonymous or other similar entity, with verification of attendance to be provided.

*Level II participants must also complete the Level I component.*

**Intensive Care Component (Level III)** – If a participant is evaluated as having a late stage substance abuse problem they are referred to Level III for participation in an intensive treatment program which will have total abstinence as its goal. The intensive treatment component consists of residential treatment or partial hospitalization designed specifically for substance abuse treatment. As part of this level participants shall be required to attend meetings of Alcoholics Anonymous, Narcotics Anonymous or other similar entity, with verification of attendance to be provided.

*Level III participants must also complete both the Level II and Level I components.*

## **Educational Component Overview**

The DUI Safety and Treatment Program shall offer the uniform, statewide Educational Component (Curricula), providing individuals arrested for the offense of driving while under the influence, with information regarding the use and abuse of alcohol and/or other drugs, including at a minimum the following:

1. An explanation of the purpose, content, and nature of the educational program, including discussion regarding the breath alcohol content device, and other chemical tests for intoxication, as well as the effects of alcohol and/or other drugs on driving;
2. Descriptions of alcohol and other drugs and the effects they have upon the body (including myths and misconceptions), as well as their effects on driving ability, including use of visual aids such as impaired driving goggles;
3. A general perspective on the disease of chemical dependency and substance abuse. Information shall be provided to the participants regarding the stages of alcoholism and other drug dependency, and the progression of the disease of addiction;
4. Explanation of the role of the family in the addiction process. Spouses and family members shall be encouraged to attend the family education session;
5. An overview of treatment resources and the concept of treatment;
6. A forum in which each participant may assess the behaviors leading to his/her DUI arrest and focus on means of preventing future arrests;
7. Participation of the individual within a victim impact panel, or video program providing a forum for victims of alcohol and other drug related offenses and offenders to share firsthand experiences on the impact of alcohol and other drug related offenses on their lives. The victim impact panels shall require at a minimum discussion and consideration of the following:
  - A. Economic losses suffered by victims or offenders
  - B. Death or physical injuries suffered by victims or offenders
  - C. Psychological injuries suffered by victims or offenders
  - D. Changes in the personal welfare or familial relationships of victims or offenders
  - E. Other information relating to the impact of alcohol and other drug related offenses upon victims or offenders

\*All Providers shall make every reasonable effort to assure that meetings between victims and offenders are non-confrontational in nature and that the physical safety of all persons involved is protected during such meetings. Providers shall also develop specific policies addressing the issue of participant conduct during victim

impact sessions and assure that all participants in such sessions are aware of these policies. Providers shall ensure the strictest confidentiality policy within victim impact sessions.

### **Intervention /Treatment Component Overview**

The Intervention/Treatment component shall provide the clinician with additional time to evaluate and assess the severity and scope of an individual's alcohol/drug related disorder. This component provides the participant with therapy and treatment for his/her alcohol/drug and related disorders as indicated by the initial assessment and per DSM/ASAM criteria. Services within this component shall be separate, distinct, based upon an individual needs assessment and open-ended. Please note that these services SHALL NOT be an extension or substitution of the Educational Component.

### **Intensive Care Component**

Intensive Treatment Component programs approved for the DUI participants are specifically designed to provide treatment for substance abuse disorders, as specified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), and approved by the provider initiating the referral. These services may be performed either through an Intensive Outpatient Program (IOP) or attendance at residential treatment and/or detoxification program. IOP may be done concurrently with the Educational Component; however, participants in a residential program must complete that program prior to attempting the educational component.

Participants completing such programming through referral or another public or private provider, including out of state programs must still complete the Educational Component of the program.

### **Staff Qualifications**

#### **Provider Responsibility**

Each provider is responsible for ensuring that the services provided through the DUI Safety and Treatment Program are delivered by competent and qualified professionals who meet requirements as established in these program Standards.

Each provider shall supply updated staff listings to the BBHFF with the names, training and job functions performed by all persons providing services for the Program.

## **Qualifications of Staff Providing Assessment and Treatment Services**

All provider staff providing assessment and treatment services shall be under the supervision of the provider's DUI Coordinator and must have the following qualifications:

- a. Is an Alcohol and Drug Counselor (ADC) recognized by the West Virginia Certification Board for Addiction and Prevention Professionals or reciprocal addiction credential and/or
- b. A Bachelor's or Master's degree from an accredited university in a human service field

## **Qualifications - Instructors of the Educational Component**

Qualified instructors must be able to document the provision of services under the supervision of an Advanced Alcohol and Drug Counselor (AADC) or an Advanced Alcohol and Drug Counselor-Supervisor (AADC-S).

Prior to facilitating the educational component, instructors shall:

- a. Attend and observe a complete cycle of the sessions of a BBHFF approved DUI Safety and Treatment Program. This training must be documented in the instructor's personnel record. Trainees must also attend a complete cycle and co-facilitate with a current, qualified instructor
- b. Before a potential Provider may be approved as a provider of DUI programming, each potential Provider's designated DUI Coordinator shall participate in the approved instructor's training in the curriculum
- c. The provider's designated DUI Coordinator shall provide the subsequent training in the DUI Safety and Treatment Program Standards to all instructors within the provider's contract service area. This training shall also be required for all instructors prior to the implementation of DUI Educational Component and will be provided by the Provider's DUI Coordinator or designee
- d. Complete a minimum of 6 hours of in-service training or continuing education each year in DUI and alcohol/drug related education/treatment areas.
- e. New providers must participate in training facilitated by experienced, qualified existing providers approved by the State DUI Program Coordinator.

## **Program Service Fees**

### **Fee Disclosure**

Prior to the provision of any services, providers are required to provide each DUI offender a written schedule of all fees and payment terms for the DUI Safety and Treatment Program. The fee schedule shall include charges for assessment, enrollment and evaluation, which includes the cost of the Educational Component and follow-up assessment as well as the Intervention/Treatment Component, if required. Additional cost may include workbooks and drug screens.

### **Initial Enrollment Fee**

The *initial fee* for enrollment in the program is four hundred (\$400.00) dollars. This fee shall cover the provision of the initial and final assessment, evaluation, enrollment fees for the Educational Component and offsets cost for indigent services.

Payment of such fees is the responsibility of the DUI offender and must be provided prior to or at the time of the enrollment in the DUI Safety and Treatment Program, unless indigent status has been established. Under no circumstances shall a participant be afforded payment or credit plans for the fee incurred for this portion of the program.

### **Provider Remittance**

Once a provider has received the four hundred (\$400.00) dollar enrollment fees, the provider shall remit to the BBHFF one hundred and twenty-five dollars (\$125.00) and the provider shall retain two hundred seventy-five dollars (\$275.00).

Once the one hundred twenty-five dollars (\$125.00) has been received, BBHFF shall deposit seventy-five dollars (\$75.00) of this amount in the Department of Health and Human Resources Safety and Treatment fund, to be used to reimburse providers for enrollment fees for participants qualifying for indigent status. The remaining fifty dollars (\$50.00) will be utilized by the BBHFF to provide for expenses incurred specific to the continued implementation, ongoing operation, monitoring, and enforcement of all standards and related program expenses for the DUI Safety and Treatment Program.

### **Treatment Costs**

Fees associated with receipt of treatment services (those services extending beyond assessment and enrollment cost for the Educational Component) will be the responsibility of the participant unless or in the event that a determination of indigent status has been made. INDIVIDUALS REQUIRING TREATMENT WILL NOT BE

## DENIED ACCESS TO THE INTERVENTION TREATMENT COMPONENT AND/OR INTENSIVE TREATMENT COMPONENT BASED UPON THE INABILITY TO PAY.

### **Indigent Status Determination**

As referenced herein individuals will not be denied access to the educational, intervention treatment component and/or intensive treatment component based upon inability to pay. As per §17C-5A-3 of the West Virginia Code, BBHFF has established an indigent determination procedure setting forth fiscal procedures governing indigent determination for participants. A person who is determined to be indigent by the Center may be eligible for a full waiver of the fees for the safety and education component.

### **Indigent Status Criteria**

For the purposes of the DUI Safety and Treatment Program a participant with family income equal to or below one hundred percent (100%) of the federal poverty standard, adjusted for family size, shall be determined to be indigent, qualifying that person for sponsorship for the full amount of fees related to enrollment in the Education Component.

<http://www.dhhr.wv.gov/bhff/resources/Pages/WVDUI.aspx>

Each provider must utilize the criteria set forth in the DUI indigent participant determination procedure for determining if fee waiver for the educational component is available for individuals accessing the WV Safety and Treatment program Educational component.

Any services rendered in addition to the Educational Component will be considered as treatment service provision and will be subject to the charity care reporting policy

<http://www.dhhr.wv.gov/bhff/resources/Pages/WVDUI.aspx>

### **Quality Assurance**

#### **Reporting and Invoicing**

Each provider administering the DUI Safety and Treatment Program must prepare and submit reports to the BBHFF for purposes of monitoring outcomes, contract negotiation and renewal. In accordance with applicable criteria and submission dates enumerated in these standards or upon request from the BBHFF, providers shall furnish data to include:

1. Number of participants served, by intensity of services provided
2. Performance data based on service type
3. Fees charged for services and enrollment fees collected
4. Other data reporting requirements deemed necessary for administration and monitoring of the program such as inserting data file layout, frequency, deadlines, forms, remit to address and contact info

## **Program Participant Evaluation Reports**

Whenever a participant is evaluated and referred to a different level of service or status, the provider shall submit all prescribed forms to the BBHFF. Applicable evaluations include but are not limited to:

1. Referral Evaluation Reports – These are the initial referrals based on the information gathered during the initial assessment of the participant
2. Revised Referral Evaluation Report – These are required for any changes to a participant's program level status following the initial assessment
3. Status Evaluation Report - These are required for any changes in the participant's status during the program up to completion

## **DUI Safety and Treatment Advisory Committee**

The DUI Safety and Treatment Advisory Committee serves to ensure that quality education, prevention, intervention, and treatment services for the individual, including the DUI offender, family members, and significant others are provided while maintaining the standards of the Program. The Committee shall accomplish this mission through procedural refinement, policy and position development, and peer review.

The Committee, which will meet quarterly, shall also assure the education of the Legislature, judicial systems, the public at large, and other interested parties and entities regarding the offense of driving under the influence, related issues, and behaviors. The BBHFF will provide facilitation to support the Committee.

## **Monitoring**

As per state rules, BBHFF is responsible for monitoring of the DUI Safety and Treatment Program. BBHFF, either directly or through its representatives, may conduct record reviews, site reviews, or investigations of any provider currently or proposing to provide services for the purposes of ensuring compliance with these standards. The extent of those monitoring activities may include, but not be limited to:

- Desk Reviews
- Audit Reviews
- Onsite Monitoring
- Technical Assistance
- Training Activities

## **Quality Assurance Protocol**

Providers shall be subject to either announced or unannounced Quality Assurance reviews. Failure to permit complete access to all records and facilities to a reviewer

whose proper credentials or acting agent status has been verified shall subject the provider to revocation of MOU or the potential Provider to denial of contract.

Reports, including findings, conclusions, and subsequent recommendations by the reviewers shall be made available to the provider being reviewed. Plans of Correction and/or subsequent responses shall be submitted from the provider to BBHFF in accordance with the prescribed timeframes.

### **Investigations**

The BBHFF either directly or through its agents, shall respond to allegations of violations of the standards promulgated herein, complaints regarding the operation of any services representative through the MOU under these standards, and suspicion of any unlawful activities related to Provider operation.

### **Division of Motor Vehicle Responsibilities**

#### **Licensing**

The West Virginia Department of Transportation, Division of Motor Vehicles (DMV) maintains responsibility for licensure to operate a motor vehicle. Any changes to licensure prior to and after the DUI Safety and Treatment Program remain the responsibility of the (DMV).

#### **Initial Notification**

The West Virginia DMV is responsible for notifying all individuals of any order of license revocation. Upon such revocation the individual shall be advised of procedures for participation in the DUI Safety and Treatment Program and the conditions that must be met prior to a license reinstatement.

#### **Reinstatement of License**

The West Virginia DMV shall not reinstate any license until confirmation has been received that the participant has successfully completed the prescribed level or levels of treatment, received a favorable status evaluation report and paid all applicable costs related to program participation.

## **APPENDICES**

- 1) WV Code §17C-5A-3. Safety and treatment program; reissuance of license**
- 2) Legislative Rule 64CSR98 (Attachment)**
- 3) Legislative Rule 91CSR15 (Attachment)**
- 4) Indigent Process**
- 5) Monthly DUI Report (Attachment )**
- 6) DUI Service Flowchart**
- 7) Safety & Treatment letter**
- 8) How to Obtain License**
- 9) Safety and Treatment brochure**
- 10) Curriculum**
- 11) Pre/Post Test**
- 12) Pre/Post Test Key**
- 13) Agreement of Understanding**
- 14) Consent for Release of Information**
- 15) Staff Member Information and Qualifications**
- 16) DUI Safety and Treatment Appeal Process Form-SAMPLE**
- 17) ASAM Guidelines chart**

**§17C-5A-3. Safety and treatment program; reissuance of license**

**§17C-5A-3. Safety and treatment program; reissuance of license.**

(a) The Department of Health and Human Resources, Division of Alcoholism and Drug Abuse shall administer a comprehensive safety and treatment program for persons whose licenses have been revoked under the provisions of this article or section seven, article five of this chapter or subsection (6), section five, article three, chapter seventeen-b of this code and shall also establish the minimum qualifications for mental health facilities, day report centers, community correction centers or other public agencies or private entities conducting the safety and treatment program: *Provided*, That the Department of Health and Human Resources, Division of Alcoholism and Drug Abuse may establish standards whereby the division will accept or approve participation by violators in another treatment program which provides the same or substantially similar benefits as the safety and treatment program established pursuant to this section.

(b) The program shall include, but not be limited to, treatment of alcoholism, alcohol and drug abuse, psychological counseling, educational courses on the dangers of alcohol and drugs as they relate to driving, defensive driving or other safety driving instruction and other programs designed to properly educate, train and rehabilitate the offender.

(c) The Department of Health and Human Resources, Division of Alcoholism and Drug Abuse shall provide for the preparation of an educational and treatment program for each person whose license has been revoked under the provisions of this article or section seven, article five of this chapter or subsection (6), section five, article three, chapter seventeen-b of this code which shall contain the following: (1) A listing and evaluation of the offender's prior traffic record; (2) the characteristics and history of alcohol or drug use, if any; (3) his or her amenability to rehabilitation through the alcohol safety program; and (4) a recommendation as to treatment or rehabilitation and the terms and conditions of the treatment or rehabilitation. The program shall be prepared by persons knowledgeable in the diagnosis of alcohol or drug abuse and treatment.

(d) There is hereby created a special revenue account within the State Treasury known as the Department of Health and Human Resources Safety and Treatment Fund. The account shall be administered by the Secretary of the Department of Health and Human Resources for the purpose of administering the comprehensive safety and treatment program established by subsection (a) of this section. The account may be invested, and all earnings and interest accruing shall be retained in the account. The Auditor shall conduct an audit of the fund at least every three fiscal years.

Effective July 1, 2010, the State Treasurer shall make a one-time transfer of \$250,000 from the Motor Vehicle Fees Fund into the Department of Health and Human Resources Safety and Treatment Fund.

(e) (1) The program provider shall collect the established fee from each participant upon enrollment unless the department has determined that the participant is an indigent based upon criteria established pursuant to legislative rule authorized in this section.

(2) If the department determined that a participant is an indigent based upon criteria established pursuant to the legislative rule authorized by this section, the department shall provide the applicant with proof of its determination regarding indigency, which proof the applicant shall present to the interlock provider as part of the application

process provided in section three-a of this article and/or the rules promulgated pursuant thereto.

(3) Program providers shall remit to the Department of Health and Human Resources a portion of the fee collected, which shall be deposited by the Secretary of the Department of Health and Human Resources into the Department of Health and Human Resources Safety and Treatment Fund. The Department of Health and Human Resources shall reimburse enrollment fees to program providers for each eligible indigent offender.

(f) On or before January 15 of each year, the Secretary of the Department of Health and Human Resources shall report to the Legislature on:

(1) The total number of offenders participating in the safety and treatment program during the prior year;

(2) The total number of indigent offenders participating in the safety and treatment program during the prior year;

(3) The total number of program providers during the prior year; and

(4) The total amount of reimbursements paid to program provider during the prior year.

(g) The Commissioner of the Division of Motor Vehicles, after giving due consideration to the program developed for the offender, shall prescribe the necessary terms and conditions for the reissuance of the license to operate a motor vehicle in this state revoked under this article or section seven, article five of this chapter or subsection (6), section five, article three, chapter seventeen-b of this code which shall include successful completion of the educational, treatment or rehabilitation program, subject to the following:

(1) When the period of revocation is six months, the license to operate a motor vehicle in this State may not be reissued until: (A) At least ninety days have elapsed from the date of the initial revocation, during which time the revocation was actually in effect; (B) the offender has successfully completed the program; (C) all costs of the program and administration have been paid; and (D) all costs assessed as a result of a revocation hearing have been paid.

(2) When the period of revocation is for a period of one year or for more than a year, the license to operate a motor vehicle in this state may not be reissued until: (A) At least one-half of the time period has elapsed from the date of the initial revocation, during which time the revocation was actually in effect; (B) the offender has successfully completed the program; (C) all costs of the program and administration have been paid; and (D) all costs assessed as a result of a revocation hearing have been paid.

Notwithstanding any provision in this code, a person whose license is revoked for refusing to take a chemical test as required by section seven, article five of this chapter for a first offense is not eligible to reduce the revocation period by completing the safety and treatment program.

(3) When the period of revocation is for life, the license to operate a motor vehicle in this state may not be reissued until: (A) At least ten years have elapsed from the date of the initial revocation, during which time the revocation was actually in effect; (B) the offender has successfully completed the program; (C) all costs of the program and

administration have been paid; and (D) all costs assessed as a result of a revocation hearing have been paid.

(4) Notwithstanding any provision of this code or any rule, any mental health facilities or other public agencies or private entities conducting the safety and treatment program when certifying that a person has successfully completed a safety and treatment program shall only have to certify that the person has successfully completed the program.

(h) (1) The Department of Health and Human Resources, Division of Alcoholism and Drug Abuse shall provide for the preparation of an educational program for each person whose license has been suspended for sixty days pursuant to the provisions of subsection (n), section two, article five-a of this chapter. The educational program shall consist of not less than twelve nor more than eighteen hours of actual classroom time.

(2) When a sixty-day period of suspension has been ordered, the license to operate a motor vehicle may not be reinstated until: (A) At least sixty days have elapsed from the date of the initial suspension, during which time the suspension was actually in effect; (B) the offender has successfully completed the educational program; (C) all costs of the program and administration have been paid; and (D) all costs assessed as a result of a suspension hearing have been paid.

(i) A required component of the treatment program provided in subsection (b) of this section and the education program provided for in subsection (c) of this section shall be participation by the violator with a victim impact panel program providing a forum for victims of alcohol and drug-related offenses and offenders to share first-hand experiences on the impact of alcohol and drug-related offenses in their lives. The Department of Health and Human Resources, Division of Alcoholism and Drug Abuse shall propose and implement a plan for victim impact panels where appropriate numbers of victims are available and willing to participate and shall establish guidelines for other innovative programs which may be substituted where the victims are not available to assist persons whose licenses have been suspended or revoked for alcohol and drug-related offenses to gain a full understanding of the severity of their offenses in terms of the impact of the offenses on victims and offenders. The plan shall require, at a minimum, discussion and consideration of the following:

(A) Economic losses suffered by victims or offenders;

(B) Death or physical injuries suffered by victims or offenders;

(C) Psychological injuries suffered by victims or offenders;

(D) Changes in the personal welfare or familial relationships of victims or offenders; and

(E) Other information relating to the impact of alcohol and drug-related offenses upon victims or offenders.

The Department of Health and Human Resources, Division of Alcoholism and Drug Abuse shall ensure that any meetings between victims and offenders shall be nonconfrontational and ensure the physical safety of the persons involved.

(j)(1) The Secretary of the Department of Health and Human Resources shall promulgate a rule for legislative approval in accordance with article three, chapter

twenty-nine-a of this code to administer the provisions of this section and establish a fee to be collected from each offender enrolled in the safety and treatment program. The rule shall include: (A) A reimbursement mechanism to program providers of required fees for the safety and treatment program for indigent offenders, criteria for determining eligibility of indigent offenders, and any necessary application forms; and (B) program standards that encompass provider criteria including minimum professional training requirements for providers, curriculum approval, minimum course length requirements and other items that may be necessary to properly implement the provisions of this section.

(2) The Legislature finds that an emergency exists and, therefore, the Secretary shall file by July 1, 2010, an emergency rule to implement this section pursuant to the provisions of section fifteen, article three, chapter twenty-nine-a of this code.

(k) Nothing in this section may be construed to prohibit day report or community correction programs, authorized pursuant to article eleven-c, chapter sixty-two of this code, from administering a comprehensive safety and treatment program pursuant to this section. **§17C-5A-3a. Establishment of and participation in the Motor Vehicle Alcohol Test and Lock Program.**

(a)(1) The Division of Motor Vehicles shall control and regulate a Motor Vehicle Alcohol Test and Lock Program for persons whose licenses have been revoked pursuant to this article or the provisions of article five of this chapter or have been convicted under section two, article five of this chapter, or who are serving a term of a conditional probation pursuant to section two-b, article five of this chapter.

(2) The program shall include the establishment of a users fee for persons participating in the program which shall be paid in advance and deposited into the Driver's Rehabilitation Fund: *Provided*, That on and after July 1, 2007, any unexpended balance remaining in the Driver's Rehabilitation Fund shall be transferred to the Motor Vehicle Fees Fund created under the provisions of section twenty-one, article two, chapter seventeen-a of this code and all further fees collected shall be deposited in that fund.

(3) (A) Except where specified otherwise, the use of the term "program" in this section refers to the Motor Vehicle Alcohol Test and Lock Program.

(B) The Commissioner of the Division of Motor Vehicles shall propose legislative rules for promulgation in accordance with the provisions of chapter twenty-nine-a of this code for the purpose of implementing the provisions of this section. The rules shall also prescribe those requirements which, in addition to the requirements specified by this section for eligibility to participate in the program, the commissioner determines must be met to obtain the commissioner's approval to operate a motor vehicle equipped with a motor vehicle alcohol test and lock system.

(C) Nothing in this section may be construed to prohibit day report or community correction programs authorized pursuant to article eleven-c, chapter sixty-two of this code, or a home incarceration program authorized pursuant to article eleven-b, chapter sixty-two of this code, from being a provider of motor vehicle alcohol test and lock systems for eligible participants as authorized by this section.

(4) For purposes of this section, a "motor vehicle alcohol test and lock system" means a mechanical or computerized system which, in the opinion of the commissioner, prevents

the operation of a motor vehicle when, through the system's assessment of the blood alcohol content of the person operating or attempting to operate the vehicle, the person is determined to be under the influence of alcohol.

(5) The fee for installation and removal of ignition interlock devices shall be waived for persons determined to be indigent by the Department of Health and Human Resources pursuant to section three, article five-a, chapter seventeen-c of this code. The commissioner shall establish by legislative rule, proposed pursuant to article three, chapter twenty-nine-a of this code, procedures to be followed with regard to persons determined by the Department of Health and Human Resources to be indigent. The rule shall include, but is not limited to, promulgation of application forms; establishment of procedures for the review of applications; and the establishment of a mechanism for the payment of installations for eligible offenders.

(6) On or before the fifteenth day of January, of each year, the commissioner of the division of motor vehicles shall report to the Legislature on:

- (A) The total number of offenders participating in the program during the prior year;
- (B) The total number of indigent offenders participating in the program during the prior year;
- (C) The terms of any contracts with the providers of ignition interlock devices; and
- (D) The total cost of the program to the state during the prior year.

(b)(1) Any person whose license is revoked for the first time pursuant to this article or the provisions of article five of this chapter is eligible to participate in the program when the person's minimum revocation period as specified by subsection (c) of this section has expired and the person is enrolled in or has successfully completed the safety and treatment program or presents proof to the commissioner within sixty days of receiving approval to participate by the commissioner that he or she is enrolled in a safety and treatment program: *Provided*, That anyone whose license is revoked for the first time pursuant to subsection (k), section two of this article must participate in the program when the person's minimum revocation period as specified by subsection (c) of this section has expired and the person is enrolled in or has successfully completed the safety and treatment program or presents proof to the commissioner within sixty days of receiving approval to participate by the commissioner that he or she is enrolled in a safety and treatment program.

(2) Any person whose license has been suspended pursuant to the provisions of subsection (n), section two of this article for driving a motor vehicle while under the age of twenty-one years with an alcohol concentration in his or her blood of two hundredths of one percent or more, by weight, but less than eight hundredths of one percent, by weight, is eligible to participate in the program after thirty days have elapsed from the date of the initial suspension, during which time the suspension was actually in effect: *Provided*, That in the case of a person under the age of eighteen, the person is eligible to participate in the program after thirty days have elapsed from the date of the initial suspension, during which time the suspension was actually in effect or after the person's eighteenth birthday, whichever is later. Before the commissioner approves a person to operate a motor vehicle equipped with a motor vehicle alcohol test and lock system, the person must agree to comply with the following conditions:

(A) If not already enrolled, the person shall enroll in and complete the educational program provided in subsection (d), section three of this article at the earliest time that placement in the educational program is available, unless good cause is demonstrated to the commissioner as to why placement should be postponed;

(B) The person shall pay all costs of the educational program, any administrative costs and all costs assessed for any suspension hearing.

(3) Notwithstanding the provisions of this section to the contrary, a person eligible to participate in the program under this subsection may not operate a motor vehicle unless approved to do so by the commissioner.

(c) A person who participates in the program under subdivision (1), subsection (b) of this section is subject to a minimum revocation period and minimum period for the use of the ignition interlock device as follows:

(1) For a person whose license has been revoked for a first offense for six months pursuant to the provisions of section one-a of this article for conviction of an offense defined in subsection (d) or (g), section two, article five of this chapter or pursuant to subsection (j), section two of this article, the minimum period of revocation for participation in the test and lock program is fifteen days and the minimum period for the use of the ignition interlock device is one hundred and twenty-five days;

(2) For a person whose license has been revoked for a first offense pursuant to section seven, article five of this chapter, the minimum period of revocation for participation in the test and lock program is forty-five days and the minimum period for the use of the ignition interlock device is one year;

(3) For a person whose license has been revoked for a first offense pursuant to section one-a of this article for conviction of an offense defined in subsection (e), section two, article five of this chapter or pursuant to subsection (j), section two of this article, the minimum period of revocation for participation in the test and lock program is forty-five days and the minimum period for the use of the ignition interlock device is two hundred seventy days;

(4) For a person whose license has been revoked for a first offense pursuant to the provisions of section one-a of this article for conviction of an offense defined in subsection (a), section two, article five of this chapter or pursuant to subsection (f), section two of this article, the minimum period of revocation before the person is eligible for participation in the test and lock program is twelve months and the minimum period for the use of the ignition interlock device is two years;

(5) For a person whose license has been revoked for a first offense pursuant to the provisions of section one-a of this article for conviction of an offense defined in subsection (b), section two, article five of this chapter or pursuant to subsection (g), section two of this article, the minimum period of revocation is six months and the minimum period for the use of the ignition interlock device is two years;

(6) For a person whose license has been revoked for a first offense pursuant to the provisions of section one-a of this article for conviction of an offense defined in subsection (c), section two, article five of this chapter or pursuant to subsection (h), section two of this article, the minimum period of revocation for participation in the

program is two months and the minimum period for the use of the ignition interlock device is one year;

(7) For a person whose license has been revoked for a first offense pursuant to the provisions of section one-a of this article for conviction of an offense defined in subsection (j), section two, article five of this chapter or pursuant to subsection (m), section two of this article, the minimum period of revocation for participation in the program is two months and the minimum period for the use of the ignition interlock device is ten months;

(d) Notwithstanding any provision of the code to the contrary, a person shall participate in the program if the person is convicted under section two, article five of this chapter or the person's license is revoked under section two of this article or section seven, article five of this chapter and the person was previously either convicted or his or her license was revoked under any provision cited in this subsection within the past ten years. The minimum revocation period for a person required to participate in the program under this subsection is one year and the minimum period for the use of the ignition interlock device is two years, except that the minimum revocation period for a person required to participate because of a violation of subsection (n), section two of this article or subsection (i), section two, article five of this chapter is two months and the minimum period of participation is one year. The division shall add an additional two months to the minimum period for the use of the ignition interlock device if the offense was committed while a minor was in the vehicle. The division shall add an additional six months to the minimum period for the use of the ignition interlock device if a person other than the driver received injuries. The division shall add an additional two years to the minimum period for the use of the ignition interlock device if a person other than the driver is injured and the injuries result in that person's death. The division shall add one year to the minimum period for the use of the ignition interlock device for each additional previous conviction or revocation within the past ten years. Any person required to participate under this subsection must have an ignition interlock device installed on every vehicle he or she owns or operates.

(e) Notwithstanding any other provision in this code, a person whose license is revoked for driving under the influence of drugs is not eligible to participate in the Motor Vehicle Alcohol Test and Lock Program.

(f) An applicant for the test and lock program may not have been convicted of any violation of section three, article four, chapter seventeen-b of this code for driving while the applicant's driver's license was suspended or revoked within the six-month period preceding the date of application for admission to the test and lock program unless such is necessary for employment purposes.

(g) Upon permitting an eligible person to participate in the program, the commissioner shall issue to the person, and the person is required to exhibit on demand, a driver's license which shall reflect that the person is restricted to the operation of a motor vehicle which is equipped with an approved motor vehicle alcohol test and lock system.

(h) The commissioner may extend the minimum period of revocation and the minimum period of participation in the program for a person who violates the terms and conditions of participation in the program as found in this section, or legislative rule, or any

agreement or contract between the participant and the division or program service provider. If the commissioner finds that any person participating in the program pursuant to section two-b, article five of this chapter must be removed therefrom for violation(s) of the terms and conditions thereof, he shall notify the person, the court that imposed the term of participation in the program, and the prosecuting attorney in the county wherein the order imposing participation in the program was entered.

(i) A person whose license has been suspended pursuant to the provisions of subsection (n), section two of this article who has completed the educational program and who has not violated the terms required by the commissioner of the person's participation in the program is entitled to the reinstatement of his or her driver's license six months from the date the person is permitted to operate a motor vehicle by the commissioner. When a license has been reinstated pursuant to this subsection, the records ordering the suspension, records of any administrative hearing, records of any blood alcohol test results and all other records pertaining to the suspension shall be expunged by operation of law: *Provided*, That a person is entitled to expungement under the provisions of this subsection only once. The expungement shall be accomplished by physically marking the records to show that the records have been expunged and by securely sealing and filing the records. Expungement has the legal effect as if the suspension never occurred. The records may not be disclosed or made available for inspection and in response to a request for record information, the commissioner shall reply that no information is available. Information from the file may be used by the commissioner for research and statistical purposes so long as the use of the information does not divulge the identity of the person.

(j) In addition to any other penalty imposed by this code, any person who operates a motor vehicle not equipped with an approved motor vehicle alcohol test and lock system during that person's participation in the Motor Vehicle Alcohol Test and Lock Program is guilty of a misdemeanor and, upon conviction thereof, shall be confined in jail for a period not less than one month nor more than six months and fined not less than \$100 nor more than \$500. Any person who attempts to bypass the alcohol test and lock system is guilty of a misdemeanor and, upon conviction thereof, shall be confined in jail not more than six months and fined not less than \$100 nor more than \$1,000: *Provided*, That notwithstanding any provision of this code to the contrary, a person enrolled and participating in the test and lock program may operate a motor vehicle solely at his or her job site if the operation is a condition of his or her employment. For the purpose of this section, job site does not include any street or highway open to the use of the public for purposes of vehicular traffic.

**LEGISLATIVE RULE 64CSR98**

64CSR98

TITLE64  
LEGISLATIVE RULE  
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

SERIES 98  
SAFETY AND TREATMENT  
PROGRAM

§64-98-1. General

- 1.1. Scope. - This legislative rule establishes a comprehensive safety and treatment program for persons found in initial and subsequent violation of W.Va. Code §§ 17C-5-1 *et seq.* and 17C-5A-1 *et seq.*
- 1.2. Authority.- W.Va. Code §§ 17 A-2-9 and 17C-5A-3.
- 1.3. Filing Date.-
- 1.4. Effective Date.-

§64-98-2. General.

- 2.1. Application- This legislative rule applies to all persons involved in the West Virginia Safety and Treatment Program Administered by the Department of Health and Human Resources, Division of Alcoholism and Drug Abuse pursuant to W.Va. Code § 17C-5A-3.
- 2.2. Enforcement- Enforcement of this legislative rule is vested with the Secretary of the Department of Health and Human Resources.

§64-98-3. Definitions.

The following definitions apply in the interpretation and enforcement of this legislative rule.

- 3.1. Secretary- The executive officer of the Department of Health and Human Resources as appointed by the Governor.
- 3.2. Department- The Department of Health and Human Resources.
- 3.3. DUI- Any act which would constitute a violation of W.Va. Code § 17C-5-2.
- 3.4. License- Any permit issued by the Commissioner of the Division of Motor Vehicles for the purpose of operating a motor vehicle.
- 3.5. Participant- A person enrolled in the West Virginia Safety and Treatment Program who has been charged with a DUI in the state of West Virginia or a West Virginia resident who has been charged with a DUI in another state.
- 3.6. Program- The West Virginia Safety and Treatment Program established pursuant to W.Va. Code § 17C-5A-3.

3.7. Provider- An entity, including the Comprehensive Community Behavioral Health Centers as defined in W.Va. Code §27-2a-I. regulated by the Department of Health and Human Resources that provides Safety and Treatment Programs pursuant to a grant agreement or a Memorandum of Understanding with the Department or an entity with an approved program operating in another state.

§64-98-4. Program Responsibilities.

4.1. The Division of Motor Vehicles is responsible for licensure to operate a motor vehicle and any changes to licensure.

4.2. The Department is responsible for establishing a comprehensive safety and treatment program for persons found in violation of W. Va. Code §§ 17C-5-1 *et seq.* and 17C-5A-1 *et. seq.* The Department shall fulfill this responsibility by developing a Program and contracting with the Community Behavioral Health Centers and other providers to conduct the Program. The Department is also responsible for ensuring that services rendered through providers, both in and out of state, are delivered by competent and qualified professionals. The Department is also responsible for the development of program standards for individuals involved in the service delivery, for approval of program curriculum for in and out of state providers and for the monitoring of compliance by providers with the standards.

4.3. West Virginia licensed Behavioral Health Providers shall offer and operate the Program under contract with the Department of Health and Human Resources.

§64-98-5. Program Levels of Referral.

5.1. Initial Notification- The Commissioner of the Division of Motor Vehicles shall issue an eOrder of License Revocation and shall communicate the procedures for participation in the Program and the conditions to be met before license reinstatement.

5.2. Initial Assessment- The first phase of the Program consists of an enrollment session and a period of Assessment, conducted by a provider, for determining which Program levels are appropriate for each participant to complete. The assessment shall use:

5.2.a. Objective information such as the participant's blood alcohol content; various assessment tests as defined in the Program standards such as the Michigan Alcohol Screening Test (MAST), the Drug Abuse Screening Test (DAST), the Numerical Drinking Profile (NDP) and the McAndrews Scale of the Minnesota Multiphasic Personality Inventory (MMPI); and prior driving under the influence, public intoxication, and other substance abuse related arrests;

5.2.b. Subjective information based on the participant's problems involving family, employment, education or training, financial, medical, recreational, emotional, legal and substance abuse problems;

5.2.c. Information on the participant's interpersonal relationships, and his or her own observation of his or her present status, the evaluator's observations of the participant, and any other significant information that is available; and

5.2.d. American Society of Addiction Medicine (ASAM) criteria to determine the appropriate level of service for participant referral. A participant found to not meet American Society of Addiction Medicine (ASAM) criteria for any level of service must still be referred for the Level I Prevention and Education Component.

5.3. Level I. Prevention and Education Component- A provider shall refer a participant who through the assessment phase is evaluated as not having a significant substance abuse problem to Level I. This level is informational and educational in nature and is intended to create an awareness of the misuse of alcohol and other drugs, particularly as the use relates to the operation of a motor vehicle. The Level I component consists of a minimum of eighteen hours and shall include the following:

- 5.3.a. Defensive Driving Instruction or other safety driving instruction;
- 5.3.b. Substance Abuse Education, of which at least one hour shall be an orientation to Alcoholics Anonymous, Narcotics Anonymous or other similar entity provided by a member of one of those organizations; and
- 5.3.c. One individual counseling session after the classroom instruction. This session shall be used to evaluate the participant's need for further services. If the counselor determines in the counseling session that the participant has not benefited significantly from participation in the program or has demonstrated a lack of involvement, additional prevention and education activities may be required to fulfill the completion criteria for Level I. The participant shall be responsible for the costs of any additional prevention and education activities.

5.4. Level II, Intervention and Treatment Component- A provider shall refer a participant who it considers as having an abuse problem according to the American Society of Addiction Medicine's (ASAM) criteria as set forth in the Program Standards to Level II of the Program. This level consists of individual or group outpatient counseling on a frequency correspondent to the determined need. Each Level II. Participant shall complete a Level I, Prevention and Education program.

5.5. Level III, Intensive Care Component- A provider shall refer a participant who is assessed as having an abuse problem according to the American Society of Addiction Medicine's (ASAM) criteria as set forth in the Program Standards to Level III. A participant at this level shall participate in an intensive treatment program which will have total abstinence as its goal. The intensive treatment component consists of intensive outpatient or residential treatment designed specifically for substance abuse treatment. The participant shall complete Level I, Prevention and Education Component and Level II, Intervention Treatment Component.

#### §64-98-6. Staff Qualifications.

6.1. Provider Responsibilities- Each provider is responsible for ensuring that the services provided through the Program are delivered by competent and qualified professionals who meet the requirements established in the Program Standards published by the Department. Each provider shall provide the Department with the names, training and job functions performed by all persons providing services for the Program.

6.2. Assessment. Evaluation and Treatment-A person providing services for the Assessment,

Evaluation, and Treatment aspects of the Program shall have at least one year work experience in the field of substance abuse treatment, or have attained the necessary skills through training, education, experience and supervision.

6.3. Prevention and Education-A person providing services for the Prevention and Education component of the program shall have at least one year of work experience in the field of substance abuse prevention, education, or treatment

6.4. Defensive Driving or other safety driving instruction- A person providing services for the course of defensive driving or other safety driving instruction shall be a qualified instructor as defined in the Program Standards.

6.5. Program Coordinator- Each provider shall designate a DUI Program Coordinator whose function is to supervise the performance of the terms of the contract between the provider and the Department. The Program Coordinator shall also work with the Department for the purposes of program Development and procedural refinement. The Program Coordinator shall meet or exceed the minimum criteria set forth in the Program Standards.

§64-98-7. Program Participant Evaluation.

7.1. Referral Evaluation Report- Based on the information gathered during the initial assessment as described in subsection 5.2 of this rule, the provider shall make a referral evaluation report on each participant on the form prescribed by the Department. The provider shall forward a copy of each report to the Department.

7.2. Change in Status- A provider may change a participant's Program level status following the initial assessment based upon application of the prescribed American Society of Addiction Medicine (ASAM) criteria. When a provider changes a participant's status, it shall notify the Department by submitting a revised Referral Evaluation Report.

7.3. Status Evaluation Report- the provider shall submit a Status Evaluation Report for each participant to the Department, on the prescribed form, upon completion of the Program.

7.4. Appeal of Referral- Each Provider shall establish procedures for resolving Participant questions concerning referral level and status evaluation.

§64-98-8. Fiscal Procedures.

8.1. Program Enrollment and Level 1 Component Fee- The initial fee for enrollment in the West Virginia Program shall be Four Hundred Dollars (\$400.00). This fee covers the provision of the Level 1 Prevention and Education component as described in Subsection 5.3 of this rule. The Participant shall pay the fee upon enrollment with the provider, unless he or she is found to be indigent.

8.2. Additional Services- The cost for all counseling and treatment services provided in addition to the Level I component as described in Subsection 5.3 of this rule is the responsibility of the participant. Each provider shall charge for additional services in accordance with its prevailing fee schedule for comparable services.

8.3. Indigent Participant-A participant may request an indigent determination for a full waiver of enrollment fees for the provision of the Level I Prevention and Education component provided that the participant meets each of the following criteria:

8.3.a. Participant must have household family income equal to or below one hundred per cent of the federal poverty standard, making adjustments for family size.

8.3.b. Participant shall be a resident of West Virginia and provide documentation thereof.

8.3.c. Participant must enroll in a program operated by a provider approved by. and operating within West Virginia.

8.4. The Department of Health and Human Resources Safety and Treatment Fund -Upon enrollment in the Program, the participant shall pay to the provider the sum of Four Hundred Dollars (\$400.00) except for those participants which are determined to be indigent under Subsection 8.3 of this rule. The provider shall remit to the Department the sum of One Hundred Twenty Five Dollars (\$125.00) and the provider shall retain Two Hundred Seventy Five Dollars (\$275.00). The Department shall deposit Seventy Five Dollars (\$75.00) of this sum in the Department of Health and Human Resources Safety and Treatment fund, to be used to reimburse providers for their portion of the enrollment fee for persons qualifying for indigent status. The remaining Fifty Dollars (\$50.00) shall be used by the Department for the administration of the Program. The Department is also responsible for collecting the One Hundred Twenty Five Dollars (\$125.00) per participant from West Virginia residents that participate in a Safety and Treatment Program in another state and from drivers that receive a DUI in West Virginia and participate in another state's approved program.

§64-98-9. Reinstatement of License.

9 .1. Completion of Program - In order to successfully complete the Program, a participant shall complete the prescribed level or levels of treatment, receive a favorable Status Evaluation Report and pay all applicable costs for program participation.

9.2. Payment of Reinstatement Fees-A Program participant shall satisfy all financial obligations to the Department and the Division of Motor Vehicles before the reinstatement of his or her license will be considered whether a participant resides in West Virginia or in another state.

9.3. Final Decision- Subject to the provisions of W.Va. Code § 17C-5A-3(b)(2), the final decision on license reinstatement is vested with the Commissioner of Motor Vehicles.

**LEGISLATIVE RULE 91CSR15**

**TITLE 91  
LEGISLATIVE RULE  
DEPARTMENT OF MOTOR VEHICLES**

**SERIES 15  
SAFETY AND TREATMENT PROGRAM**

**'91-15-1. General.**

1.1. Scope. -- These legislative rules establish a comprehensive safety and treatment program for persons found in initial and subsequent violation of Chapter 17C, Articles 5 and 5A of the Code.

1.2. Authority. -- W. Va. Code ' ' 17A-2-9 and 17C-5A-3.

1.3. Filing Date. -- April 4, 1984.

1.4. Effective Date. -- May 4, 1984.

**'91-15-2. Application and Enforcement.**

2.1. Application - These legislative rules apply to persons involved in the Safety and Treatment Program administered by the Department of Motor Vehicles pursuant to ' 17C-5A-3.

2.2. Enforcement - Enforcement of these legislative rules is vested with the Commissioner of Motor Vehicles or lawful designee.

**'91-15-3. Definitions.**

The following definitions shall apply in the interpretation and enforcement of these legislative rules.

3.1. Centers - Means the Community Behavioral Health Centers and Guilds regulated by the Department of Health and contracted by the Department of Motor Vehicles as the provider agency for services relating to the Safety and Treatment Program.

3.2. Code - Means the Code of West Virginia of 1931, as amended.

3.3. Commissioner - Means the executive officer of the Department of Motor Vehicles appointed by the Governor pursuant to ' 17A-2-2, or lawful designee.

3.4. Department - Means the Department of Motor Vehicles.

3.5. License - Means any permit issued by the Commissioner for the purpose of operating a motor vehicle in this state.

3.6. Participants - Means persons enrolled in the Safety and Treatment Program.

3.7. Program - Means the Safety and Treatment Program established pursuant to ' 17C-5A-3.

3.8. Sliding Fee Scale - Means the scale of fees charged by the Centers for services rendered over and above the basic Level I Program, which insures that no person will be denied such services because of an inability to pay.

**'91-15-4. Program Responsibilities.**

4.1. Department of Motor Vehicles - Is responsible for establishing a comprehensive safety and treatment program for persons found in violation of Chapter 17C, Articles 5 and 5A of the Code. The Department fulfills this responsibility by developing a Program in cooperation with the Department of Health and contracting with the Community Behavioral Health Centers to conduct the Program. The Department is also responsible for insuring that services rendered through the Program are delivered by competent and qualified professionals.

4.2. Department of Health - Serves in an advisory capacity to both the Department and the Centers regarding policy resolutions and modifications pertaining to the operation of the Program. The Department of Health also monitors compliance with established policies and procedures by the Centers conducting the Program.

4.3. Community Behavioral Health Centers and Guilds - Offer and operate the Program under contract with the Department in consultation with the Department of Health.

**'91-15-5. Program Levels of Referral.**

5.1. Initial Notification - When notified of the Commissioner's order of license revocation, persons are advised of the procedures for participation in the Program and the conditions to be met before license reinstatement.

5.2. Initial Assessment - The first phase of the Program consists of an enrollment session and a period of assessment for determining which Program levels are appropriate for each Participant to complete.

The assessment shall utilize:

(A) Objective information such as the Participant's blood alcohol content; various assessment tests such as the Michigan Alcoholism Screening Test (MAST), the Numerical Drinking Profile (NDP) and McAndrews Scale of the Minnesota Multiphasic Personality Inventory; and prior driving under the influence, public intoxication, and other drug related arrests.

(B) Subjective information based on the Participant's problems involving family, employment, education/training, financial, medical, recreational, emotional, legal, and alcohol and other drug abuse problems.

(C) Information on the Participant's interpersonal relationships, and his own observation of his present status; the evaluator's observations of the participant, and any other significant information that is available.

5.3. Level I, Prevention/Education Component - Participants who through the assessment phase are evaluated as not having a significant problem with the use of alcohol and other drugs are referred to Level I. This phase is informational and educational in nature and is intended to create an awareness of the misuse of alcohol and other drugs, particularly as the use relates to operating a motor vehicle. The Level I component

shall consist of a minimum of nineteen hours and shall include the following:

(A) Defensive Driving Instruction.

(B) Alcohol and Other Drug Abuse Education of which at least one hour shall be an orientation to Alcoholics Anonymous provided by a member of Alcoholics Anonymous.

(C) One individual counseling session after the classroom instruction.

This session shall be used to evaluate the Participant's need for further services. If it is determined in this counseling session that the participant has not benefited significantly or has demonstrated a lack of involvement, additional prevention/education activities may be required to fulfill the completion criteria for Level I.

5.4. Level II, Intervention/Treatment Component - Participants who are considered as having a potential, probable, early stage or middle stage problem with the abuse of alcohol or other drugs are referred to Level II. This component shall consist of individual or group outpatient counseling on a frequency correspondent to the determined need and completion of the Level I, Prevention/Education component. Verified attendance at meetings of Alcoholics Anonymous may be required.

5.5. Level III, Intensive Care Component - Participants who are assessed as having a late stage alcohol or other drug abuse problem are referred to Level III. Participants at this level shall participate in an intensive treatment program which will have total abstinence as its goal. The intensive treatment component shall consist of residential treatment or partial hospitalization designed specifically for substance abuse treatment. Verified attendance at meetings of Alcoholics Anonymous may also be required. Completion of Level I, Prevention/Education and Level II, Intervention Treatment Component for aftercare purposes is also required.

**'91-15-6. Staff Qualifications.**

6.1. Center Responsibilities - Each Center shall be responsible for insuring that the services provided through the Program are delivered by competent and qualified professionals in the field of substance abuse. Each Center shall provide the Department with the names, training and function performed of all persons providing services for the Program.

6.2. Assessment, Evaluation and Treatment - Persons providing services for the Assessment, Evaluation, and Treatment aspects of the Program shall have at least one year work experience in the field of substance abuse treatment, or have attained the necessary skills through training, education, experience, and supervision.

6.3. Prevention/Education - Persons providing services for the Prevention/ Education component of the program shall have at least one year of work experience in the field of substance abuse prevention/education and/or treatment or have attained the necessary skills through training, education, experience, and supervision.

6.4. Defensive Driving - Persons providing services for the course of defensive driving shall be qualified instructors.

6.5. Program Coordinator - Each Center shall designate a D.U.I. Program Coordinator whose function is to supervise the performance of the terms of the contract between the Center and the Department. The Program Coordinator shall also work with both the Departments of Health and Motor Vehicles for the purposes of program development and procedural refinement.

**'91-15-7. Program Participant Evaluation.**

7.1. Referral Evaluation Report - Based on the information gathered during the initial assessment as described in 5.2 of these legislative rules, a referral evaluation report is made by the Center on each Participant on the form prescribed by the Department. The Center shall forward each report to the Department.

7.2. Change in Status - The Centers have the authority to change a Participant's Program level status following the initial assessment. When a Center changes a Participant's status, it shall notify the Department by submitting a revised Referral Evaluation Report.

7.3. Status Evaluation Report - The Center shall submit a Status Evaluation Report on each Participant to the Department, on the prescribed form, upon completion of the Program.

7.4. Overall Responsibility - By virtue of its legislative mandate relative to the Safety and Treatment Program, overall responsibility for the level and quantity of treatment provided by the Center for any Participant rests with the Commissioner.

7.5. Appeal Of Referral - Each Center shall establish procedures for resolving Participant questions concerning referral level and status evaluation.

**'91-15-8. Fiscal Procedures.**

8.1. Program Enrollment Fee - The fee for enrollment in the Program is established by the Commissioner in cooperation with the Department of Health. This fee covers the provision of the Level I Prevention/Education treatment component as described in 5.3 of these legislative rules. The fees shall be paid by the Participant upon enrollment at the Center. Payment shall be in the form of a postal money order, bank money order, or certified check made payable to the Driver's Rehabilitation Fund.

8.2. Additional Services - The cost for all counseling and treatment services provided in addition to the Level I component as described in 5.3 of these legislative rules is the responsibility of the Participant. Each Center shall charge for such additional services in accordance with its prevailing fee schedule for comparable services. A sliding fee scale shall be utilized if it is determined that the Participant cannot afford the full fee for additional services.

8.3. Driver's Rehabilitation Fund - The enrollment fee collected from each Program Participant by the Center shall be forwarded to the Department for deposit in the Driver's Rehabilitation Fund. The Center shall be reimbursed as stipulated in the contracts for each Participant the Center has enrolled. The Health Department shall be reimbursed as stipulated in the contracts for each Participant enrolled in consideration for consulting services performed.

**'91-15-9. Reinstatement of License.**

9.1. Completion of Program - Successful completion of the Program is contingent on completion of the prescribed level or levels of treatment, a favorable Status Evaluation Report, and payment, as requested by the Center, of all applicable costs for program participation.

9.2 Payment of Reinstatement Fees - All financial obligation to the Department must be satisfied before

the reinstatement of a Program Participant's license will be considered.

9.3. Final Decision - Subject to the provisions of '17C-5A-3(b)(2), the final decision on license reinstatement is vested with the Commissioner.

**INDIGENT PROCESS**



<b>Original Date:</b>	1 July 2011
<b>Revision Date:</b>	16 November 2011
<b>Effective Date:</b>	1 July 2011

**I. PURPOSE / GENERAL PROCEDURAL STATEMENT**

The purpose of this procedure is to offer specific, uniform procedures, eligibility criteria, and forms to be utilized for determining indigent status for individuals enrolling into West Virginia Department of Health and Human Resources (DHHR's) DUI Safety and Treatment program components as described in Chapter 17C-5A-3 of the West Virginia State Code. DUI Safety & Treatment program components must be provided to clients regardless of their ability, or inability, to pay for such services.

**II. APPLICABILITY**

This procedure will apply to all DHHR/BBHFF enrolled providers administering the DUI Safety and Treatment program. A current Memorandum of Understanding between the Bureau for Behavioral Health and Health Facilities (BBHFF) and the education program provider shall be maintained by the BBHFF and the enrolled provider.

**III. AUTHORITY**

WV Code 17C-5A-3, 17A-2-9 and related sections, Articles, Legislative Rules, and DUI Program Standards.

**IV. ENFORCEMENT**

Enforcement and oversight responsibilities for this procedure are vested with the Secretary of the DHHR.

**V. IMPLEMENTATION**

This policy is effective upon date of release.

**VI. CANCELLATION**

This procedure is subject to revision and is not intended to supersede any existing policies or regulations. In the event of conflict, requirements shall be observed in the order of precedence.

**VII. RESPONSIBILITY**

To be approved as a contracted provider to offer the DUI Safety and Treatment Program, the enrolled provider must adhere to standards/revisions herein, Chapter 17 of the West Virginia State Code, specific to "Driving While Under the Influence", Chapter 17C-5A-3, Chapter 17A-2-9 and related State Code Sections, Articles, Legislative Rule, and DUI

Program Standards including the mandatory determination of indigent status where a waiver of fees or a reduction of fees for participation in program components is requested or determined to be necessary.

## VIII. DEFINITIONS

- 1) **MOU** - Memorandum of Understanding which describes the bilateral agreement between the Provider and Bureau for Behavioral Health and Health Facilities or the Division of Motor Vehicles and Bureau for Behavioral Health and Health Facilities which serves to document the terms and conditions of the agreement.
- 2) **Department of Health and Human Resources Safety and Treatment Fund** – WV Code 17C-5A-3 (d) created a special revenue account within the State Treasury to be administered by the Secretary of the Department of Health and Human Resources for the purpose of administering the comprehensive safety and treatment program.
- 3) **BBHFF** - West Virginia Department of Health and Human Resources, Bureau for Behavioral Health and Health Facilities.
- 4) **DMV** - The West Virginia Department of Transportation, Division of Motor Vehicles Division of Motor Vehicles.
- 5) **Program Standards** - Uniform program standards for approval/operation of entities providing DUI Safety and Treatment Program as described in Chapter 17C-5A-3 of the West Virginia State Code.
- 6) **DUI Enrollment/Evaluation/Assessment** - The initial session used to determine the severity and scope of the DUI offender's abuse/addiction, as well as the determination of the intensity of treatment services required.
- 7) **DUI Offender** - Anyone arrested for driving under the influence of alcohol and/or other drugs or permitting another individual to drive while under the influence, per Chapter 17C-5-2 of the State Code.
- 8) **Enrolled Provider** - Any individual, government, or governmental subdivision, agency, corporation, partnership, firm, business trust, estate, organization, or association acting individually or as a group which is contracted to operate the DUI Safety and Treatment Program.
- 9) **Service** – Any DUI Safety and Treatment program component as referenced in Chapter 17C-5A-3 of the West Virginia State Code and as referenced in Title 64, Legislative Rules, Series 98, entitled Safety and Treatment Program.
- 10) **Enrolled Provider Staff** - Applies to all individuals and supervisors providing services on behalf of the enrolled provider as indicated in the Program Standards or referenced in this procedure.

- 11) Education Component (Level I)** - Services including the enrollment, initial assessment, evaluation, 18 hours of educational instruction and the final assessment session. The sessions must be administered by a qualified individual as defined by the Program Standards.
- 12) Intervention/Treatment Component (Level II)** - Intervention and/or treatment services which are recommended beyond the 18 hour Education Component which may include individual/group modalities. These services may include planned, therapeutic, intervention with the ultimate goal of the participant discontinuing the substance use or abuse. *The services are separate and distinct from the Education Component.*
- 13) Intensive Care Component (Level III)** - Treatment services which are recommended beyond the 18 hour Education Component and Prescribed Intervention/ Treatment Component. These services may consist of day treatment, intensive outpatient, medically monitored/managed inpatient residential, and aftercare services. A period of detoxification may also be required prior to involvement in intensive modalities. *The services are separate and distinct from the Education Component*
- 14) Sliding Fee Scale** – The scale of fees charged by the enrolled provider for services rendered to eligible DUI offenders over and above the basic Level I Safety and Treatment Education Component. Each DUI S&T enrolled provider must maintain a written policy outlining agency specific sliding scale fee rates, terms, and conditions for all services administered to DUI Safety and Treatment clients for any services beyond the education component deemed necessary for driver rehabilitation.

## IX. PROCEDURES

### 1) Eligibility Criteria

- a) Driver must have possessed a valid West Virginia driver's license at the time of the DUI arrest.
- b) Driver must meet financial eligibility of family income less than 100% of the federal poverty standard for level I basic education component full fee waiver.
- c) Driver must meet applicable financial eligibility guidelines to be eligible for assistance in accordance with the provider's sliding fee scale.
- d) Driver must be a legal resident of the State of West Virginia and provide documentation of such.

### 2) Eligibility Determination

- a) Indigent applications for the Education Component will only be accepted and considered for West Virginia drivers not previously receiving indigent assistance with DUI Safety and Treatment Education Component.

- b) Indigent eligibility status must be determined **prior** to enrollment in any DUI S&T program component.
- c) Indigent determination shall be utilized as a last resort only after providers have determined that no other source of funds is available to the DUI Offender.
- d) Indigent determination forms and instructions shall be furnished to clients when:
  - 1. Indigent determination is requested or
  - 2. Financial screening indicates potential need.
- e) All applications for indigent determination must be maintained by the enrolled provider and accompanied by documentation to verify income amounts indicated on the application form. One or more of the following types of documentation may be acceptable for purposes of verifying income:
  - 1. W-2 withholding statements for all employment during the most recent tax year;
  - 2. Bring official driving record from the West Virginia Department of Motor Vehicles;
  - 3. An income tax return from the most recently filed calendar year;
  - 4. Forms approving or denying unemployment compensation. *Documentation must also include income proof that the client is below 100% of the poverty level; or*
  - 5. An Indigent Determination Form (completed only as a last resort in the event that the DUI Offender is not able to produce sufficient income verification documentation as described in items (1) through (4) within this sub-section.)
- f) Each provider is required to have a written policy regarding the administration of indigent determination procedures. Each enrolled provider's policy must be made available to the BBHFF upon request. This policy should disclose all steps and procedures that the enrolled provider will utilize to obtain adequate financial documentation. Only after these procedures described therein have been fully executed shall the justification form be completed and a conclusion reached on the determination form. Income shall be annualized from the date of application based upon documentation provided by the client. The annualization process will also take into consideration seasonal employment and temporary increases and/or decreases to income based upon information provided by the client.
- g) An official form of identification should be photocopied to serve as documentation that the client is a WV resident. One or more of the following types of documentation may be acceptable for purposes of verifying residency:
  - 1. Official Photo ID showing current address.
  - 2. Recent personal property tax assessment.
  - 3. Current vehicle registration in Driver's name.
- h) All information relating to the indigent determination process must be kept confidential. Copies of the documents that support the application may be kept with application form or electronic record.

### 3) Reporting / Submission Requirements

All enrolled providers must report DUI S&T program utilization data on a monthly basis per the required reporting criteria communicated in the DUI Safety and Treatment Program Administrative Standards.

- a) The portion of all enrollment fees established by the DHHR Secretary and communicated within the MOU and Program Standards shall be submitted monthly and shall match the DUI Offender client information reported for that month.
- b) Sliding Fee Scale adjustments for DUI Safety and Treatment services shall be treated as any other sliding scale fee adjustments are treated within the policy established by each enrolled provider and shall not be offset against education component revenue submission.



Bureau for Behavioral Health & Health Facilities (BBHFF)  
Fiscal Procedure 1001  
DUI Safety & Treatment Program Indigent Determination Procedure

Application - Page 1

**WV DUI S & T PROGRAM  
INDIGENT DETERMINATION FORM**

APPLICATION DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

DRIVER'S NAME: BIRTHDATE:

DRIVER LICENSE #: Issuing State

DRIVER'S ADDRESS: Street:

City: State: Zip code:

TELEPHONE NUMBER: ( ) -

DEPENDENTS LIVING IN HOUSEHOLD (name and relationship):

Name:	DOB	Relationship



Application – Page 2

**WV DUI S & T PROGRAM  
 INDIGENT DETERMINATION FORM - FINANCIAL STATEMENT**

**FAMILY INCOME\*\* BY SOURCE**

Driver Name:

Date of Birth:

	DRIVER	SPOUSE	TOTAL
ANNUAL SALARY (GROSS)			
UNEMPLOYMENT BENEFITS			
SOCIAL SECURITY BENEFITS			
INVESTMENTS			
WORKERS COMPENSATION			
CHILD SUPPORT			
OTHER (ALIMONY, ETC.)			
OTHER			
TOTAL			

TOTAL FAMILY INCOME \$  (from above)

TOTAL FAMILY MEMBERS  (from page 1)

The above two data elements will be utilized to determine Indigent Status based on current federal poverty guidelines.

**Please provide one or more of the documents described in section 4.2 (items a-d) of this procedure to verify the information reported.**

\*\*\*\*\*

***I HEREBY ACKNOWLEDGE THAT THE INFORMATION GIVEN HEREIN IS TRUE AND CORRECT. I AUTHORIZE THE DUI SAFETY & TREATMENT ENROLLED PROVIDER TO VERIFY ANY INFORMATION CONTAINED IN THIS DOCUMENT FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED.***

\_\_\_\_\_  
 SIGNATURE OF PERSON MAKING REQUEST \_\_\_\_\_ DATE \_\_\_\_\_



Application - Page 3

ENROLLED PROVIDER DETERMINATION
Charity Care Determination

DO NOT WRITE IN THIS SECTION -
FOR DUI S&T ENROLLED PROVIDER PERSONNEL USE ONLY

This document was received and reviewed by:

Name: [ ]

Position/Title: [ ]

Date: Click here to enter a date.

On behalf of:

Driver Name: [ ]

Date of Birth: [ ]

- 1. Driver reports all sources of funds. Yes [ ] No [ ]
2. Driver possessed a valid WV driver's license at the time of the DUI arrest. Yes [ ] No [ ]
3. The Driver brought his/her driving record from the WV Department of Motor Vehicles. Yes [ ] No [ ]
4. Driver meets financial eligibility of family income less than 100% of the federal poverty standard for level I basic education component full fee waiver. Yes [ ] No [ ]
5. Driver is a legal resident of West Virginia and has provided documentation of such. Yes [ ] No [ ]
6. This is the first time the driver has received Indigent Status. Yes [ ] No [ ]

Determination:

DUI Offender is eligible for Level I indigent waiver? Yes [ ] No [ ]

DUI Offender is eligible for Sliding Fee Scale for services beyond Level I? Yes [ ] No [ ]

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



Bureau for Behavioral Health & Health Facilities (BBHFF)  
Fiscal Procedure 1001  
DUI Safety & Treatment Program Indigent Determination Procedure

**2011 FEDERAL POVERTY GUIDELINES**

Persons in Household	100% Federal Poverty Standard (Annual Limits)	100% Federal Poverty Standard (Monthly Limits)
1	\$10,890	\$908
2	\$14,710	\$1,226
3	\$18,530	\$1,544
4	\$22,350	\$1,863
5	\$26,170	\$2,181
6	\$29,990	\$2,499
7	\$33,810	\$2,813
8	\$37,630	\$3,136
For each additional member over 8 add...	\$3,820	\$318

Poverty Guidelines

Federal Register, Vol. 76, No. 13, January 20, 2011, pp. 3637-3638

<http://aspe.hhs.gov/POVERTY/>

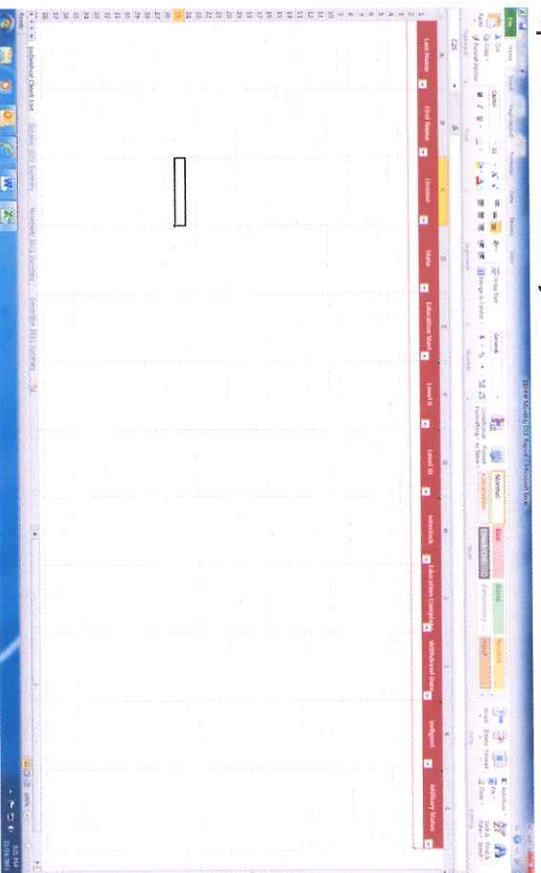
**MONTHLY DUI REPORT**

# Step-By-Step Instructions for BBHHF Monthly DUI Report

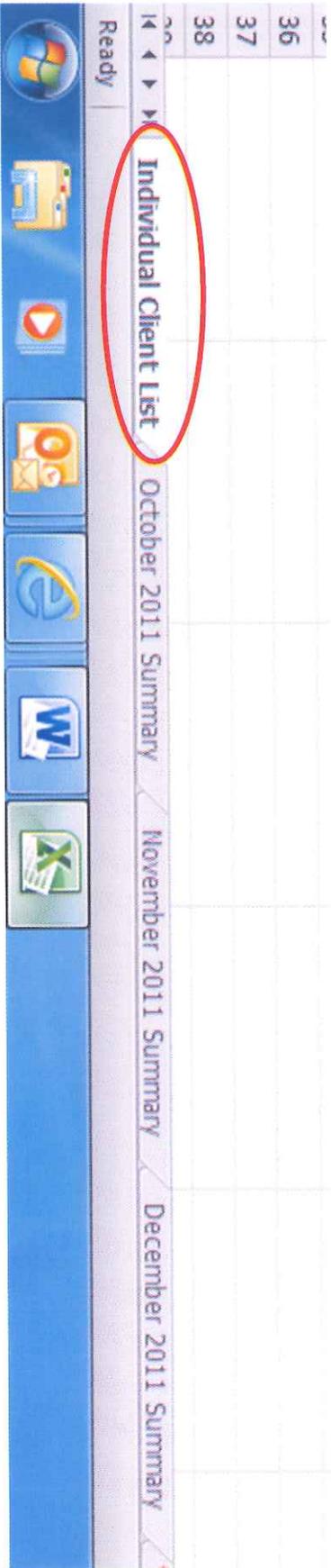
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The **BBHHF Monthly DUI Report** is an Excel workbook that will collect specific data intended for BBHHF. There are two sections to the monthly report. The first section is the **Individual Client List**. The **Individual Client List** is a log of all the clients you treat for DUI. This log will grow each month as you serve more clients. **This information should be collected during the individual assessment of the client.** This section contains the client specific data (name, license number, military status, etc.). The second section of the monthly report is the **Monthly Summary**. You should see a separate worksheet tab for each month of the year at the bottom of the left-side of the worksheet. This section contains a summary of the clients your site served during the month. This worksheet does not include individual client information like names, or license numbers. Each month you will add the clients you served to the **Individual Client List** and provide a **Monthly Summary** of the totals for that given month you are reporting on. The Instructions below describe the steps to reporting the **BBHHF Monthly DUI Report**.

1. Open **BBHHF Monthly DUI** Workbook File in Microsoft Excel



2. The Workbook will open to the **Individual Client List** worksheet. This screen shot shows you **Individual Client List** worksheet circled in red and the remaining Monthly Summary worksheets to the right. Each worksheet is identified by the month the summary data represents e.g. **October 2011 Summary**.



3. The next step is to add your individual client data to the **Individual Client List**. The following shows you the titles of the variables needed for each client in the **Individual Client List** worksheet. Below is a table that describes the data for each client level field. **This data is collected initially during the individual assessment of the client.** Individual data must be submitted for each enrolled participant at the time of the enrollment and at the time of completion, withdrawal, or removal from the education component. At any change of service, status, or any of the information reported, will require the provider to update the field(s) in the **Individual Client List** in order to update the data reported to BBHFF. A filter has been placed and formatted for you in this worksheet so that this list can be sorted alphabetically or by date.

Last Name	First Name	License	State	Enrollment Date	Program ID	Level II	Level III	Interlock	Exit	Withdrawal Date	Indigent	Military Status

**Individual Client List Worksheet**

Field Name	Description
<b>Last Name</b>	Last name of client.
<b>First Name</b>	First name of client.
<b>License</b>	WV DMV License number. If the client is an out-of-state driver WV will issue them a WV DMV license number. Type number as it appears from DMV.
<b>State</b>	Two digit state code of the of the driver's license at the time of DUI. If the client does not have a WV license then this is where the out-of-state two digit state code is identified.
<b>Enrollment Date</b>	Date the client enrolled in the program, education component (Level I). Enter date as a 2 digit month, day, and year MM/DD/YY.
<b>Level II</b>	Is the client currently enrolled or planning on enrolling in Level II Treatment? This cell is a drop down box. Choose Yes or No for the corresponding answer.
<b>Program ID</b>	What location the client is attending the program services at based on the Program ID. For a list of Program IDs see Appendix.
<b>Level III</b>	Is the client currently enrolled or planning on enrolling in Level III treatment? This cell is a drop down box. Choose Yes or No for the corresponding answer.

**Interlock** Is the client planning on or currently enrolled in an interlock program? This cell has a drop down box. Choose Yes or No for the corresponding answer.

**Exit** Date the client completed the exit interview. Enter date as a 2 digit month, day, and year MM/DD/YY.

**Withdrawal Date** Date client withdrew from the program or stopped attending classes. Leave blank if not applicable.

**Indigent** Is this client determined to be indigent based on the criteria? This cell is a drop down box. Choose Yes or No for the corresponding answer.

**Military Status** This field captures the military status of the client. This cell is a drop down box. Please choose answer that best fits the client: (Chose 1, 2, or 3)

1. I have never been in the Armed Forces
2. I am a veteran or currently serving in the Armed Forces
3. I am a spouse/dependent of a veteran or someone serving in the Armed Forces

#### 4. Example of Individual Client List

	Last Name	First Name	License	State	Education Start	Level II	Level III	Interlock	Education Complete	Withdrawal Date	Indigent	Military Status
1	Drunk	Doug	123456	WV	1/1/2011	Yes	No	No	2/11/2011	1/15/2011	Yes	I have never been in Armed Forces
2	Tipsey	Ted	987654	OH	1/14/2011	No	No	No			No	I am a veteran or currently serving

5. Example of drop down cell in Individual Client Level worksheet

The screenshot shows a Microsoft Excel spreadsheet titled "BBHHF Monthly DUI Report - Microsoft Excel". The spreadsheet has columns labeled A through I and rows 1 through 9. The data is as follows:

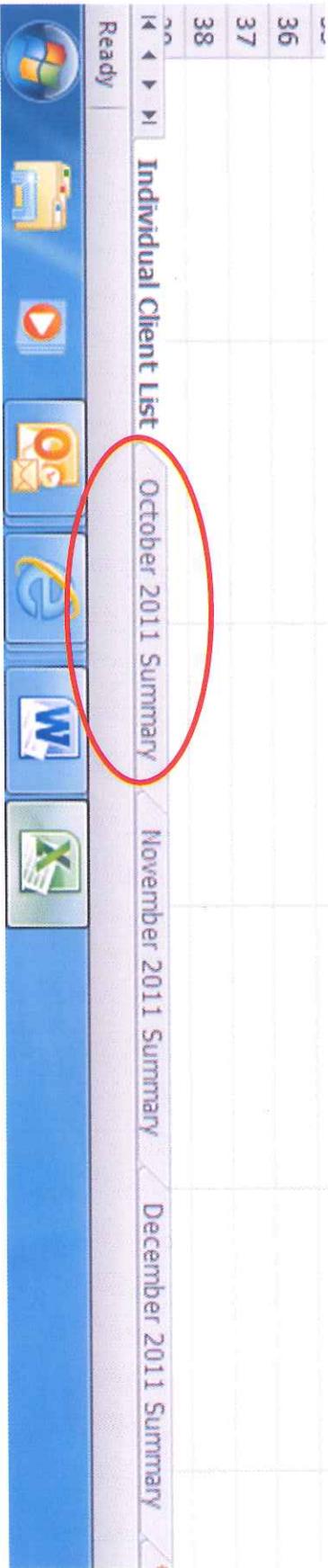
	A	B	C	D	E	F	G	H	I
	Last Name	First Name	License	State	Education Start	Level II	Level III	Interlock	Education Complete
1									
2	Drunk	Doug	123456	WV	1/1/2011	Yes	No	No	
3	Tippsy	Ted	987654	OH	1/14/2011	No	No		
4									
5									
6									
7									
8									
9									

The dropdown menu for cell G2 (Level III) is open, showing the following options:

- Yes
- No

A red circle highlights the dropdown cell and the menu options. A tooltip is visible at the bottom of the dropdown menu with the text: "Is the Client planning on currently enrolled in the Interlock Program? (Select one answer)".

6. The second section of the **BBHF Monthly DUI** is the **Monthly Summary**. The monthly summary does not contain client level data, but rather a summary of the treatment services provided through each program. **Some providers may have multiple sites and therefore will need to summarize each location based on the Program ID on a separate row**. This screen shot shows you **Monthly Summary** worksheet circled in red and the remaining Monthly Summary worksheets to the right and the **Individual Client List** to the left. Each worksheet is identified by the month the summary data represents e.g. **October 2011 Summary**.



7. The next step is to add your **Monthly Summary** data. You will need to complete this worksheet each month. The following shows you the titles of the variables needed for each program in the **Monthly Summary** worksheet. Below is a table that describes the data for each summary field.

Provider Name	Program ID	Reporting Period	New Enrollment	Enrollment Fee	Indigent	Total Due to BBHHF	Total Indigent	Education Complete	Total Withdrawn

**Monthly Summary Worksheet**

Field Name	Description
<b>Provider Name</b>	Provider Name
<b>Program ID</b>	This is the Program ID we e-mailed you. Each site will have a different Program ID. Each Program ID should be listed on a separate row in the monthly summary.
<b>Reporting Period</b>	Two digit month and year you're reporting MM/YY.
<b>New Enrollment</b>	Total number of new enrollments in the program, education component (Level I) for the month for which you are reporting.
<b>Enrollment Fee</b>	Total number of new clients in the program, education component (Level I) that submitted the \$400 enrollment fee during the month for which you are reporting.
<b>Indigent</b>	Total number of new clients who have been determined indigent.
<b>Total Due To BBHHF</b>	Total amount due to BBHHF. Providers will remit \$125 to BBHHF/DUI for each client that has not been determined to be indigent. This field will self-populate based on the number of new enrollments you report.
<b>Total Indigent</b>	Total amount due from BBHHF for indigent clients. Providers will receive \$275 for each client determined to be indigent. This field will self-populate based on the number of indigent clients you report.
<b>Education Complete</b>	Total number of clients who completed the program, education component (Level I) during the month for which you are reporting.
<b>Total Withdrawn</b>	Total number of clients who have withdrawn from the program, education component (Level I) or have stopped attending during the month for which you are reporting.

## 8. Example of Monthly Summary

Provider Name	Program ID	Reporting Period	New Enrollment	Enrollment Fee	Indigent	Total Due to BBHFF	Total Indigent	Education Complete	Total Withdrawn
McBee's Wellness Center	123456	11-Nov	10	5	5	\$1,250.00	\$1,125.00	30	1
						\$0.00	\$0.00		
						\$0.00	\$0.00		

Example of Monthly Summary with Multiple Sites (Program IDs)

Provider Name	Program ID	Reporting Period	New Enrollment	Enrollment Fee	Indigent	Total Due to BBHFF	Total Indigent	Education Complete	Total Withdrawn
Wellness Center A	1234	11-Oct	20	18	2	\$2,500.00	\$450.00		
Wellness Center B	4321	11-Oct	50	49	1	\$6,250.00	\$225.00		
Wellness Center C	9999	11-Oct	5	5	0	\$625.00	\$0.00		
						\$0.00	\$0.00		

- Once you have completed the **BBHFF Monthly DUI Report** save the workbook. Saving your data as a workbook file will allow you to reuse it again to report next month. Once you have saved the workbook, e-mail the file as an excel workbook attachment to an e-mail containing the subject line of **DUI Monthly Report to [DHHR.BHHReporting@wv.gov](mailto:DHHR.BHHReporting@wv.gov)**.

For Questions or Concerns Please Contact Shannon McBee, Epidemiologist at 304-356-4808

# Appendix

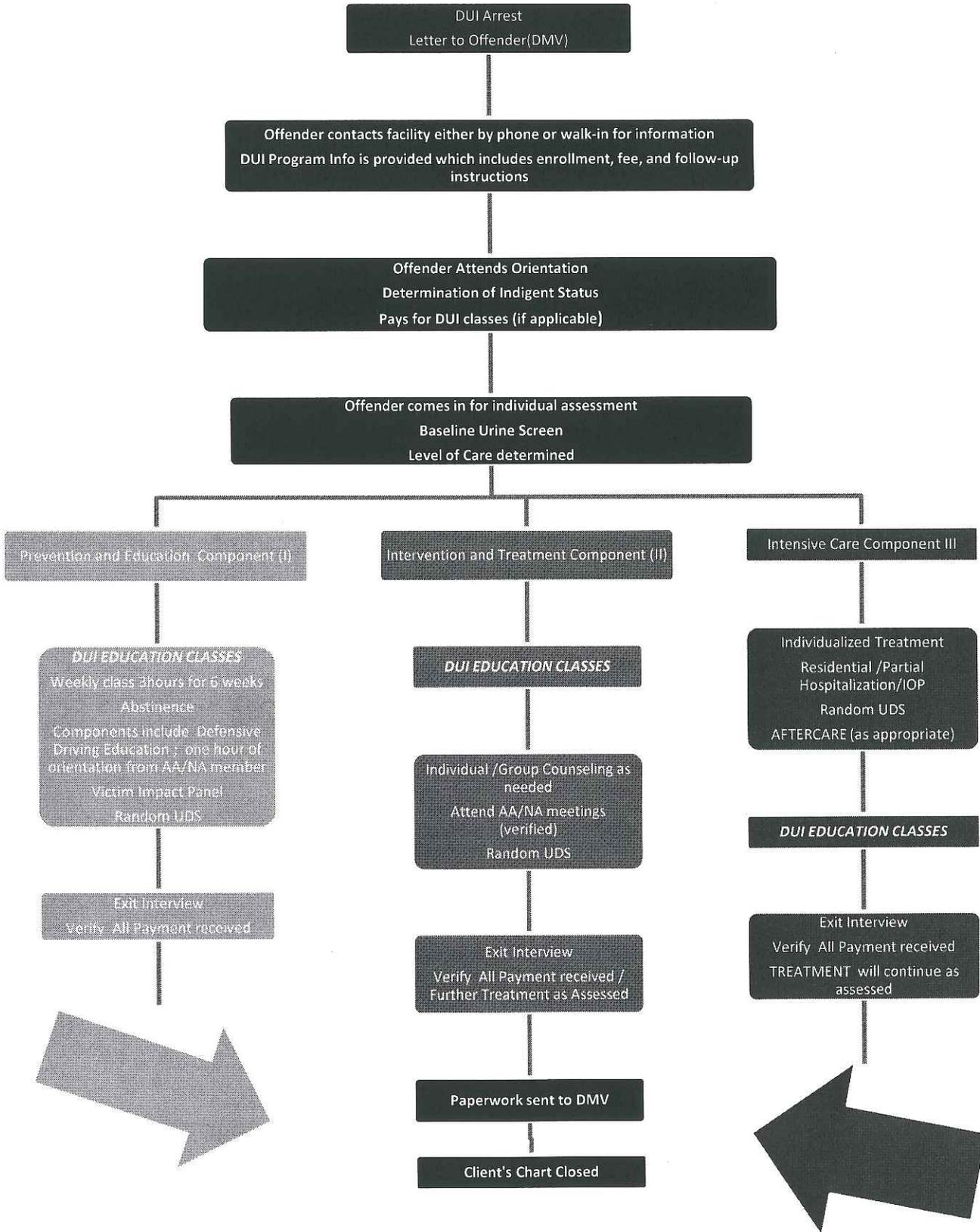
## DUI Program ID

PROGRAM ID	PROVIDER NAME
02147856	APPALACHIAN COMMUNITY HEALTH CENTER (BELLINGTON)
08438964	APPALACHIAN COMMUNITY HEALTH CENTER (BUCKHANNON)
08421062	APPALACHIAN COMMUNITY HEALTH CENTER (PARSONS)
11064923	APPALACHIAN COMMUNITY HEALTH CENTER (ELKINS)
12139556	CALLAHAN COUNSELING SERVICES
01811007	EASTRIDGE HEALTH SYSTEMS, INC
04727880	FMRS
2C006100	HEALTHWAYS, INC
00103106	LOGAN-MINGO AREA MENTAL HEALTH
12149131	NEW HORIZONS PSYCHOLOGICAL ASSOCIATES
10708911	NORTHWOOD HEALTH SYSTEMS
08486794	NORTHWOOD HEALTH SYSTEMS N MAIN ST NEW MARTINSVILLE
00371904	POTOMAC HIGHLANDS GUILD
12336010	PRESTERA - PRESTERA AT PINCREST
08713241	PRESTERA CENTER (POINT PLEASANT)
11408830	PRESTERA CENTER(DUNBAR)
12202958	PYRAMID COUNSELING LLC (BECKLEY)
12223052	PYRAMID COUNSELING LLC (CHARLESTON)
12215033	PYRAMID COUNSELING LLC (LEWISBURG)
11009910	SENECA HEALTH SERVICE, INC (SUMMERSVILLE)
08522896	SENECA HEALTH SERVICES INC. (MARLINTON)
07606668	SENECA HEALTH SERVICES INC. SPECIALTY SERVICES (LEWISBURG)
12159884	SHENANDOAH VALLEY BEHAVIORAL HEALTH SERVICES
00436952	SOUTHERN HIGHLANDS
09203357	SOUTHERN HIGHLANDS (MULLENS)
07553845	SOUTHERN HIGHLANDS COMMUNITY MENTAL HEALTH CENTER - WELCH
13402340	THE LEARNING PLACE

00447533	UMITTED SUMMIT CARE
2E004500	VALLEY HEALTH CARE SYSTEM
2D086000	VALLEY HEALTH CARE SYSTEM (GRAFTON)
2E085900	VALLEY HEALTH CARE SYSTEM (KINGWOOD)
2D076400	VALLEY HEALTH CARE SYSTEM LEONARD (FAIRMONT)
00485020	WESTBROOK HEALTH SERVICES
08636666	WESTBROOK HEALTH SERVICES (HARRISVILLE)
08616837	WESTBROOK HEALTH SERVICES (RIPLEY)
08624893	WESTBROOK HEALTH SERVICES (SAINT MARYS)
08645947	WESTBROOK HEALTH SERVICES (SPENCER)

**DUI FLOWCHART**

# West Virginia DUI Service Overview



**SAFETY AND TREATMENT LETTER**



STATE OF WEST VIRGINIA  
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Earl Ray Tomblin  
Governor

Bureau for Behavioral Health and Health Facilities  
350 Capitol Street, Room 350  
Charleston, West Virginia 25301  
Telephone: (877) 215-2522 Fax: (304) 558-3275

Michael J. Lewis, M.D., Ph.D.  
Cabinet Secretary

**Safety & Treatment Program**

IMPORTANT INFORMATION • READ CAREFULLY

West Virginia Motor Vehicle Law §1 7C-SA-3 establishes the development of the Safety and Treatment Program through the Department of Health and Human Resources, Bureau of Behavioral Health and Health Facilities. The Safety and Treatment Program is to provide a comprehensive program for persons whose licenses have been revoked for driving a motor vehicle under the influence of alcohol, controlled substances and/or drugs.

**What do I need to do in order to get my license re-instated?**

1. Call the program provider nearest you
2. Bring a **complete copy** of the your driving record from the Division of Motor Vehicles that is inclusive of all states and territories of the US
3. If it is determined by your individual assessment and evaluation that alcohol and/or drugs are or have the potential for creating problems for you, additional treatment will be required. The extent of treatment will be determined upon completion of your assessment by the provider. The enrollment fee **does not** include treatment costs.
4. The cost for enrolling in the Safety and Treatment Program starts at **\$400**. If you believe that you may qualify for financial assistance you must bring the following documentation to support you:
  - a. Information from the local DHHR that an eligibility determination has been conducted and you and your family are considered to be eligible for financial assistance, or each of the following:
    - i. Documentation verifying your **annual** income (most recent IRS tax forms signed-1040 and W-2) or
    - ii. income tax return from the most recently filed calendar year
  - b. Documentation to prove West Virginia residence:
    - i. Recent personal property tax assessment or
    - ii. Current vehicle registration in the your name
    - iii. Government issued ID

**West Virginia Motor Vehicle Laws require that any and ALL fees related to reinstatement must be paid before any consideration can be given to reinstating the driving privileges. The final decision to reissue your driver's license will be made by the Commissioner of Motor Vehicles or his designee.**

## **HOW TO OBTAIN YOUR LICENSE**



STATE OF WEST VIRGINIA  
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Earl Ray Tomblin  
Governor

Bureau for Behavioral Health and Health Facilities  
350 Capitol Street, Room 350  
Charleston, West Virginia 25301  
Telephone: (877) 215-2522 Fax: (304) 558-3275

Michael J. Lewis, M.D., Ph.D.  
Cabinet Secretary

**How to Obtain your Driving Record**

**INDIVIDUAL REQUESTS:**

You may request of copy of your own driving record in person at any branch office of the DMV or by mail by providing the following:

- Completed driving record request form (DMV-101-PS)
- A copy of your state issued photo identification
- A \$5.00 processing fee if you provide your name and driver's license number or
- A \$6.00 processing fee if you do not have your driver's license number (Must include DOB and/or SS Number)
- Please clearly indicate where the driving record is to be mailed. (If Applicable)

**ALL OTHER DRIVING RECORD REQUESTS:**

- Completed driving record request form (DMV-101-PS)
- Completed Release Authorization form (Included in DMV-101-PS)
- A copy of the requestor's state issued photo identification
- A \$5.00 processing fee per request if you have the driver's license number and name or
- A \$6.00 processing fee per request, if you do not have the driver's license number. (Must include DOB and/or SS Number)

All requests for a driving record on an employee or client must have a completed Release Authorization form and must be mailed to the below address. You may not obtain information about others without their written consent on the Release Authorization form or unless the request is made on company or business letterhead and provides a legitimate and detailed reason for the request as defined by the Uniform Motor Vehicles Records Disclosure Act.

Mail To: DIVISION OF MOTOR VEHICLES  
DRIVING RECORDS/INSURANCE SECTION  
POST OFFICE BOX 17020  
CHARLESTON, WV 25317

Any Questions, please contact 304-558-4444

**CURRICULUM**

**EDUCATIONAL CURRICULUM  
OF THE  
WEST VIRGINIA DUI SAFETY AND TREATMENT PROGRAM**

*Instructors are reminded that they must adhere to the curriculum standards at all times.*

**SESSION I**

Introduction to the DUI Safety and Treatment Program and the West Virginia DUI Law.

**GOAL:**

This session of the DUI Safety and Treatment Program shall provide participants with an explanation of the purpose, content, and nature of the Safety & Treatment Program. Information regarding the West Virginia DUI Law will also be provided.

**OBJECTIVES:**

1. Participants will understand the nature of the DUI Safety & Treatment Program and its requirements.
2. Participants will increase their knowledge of the WV DUI Law, as it relates to BAC, and have a working understanding of its procedural processes.
3. Participants will have an opportunity to discuss the circumstances surrounding their arrests, and in doing so, they will become acquainted with other class participants.
4. Participants will have an increased awareness regarding the effects of alcohol/drugs on driving.

**RESOURCE MATERIALS:**

1. West Virginia DUI Law Handout(s)
2. Approved video

**INSTRUCTOR'S GUIDELINES:**

This curriculum is designed to be an 18 hour educational program focusing on driving under the influence and chemical dependency.

I. Introduction to the DUI Safety & Treatment Program

This includes, but is not limited to:

- A. Introduction of Instructor(s);
- B. Introduction of class participants (ask class members to introduce themselves now or wait until they discuss their DUI circumstances in the second half of class);
- C. Rules/Requirements of the Program, including, but not limited to:
  - 1. Absentee policy
  - 2. Abstinence policy
    - a. Intoximeter demonstration
    - b. Drug screening
  - 3. Fee - payments
  - 4. Confidentiality
  - 5. Housekeeping policies, i.e., no smoking, no eating, no electronic devices (cell phones, beepers or other electronic devices, etc.), no weapons, location of bathroom, etc.
  - 6. Inclement weather policy
  - 7. Classroom behavior policies
  - 8. Break Information
  - 9. Treatment plan requirements
- D. BHHF completion requirements
  - 1. Abstinence Monitoring Requirements
- E. Review of the Six Week Program
  - 1. Introduction to the DUI Safety and Treatment Program and the West Virginia DUI Law.
  - 2. Physiological Aspects of Chemical Dependency: How do drugs and alcohol affect the human body?

3. Dynamics of Chemical Dependency: What is it? What are its signs, symptoms, and stages?
4. Family Dynamics of Chemical Dependency: How does chemical dependency affect family members?
5. Treatment Resources: What is treatment and where do you go for treatment? What's available? During this session, a speaker from a local 12 Step group will also address the class.
6. Countermeasures: How can I prevent other problems associated with my drinking and/or drug use? This session will include a Victim Impact Panel.

## II. Discussion of the West Virginia DUI Law and BAC

The instructor shall demonstrate thorough understanding of the DUI law and all major legal ramifications of DUI. He/she shall present the following information competently to class participants in an educational/lecture format:

- A. Explanation of the West Virginia DUI law, including offenses, crime, confinements, sentences, fines, and license suspensions. Specific information will be presented in regard to penalties for the following:
  1. Knowingly permitting DUI with one's vehicle;
  2. Death by reckless disregard;
  3. Death by neglect;
  4. DUI and bodily injury;
  5. Driving while under a suspended license for DUI;
  6. Driving with any measurable amount of alcohol.
  7. Driving while previously suspended or revoked results in additional one (1) year period of revocation for each offense
    - a. Not served concurrently
    - b. Effectively only upon resolution of DUI administration suspension.
  8. Felony Fleeing
  9. DUI with a Unemancipated Minor in the Vehicle

- B. Explanation(s) of the legal limits of intoxication (.08) and limits of impairment (.05);
- C. Explanation of Implied Consent Law;
- D. Information regarding the Interlock Program (use handout only);
- E. Explanation of bifurcated proceedings (2 Tracks Administrative and Judicial Processes);
- F. Current & local House Arrest Proceedings;
- G. Additional information, including:
  - 1. State high risk insurance;
  - 2. DUI arrests/driving record - statute of limitations;
  - 3. Current state, local and national DUI statistics.
  - 4. Handout-DUI Penalties

### III. Intoxication and BAC

All students should be aware that one drink of beer, wine, liquor, and wine cooler are equivalent. 0.6 of pure ethyl alcohol is present in a ½ ounce shot of 80 proof whiskey. The same amount of alcohol is present in a 5 ounce glass of table wine, a 10 ounce glass of wine cooler or a 12 ounce glass of beer. The reason for this is the concentration of alcohol in each of the four types of drinks is different. 80 proof whiskey is approximately 40 percent alcohol, table wine is approximately 12 percent alcohol, wine cooler is approximately 6 percent alcohol and beer is approximately 5 percent alcohol. The reason some people become more intoxicated than others is not due to the type of alcoholic beverage they choose. People drink different amounts, and therefore, get more or less intoxicated, regardless of whether they are drinking beer, wine, liquor, or wine coolers.

Intoxication and B.A.C.:

Handout- Breath Alcohol Content & Effects

One drink, as described above, will raise the B.A.C. of a 150-lb. person approximately .02 percent. This is a basic concept for much of the section on intoxication, and will be used in activities later in the program. Instructors should be certain that every student clearly understands B.A.C. and .02 and can apply it to his/her personal situation. B.A.C. is calculated by:

1. Determining the amount of alcohol in the glass or bottle of beverage being consumed. This is necessary because drinks vary in the amount of alcohol, based on whose pouring: sober friends, drinking friends, bartenders, etc. Also, alcoholic

beverages usually do not come in single-serving packages. Even beer comes in pints and quarts and wine coolers often are sold in 12 ounce bottles.

2. For every drink as described under equivalence, above or for every 0.6 ounce of alcohol (pure alcohol) consumed, one may figure the blood alcohol of a drinker to increase approximately .02 percent. In larger persons, the blood alcohol concentration per drink will be lower; in smaller persons the blood alcohol concentration will be higher. If a person has eaten just prior to beginning drinking, his/her initial blood alcohol level will start out low, but if he/she continues drinking, the amount of alcohol in his/her stomach will get stronger. When the alcohol, which is mixed with food in the stomach, passes into the small intestine, it may result in a B.A.C. which is higher than expected.

3. The liver metabolizes alcohol at the rate of approximately .02 percent B.A.C. per hour, at least for the first three or four drinks. As the liver becomes overloaded, its efficiency decreases somewhat in ridding the body of alcohol.

### **B.A.C. REACTIONS**

.01% to .05%	Lowered alertness; usually a good feeling; extroversion; thought and judgment impaired; restraint loosened.
.06% to .10%	Major, consistent decreases in reaction time; depth perception, distance acuity, peripheral vision, glare recovery are all impaired; diminished awareness. See also Section IV, which follows.
.11% to .20%	Marked decrease in motor capability; decidedly intoxicated; sometimes emotional demonstrations of anger, joy, weeping, shouting.
.21% to .25%	Severe motor disturbances, e.g., blurred vision; both social and addictive drinkers are obviously affected beyond .24%.
.30%	Semi-stupor
.35 %	Surgical anesthesia; minimal level to cause death in some people.
.40%	Coma
.50%	Cessation of breathing and heartbeat likely.

A reported B.A.C. level of .15 percent or higher for a drinking driver offender is probably indicative of a developed tolerance for alcohol since persons without

tolerance typically would be unable to function behind the wheel of a vehicle at that B.A.C. level. Increase in tolerance is an indicator that the person is likely to be abusing alcohol regularly.

### Individual Factors

Human characteristics are variable and have an effect on intoxication. As mentioned earlier, heavier persons are less likely to be impaired by the same amount of alcohol as light persons. Instructors may refer to the alcohol wheel or the Play It Safe pamphlet, or their own charts. The age of the individual makes a difference because younger people have no experience in controlling their reactions to alcohol, and elderly people tend to react in an impaired way due to deteriorating physical condition. Individual factors such as liver efficiency, drinking experience, and tolerance also have an effect.

### Time and B.A.C.

There are no quick methods for people to use in sobering up. If you have a high blood alcohol concentration, you can only reduce it by not drinking for a substantial period of time. The myths of coffee or use of cocaine, or by taking a cold shower will reduce intoxication IS NOT TRUE; ONLY TIME can reduce these effects. That is, there is approximately .02 percent reduction of blood alcohol concentration for every hour not spent drinking.

### Hangover

Due to the irritant effects of alcohol, hangovers are present in alcohol intoxication. Unlike marijuana, which remains in the blood stream for an extended period of time, the removal of alcohol from the bloodstream and oxidation by the liver causes withdrawal effects, which are often unpleasant. These effects include nausea, headaches, vomiting, dizziness, and a general feeling of malaise. The discussion of the irritant effects of alcohol will help set the stage for discussion of substance abuse/addiction in Session IV.

### HOW AND WHY DOES ALCOHOL AFFECT CONTROL AND COORDINATION?

Your brain contains a great amount of blood (water) therefore, your brain will attract a great amount of alcohol. Since the brain controls all body functions, these functions will be influenced and impaired when the brain is influenced and impaired by alcohol.

There are three different parts of your brain, all controlling different functions. These parts and functions, along with the Blood Alcohol Content (B.A.C.) at which these functions are impaired, are shown on the diagram below.

### III. Recollection of DUI Events

Ask participants to recall their DUI arrests and then describe the circumstances surrounding them. Limit this exercise to B.A.C. and a brief description of the events surrounding the arrest. The total time allowed for this exercise will depend upon the class size.

The class concludes with a suggested video and discussion.

<b>Offense</b>	<b>Administrative Penalty</b>	<b>Criminal Penalty/Jail/Fines</b>
1 <sup>st</sup> offense Zero Tolerance – Under 21 with any measurable alcohol	30 day revocation	\$25 to \$100 in fines
2 <sup>nd</sup> offense Zero Tolerance – Under 21 with any measurable alcohol	Minimum 60 day revocation or until 18 <sup>th</sup> birthday, whichever is greater	24 hours in jail \$100 - \$500 in fines
1 <sup>st</sup> offense DUI BAC .05 to .15	Option A 15 day revocation followed by 4 months on interlock and completion of the Safety and Treatment Program	Up to 6 months in jail \$100 - \$500 in fines
	Option B Minimum 3 months revocation – up to 6 months. Must complete the Safety and Treatment Program	
1 <sup>st</sup> offense aggravated DUI, BAC .15 and above	Minimum 45 day revocation followed by 9 months on interlock and completion of the Safety and Treatment Program	2 days to 6 months in jail, actual confinement of not less than 24 hours \$200-\$1000 in fines
2 <sup>nd</sup> offense DUI	Minimum 1 year revocation followed by 1 year on interlock and completion of the Safety and Treatment Program	6 months to 1 year in jail \$1000 - \$3000 in fines
3 <sup>rd</sup> or subsequent offense DUI	Minimum 1 year revocation followed by 3 years on interlock plus one additional year for each offense, completion of the Safety and Treatment Program	1 to 3 years in prison \$3000 - \$5000 in fines
DUI on a controlled substance, any other drug or the combined influence of alcohol and controlled substance or any other drug.	1 <sup>st</sup> Offense Minimum 3 month revocation up to 6 months and completion of the Safety and Treatment Program	Up to six months in jail \$100 - \$500 in fines
	2 <sup>nd</sup> Offense Minimum 5 year revocation, up to 10 years and completion of the Safety and Treatment Program	6 months to 1 year in jail \$1000 - \$3000 in fines
	3 <sup>rd</sup> and Subsequent Offense Lifetime suspension, eligible for administrative appeal after 10 year revocation and completion of the Safety and Treatment Program	1 – 3 years in prison \$3000 - \$5000 in fines
1 <sup>st</sup> Offense Refusal Option A	Minimum 45 day revocation followed by 1 year on interlock and completion of the Safety	

to submit BAC (implied consent)	Option B	and Treatment Program	Up to 6 months in jail, \$100 to \$500 in fines
		Minimum 1 year suspension and completion of the Safety and Treatment Program	
Refusal to submit BAC	2 <sup>nd</sup> Offense	Minimum 1 year revocation followed by 1 year on interlock and completion of the Safety and Treatment Program	If charged with 2 <sup>nd</sup> Offense DUI from this arrest and convicted 2 <sup>nd</sup> Offense DUI penalties are applicable
	3 <sup>rd</sup> and Subsequent Offense	Minimum 1 year revocation followed by 3 years on interlock plus one additional year for each offense, completion of the Safety and Treatment Program	If charged with 3 <sup>rd</sup> Offense DUI from this arrest and convicted 3 <sup>rd</sup> Offense DUI penalties are applicable
	1 <sup>st</sup> Offense	Minimum 3 month revocation, up to 6 months and completion of the Safety and Treatment Program	1 <sup>st</sup> Offense Up to 6 months in jail \$100 - \$500 in fines
Permitting DUI	2 <sup>nd</sup> Offense	Minimum 5 year to 10 year revocation and completion of the Safety and Treatment Program	2 <sup>nd</sup> Offense 6 months – 1 year in jail \$1000 - \$3000 in fines
	3 <sup>rd</sup> and Subsequent Offense	Lifetime revocation, eligible for administrative appeal after 10 years and completion of the Safety and Treatment Program	3 <sup>rd</sup> and Subsequent Offense 1 – 3 years in jail \$3000 - \$5000 in fines
	6 month revocation to be served concurrent with any other suspension		1 <sup>st</sup> Offense 30 days – 6 months in jail \$100 - \$500 in fines 2 <sup>nd</sup> Offense 6 months – 1 year in jail \$1000 - \$3000 in fines 3 <sup>rd</sup> and Subsequent Offense 1 – 3 years in prison \$3000 - \$5000 in fines
Driving while revoked for DUI			

\*Minimum revocation periods are based upon participation in the West Virginia Alcohol Test and Lock Program (Interlock). Participation in the Interlock program may be an option for some DUI offenders, while for others it is a mandatory requirement. Interlock is a mandatory requirement for any offender whose license is revoked for two or more alcohol-related offenses within a ten year period. Participation periods may vary depending on the type and number of offenses. Individuals revoked for driving under the influence of a controlled substance or drugs are not eligible to participate in Interlock and must serve the minimum revocation period of six months to life, depending on the number of previous DUI's.

**\*\*Anytime your license is revoke for DUI, you must successfully complete the Safety and Treatment Program before you will be eligible to have your driving privileges reinstated.**

## B.A.C. REACTIONS

.01% to .05%	Lowered alertness; usually a good feeling; extroversion; thought and judgment impaired; restraint loosened.
.06% to .10%	Major, consistent decreases in reaction time; depth perception, distance acuity, peripheral vision, glare recovery are all impaired; diminished awareness. See also Section IV, which follows.
.11% to .20%	Marked decrease in motor capability; decidedly intoxicated; sometimes emotional demonstrations of anger, joy, weeping, shouting.
.21% to .25%	Severe motor disturbances, e.g., blurred vision; both social and addictive drinkers are obviously affected beyond .24%.
.30%	Semi-stupor.
.35%	Surgical anesthesia; minimal level to cause death in some people.
.40%	Coma.
.50%	Cessation of breathing and heartbeat likely.

A reported B.A.C. level of .15 percent or higher for a drinking driver offender is probably indicative of a developed tolerance for alcohol since persons without tolerance typically would be unable to function behind the wheel of a vehicle at that B.A.C. level. Increase in tolerance is an indicator that the person is likely to be abusing alcohol regularly.

## **Drunk Driving Penalties in Other Countries**

### **Australia**

The names of drunk drivers are sent to the local newspapers and are printed under the heading "He's Drunk and in Jail".

### **Malaysia**

The driver is jailed and if married, his wife is jailed too.

### **South Africa**

A 10 year prison sentence and the equivalent of a \$10,000 fine.

### **Turkey**

Drunk drivers are taken 20 miles outside of town by police and are forced to walk back under escort.

### **Norway**

Three weeks in jail at hard labor, one year loss of license. Second offense within 5 years, license is revoked for life.

### **Finland and Sweden**

Automatic jail for one year with hard labor.

### **Costa Rica**

Police remove plates from car.

### **Russia**

License revoked for life.

### **England**

One-year suspension of driving privileges, \$250 fine and jail for one year.

### **France**

Three-year loss of license, one year in jail and a \$1000 fine.

### **Poland**

Jail, fines, and forced to attend political lectures.

### **Bulgaria**

A second conviction results in execution.

### **El Salvador**

Your first offense is your last – execution by firing squad.

## SESSION II

### Physiological Aspects of Alcohol and Effects of Alcohol and Other Drugs on the Driving Task

**GOAL:** This session will provide a general overview of the short and long term effects of alcohol use on the body and the effects of alcohol and other drugs on the driving task.

#### OBJECTIVES:

1. To increase the participants' awareness of the characteristics of alcohol and other drugs and how they are assimilated in the body.
2. To increase the participants' awareness of intoxication, B.A.C., and equivalence.
3. To increase the participants' understanding of alcohol and other drugs effect on the driving task.
4. To increase the participants' knowledge of effects of alcohol on pregnancy. (Fetal Alcohol Syndrome)

#### RESOURCE MATERIALS/EQUIPMENT

1. Audio Visual Equipment and Materials
2. Approved Videos
3. Handouts
4. Use of the Driver Impairment Goggles

#### PHYSIOLOGY OF ALCOHOL

##### AFTER I DRINK ALCOHOL, WHAT HAPPENS TO IT? WHERE DOES IT GO?

After you drink, alcohol goes into your stomach, where some of it (about 20%) seeps through the stomach wall. The remainder of it (about 80%) goes into the small intestine and then seeps through the intestine wall directly into your system (see diagram below).

Alcohol seeps through your stomach and intestine walls into your blood. Your blood will carry the alcohol throughout your body. The alcohol, once in your body, will begin to work almost immediately. Alcohol is attracted to body fluids. Those elements in your body that contain a greater amount of water, such as your blood, will contain a greater amount of alcohol than elements with lesser amounts of water, such as your muscles.

## HOW DOES MY LIVER GET RID OF THE ALCOHOL, AND CAN I SPEED UP THE PROCESS?

Your liver will get rid of the alcohol by a process called oxidation. This process will chemically change the alcohol several times with a final outcome of water and carbon dioxide. Your body will then rid itself of these substances through urination, breathing (exhaling) and perspiration. Your liver is its own boss in terms of work. Your brain cannot tell it to get rid of more alcohol because there is "too much" in your system, nor can you do anything to speed up the liver's work. The liver will get rid of approximately one standard drink per hour. Cold showers, coffee or exercise will not influence the liver. These things tend to make the intoxicated person more awake, but not less intoxicated. (For example, an intoxicated person may doze and fall off his/her chair and appear to be more intoxicated than if he/she had caffeine (coffee) in his/her system and was able to stay awake and seated.)

## THEN HOW CAN I DRINK AND NOT GET INTOXICATED?

This is simple mathematics. Assuming your liver is normal, if your liver gets rid of one drink per hour, then if you only drink one per hour, you will not get intoxicated. However, on the average, if you go out drinking you'll consume more than one per hour. So, how do you keep within the legal limits? You'll notice that your body weight has a lot to do with how much you can drink. A small person will get more intoxicated with the same amount of alcohol than a large person. This is because a smaller person has less body fluid and mass than a larger person. For example, one pint of water will fill a quart bottle 1/4 full whereas the same pint of water will be lost in a 5 gallon jug! The larger person has more fluid to dilute the alcohol while the liver works to get rid of it.

### Intoxication:

All students should be aware that one 12 ounce beer, 5 ounces of wine, 10 ounces of wine cooler and 1 ½ ounce of 80 proof liquor all contain about 0.6 ounce of pure ethyl alcohol. 80-proof whiskey is approximately 40 percent alcohol, table wine is approximately 12 percent alcohol, wine cooler is approximately 6 percent alcohol and beer is approximately 5 percent alcohol. The reason some people become more intoxicated than others is not due to the type of alcoholic beverage they choose. People drink different amounts and therefore, get more or less intoxicated, regardless of whether they are drinking beer, wine, liquor, or wine coolers.

### Handout - Breath Alcohol Content & Effects

One drink, as described above, will raise the B.A.C. of a 150-lb. person approximately .02 percent. This is a basic concept for much of the section on intoxication, and will be used in activities later in the program. Instructors should be certain that every student clearly understands B.A.C. and .02 and can apply it to his personal situation. B.A.C. is calculated by:

1. Determining the amount of alcohol in the glass or bottle of beverage being consumed. This is necessary because drinks vary in the amount of alcohol, based on whose pouring: sober friends, drinking friends, bartenders, etc. Also, alcoholic beverages usually do not come in single-serving packages. Even beer comes in pints and quarts, and wine coolers often are sold in 12-oz. bottles.
2. For every drink as described under "equivalence," above or for every 0.6 ounce of alcohol (pure alcohol) consumed, one may figure the blood alcohol of a drinker to increase approximately .02 percent. In larger persons, the blood alcohol concentration per drink will be lower; in smaller persons the blood alcohol concentration will be higher. If a person has eaten just prior to beginning drinking, his initial blood alcohol level will start out low, but if he continues drinking, the amount of alcohol in his stomach will get stronger. When the alcohol, which is mixed with the food in his stomach, passes from the stomach into the small intestine, it may result in a B.A.C. which is higher than expected.
3. The liver metabolizes alcohol at the rate of approximately .02 percent B.A.C. per hour, at least for the first three or four drinks. As the liver becomes overloaded, its efficiency decreases somewhat in ridding the body of alcohol.

#### Individual Factors

Human characteristics are variable and have an effect on intoxication. As mentioned earlier, heavier persons are less likely to be impaired by the same amount of alcohol as light persons. Instructors may refer to the alcohol wheel or their own charts. The age of the individual makes a difference because younger people have no experience in controlling their reactions to alcohol, and elderly people tend to react in an impaired way due to deteriorating physical condition. Individual factors such as liver efficiency, drinking experience, and tolerance also have an effect.

#### Time and B.A.C.

There are no quick methods for people to use in sobering up. If you have a high blood alcohol concentration, you can only reduce it by not drinking for a substantial period of time. The myths of coffee or cocaine myth that cold showers will reduce intoxication is not true; only TIME can reduce these effects. That is, there is approximately .02 percent reduction of blood alcohol concentration for every hour spent not drinking.

#### Hangover

Due to the irritant effects of alcohol, hangovers are present in alcohol intoxication. Unlike marijuana, which remains in the bloodstream for an extended period of time, the removal of alcohol from the bloodstream and oxidation by the liver causes withdrawal effects, which are often unpleasant, including headaches, nausea, vomiting, dizziness and a general feeling of malaise. The discussion of the irritant effects of alcohol will help set the stage for discussion of alcoholism/ dependency in Session III.

## HOW AND WHY DOES ALCOHOL AFFECT CONTROL AND COORDINATION?

Your brain contains a great amount of blood (water), therefore, your brain will attract a great amount of alcohol. Since the brain controls all body functions, these functions will be influenced and impaired when the brain is influenced and impaired by alcohol.

There are three different parts to your brain, all controlling different functions. These parts and functions, along with the Blood Alcohol Content (B.A.C.) at which these functions are impaired, are shown on the diagram below.

**ALCOHOL AND THE BRAIN** (Optional: Instructors may choose to show the video "Alcohol and the Mind" available through AIMS Media.)

The first area to mature is located at the base of the brain. Area one controls vital functions such as heartbeat and breathing. Area two, which develops next, controls muscular function. Area three, controlling those mental functions that make humans unique, is the last to develop.

With the development of higher learning centers comes the ability to identify selected objects, judge their merit relative to a given action, predict certain actions, make decisions and execute what appear to be appropriate behaviors.

The typical, unimpaired individual has full control over all of these functions. When blood alcohol levels start to rise in the bloodstream, the brain becomes increasingly sedated. The effect is progressive but acts in a reverse order - starting with the higher learning centers and working back to vital functions.

When an individual has consumed alcohol, the higher learning center is influenced and the ability to process information is impaired (dependent upon the amount of alcohol consumed). In this condition the driver retains certain physical abilities but the level of self-control normally exhibited may be adversely affected to some degree. As drinking continues, speech and muscular control tend to diminish. If drinking continues, an individual runs the risk of losing consciousness and, in extreme circumstances, vital functions may be lost and death may result.

Sensors in the body pick up information and transmit it via the central nervous system to the brain (specifically our higher learning center.) Here this information is processed and sent on to our neuromuscular system which reacts to the information processed by our sensors. The speed at which this happens is obviously extremely fast in most individuals. Alcohol has a strong effect on both the time required for our "sensors" to pick up and transmit the information and also on the brain's processing ability (reaction time). A small amount has a small effect; a large amount, a large effect.

## EFFECTS OF ALCOHOL ON THE DRIVING TASK

A. Identify: The ability to identify significant parts of the traffic scene is crucial. Drivers must first see, and then recognize, the relevant characteristics of the driving picture. Alcohol impairs the ability to see, as follows:

1. Peripheral vision decreases;
2. Eye reactions are slower;
3. Visual acuity is reduced by an amount comparable to wearing dark glasses at night;
4. Recovery time from headlight glare is longer, from 7 to 32 seconds, depending upon the individual;
5. Night vision is impaired;
6. Vision is blurred;
7. Nystagmus (involuntary oscillation of the eyes) becomes pronounced;
8. Diplopia (double vision) occurs;
9. Stereopsis (three dimensional vision) occurs; and,
10. Visual hallucinations occur.

The ability to recognize an object or event is decreased. Judgment as to distance and speed is less accurate. Attention to details is lacking.

B. Predict: Once a significant aspect of the traffic picture has been seen and recognized by the driver, he must predict accurately what will happen next so that he can make an appropriate decision. The ability to predict is impaired by the fact that judgment as to distance and speed is less accurate, Attention to details is lacking, there is a false increase in the confidence of the driver, and precautions are curbed due to the relaxation of personal control.

C. Decide: The decision that follows is based upon impaired identification and impaired predictive ability. In addition, the false feeling of self-confidence, judgment as to distance and speed and the possible presence of visual hallucination make accurate, safe decisions very difficult. Decisions are impaired by reduction in judgment about appropriate actions to take, and often critically delayed by confusion.

D. Act: Whatever the decision, the motorist must execute that decision. Unfortunately, due to the fact that complex reaction time is slowed 15 to 25 percent

under the influence of 2 or 3 drinks, the driver's ability to act on his decision is more doubtful.

E. The effects of other drugs on driving are presented in the following 12-page review and in the chart titled "Summary, Common Drugs And Their Impact On Driving."

## ALCOHOL

### 1. Properties of Alcohol

- a. Beverage alcohol (ethanol) is the most widely-used psychoactive drug. It can be produced synthetically or naturally by fermenting fruit, grain, or vegetables.
- b. In moderation, alcohol promotes relaxation and restfulness. Higher levels induce sleep or even coma. Because of these properties, alcohol is known as a sedative-hypnotic or depressant.
- c. Alcohol, when absorbed into the bloodstream, depresses the central nervous system. Once absorbed, it is distributed uniformly in all body fluids. It enters the brain easily. The rate of absorption depends on the kind of drink, and on the contents of the stomach. If the stomach is empty, absorption will be more rapid and effects more acute than if the stomach were full. The effects will depend on the amount consumed, the circumstances of consumption, on the body size, and experience of the drinker.
- d. Drivers unaccustomed to alcohol use are more likely to show signs of impairment than a conditioned drinker who has learned to compensate for impaired behavior. Tolerance to most of the immediate effects of alcohol develops with frequent use. Regular heavy drinkers usually have to drink more and more in order to obtain the same effect. The range of physical reactions to varying doses of alcohol is vast. One or two drinks may induce talkativeness, slight flushing, and may also reduce the drinker's inhibitions so he appears more expansive and more animated. One person may become emotional or amorous, another aggressive and hostile. Extremely high doses can kill, if the central nervous system is depressed to the point that certain critical bodily functions, like breathing, cease altogether.

### 2. Effects of Alcohol

- a. Alcohol in even moderate doses generally reduces one's performance in tasks that require physical coordination or mental agility.
- b. A blood alcohol content (B.A.C.) of .05% or higher produces some driving impairment in most people. In a 160-pound person, this level requires only two ordinary drinks (1/4 ounces of liquor in each, two bottles of beer, or 10 ounces of

wine) in a short time. It is the overall amount of alcohol consumed, not the beverage form, which is important.

- c. Depending on B.A.C., alcohol results in:
- (1) Impaired muscle coordination;
  - (2) Decreased peripheral vision, multiple vision, blurring, dizziness, and night vision impairment;
  - (3) Slowed complex reaction time - a factor which particularly compromises an intoxicated driver's ability to track in emergency or unanticipated situations; and,
  - (4) Drowsiness with increased drowsiness after the high, with the potential for unconsciousness, coma, and death.
- d. In addition to the physical decrements, alcohol lowers inhibitions, thereby making a driver more aggressive and less defensive. Again, the B.A.C. level usually is the determining factor. On the other hand, very high B.A.C. levels can result in extremely defensive actions.

ACTIVITY: Time permitting, the effects of drugs on the driving task can be discussed in a manner similar to that used in the discussion of the effects of alcohol on the driving task.

## COMMON DRUGS AND THEIR IMPACT ON DRIVING

- I. Drugs and the Mind (Optional: Instructors may use an approved video on the effects of drugs and the body.)

Alcohol and other psychoactive drugs alter mood and affect the mind by interfering with the central nervous system's signal system. Communication is the brain's major industry. Whole systems are involved in regulating different aspects of personality and bodily functions. The limbic system, for example, has a lot to do with regulating emotion. Because benzodiazepine tranquilizers such as Valium and Librium manage to slow down communication in this system, they can relieve symptoms of anxiety without interfering with other activity.

Alcohol and other drugs enter the central nervous system via the bloodstream, which they enter directly (by injection into a vein) or indirectly (by injection under the skin or by absorption through membranes in the nose, bowels, lungs or stomach). The speed and degree with which effects are felt depend, in large measure, on how much and how quickly the drug or alcohol gets to the central nervous system. The way a drug is taken helps determine speed and extent of reaction. The central nervous system, most psychoactive drugs affect neurotransmitters. Drugs can stimulate, inhibit, or halt the release of neurotransmitters. For example, some neurotransmitters inhibit rather than

convey impulses. Certain amino acids that appear to function in an inhibitory manner will reduce the rate at which impulses travel. It is on these neurotransmitters that valium acts to retard activity in the limbic system.

Drugs do not affect all users the same way, and few have only a single effect. Nevertheless, we describe drugs by their potency in terms of the average effective dose - how much is required to produce the desired or primary effect in an average user. This can vary greatly among drugs that may appear quite similar, for potency is determined not only by ingredients, but also by how it is absorbed, what happens if it must pass through the liver, and how long it remains in the body.

Of greater significance than potency is a drug's maximum effect, the upper limit of reaction. Although caffeine, for example, will certainly stimulate the central nervous system, no amount of caffeine will match the effect of amphetamine, just as no amount of aspirin will relieve as much pain as morphine.

For every drug and each of its effects, pharmacologists can chart a response curve showing the dosages needed to produce various levels of response. The steeper the slope of this curve -- how quickly it rises from minimum to maximum effectiveness -- the smaller the difference between the amounts required to produce any effect and the amount that will produce all the effect of which the drug is capable. A very steep slope, applicable to many depressants, indicates a small margin for error and great potential for overdose. The greater the slope or impact, the greater the rebound or low. Such lows are frequently associated with drivers' drowsiness and blurred vision.

The growing trend of poly-substance use involves taking two or more substances simultaneously. The drugs may potentiate or inhibit each others' effects, or create new effects. This process, known as synergism, results in a combined effect greater than the sum of the substances. Alcohol is the most common substance in poly-substance cases.

## II. Drug Blood Levels and Drug Groups

While studies clearly indicate drug performance impairment, studies which attempt to correlate drug blood levels with relative frequency of accidents have been hindered because most drugs do not exhibit a simple relationship between drug blood level and impairment level. This is in contrast to alcohol, in which the degree of behavioral impairment is highly correlated with blood alcohol concentration (B.A.C.). Most other drugs do not have the relatively simple absorption, distribution and metabolism characteristics of alcohol. For many drugs, absorption rates vary greatly, and distribution throughout the body is not uniform. Accordingly, the resulting degree of impairment is uncorrelated with the drug blood level.

Depressants (alcohol, barbiturates, barbiturate-like, narcotics, etc.) are the most frequently prescribed, used and abused substances. They are more dangerous than stimulants. Aside from the traffic safety problem, depressants produce a wider variety

of effects from relaxation to euphoria in low dosages, to coma and even death at higher dose levels. Depressants in low dosages give a driver a false sense of confidence -- higher dosages affect motor coordination, vision, judgment and the ability to react to emergency situations. Because withdrawal from a depressant high is often a negative experience, other substances, such as alcohol and/or other depressants, are commonly used. The additive factor of multiple depressant use is particularly dangerous because the drowsiness factor is accentuated, even to the point of death.

Stimulants (amphetamines, cocaine, etc.) on the other hand, stimulate the central nervous system. Stimulants, crack in particular, give users a sense of power and concentration -- a "can do" feeling. Because of this, many drivers use stimulants, particularly amphetamines and cocaine/crack because they mistakenly believe their driving performance is improved. Stimulants do affect driving. Abuse, i.e., high dosage levels, lead to unpredictable results -- hallucinogens, in particular.

Marijuana is neither a stimulant nor a depressant, but has the characteristics of both. THC or tetrahydrocannabinol is the active ingredient, and studies have demonstrated that THC levels correspond to impairment in driving capabilities. Alcohol and marijuana are the drugs most commonly used in combination, and synergistic effects, which are unpredictable, make this a clear driving hazard.

### III. Specific Drugs and Their Impact

#### A. MARIJUANA

##### 1. Properties of Marijuana

- a. Marijuana and hashish come from the hemp plant, *cannabis sativa*, which grows throughout most of the tropical and temperate zones of the world. Marijuana is typically sold in the form of cut, dried leaves, stems and flowers of a hemp plant. It may be rolled in paper and smoked like a regular cigarette, or in pipes. Hashish oil is extracted from the hemp resin; a drop or two of the oil on a tobacco cigarette produces roughly the same effect as a marijuana cigarette.
- b. While marijuana is neither a stimulant nor a depressant, it has features of both--many regard it as a mild psychedelic.
- c. Marijuana has been used in treatment of asthma, glaucoma, and nausea caused by cancer chemotherapy. The major active ingredient in marijuana and hashish is delta-tetrahydrocannabinol (THC). The exact nature of its action is not entirely understood, although it is believed to change to a psychoactive compound in the liver.
- d. Unlike most other drugs, marijuana components are not water soluble, thus traces can remain in the body for weeks. This is a complicating factor for law enforcement, because the positive result of a chemical test would not necessarily

prove a driver was under the influence of marijuana at the time of arrest.

- e. Some street names for marijuana are: "grass," "Mary Jane," "pot," and "smoke"; marijuana cigarettes are called "joints" or "reefers"; hashish is commonly referred to as "hash".

## 2. Effects of Marijuana

- a. The effect sought in cannabis use is euphoria, an illusion of well-being and elation. This is usually accompanied by a state of altered perception, particularly of distance and time, and impaired memory and physical coordination.
- b. Studies now show that the amount of THC can directly affect driving ability. While motor coordination is only minimally affected at low dose levels, it is clear that tracking capabilities are sensitive to the decrements of marijuana over a wide range of dosages and durations. This is because perceptual functions of importance for driving are clearly and greatly impaired, and would be expected to interfere with the ability of drivers to monitor the environment for important signals and potential dangers. The using driver's capability to react to unusual situations, therefore, is very much affected by marijuana.
- c. Studies have also shown that some drivers are even more impaired a half-hour after they had "come down" and assumed they could drive normally;
- d. Marijuana impairment can last for at least four hours after a "joint";
- e. Drivers not familiar with the effects experience more driving problems than experienced users; and,
- f. Some drivers mistakenly believe their driving performance is better while under the influence, because their sense of concentration is perceived to be heightened.
- g. There is no evidence, however, that emotional or attitudinal changes under the influence of marijuana would be likely to lead to increased risk-taking in a driving situation.
- h. The most widely used drug combination involves alcohol and marijuana. Numerous studies point to the synergistic decrements. In particular, the driver's tracking ability is compromised when unusual or emergency situations arise. The results of this combination are also unpredictable. After the high, the two drugs promote drowsiness.

## B. STIMULANTS - DRUGS THAT STIMULATE THE CENTRAL NERVOUS SYSTEM

## 1. Types

### a. Amphetamines and Amphetamine-Like Drugs:

1. Dextroamphetamine (Dexedrine)
2. Dextroamphetamine and amobarbital (Dexamyl)
3. Dextroamphetamine and prochlorperazine (Eskatrol)
4. Methamphetamine (Methedrine, Crystal)
5. Amphetamine 10 mg.: dextroamphetamine 10 mg. (Biphedamine- 20)
6. Amphetamine (Benzedrine)
7. Phenmetrazine hydrochloride (Preludin)
8. Methamphetamine (Desoxyn)
9. Diethylpropion hydrochloride (Tenuate, Tepanil)
10. Phenteramine (Ionamin)
11. Mazindol (Sanorex)
12. Fenfluramine hydrochloride (Pondimin)
13. Phenteramine HCL (Fastin)
14. Methlypenidate (Ritalin)

### b. Related Stimulants:

1. Benzphetamine (Didrex)
2. Chlorphentermine (Pre Sate)
3. Phendimetrazine (Plegine)

### c. Cocaine, Crack

## 2. Properties, Amphetamines/Related Stimulants

a. These drugs produce excitatory effects in the central nervous system, characterized by increased wakefulness, alertness, feelings of increased initiative and ability, and depression of appetite. Taken in prescribed low dosage levels, their effects on driving abilities are minimal.

b. Amphetamines have a high potential for abuse, and acute intoxication when combined with alcohol. The most popular are Benzedrine, Dexedrine, and Methedrine or Desoxyn. Excessive dosage, particularly when administered intravenously ("speed"), produces a delirious or psychotic state. The period of excitement and stimulation is followed by an after-depression. This may cause self-perpetuating use of these drugs in binges. Tolerance develops rapidly, sometimes accompanied by psychological dependence. Extreme usage can lead to convulsions, coma, and circulatory collapse.

c. Other characteristics are talkativeness, abnormal cheerfulness, increased initiative, irritability, restlessness and aggressiveness.

d. The drugs, when abused, are usually ingested, injected intravenously

(amphetamine-speed), and smoked or "skin-popped" (subcutaneous injection).

### 3. Effects Amphetamines/Related Stimulants

- a. As indicated, low dosages have minimal impact on driving performance; their controlled use can assist because they promote alertness. Because these drugs boost alertness, they may also promote the delusion of overconfidence.
- b. Because tolerance to amphetamines builds so quickly, some abusers tend to take them in staggering amounts – up to 300 to 400 milligrams daily. High dosage levels influence driving capabilities, including dizziness, panic reactions, and hallucinations. Some high dose abusers degenerate to total loss of control.
- c. Some drivers use amphetamines to counter the effects of alcohol. Initially, this can appear to help a little in some cases. However, after the beneficial amphetamine reaction diminishes, accentuated drowsiness results. It should be noted that some studies indicate that there is no beneficial effect in using amphetamines with alcohol - the combined use should be avoided. It has also been learned that some amphetamine abusers take alcohol or other depressants to counter the resulting depression from an amphetamine high. Again, this mix is dangerous in terms of driving capability.

### 4. Properties, Cocaine/Crack

- a. Crack is the street name given to a freebase form of cocaine that has been processed from the powdered cocaine hydrochloride form to a smokable substance. The term "crack" refers to the crackling sound heard when the mixture is smoked. Crack cocaine is processed with ammonia or sodium bicarbonate (baking soda) and water, and heated to remove the hydrochloride.
- b. Some users think that smoking is a less dangerous method of using the drug. But smoking crack brings the vapors directly into the lungs, where they are immediately absorbed into the bloodstream, and large doses of the drug are carried to the brain in a highly concentrated form. It is one of the most efficient ways of taking the drug, producing a rapid and intense, short-lived reaction. Crack can produce acute intoxication and has a high potential for dependence, possible brain damage and other medical problems.

### 5. Effects Cocaine/Crack

- a. Crack's appeal is euphoria. Initially, the crack high produces a false sense of power or confidence, thereby reducing defensive-driving instincts. Some drivers mistakenly believe that cocaine improves their ability to drive by enhancing concentration. While some may experience elevated concentration, cocaine is a

danger. The drug narrows the driver's attention to very specific tasks, thereby reducing attention to secondary tasks, e.g., reacting to events which are observed through peripheral vision. The influenced driver's capability to react to unusual situations, then, is very much affected. After the high, drowsiness sets in and the driver is in danger of falling asleep. If used for an extended period, cocaine and crack can mask symptoms of fatigue, so that a driver may become totally disabled without knowing it.

- b. Sudden convulsions or heart attacks are also possible. With the addition of alcohol, the drowsiness effect is intensified.
- c. Other general effects of cocaine use include: extreme changes in blood pressure; increases in hearing and respiration rates; anxiety; nausea and tremors. Researchers have indicated that smoking crack can also cause lung damage; respiratory problems, including congestion, wheezing and spitting-up of black phlegm, burning of the lips, tongue and throat; weight loss; and generally poor health.
- d. Because of the intense and often unpleasant withdrawal effects, many use alcohol to help negate withdrawal symptoms. In fact, many combinations of depressants and/or stimulants are used, and all diminish driving performance. In particular, drowsiness is accentuated after the high, especially when depressants, such as alcohol, are used.

### C. SEDATIVE HYPNOTICS//BENZODIAZEPINES

- 1. Diazepam (Valium)
- 2. Flurazepam (Dalmane)
- 3. Triazolam (Halcion)
- 4. Alprazolam (Xanax)
- 5. Oxazepam (Serax)
- 6. Lorazepam (Ativan)
- 7. Temazepam (Restoril)
- 8. Klonopin

#### 1. Properties of Benzodiazepines

Benzodiazepines are anti-anxiety agents. While their effects on driving are less than the Barbiturate class, they are widely used and abused. Benzodiazepines are some of the most commonly prescribed drugs in the world. In combination with alcohol, these drugs have the potential for possible acute intoxication.

#### 2. Effects of Benzodiazepines

- a. Physical and psychological dependence may develop from prolonged or repeated use; the withdrawal syndrome is characteristically different from and

more serious than the syndrome produced by narcotic analgesics. There is cross-tolerance and cross-dependence among all drugs in this class - they are also mutually addictive.

- b. Low dosages affect driving capabilities only minimally. Higher dosages result in intoxication similar to alcohol intoxication, and is often accompanied by impaired thinking, lack of emotional control, aggressive behavior, followed by drowsiness.
- c. Other deteriorations include degraded motor control and simple reaction time, decreased visual-motor coordination, and loss of balance.
- d. From a theoretical perspective, minor tranquilizers, used in controlled prescribed dosages, should improve the driving skills of some, by calming them in stressful situations and relieving them from anxiety. At present, however, there are no conclusive studies to support this.
- e. Minor tranquilizers at low dosage levels do affect driving performance, causing low levels of impairment. Studies have shown that Diazepam (Valium) impairment is associated with greater dose levels affecting tracking, information processing, and visual search tasks. Because Diazepam is frequently abused and taken in massive dosage levels, this drug is a serious traffic safety problem.
- f. The use of alcohol and minor tranquilizers is widespread. Most minor tranquilizers potentiate the depressant effects of alcohol. Increased drowsiness is the major problem once the initial high diminishes.

#### D. Opioids

- 1. Opium
- 2. Heroin
- 3. Morphine
- 4. Codeine
- 5. Hydromorphone (Dilaudid)
- 6. Oxycodone (Percodan)
- 7. Hydrocodone (Hycodan)
- 8. Oxymorphone (Numorphan)

#### Narcotic-Like (Synthetic)

- 1. Methadone (Dolophine, etc.)
- 2. Propoxyphene HCC (Darvon)
- 3. Pentazocine HCL (Talwin)
- 4. Meperidine (Demerol)

#### 1. Properties of Opioids

- a. Narcotics, also known as opioids or opiates, include opium and other drugs derived from the oriental poppy (*papaver somniferum*) - e.g. morphine, codeine,

and heroin. Certain semi-synthetic chemicals that have a morphine-like action, such as eperidine (Demerol), are also considered narcotics. Methadone (Dolophine) is a synthetic opiate-like drug used to block the craving for heroin, and is used extensively in chemotherapy programs. It is effective for 24-36 hours, at which time another dose is needed for stability.

- b. These drugs are taken by mouth, sniffed, injected subcutaneously or intravenously and smoked (opium).
- c. Narcotics relieve pain, induce sedation or sleep and elevate mood to the point of euphoria -- major problems and everyday irritations fade. They also suppress coughing and are constipating. A high degree of tolerance and severe physical and psychological dependence usually develop with prolonged and repeated use. The withdrawal syndrome is severe and uncomfortable. Overdose can cause death by respiratory depression.

## 2. Effects of Narcotics and Synthetics

- a. Methadone clients who are well stabilized on the drug and follow the prescribed dosage can drive without impairment. Studies indicate that the accident rate of methadone clients cannot be differentiated from the performance of non-drug using individuals. Suboxone is an alternative to Methadone for some individuals.
- b. High doses or abuse of short-acting narcotics, such as heroin or morphine, can have marked effects on skills related to driving performance such as reaction time. However, it is not clear whether the narcotics degrade psychomotor activity directly, or lead to a decline in interest in all activity. Higher chronic use and use in combination with alcohol is particularly dangerous, especially after the euphoric high when drowsiness, and even coma, may result.
- c. Other characteristics of abuse after euphoria include: drowsiness, nodding, drunken behavior, confusion, inattentiveness, irritability, slow pulse, and pinpoint pupils.
- d. Alcohol and narcotics, both being depressants, potentiate the drowsiness problem. In fact, all multiple use combinations of depressants are extremely dangerous in driving situations, producing effects so severe they can lead to coma and death.

## E. HALLUCINOGENS

### 1. Types

#### a. LSD-Type (Indolealkylamines)

- (1) D-lysergic acid diethylamide (LSD). LSD is usually taken orally on a sugar cube, blotter paper, cookie, etc. It is occasionally injected intravenously.

It is often used in a group setting. The trip's duration is 8-12 hours, with possible recurrences of the "trip" long after use has stopped.

- (2) Psilocybin (Mushrooms): Duration 4-6 hours; swallowed.
- (3) Alpha-acetyl, LSD (ALD): Duration 8-12 hours; swallowed.
- (4) Diethyltryptamine (DET): Duration 2-3 hours; smoked or injected.

b. Mescaline Type

- (1) Mescaline (Peyote buttons): Duration 8-12 hours; swallowed or occasionally injected.
- (2) Dimethoxy methylamphetamine (DOM or STP): Effects are similar to mescaline and amphetamine. Duration 2-4 days; swallowed.
- (3) Methylene dioxyamphetamine (MDMA), the "love drug." In minute doses resembles LSD, in larger doses highly toxic. Taken by mouth in capsules. Little valid information is available.

c. Dissociative Type (Phencyclidines):

- (1) Phencyclidine (PCP), was formerly used as an animal tranquilizer (Sernyl). "Street" names are Peace Pill, hog, rhino, angel dust, killer weed.

2. Properties of Hallucinogens

LSD, the best known modern hallucinogen or psychedelic, is derived from the fungus ergot. While these drugs rarely produce acute intoxication and have a low potential for addiction, they are extremely dangerous because of their very unpredictable results.

3. Effects of Hallucinogens

- a. These drugs, which are strong stimulants, produce a toxic delirium characterized by visual illusions and hallucination, and sometimes accompanied by bizarre acts, perceptual distortions, and difficulties in concentration. Changes may range from hilarity to depression or panic states. The duration and intensity of these effects vary a great deal from drug to drug, and individual to individual. Tolerance occurs with some drugs; psychological dependence may occur occasionally, but there are no clear-cut signs of physical dependence.
- b. A "trip" is characterized by hallucinations and visual distortion of sensory perceptions. Additionally, the drug results in exaggerated sense of comprehension: one may "see" smells, "hear" colors. A false sense of achievement, ability and strength occurs. Other effects are: loss of sense

of reality, depersonalization, and alteration of body image; Hallucinogens tend to intensify existing psychosis, and may trigger suicidal tendencies. For some, panic and violence may be present; others experience less anxiety leading into a deep and transcendental experience.

- c. The physical results include: dilated pupils, uncoordination, numbness, tingling, nausea, mild hypertension, and inflamed eyes.
- d. PCP produces distinctive effects which include aggressiveness, decreased sensitivity to pain, a weak rubbery sensation in the legs, impaired coordination and sometimes dizziness.
- e. Obviously, a driver under the influence of any hallucinogen is a severe threat to him/herself and others. The results can be totally unpredictable and, in the case of LSD, they can recur spontaneously (flashback) – a severe highway safety threat in itself.
- f. Alcohol further aggravates the problem by synergistically contributing to the impairments and unpredictable results.

## F. INHALANTS

### 1. Types

- 1. Gasoline
- 2. Airplane Glue
- 3. Paint Thinner
- 4. Dry Cleaner Solution
- 5. Nail Polish Remover
- 6. Nitrous Oxide
- 7. Amyl Nitrite, Butyl Nitrite
- 8. Computer Keyboard Duster

### 2. Properties of Inhalants

Properties include methyl-alcohol, aliphatic hydrocarbons, anesthetics, aromatic hydrocarbons.

### 3. Effects of Inhalants

Volatile substances prompt recklessness. Other characteristics resulting from high dose abuse include: hazy euphoria, slurred speech, and impaired perception, coordination and judgment. Initial excitation may be followed by hallucinations, occasional psychotic outbursts, depression and stupor. Daily use for 6 months' duration or longer may cause irreversible brain damage. These substances can also cause kidney and liver damage and even death. Alcohol intensifies the drowsiness problem when used with inhalants.

## G. DESIGNER DRUGS/CLUB DRUGS

### 1. Types

1. Ecstasy (MDMA)
2. Ketamine
3. Gammahydroxybutyrate (GHB)
4. Rohypnol

### 2. Properties of Designer Drugs/Club Drugs

- a. Ecstasy is a synthetic, psychoactive drug chemically similar to methamphetamine and mescaline.
- b. Ketamine is an anesthetic that is approved for both human and animal use in medical settings. About 90% of the Ketamine legally sold is intended for veterinary use.
- c. GHB and Rohypnol are predominately central nervous system depressants. Because they are odorless, tasteless, and colorless, they can be ingested unknowingly.

### 3. Properties of Designer Drugs/Club Drugs

- a. Ecstasy exerts its primary effect in the brain on neurons that use the chemical serotonin to communicate with other neurons. Serotonin plays an important role in regulating mood, aggression, sexual activity, sleep and sensitivity to pain. Withdrawal symptoms include fatigue, loss of appetite, depressed feelings and trouble concentrating. Chronic users of Ecstasy perform more poorly than nonusers on certain types of cognitive memory tasks. In high doses, Ecstasy can interfere with the body's ability to regulate temperature. This can lead to a sharp increase in body temperature resulting in liver, kidney, and cardiovascular system failure and death. Other risks include increase in heart rate and blood pressure, muscle tension, involuntary teeth clenching, nausea, blurred vision, faintness and chills or sweating. Psychological effects include confusion, depression, sleep problems drug craving and severe anxiety.
- b. Ketamine can be injected or snorted. Certain doses of Ketamine can cause dream-like states and hallucinations. In high doses, Ketamine can cause delirium, amnesia, impaired motor function, high blood pressure, depression, and potentially fatal respiratory problems.
- c. GHB is abused for its euphoric, sedative and anabolic (body building) effects. It is a central nervous system depressant that was widely available over-the-counter in health food stores during the 1980's and until 1992. It was purchased largely by body builders to aid in fat reduction and muscle building. Coma and

seizures can occur following use of GHB. Combining GHB with other drugs such as alcohol can result in nausea and breathing difficulties. Withdrawal from GHB includes insomnia, anxiety, tremors and sweating. GHB has been involved in poisonings, overdoses, date rapes and death.

- d. Rohypnol can incapacitate victims and prevent them from resisting sexual assault. It can produce "anterograde amnesia" which means individuals may not remember events while under the effects of the drug. Rohypnol can be lethal with mixed with alcohol and/or other depressants. The drug is not approved for use in the United States.

### 3. Effects of Alcohol in Combination with Other Substances

- a. Alcohol is very commonly used with other substances. Alcohol/marijuana is the primary combination, and is more hazardous than using either substance alone due to the synergism, and the results are more unpredictable.
- b. Alcohol, when used with like depressants such as tranquilizers and other sedative hypnotics, will synergistically boost the impairing effects with increased drowsiness resulting when the high subsides. Death is even a possibility with this most dangerous combination of drugs.
- c. Alcohol, when used in combination with stimulants such as amphetamines, gives the driver a false sense of confidence and alertness. Generally, the results are unpredictable. Added drowsiness occurs after the high passes.
- d. The combination of alcohol and hallucinogens results in totally unpredictable actions.
- e. The combination of alcohol and inhalants impacts on drowsiness once the high subsides.

## **IT'S DANGEROUS TO MIX ALCOHOL AND OTHER DRUGS**

In recent years, hundreds of new drugs have been introduced for inducing sleep, for tranquilization and sedation, and for relief of pain, motion sickness, head colds, and allergy symptoms. Too numerous to name, they include narcotics, barbiturates and other hypnotic-sedative drugs, tranquilizers, and antihistamines.

Alcohol is a drug. It can produce feelings of well-being, sedation, intoxication, unconsciousness, and death. Because alcohol and some of these other drugs work on the same areas of the brain, taking them fairly close together (not necessarily simultaneously) can produce a combined effect much greater than is expected. For example, alcohol and barbiturates in combination can be particularly dangerous, as they increase each other's effects on the central nervous system. Alcohol in combination

with any drug that has a depressant effect on the central nervous system likewise represents a special hazard to health and safety--sometimes to life itself. The drug adds to the normal depressant effects of alcohol, further depressing the nervous system that regulates vital bodily functions. Death can result.

Some understanding of metabolism, i.e., the way our bodies chemically process the things we eat, drink, or take, is necessary to explain a second kind of interaction. If drugs were not metabolized within the body their effect would continue for the remainder of a person's life. In the metabolic process, drugs are transformed into other substances, which are eventually eliminated through normal bodily functions. The more rapidly a given drug is metabolized, the less impact it has. When drugs are forced to compete with alcohol for processing by the body, one or both are metabolized more slowly. As a result, the effect of the alcohol and/or the drug is exaggerated because it remains active in the blood for an extended period of time.

There are other dangers that can also lead to serious problems in persons who habitually drink large amounts of alcohol. Liver damage resulting from prolonged drinking can reduce the metabolism of many drugs, causing a normal dose to be unexpectedly potent. On the other hand, barbiturates or sedatives will have less effect in heavy drinkers during periods of sobriety, as excessive drinking eventually increases the body's ability to metabolize them. It is therefore not uncommon for heavy drinkers to take even larger doses of these drugs, because the usual quantities taken by nondrinkers or moderate drinkers will have little effect. The results of taking the larger dose and then drinking can place these persons in even greater jeopardy and can be fatal.

## **CHEMICAL EFFECTS ON VARIOUS BODY SYSTEMS**

When chemicals are consumed faster than they can be used up, they accumulate in the bloodstream and then reach every cell in the body. As a result, the effects of excessive chemical consumption are extensive. Chemicals adversely affect nearly every body system, with some systems being more affected than others.

**MOUTH AND THROAT:** Excessive consumption has been associated with an increased incidence of cancer in general and oral cancer in particular. Smoking increases this risk.

**ESOPHAGUS:** Alcohol irritates the lining of the esophagus. Vomiting after drinking may cause the esophagus to tear and bleed, or bring up stomach acid which irritates the esophagus. Alcoholics are also known to develop esophageal varices, which are swollen vessels like a hemorrhoid which can bleed and may lead to death if unchecked.

**STOMACH:** Pain, nausea, vomiting and distention are symptoms of gastritis. This is caused by alcohol's effect on the protective lining of the stomach. When this layer of skin is irritated, the blood vessels can be eroded and bleed. Aspirin can irritate the stomach and only well-buffered aspirin or Tylenol should be used.

**INTESTINES:** The intestines are responsible for the absorption of nutrients from the food we eat. When the intestines become irritated, they don't absorb well and we see even well fed drinkers/addicts have the signs and symptoms of nutritional deficiencies. Colitis and hemorrhoids are two alcohol associated effects on the large intestine. Colitis is caused by alcohol's irritant effects, whereas hemorrhoids occur as a result of poor circulation. Signs and symptoms of colitis include diarrhea, hyperactive colon, abdominal pain at times and blood in the stool. The taking of codeine can cause severe constipation.

**LIVER:** The liver is highly susceptible to the effects of chemicals because it is the primary site of chemical metabolism. The longer and more continuous the drinking/drugging, the greater the risk of harm to the liver. Excessive alcohol consumption can cause fatty liver, alcoholic hepatitis or cirrhosis.

An increase in fatty acids from alcohol causes an increase of concentration of fat within the liver cell. Most often a fatty liver is completely reversible with abstinence. If fatty liver becomes acute, the symptoms such as abdominal pain, loss of appetite and jaundice may occur.

Alcohol hepatitis is the death of liver tissues and inflammation that can be a serious, life-threatening condition. Loss of liver substance and scarring can occur gradually over many months or years or may occur in the course of a few weeks. When damage reaches a stage of irreversible distortion, neither abstinence nor continuation of drinking deters further development of the disease nor cirrhosis is the result.

Cirrhosis is the advance death of liver tissues with large amounts of scarring which distorts the normal liver. When this distortion changes the shape of the livers' lobes, it is generally irreversible even with abstinence from alcohol. Drugs such as PCP, LSD and marijuana store themselves in the liver and cause toxic effects to the liver.

**PANCREAS:** Pancreatitis is an inflammation of the pancreas. Half of those that are affected by pancreatitis are alcohol related. Pancreatitis causes diabetes. The signs and symptoms of pancreatitis are severe, constant epigastric pain, nausea and vomiting, and abdominal tenderness and distention. These are directly related to bouts of drinking and may become chronic and cause fat malabsorption and weight loss. This can lead to malnutrition and a change in stools. Free lipase and amylase may be released in the blood stream and deposit in the lungs and can cause permanent changes and cough production. The only treatment is abstinence.

**NERVOUS SYSTEM:** It is well known that chemicals cause nerve cell death, accelerating the "normal" aging process by increasing the rate of nerve cell death. The effects on the brain can produce memory loss, confusion, disorientation and poor judgment. Patients may also show an unsteady walk and persistent tremors even after detoxification. Seizures may develop when alcoholism progresses. People may experience sensory changes in their feet and hands like numbness or tingling. Drugs

such as PCP and LSD can cause permanent brain damage.

**SLEEP DISTURBANCES:** The result of chemicals on the sleep pattern causes frequent awakening, restless sleep, insomnia, and night terrors. Alcohol decreases the amount of dream sleep obtained during a normal nights sleep. This deprivation impairs concentration and memory and causes anxiety, tiredness, and irritability. It may take months of abstinence to correct this problem.

**KIDNEYS:** The kidneys are also affected by chemicals. When drinking there is an increase in urination and an increase in potassium and magnesium secretion which affects the heart function.

**HEART:** With large doses of chemicals, the mechanical performance of the heart is decreased, which slows the circulatory system, and eventually puts a strain on the heart. Symptoms include shortness of breath, a decrease tolerance for exercise, palpitations, increased heart size, swelling in the extremities and as the condition worsens, heart failure. It may also cause excessive sweating at night and difficulty breathing. Cocaine speeds up the cardiovascular system and people have had heart attacks while using.

**RESPIRATORY:** The direct harmful effect of chemicals on lung tissue prevents normal removal of bacteria. The result is an increase in lung infections, bronchitis, pneumonia and so on. The incidence of tuberculosis is also high among alcoholics. There is a high potential for permanent lung damage from free basing.

**SEXUALITY:** Although for some, short term effects are increased sexual performance, long term effects from chemicals, especially cocaine, interfere with hormones and causes decreased sex interest and decreased performance. This may lead to impotence in males and loss of sexual desire in females. Children conceived where alcohol was present may have Fetal Alcohol Syndrome as seen by various levels of retardation and physical abnormalities.

**SKIN:** Skin problems are common. Many are linked to liver disease and may include jaundice, itching, and diminished body hair. Other skin lesions such as psoriasis are also seen. There is a decreased response to chemical, physical and bacterial injury. The proteins that protect the body are produced by the liver.

**IMMUNE SYSTEM/BLOOD:** Anemia, difficulty in fighting infections and poor blood clotting are common. Alcoholics typically bruise easily.

#### IV. WOMEN AND ALCOHOL

For many, many years drinking was a man's thing to do. Even now almost all written and spoken language refers to the male gender. "He got drunk," "drinking with the boys," "the alcoholic may lose his job, his family, etc." Until recently little has been said

about women and alcohol. That situation is changing.

Forty years ago most women did not drink, but today more than 60 percent of adult American women, and nearly 90 percent of college-age women, drink. There are some special issues concerning women and drinking. The most important has to be: Alcohol and Pregnancy. The following information is taken from a Department of Health and Human Services publication, titled "Alcohol and Your Unborn Baby."

### 1. Effects of Heavy Drinking on the Unborn Baby

In the last several years, researchers have conducted a number of studies on infants born to women who drank heavily during pregnancy. The results are disturbing. A significant number of the infants studied were born with a definite pattern of physical, mental and behavioral abnormalities which researchers named the "fetal alcohol syndrome." The babies with this syndrome were shorter and lighter in weight than normal and didn't "catch-up," even after special postnatal care was provided. They also had abnormally small heads, several facial irregularities, joint and limb abnormalities, heart defects, and poor coordination. Also, most were mentally retarded and showed a number of behavioral problems, including hyperactivity, extreme nervousness, and poor attention spans. Some of the infants were born with all the characteristics described above, while others showed only some features of the syndrome.

### 2. How Alcohol Affects the Fetus

It may be hard to believe that alcohol can wreak such devastating effects on the unborn baby, but an understanding of how alcohol interacts with the fetus may help. When a pregnant woman takes a drink, the alcohol readily crosses the placenta to the fetus. Moreover, the alcohol travels through the baby's bloodstream in the same concentration as that of the mother. So if the expectant mother becomes drunk at a party, her unborn baby becomes drunk as well. But of course the tiny, developing system of the fetus is not equipped to handle alcohol, so the unborn baby must depend on its adult mother to burn up the alcohol. The fetus stays drunk as long as the mother stays drunk, but unfortunately, the fetus can't say "no" when it has had enough.

### 3. How Much Drinking is Harmful?

Research is just beginning to show the amount of alcohol which may harm the developing baby. Women who consume two normal size drinks a day are likely to give birth to babies weighing, on the average, six ounces less than babies of others who drink infrequently or not at all. This implies that alcohol, even at this low level, can affect the growth of the unborn baby. Relatively small amounts of alcohol-as little as two drinks a day, twice a week-can increase the risk of miscarriage. The more the mother drinks, the greater the chances of health problems for the newborn baby. Among these are premature birth, pronounced low birth weight, small head size, nervous system damage and birth defects. When a woman drinks very heavily-more than six drinks a day-she risks giving birth to a child with fetal alcohol syndrome.

#### 4. Risk Factors

What risks are there for the woman who drinks only occasionally, but perhaps heavily each time? We still don't know the answer to this question. But we do know that the fetus gets a potent, long lasting dose of alcohol each time the mother takes a drink. Therefore, it would not be surprising if further research confirmed the danger of periodic heavy drinking.

#### 5. Women are Affected in Other Ways

Recent research suggests that women may become more intoxicated than men on the same amount of alcohol, even when body weights are the same. One explanation for this is that a woman generally has less body fluid and more body fat than a man of the same weight does. Since alcohol does not diffuse as rapidly into body fat, the concentration of alcohol in a woman's blood will be higher even if she drinks the same amount as a man. Also, many women's reactions to alcohol vary throughout the menstrual cycle. It seems that a woman will often be more affected by alcohol right before the beginning of her period. Since alcohol may affect her more profoundly at her menstrual period, she may want to adjust her drinking patterns to avoid negative reactions.

Moreover, it appears that medications containing estrogen, such as birth control pills or "hormone" pills, will affect how a woman's body reacts to alcohol. If she takes medication containing estrogen, she may not recover as quickly from the effects of drinking. The best course of action is to check with a physician or pharmacist and to read the label before using alcohol with any other drug.

In men, an enzyme located in the stomach breaks down alcohol before it reaches the bloodstream. Women have little, if any, of this enzyme in their stomachs.

#### 6. Women Sometimes Drink Differently and For Different Reasons

Although alcoholism and other addictive disorders are diseases on their own, people begin using alcohol and other drugs for a variety of reasons. Some people become addicted while others do not. People use mood altering chemicals to change the way they feel. If a person does not like the way she feels most of the time, then her chances of becoming addicted to alcohol or drugs is increased.

There are many things in people's lives which can cause negative feelings. Although women have made great strides toward equality in recent history, there is still a long way to go. The problems and issues which face women may be quite different from those which affect men. When a woman becomes addicted, these needs must be addressed in treatment in addition to the goals directed at maintaining sobriety.

#### 7. Discuss and Present Information Regarding Fetal Alcohol Syndrome

For centuries, the relationship between heavy alcohol use during pregnancy and abnormal development of the baby has been suspected. We now know that even well-nourished alcoholics put their unborn babies in jeopardy. Almost half the infants born of alcoholic women have birth defects. The distinctive features of Fetal Alcohol Syndrome include varying degrees of mental retardation, behavioral problems like hyperactivity and irritability, small heads, abnormal eyes and facial features such as short eye slits and cleft palate. They may have low birth weight and be relatively short. Throughout childhood and adolescence, their physical and mental growth is retarded.

For the mother, the alcohol may just help her relax, but it is very hard on the baby's developing systems. Alcohol easily crosses through the placenta, but the baby cannot handle or metabolize it with an undeveloped liver. It is not unusual for a baby to be born with alcohol on its breath when the mother has begun labor when intoxicated. But drinking is not only dangerous during the last stages of pregnancy, it can cause serious problems throughout, especially during the first three months when alcohol affects the cells within the fetus that will become all the organs of the body.

Since there is no known safe time or amount to drink during pregnancy, even moderate or occasional drinkers run the risk of harming their unborn babies. The U. S. Surgeon General has advised pregnant women not to drink alcoholic beverages at all. It is also recommended that women trying to become pregnant stop drinking entirely. Even nursing mothers can cause problems by passing alcohol to the baby through her breast milk. It is not yet clear what effect the alcoholic fathers may have on the fetus. There is a lot more to be learned medically about Fetal Alcohol Syndrome, but for now we know this is a major preventable birth defect.

Additionally, if women are accustomed to coping with tension or depression by having a few drinks, they should not fill the void by using other mood-altering drugs, such as tranquilizers or antidepressants. Some of these drugs also may be harmful to the baby when taken during pregnancy, although no proof has yet been established. In fact, since most drugs cross the placental barrier to the baby, it is a good idea to take only those which are absolutely necessary during pregnancy. One should always check with a physician before taking any drugs, including simple over-the-counter medicines such as aspirin and sleeping preparations.

## SESSION III

### DYNAMICS OF SUBSTANCE ABUSE/ADDICTION

A general overview of chemical abuse/addiction and the disease of addiction. Information will also be provided to the participants regarding the signs, symptoms, stages and progression of the disease.

#### OBJECTIVES:

1. The participants will have increased understanding of the differences between substance abuse and addiction.
2. The participants will have increased knowledge and understanding of the definition of addiction, including the differentiation between social drinking, alcohol abuse, and addiction.
3. The participants will have increased understanding of the biological predisposition and other factors that increase the risk of addiction.
4. The participants will have increased knowledge of the signs, symptoms, stages, and progression of the disease.

#### RESOURCE MATERIALS/HANDOUTS/EQUIPMENT:

1. Approved Video
2. Handouts
  - a. Stages of alcoholism
  - b. Definition of alcoholism
  - c. Glatt (progressive disease of alcoholism)

#### INSTRUCTORS' GUIDELINES:

- I. Discuss myths and misconceptions regarding alcoholism. (Optional Discussion)
  - A. Most people have preconceived ideas of what an alcoholic is, i.e., old man, down on his luck, in the gutter, Mad Dog in paper bag). The purpose of this discussion is to explore and dispel misconceptions about alcoholism. (Instructor will need a flip chart or overhead projector).
  - B. Some of the myths to be dispelled include:
    1. Only those who drink every day can become alcoholic.

2. I'm too young to become an alcoholic - only old people are alcoholics.
  3. Alcoholics are usually men.
  4. The amount of consumption - "I don't get drunk every time I drink."
  5. The type of alcohol a person drinks (i.e., "I only drink beer and can't be an alcoholic.")
  6. "I can quit any time I want to."
- II. Define alcoholism, including the difference between social drinking, alcohol abuse, and alcoholism. (Instructors may want definitions of each on flip chart).  
 Social drinking: Social drinkers seldom consume alcohol, their social activities do not usually revolve around alcohol, and they attach no importance to alcohol. They do not socialize specifically to drink, and their circle of friends typically includes nondrinkers.
- A. Alcohol abuse: Alcohol abusers are those who include alcohol in more social situations. They tend to plan activities that more often include drinking. They may have had some problems from their drinking, but the alcohol-related problems they have had are outweighed by the benefits they feel they receive from use of alcohol.
- B. Alcoholism: *The instructor is encouraged to dissect the above definitions so that the following are emphasized:*
1. Primary nature of the disease;
  2. Progressive nature of the disease;
  3. Chronic incurable nature of the disease;
  4. Compulsive nature of the disease: despite many negative consequences associated with drinking, the individual is unable to control his/her consumption of alcohol;
  5. Irreversible nature of the disease - The disease can be arrested, but not cured. If a person stops use of alcohol for a long period of time and then resumes use of alcohol, he or she will very quickly progress physically and psychologically to where he or she would have been had drinking been continuous.
  6. Fatal nature of the disease - If the alcoholic does not stop use of alcohol, he or she will die from the disease.

- III. Discuss the causes of alcoholism.
  - A. Heredity - Researchers have determined that the disease is hereditary, or biologically linked. Alcoholism tends to run in families. It seems to be sex-linked; i.e., sons whose fathers are alcoholic are at high risk for developing alcoholism (4 times more likely). Alcoholism is more prevalent in certain ethnic and racial groups (i.e., Irish, Polish, whites more than blacks, etc.).
  - B. Culture - In some cultures, use of alcohol is the norm, but uncontrolled use is not acceptable. For instance, the French introduce alcohol to their children early on, but teach that minimal use/consumption is appropriate. Ethnic groups who have had alcohol in their culture the longest, tend to have the lowest rates of alcoholism, i.e., individuals of Jewish or Italian ancestry.
  - C. Psychological factors: Relief drinking, to give courage, reduce inhibitions
  - D. Sociological factors: Peer pressure, rite of passage
- IV. Discuss the disease concept of alcoholism.

In the mid-1950's, the American Medical Association (AMA) designated alcoholism as a disease.

- A. A disease is a condition where the body is functioning incorrectly from heredity, infection, diet or environment.
- B. A disease has:
  - 1. An etiology or cause;
  - 2. Symptoms/unique characteristics;
  - 3. Stages of progression with increased severity;
  - 4. Predictable outcome without treatment;
  - 5. A treatment.
- C. A definition of alcoholism, which highlights behavioral signs including control and denial, has been developed by a joint committee of the National Council on Alcoholism and Drug Dependence (NCADD) and the American Society of Addiction Medicine (ASAM). The definition states: Alcoholism is a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic.
- D. THIQ – In 1979, a discovery was made by researchers which indicates that some

of the chemical changes that take place in the brain are similar to the changes in the brain of opiate addicts. After a complicated chemical change in the brain, alcohol leaves a component which is highly addictive and never leaves the brain. This change seems to be unique to alcoholics and opiate addicts. These chemicals are known as tetrahydroisoquinoliones or THIQ. THIQ studies suggest the tendency for individuals to produce this change in brain chemistry is genetic, or hereditary. Further studies demonstrate that THIQ develops further as alcohol or other drugs "feed" it. These studies suggest that this change in brain chemistry is the cause of the disease of addiction being chronic and progressive.

## **STAGES OF ALCOHOLISM**

### **First Stage Symptoms**

Relief drinking (or using primarily for the effects)  
Increased tolerance  
Increased consumption (gulping drinks)  
Feelings of guilt regarding drinking  
Onset of blackouts  
Preoccupied with drinking  
Inability to discuss alcohol-related problems (especially with family or friends)  
Tendency to hide alcoholic beverages  
First alcohol-related arrest may occur

### **Second Stage Symptoms**

Noticeable increase in tolerance  
Increased lying and empty promises regarding drinking behavior  
Blackouts occur more frequently  
Feeling a need to drink frequently  
Grandiose and aggressive behavior/personality changes  
Drinking bolstered with excuses  
Persistent remorse regarding drinking  
Efforts to control drinking repeatedly fail  
Decreased ability to stop drinking when others do  
Loss of other interests  
Avoidance of family and friends (also becomes selective of friends)  
Appearing at work and for appointments with a hangover  
Alcohol-related arrests may increase  
Employment and financial difficulties  
Neglect of physical health

### **Third or Advanced Stage Symptoms**

Drinking to live and living to drink (obsessed with drinking)  
Noticeably drunk on important occasions (i.e., a special dinner or meeting)  
Prolonged benders or constant inebriation  
Loss of willpower or self-control  
Tremors with early morning drinks to counteract effects  
Blackouts and passing out frequently  
Loss of concern for family and friends  
Possible decrease in tolerance  
Physical deterioration (i.e., liver damage, ulcers, pancreatitis, blood in urine and/or stool, coughing blood, seizures, etc.)  
Moral deterioration  
Impaired thinking  
Numerous alcohol-related arrests may occur

All alibis regarding drinking exhausted  
Physical dependence on alcohol  
Loss of Control

### The Jellinek Curve

Handout and Discussion: Jellinek developed his model of the stages of alcoholism with behavioral components, then coupled these with concomitant steps for recovery. The recovery process was prefaced on a bottoming-out on the assumption that the person would eventually reach a final end-point.

The Jellinek identifies various steps in recovery, but the first three are imperative. First, the person must honestly desire help; second, he/she must accept that alcoholism is a disease; third, the person must stop drinking alcohol. While later material will further delineate the difference, it bears mentioning that treatment is often the first necessary step toward helping the person to achieve an understanding of his/her illness and to "stop drinking alcohol." Alcoholics Anonymous (AA) offers an opportunity for self-help, assisting the person to begin coping with his/her illness and the concomitant required abstinent lifestyle.

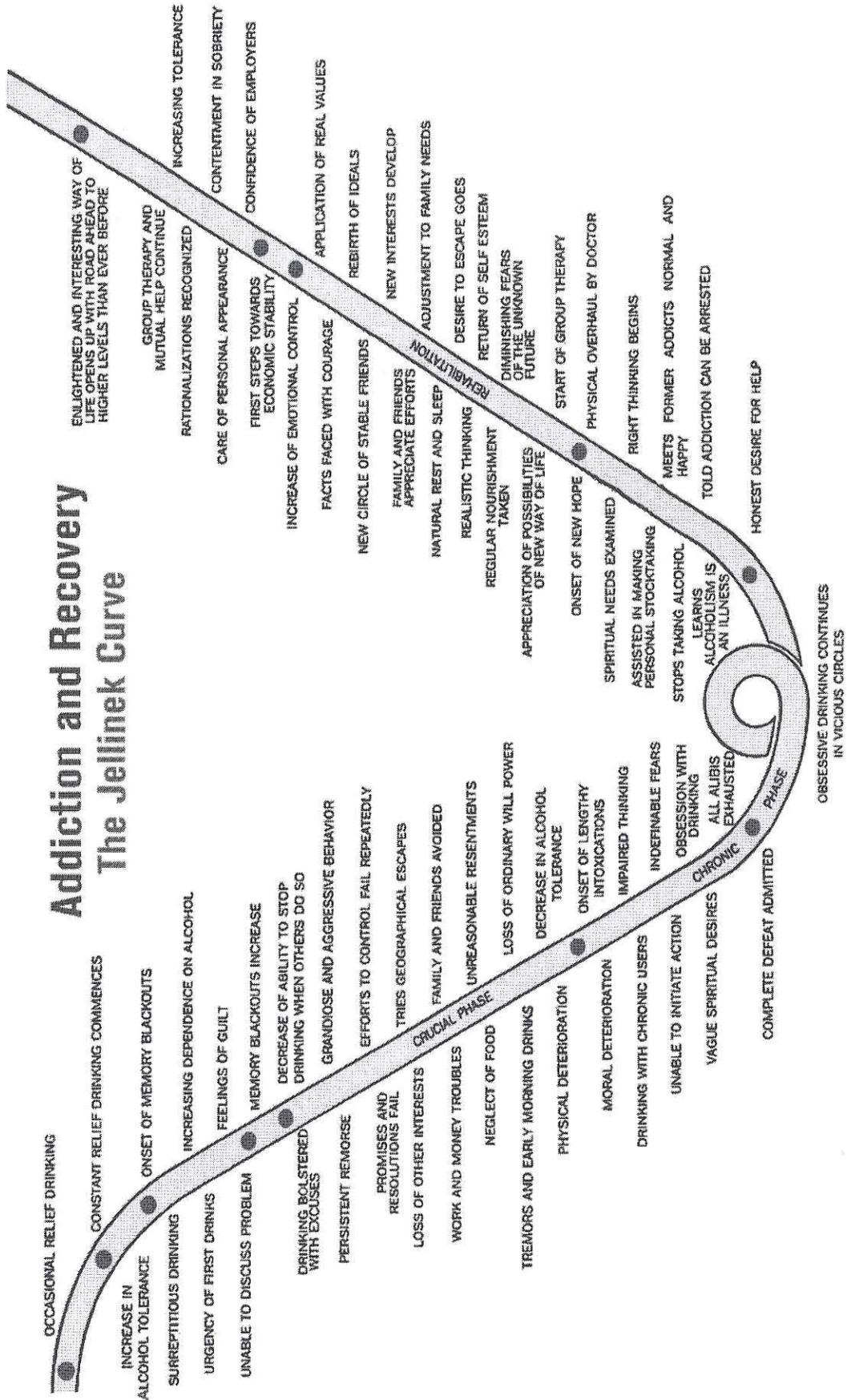
### DEFINITION OF ADDICTION

Addiction including addiction to alcohol and other drugs as defined by a joint committee of the National Council on Alcoholism and Drug Dependence and the American Society of Addiction Medicine, is a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by impaired control over drinking or use of other drugs, preoccupation with the drug alcohol or other drugs, use of alcohol or other drugs despite adverse consequences, and distortions in thinking, most notable, denial. Each of these symptoms may be continuous or periodic.



# Addiction and Recovery

## The Jellinek Curve



## SESSION IV

### FAMILY DYNAMICS OF SUBSTANCE ABUSE AND ADDICTION

#### GOAL:

This session will increase the participants understanding of the role of the family in the addiction process and the effects of addiction and substance abuse on family members.

#### OBJECTIVES:

1. The participant will increase his/her awareness and understanding of the effects of substance abuse and addiction on family members.
2. The participant will learn about enabling behaviors and symptomatology of co-dependency.
3. The participant will have an understanding of the distinct roles of a dysfunctional family and the behaviors and feelings associated with each role.
4. The participant will be made aware of the community resources and options available for family members.

#### RESOURCE MATERIALS

##### Handouts:

1. An Elephant in the Living Room
2. Roles of a Chemically Dependent Family
3. Co-dependence Family Chart
4. Common Characteristics of People Who Grew Up in a Dysfunctional Environment
5. The Progression and Recovery of the Family

##### Approved Video

#### I. INSTRUCTORS' GUIDELINES

Review major points of Session #3

#### II. FAMILY EFFECTS

Discuss the effects of substance abuse/addiction on family members.

- A. The family of an addicted person is deeply affected. The family is affected emotionally, socially, economically, and often physically. Everyone within the family system feels the effects.
- B. Instructor reads the story or shows the video: An Elephant in the Living Room.

### AN ELEPHANT IN THE LIVING ROOM

Imagine an ordinary living room . . . chairs, couch, coffee table, a TV set and, in the middle, a LARGE, GRAY ELEPHANT.

The ELEPHANT stands there, shifting from one foot to another and slowly swaying from side to side.

Imagine also the people that live in this house; you, along with your mother and father and maybe some sisters and brothers. People have to go through the living room many times a day and you watch as they walk through it very . . . carefully. . . around . . . the . . . ELEPHANT. No one ever says anything about the ELEPHANT. They avoid the swinging trunk and just walk around it. Since no one ever talks about the ELEPHANT, you know that you're not supposed to talk about it either. And you don't.

But sometimes you wonder why nobody is saying anything or why no one is doing anything to move the ELEPHANT. After all, it's a very big elephant and it's very hard to keep walking around it all the time and people are getting very tired. You wonder if maybe there is something wrong with you. But you just keep wondering, keep walking around it, keep worrying and wishing that there was somebody to talk to about the ELEPHANT.

Living in a family where chemical dependency is a problem is a lot like living with an ELEPHANT in the living room.

### C. THE ENABLER: THE COMPANION TO ADDICTION

Addiction is a devastating disease. One of the most tragic aspects of it is the way in which it typically enmeshes those who work or live with the dependent person. As they react to symptoms of the disease, these "concerned individuals" unwittingly conspire with the illness and actually enable it to progress to later and more serious stages. We will attempt to describe some of the enabling behavior which often surrounds and feeds the dependency.

Before we explore the problem of enabling, however, we need to understand how the disease and its symptoms affect the dependent. The disease results in a total loss of the dependent's ability to predict accurately what will happen once the use of the drug begins. Because of this, the victim becomes engaged repeatedly and unexpectedly in such destructive behaviors.

## Breaking commitments

Spending more money than planned

Driving under the influence violations

Making inappropriate statements to friends, family and co-workers

Engaging in arguing, fighting, and other anti-social behavior

Drinking more than planned

These and other similar behaviors violate the dependent's internal values and cause growing feelings of guilt, remorse, and self-hatred. The feelings in turn are blocked from the dependent's conscious awareness by a growing system of spontaneous rationalizations and projections. The rationalizations convince the dependent that "last night wasn't that bad", while the projections cause the dependent to believe that "anyone would use drugs like I do if he had to put up with the people I put up with." The effect of these defenses is to put the person increasingly out of touch with reality. This distortion, in fact, is so thorough that the dependent will be the last person to recognize that drugs represent any type of personal problem.

With this understanding of the dynamics of addiction, let's now examine how the enabler becomes ensnared in this deteriorating disease of self-deception. What is an enabler? An enabler is an individual who reacts to the above symptoms of the illness in such a way as to shield the dependent from experiencing the full impact of the harmful consequences of the disease. Thus, the dependent loses the opportunity to gain what is needed most, namely, significant insight regarding the severity of the addiction. Without this insight, the dependent remains a victim of the defenses and is incapable of recognizing the need to seek the appropriate and necessary help. Tragically, the enablers play an increasingly well intended and yet destructive role as the disease continues to progress.

If the enabler role is so harmful, why does a person become one? Usually, the enabler sees all that is being done as a sincere effort to help. Chemical dependency is a progressive disease which initially presents only a few episodes of loss of control. The enabler, therefore, perceives the episodes as isolated instances of intoxication and not a pattern of harmful dependency. From this point of view, the enabler rationalizes why the individual became intoxicated and acted in such an inappropriate manner. The enabler does not view the person as dependent, but rather as an individual who simply chose to use a drug to try to cope with some type of pressure and "subsequently let things get a little out of hand." Thus, the enabler, by not recognizing the presence of the dependency, usually responds to episodes of intoxication in such typical ways as:

1. Excusing the behavior because it is seen as normal. The enabler would reason such things as:
  - "Who doesn't need to blow off some steam once in a while?"
  - "It's vacation time. Why shouldn't a person be allowed to do what that person wants?"
  - "Lots of people get loaded at that type of party," i.e., New Year's Kegger, Promotion, Wedding.

- "It was no big deal last night. Why dwell on the broken lamp (or cigarette burn, etc) It would just be upsetting."
2. Excusing the behavior because it is seen as the result of another problem. The enabler would reason such things as:
- "With those job pressures, anyone would drink."
  - "She's just going through that phase in life."
  - "It's the peer group that is to blame."
  - "The problem is loneliness and not knowing how to mix very well."

At this stage, the enabler either believes that a chemical problem does not exist or if it does then it will disappear as soon as the "real" problem is resolved. This makes the enabler highly vulnerable to the developing defenses which victimize the dependent. The rationalizations of both persons now are supporting each other's misunderstanding of the true nature of the problem. The result is that both the dependent and the enabler are engaged in a successful self-deception which allows the disease to remain hidden and to progress towards more serious stages.

The disease now continues to have an increasingly adverse effect on both the dependent and the enabler. For the dependent, the growing negative feelings about self resulting directly from the inappropriate behavior while intoxicated are unconsciously and with an increased frequency being projected onto the enabler. The enabler becomes the focus of such projections as:

- "If you cared about me half as much as you care about your friends, maybe I wouldn't want to drink so much!"
- "With the type of work load you're dumping on me, it's no wonder I need long lunch hours."
- "I come home and all I hear are you kids fighting over which program to watch on T.V. You are enough to drive anyone to drink."
- "School's a bore, the teachers are stupid, and you just don't understand my friends, so I got caught smoking grass - Big Deal."
- "If you would shape up, I would be all right!"
- "My son/daughter was just arrested for first offense DUI, He/she is just a kid...everyone in college does it...I did...After all. it's just a first offense. I'm sure you have kids that have done the same thing"
- "The counselors are forcing me (my son/daughter) to believe I'm (he/she is) alcoholic...when I'm (he/she is) not..... I know my (son/daughter) much better than the counselor...I would know there is a problem and there isn't one"

D. Before we examine how these types of projections affect the enabler, we need to understand the basic dynamics of the projection process. Two important points that should be noted regarding how projections work successfully as a defense system are:

1. The primary function of projection is to dump unconscious and growing negative feelings about one's self onto other people's circumstances. This survival mechanism, of course, is without insight and therefore the dependent continues to experience more pain which produces even more unconscious projections.
2. When the dependent is verbalizing a projection such as "if you (or that) would shape up I'd be all right" there is no realization on the dependent's nor the enabler's part that this is being said out of self-hatred. Both believe that the dependent does "hate" the enabler and for good reason. The effect is that both persons now focus their attention on the enabler's behavior and this allows the disease to continue to go undetected.

With this understanding of the projection process, it is easy to see that this defense can and does have a tremendous emotional impact on the enabler. This becomes a pivotal point in the enabling process. As the pain caused by the projections becomes more uncomfortable, the enabler reacts by feeling hurt and vaguely guilty. If the interpersonal relationship between the dependent and the enabler is somewhat superficial, then the enabler, in an effort to find relief from the pain, will begin to avoid contact with the dependent. The enabler still doesn't identify the presence of the chemical dependency, but instead reasons such things as:

- "After what he said and did last night, let's just not invite him to our parties anymore."
- "She just doesn't seem to fit into this department. I'll have to transfer her to shipping."
- "She isn't as reliable as she used to be. I don't think we should ask her to be on our committee."
- "After the way he nearly capsized the boat, I'm not going on another fishing trip with him."

These avoidance reactions, again, only allow the disease to progress. The dependent, still out of touch with reality, does not receive from the enabler a direct description of the behaviors causing the strained relationship. Usually the enabler simply withdraws from all possible contact. Because of this "No Talk Rule" the dependent remains victimized by personal rationalizations such as:

- "If they weren't so boring, they wouldn't need to push so much booze at their parties."
- "This company just keeps piling on the paperwork so much that no one can get a job done!"
- "They have exploited my talents in the past, so let them try to organize their own committee."
- "Those guys don't know how to have a good time. They make fishing work rather than fun."

Thus, by not talking directly with the dependent, the enabler has shielded the victim

from insight into the harmful consequences of the disease! Not all enablers, however, can simply avoid the dependent. If the interpersonal relationship between the two is a deep one, then the increased projections create in the enabler growing feelings of guilt and blame. The enabler begins to feel and accept the responsibility for the dependent's chemical intoxications. This, it turn, leads the enabler to reason such things as:

- "What am I doing to cause this?"
- "Maybe I wasn't clear enough in my instructions to her or maybe I am putting too much work on her shoulders."
- "If I were home more maybe. . ."
- "Maybe we didn't give him enough love when he was younger."
- "Maybe if I change, this will go away."

These feelings of self-doubt, inadequacy, and guilt continue to mount as the disease progresses and as the projections from the dependent increase in frequency and severity. The enabler continues to accept the blame ("I know I'm not perfect by a long shot") for current stressful situations created by the chemical dependency.

It is important to realize what is happening to the enabler at an emotional level. Because of increasingly low self-esteem, the enabler becomes more and more compulsive in reactions to the dependent. The dependent's chemical use becomes an outward display of the enabler's internal guilt and inadequacy. In other words, the enabler's self-worth is tied directly to the dependent's chemical use. The more the dependent uses, the more the enabler feels responsible, guilty and inadequate. The only way, now, for the enabler to feel any positive self-worth is to make sure that the dependent's chemical use does not get out of control. "If there were some things I did to make this come to pass, there must be things I can do to make it go away."

At this point in the disease process, the enabler becomes incapable of achieving the emotional stability and insight needed to deal with the disease in an effective manner. Instead, the enabler reacts unconsciously and spontaneously to personal feelings of low self-worth. The enabler ends up trying to control the dependent's drug use by reacting in such typical ways as:

- Canceling social events where there is drinking
- Disposing of extra quantities of liquor or other chemicals.
- Calling home at mid-day to determine whether the dependent is sober or intoxicated.
- Relieving the dependent of a portion of the workload and personally doing the work.
- Explaining to the school counselor or teacher why there are problems in school and agreeing to see that the problems get resolved.
- Assuming household responsibilities that the dependent used to hold.

These types of manipulations, of course, are doomed to fail because the enabler is trying to control the uncontrollable. With each failure, the enabler's low self-worth

grows, which triggers even more desperate attempts to control. As the vicious circle goes on, both the dependent and the enabler become increasingly alienated and dysfunctional.

At this point the enabler needs as much help as the dependent. The way to break this circle requires the enabler to gain knowledge and awareness in the following areas:

- The dynamics of chemical dependency.
- The dynamics of enabling.
- The personal identification with compulsive enabling behavior.

With this knowledge and personal insight, the enabler can begin to respond to the dependent in meaningful ways rather than in compulsive and manipulative reactions. This new type of interaction will help the enabler to "let go" of the responsibility for the dependent's drug use and subsequent behavior. With this new sense of freedom, the enabler can stop shielding the dependent from the harmful consequences of the disease. The enabler can, then, directly intervene with the illness by presenting to the dependent the specific ways in which the disease is creating increasing and worsening problems for both of them. By breaking the "No Talk Rule" the enabler has stopped protecting the disease and instead provided the dependent with the data necessary to begin to see the seriousness and true chemical nature of the situation. With this new insight, the dependent and the enabler can seek the appropriate type of continuing care that is necessary to help them lead a more meaningful life.

### III. FAMILY ROLES AND DYNAMICS

When addiction exists in a family member, family roles change, and the normal rules which govern family behavior are altered to mask the demands of the situation. The existence of addiction appears to have a predictable pattern in families. The following are the roles, behaviors, and feelings most often seen in these family patterns:

Instructors may use a lecture format or a family sculpture to describe the following roles.

Handouts: Family Roles/Co-dependent Chart

1. Discussion of each follows: (The Instructor may use the following descriptions to describe these roles in their lecture or family sculpture.)
  - A. Role Description
    1. Addicted Person
    2. Chief Enabler
    3. Hero
    4. Scapegoat
    5. Lost Child
    6. Mascot

## **ADDICTED PERSON**

Blames, threatens, charms, boasts, avoids, uses alibis.

Turns off painful feelings, keeps them turned off with more alcohol, and buries them in the subconscious.

Buries positive feelings such as love and compassion.

Gets further and further out of touch with reality.

Boasts - voices grandiose delusions, fills vacuum that was once self-esteem.

Blames - transfers his/her own guilt to someone else.

Alibis are rationalizations

Rigidity in relation to compulsive use of the chemical.

## **CHIEF ENABLER**

Acts out of a sincere but misguided sense of loyalty.

Inside -

Fear: Of sharing the consequences

Pain: Due to low self-esteem

Anger: Due to resentment of the chemically dependent person

Guilt: Due to the realization that, despite everything he or she does, things still aren't right with the family

Hurt: By embarrassment and constant assaults on the self-esteem

Outside -

Fragility: "I don't know how much more I can take."

Pity-Seeking: "What did I do to deserve this?"

Manipulation: Lying to family, friends, or the chemical dependent's employer to cover up what's going on.

- Super Responsibility: If the household is going to function, he or she had better take charge.
- Self-Blaming: "If I had...; I should have..."
- Seriousness: Loss of sense of humor. Life is so rotten that nothing's funny any more.
- Powerlessness: Doesn't feel he or she has any options.
- Stress wreaks havoc - digestive problems, ulcers, colitis, headaches and backaches, high blood pressure, heart episodes, nervousness, irritability and depression may occur.

Health may offer an enabler his/her only opportunity to receive nurturing. May suffer from a chronic illness or hypochondria.

From avoiding family and friends, the chief enabler ends up feeling isolated.

Eventually, the chief enabler is mentally, spiritually, emotionally and physically exhausted.

If the chief enabler doesn't get help, he or she may become addicted or play the role of chief enabler indefinitely

### **FAMILY HERO-"LITTLE ENABLER"**

The outward appearance of good nature and success is an illusion. Inside, the hero is miserable.

The dependent is more distant from both the enabler and the hero than they are from each other.

"Little Enabler" - The hero is taught how to enable by the enabler.

Inside:

- Inadequacy: Nothing the hero does is enough to make things right.
- Confusion: Everyone at home seems to be saying one thing and feeling another.
- Anger: "Good" children don't show anger toward their parents, so he or she buries it

- Loneliness: Did not learn how to relate to others early on and is unable to form friendships. The hero is afraid to lower defenses and trust others.
- Hurt: Mom spends most of her time taking care of dad and the house and doesn't have time for the hero.
- Outside:
- Success: Excels in everything he or she does. In a kid like this, there can't be anything wrong. The payoff for being successful outweighs the inner feelings.
- Super Responsible: Takes it on himself to correct the imbalance within the family.
- "All Together": Everyone thinks this is a perfect kid who has no problems.
- Works Hard for Approval: Stays late after school, works to earn own money, etc.
- Special: Grandparents, aunts, uncles all dote on the hero. He or she receives more parental time and attention than his or her siblings are ever likely to enjoy.
- Develops: Takes extra courses in school or gets into sports; own life leaves home immediately after graduation and away from never returns as a full-time member of the family.

### THE SCAPEGOAT

This child provides distraction from the problem of chemical dependency by rebelling, getting into trouble at school, etc. While the family focuses on the scapegoat's problems, they can continue to ignore the chemical dependency.

Inside:

- Loneliness & Rejection: The hero receives all of the positive attention. The scapegoat can do the same things and not get that same attention.
- Guilt: The scapegoat really doesn't want to be a "bad kid."
- Hurt: No matter how good or talented he or she is, he or she can't compete.

Fear: Fighting is easier than facing the parents' angry retaliation.

Anger: May lash out at the dependent, chief enabler, or hero.

Outside:

Highly Valued By Peers: Will usually be the leader to fill an unsatisfied need to belong.

Withdrawal From Family: Spends more time with friends; Acts like he/she just wants to be left alone.

Unplanned Pregnancy: Proves to the family that someone loves her and insures I love from someone (the child). Parental Adulthood

Defiance: Rebellious to authority - parents, school, etc...

Acting Out: Lying, stealing, anything to get attention. Eventually drugs and alcohol, to kill the pain and feeling.

Sullenness: Won't communicate at all.

Chemical Use: Drinking and using drugs; can react to accidents, promiscuity, venereal infections, etc. by using chemicals.

The scapegoat's self hatred can lead to suicide.

### THE LOST CHILD

The lost child makes no demands on the family and provides relief from the problem of chemical dependency. He or she often feels confused and left out because no one tells him or her what's going on.

Inside -

Loneliness: Protects the lost child from the family's pain. Because he or she is out of sight, he or she is out of mind.

Anger: Very little. The lost child feels that he or she deserves the negative things that happen, and so he or she remains very passive

- Inadequacy: Blames himself or herself for not fitting in.
- Hurt: Because he or she is ignored by other family members.
- Outside -
- Withdrawal: More comfortable with imaginary friends during childhood. The lost child prizes possessions but they don't fill the void left by lack of relationships.
- Aloofness: Never developed closeness to family, and so is unable to develop closeness to others throughout life; rarely dates, and as he or she gets older, questions sexual normalcy.
- Sometimes Overweight: Finds relief in overeating and bingeing; also, high instance of allergy and asthma, accidents, and sometimes bed-wetting to get attention.
- Rejection: Rejects others in order to avoid being rejected first.
- Super-Independent: Always looks after him/herself; doesn't need help from others.
- Distance: Never learned intimacy from the family and isn't comfortable with intimacy
- Quietness: Stays away from the family, causes no problems.

### THE MASCOT

Where the family doesn't think to tell the lost child what's going on, they consciously withhold information from the mascot and may even say things that are misleading or untrue in order to protect him or her.

Inside -

- Loneliness: Feels left out because he or she is.
- Confusion: Can see and hear what's going on in the family but when he or she asks about it, the mascot is told something different.
- Insecurity: Wonders if he or she is going crazy.
- Fear: The overriding charismatic emotion of the mascot. The very foundations existence, -family, parents, his or her own sanity are in

danger, but the mascot can't see it or name it. This is what makes it all the more frightening.

Outside -

Humor: Showing off can bring rewards. Everybody laughs.

Hyperactivity: Annoying habits and bursts of sudden erratic behavior.

Fragility: Knows he or she is being protected from something.

Super Cute: Hard to ignore.

Clowning: Resorts to this when life presents him or her with difficult situations.

Attention Seeking: Uses diversionary tactics to seek desired responses.

The mascot never learns to deal with stress. Instead, he or she just runs away.

If the mascot doesn't receive help, ever-present fears for his or her sanity may drive him or her to suicide.

## COMMON CHARACTERISTICS OF PEOPLE WHO GREW UP IN AN ADDICTED ENVIRONMENT

Discuss handouts and possible future characteristics of each role:

### **Family Hero:**

Without help:

Workaholic

Never wrong

Responsible for everything

Marry dependent

With help:

Accept failure

Responsible for self, not all

Good executives

### **Scapegoat:**

Without help:

Unplanned pregnancy

Trouble-maker in school; later in workplace

Prison

With help:

Accept responsibility

Good counselors

Courage

Ability to see reality

**Lost Child:**

Without help:

Little zest for life

Sexual identity problems

Promiscuous or stay alone

Often dies at early age

With help:

Independent

Talented

Creative

Imaginative

Self-Actualized

**Mascot:**

Without help:

Ulcers

Can't handle stress

Compulsive clown

Marry "hero" type for care

Remains immature

With help:

Takes care of self

Fun to be with, good sense of humor

**V. CONCLUSION**

Conclude with Video.

If time allows, discussion of The Progression and Recovery of the Family in the Disease of Chemical Dependency handouts may be used.

## SESSION V

### TREATMENT RESOURCES

#### GOAL:

To increase participants' knowledge and understanding of treatment, community treatment resources, and the recovery continuum.

#### OBJECTIVES:

1. The participant will be able to define the goal of treatment as living comfortably without chemicals.
2. The participant will be able to identify community treatment resources.
3. The participant will gain knowledge of the recovery continuum.
4. Review major points of Family Dynamics from Session 4 as:
  - a. Effects on family
  - b. Enabling
  - c. Roles of CD family
  - d. Resources for family
5. Concept of Treatment
  - a. Treatment, education, and rehabilitation are major counter- measures.
  - b. Goal of treatment is living comfortably without chemicals.
  - c. Successful treatment depends on one's readiness to seek a solution, willingness to utilize available help, and commitment to change and recover.

#### RESOURCE MATERIALS

1. Community Treatment Resources (program flyers, etc.; hand out a listing of behavioral health care providers)
2. Jellinek Curve
3. Signs/Symptoms Relapse
4. Meeting Schedules (AA, NA, etc.)
5. Provide listing of addiction/treatment resources available online and the internet
6. Approved Video

## OUTLINE:

Treatment, education, and rehabilitation are major countermeasure approaches for drinking and driving. Problem drinkers, substance abusers, alcoholics, and addicts are over-represented among apprehended drinking drivers. Treating addiction to alcohol and other drugs will reduce subsequent drinking and driving.

The goal for treatment of alcoholism/chemical dependency is to learn to live comfortably without any mood altering chemicals.

The only way to recover from this disease is to stop drinking completely and/or taking drugs. Successful treatment depends on one's readiness to seek a solution, willingness to utilize the help available and personal commitment to make changes necessary for recovery.

1. **Define Treatment:** The broad range of planned and ongoing inpatient, residential, and outpatient services designed to facilitate recovery on the part of substance abusers and the chemically dependent. Treatment includes assessment, diagnostic impression, treatment planning, individual and/or group counseling, education, and discharge planning. It may also include medical, psychiatric and psychological input, and related services. The focus of treatment is not only to help the individual, but also to assist the entire family system.
2. **Types of Treatment and Community Availability:** Treatment services are varied and most are available in the surrounding area and treatment is certainly a cost-effective means to reduce drinking/driving as well as other probable consequences of substance abuse (i.e. alcohol/drug related accidents, health problems, legal problems, social/emotional problems, family deterioration, spiritual problems, etc.) Listings of substance abuse treatment resources for adults and adolescents are presented in Appendix J.

Addiction is one of the most treatable chronic illnesses. The individual and the stage of the disease determine the type of treatment that's most effective. Factors to be considered are length of addiction, type of chemicals used, attitude of family and friends, the individual's desire to make changes and recover, and complicating factors such as acute physical withdrawal symptoms, acute or chronic medical conditions, and behavioral/emotional problems.

## TYPES OF TREATMENT

- A. **Low Intensity Outpatient Treatment Services:** Chemical dependency services occurring at a frequency of 6 hours per week or less.
- B. **Intensive Outpatient Treatment Services:** Organized and structured treatment services, non-residential in nature, consisting of 2-3 visits per week with 6-20

hours of client contact per week.

- C. **Non-Medical Detoxification Services:** Services facilitating the process eliminating the toxic effects of drugs and alcohol from the body. Supervised detoxification methods, ranging from 1-5 days include social detoxification and continuing assessment to rule out the need for medical monitoring or management.
- D. **Day Treatment Services:** Outpatient services consisting of 20 or more hours of client contact per week occurring on a 4-5 day basis, offering services similar to intensive outpatient services within a more restrictive setting.
- E. **Long-Term Residential Rehabilitation Services:** Non-hospital-based, 24 hour per day supervised treatment with decreasing intensity over time; combines chemical dependency and community ancillary services averaging 40 hours of service per week
- F. **Medically Monitored Inpatient/Residential Treatment Services:** Non-hospital-based 24 hour per day supervised care; client resides in the treatment setting and participates in treatment activities 50 or more hours per week
- G. **Medically Managed Acute Inpatient Treatment Services:** Chemical dependency services provided in a 24 hour acute care hospital setting
- H. **Transitional Living/Halfway House Service:** 24 hour residential living facility that provides a safe, supportive, drug-free environment for recovering substance abusers.

## FAMILY TREATMENT RESOURCES

Discuss the treatment resources available for family members: ACOA, AI ANON, CODA, etc. ... therapy education.

Explain what is available and where to get it. Have support groups listing if available from your community.

3. **Relapse (Review Handout on Relapse):** As with all chronic, incurable illnesses, chemical dependency is characterized by relapse. If an individual doesn't do what is necessary to keep this disease in check, relapse is probable. (Correlate similarities with diabetic). It's important to know that it's a characteristic of a chronic illness and it's not a failure. Rather, the disease has become active. Relapse is dangerous because the disease progresses with use. However, relapse can play a positive role in recovery when individuals realize the power of the disease and learn from the events, signs and symptoms of relapse, and begin abstinence with a stronger foundation for continued recovery.

4. **Self-Help Program (Speaker or video):** One of the most effective modes of

treatment for chemical dependency is active involvement in a self-help group. Since the 1930's, Alcoholics Anonymous has been a voluntary fellowship of men and women from all areas of life who meet together to acquire and maintain their sobriety.

We are fortunate to have an individual from the fellowship of AA to share a basic understanding of AA, traditions as well as their experience, strength, and hope. This is an anonymous program and therefore, only first names are used so it's my privilege to introduce FIRST NAME from AREA.

At end of speaker, provide local meeting schedules, and information sheet. Invite the speaker to stay after session to talk to those desiring to do so.

\*Also explain N.A/Ala-Non/Ala-Teen, and Alternative Self-Help support.

## RELAPSE SIGNS AND SYMPTOMS

Relapse clues may relate to changes in behavior, attitudes, feelings, thought, or a combination of these. The following are examples of "relapse clues" preceding relapses of other alcoholics and drug dependent persons:

- 1) Behavior Changes; increased episodes of arguing with others, for no apparent reasons; "forgetting" to take ant abuse; decreasing or stopping AA/NA meetings; stopping in a bar to socialize and drink soda; increased stress symptoms such as smoking more cigarettes or eating more food than usual.
- 2) Attitude changes: Not caring about sobriety; not caring what happens; becoming too negative about life and how things are going.
- 3) Changes in feelings or moods: Increased moodiness or depression; strong feelings of anger at oneself or another; increased feelings of boredom; sudden feelings of euphoria.
- 4) Changes in thoughts: Thinking you "deserve" alcohol or other drugs because you've been sober or abstinent for six months; thinking it wouldn't be harmful to substitute one drug for another (for example, giving up cocaine, but continuing to smoke marijuana, or abstaining from alcohol but continuing to use uppers); thinking the alcohol or drug problem was "cured" because no substances were used for a period of weeks or months.

These are just a few examples which may or may not relate to you. The important point to remember is that changes in your behaviors, attitudes, feelings, thoughts, or a combination of these could indicate that your relapse process is set in motion.

## INFORMATION ON ALCOHOLICS ANONYMOUS

FOR ANYONE NEW COMING TO A.A.

FOR ANYONE REFERRING PEOPLE TO A.A.

This information is both for people who may have a drinking problem and for those in contact with people who have or are suspected of having a problem. Most of the information is available in more detail in literature published by A.A. World Services, Inc. A list of recommended pamphlets and Guidelines is given on the other side of this sheet. This tells what to expect from Alcoholics Anonymous. It describes what A.A. is, what A.A. does, and what A.A. does not do.

What is A.A.?

Alcoholics Anonymous is an international fellowship of men and women who once had a drinking problem. It is nonprofessional, self-supporting, nondenominational, multiracial, apolitical, and available almost everywhere. There are no age or education requirements. Membership is open to anyone who wants to do something about his or her drinking problem.

What does A.A. do?

1. A.A. members share their experience with anyone seeking help with a drinking problem; they give person-to-person services or "sponsorship" to the alcoholic coming to A.A. from any source.
2. The A.A. program, set forth in Twelve Steps, offers the alcoholic a way to develop a satisfying life without alcohol.
3. This program is discussed at A.A. group meetings.
  - a. Open speaker meetings - open to alcoholics and non-alcoholics. (Attendance at an open A.A. meeting is the best way to learn what A.A. is, what it does, and what it does not do.) At speaker meetings, A.A. members "tell their stories." They describe their experiences with alcohol, how they came to A.A., and how their lives have changed as a result of A.A.
  - b. Open discussion meetings - one member speaks briefly about his or her drinking experience, and then leads a discussion on A.A., recovery, or any drinking-related problem anyone brings up. (Closed meetings are for A.A. members or anyone else who may have a drinking problem.)
  - c. Closed discussion meetings-conducted just as open discussions are, but for alcoholics or prospective A.A. members only.

## MEMBERS FROM COURT PROGRAMS AND TREATMENT FACILITIES

In the last years, A.A. groups have welcomed many new members from court programs and treatment facilities. Some have come to A.A. voluntarily; others, under a degree of pressure. In our pamphlet "How A.A. Members Cooperate," the following appears:

We cannot discriminate against any prospective A.A. member, even if he or she comes to us under pressure from a court, an employer, or other agency.

Although the strength of our program lies in the voluntary nature of membership in A.A., many of us first attended meetings because we were forced to, either by someone else or by inner discomfort. But continual exposure to A.A. educated us to the true nature of the illness. Who made the referral to A.A. is not what A.A. is interested in. It is the problem drinker who is our concern. We cannot predict who will recover, nor have we the authority to decide how recovery should be sought by any other alcoholic.

#### PROOF OF ATTENDANCE AT MEETINGS

Sometimes, courts ask for proof of attendance at A.A. meetings. Some groups, with the consent of the prospective member, have the A.A. group secretary sign or initial a slip that has been furnished by the court together with a self-addressed court envelope. The referred person supplies identification and mails the slip back to the court as proof of attendance. Other groups cooperate in different ways. There is no set procedure. The nature and extent of any group's involvement in this process is entirely up to the individual group.

The proof of attendance at meetings is not part of A.A.'s procedure. Each group is autonomous and has the right to choose whether or not to sign court slips. In some areas the attendees report on themselves at the request of the referring agency, and thus alleviate breaking A.A. members' anonymity.

#### THE NONALCOHOLIC ADDICT

Many treatment centers today combine alcoholism and drug addiction under "substance abuse" or "chemical dependence." Patients (both alcoholic and nonalcoholic) are introduced to A.A. and encouraged to attend A.A. meetings when they leave. As stated earlier, anyone may attend open A.A. meetings. But only those with a drinking problem may attend closed meetings or become A.A. members. People with problems other than alcoholism are eligible for A.A. membership only if they have a drinking problem.

Dr. Vincent Dole, a pioneer in methadone treatment for heroin addicts and for several years a trustee on the General Service Board of A.A., made the following statement: "The source of strength in A.A. is its single-mindedness. The mission of A.A. is to help alcoholics. A.A. limits what it is demanding of itself and its associates, and its success lies in its limited target. To believe that the process that is successful in one line guarantees success for another would be a very serious mistake." Consequently, we welcome the opportunity to share A.A. experience with those who would like to develop self-help programs for the nonalcoholic addict using A.A. methods, but using the experience of the nonalcoholic addict during drug addiction and recovery.

#### WHAT A.A. DOES NOT DO

A.A. does not:

1. Furnish initial motivation for alcoholics to recover

2. Solicit members
3. Engage in or sponsor research
4. Keep attendance records or case histories
5. Join "councils" of social agencies
6. Follow up or try to control its members
7. Make medical or psychological diagnoses or prognoses
8. Provide drying-out or nursing services, hospitalization, drugs, or any medical or psychiatric treatment
9. Offer religious services
10. Engage in education about alcohol
11. Provide housing, food, clothing, jobs, money, or any other welfare or social services
12. Provide domestic or vocational counseling
13. Accept any money for its services, or any contributions from non-A.A. sources
14. Provide letters of reference to parole boards, lawyers, court officials

## CONCLUSION

The primary purpose of A.A. is to carry out the message of recovery to the alcoholic seeking help. Almost every alcoholism treatment tries to help the alcoholic maintain sobriety. Regardless of the road we follow, we all head for the same destination, recovery of the alcoholic person. Together, we can do what none of us could accomplish alone. We can serve as a source of personal experience and be an ongoing support system for recovering alcoholics.

## HOW TO ATTEND AN A.A./N.A. MEETING

1. Attend only OPEN (O) meetings unless you have a sincere desire to stop drinking alcohol or using chemicals.
2. You need not say anything, but you may share if you wish and are called upon.
3. You don't need to say the prayers, or stand and hold hands.
4. You are welcome to the coffee and any refreshments.
5. You don't need to put money in the basket. It is for A.A./N.A. members only, but feel free to donate if you choose to.
6. You are asked not to tell anyone who you saw at the meetings. Your anonymity will be protected, also.
7. You should listen to see if you can identify with what is being discussed. Does it apply to you?
8. Feel free to ask questions before and after the meeting, and help yourself to the informational pamphlets.
9. Being helpful - setup/cleanup - is your choice, but it will help you fit in and develop a sense of belonging.
10. Ask for phone numbers and look for a temporary sponsor.
11. No interruptions. If you're not the one talking, you need to be the one listening.
12. No side talking. Respect those speaking. You don't have to agree with them, but they may have a lot to offer you.

RECOMMENDED MATERIAL AVAILABLE FROM A.A. WORLD SERVICES, INC.

Pamphlets:

- "A Member's Eye View of Alcoholics Anonymous"
- "How A.A. Members Cooperate With Other Community Efforts to Help Alcoholics"
- "If You Are a Professional, A.A. Wants to Work With You"
- "Problems Other Than Alcohol"
- "Understanding Anonymity"
- "Let's Be Friendly With Our Friends"
- "Is A.A. For You?"
- "A.A. in Treatment Facilities"
- "A.A. and Occupational Alcoholism Programs"
- "A.A. As a Resource For The Medical Profession"

Guidelines:

- For A.A. Members Employed in the Alcoholism Field
- Forming Local Committees on Cooperation With the Professional Community
- Public Information
- Cooperating With Court, A.S.A.P., and Similar Programs

For copies of the previous page, or a catalog of our literature, write to:

A.A. World Services, Inc.  
Box 459  
Grand Central Station  
New York, NY 10163

[www.aa.org](http://www.aa.org)

Substance Abuse/Addiction Related Web Sites

1. AL-ANON and ALATEEN: [www.Al-Anon-Alateen.org/eng.index.html](http://www.Al-Anon-Alateen.org/eng.index.html)
2. Alcoholic's Anonymous: [www.alcoholics-anonymous.org/](http://www.alcoholics-anonymous.org/)
3. American Psychological Association: [www.apa.org/divisions/div28/](http://www.apa.org/divisions/div28/)
4. APA Division 50 Addictions Newsletter: [www.kumc.edu/addictions\\_newsletter](http://www.kumc.edu/addictions_newsletter)
5. ASAM (American Society for Addiction Medicine: [www.asam.org](http://www.asam.org)

6. Behavior On-Line: [www.behavior.net/index](http://www.behavior.net/index)
7. Children of Alcoholics: [www.health.org/nacoa/](http://www.health.org/nacoa/)
8. Dual Diagnosis: [www.erols.com/ksciacca/index](http://www.erols.com/ksciacca/index)
9. Grants Net: [www.os.dhhs.gov/progorg/grantsnet](http://www.os.dhhs.gov/progorg/grantsnet)
10. Habit Smart Homepage: [www.ctc.com/crash/habtsmrt](http://www.ctc.com/crash/habtsmrt)
11. Hazelden: [www.hazelden.com](http://www.hazelden.com)
12. The Journal: [www.arf.org/Intropage.html](http://www.arf.org/Intropage.html)
13. Mayo Clinic Mental Health Library:  
[www.mayo.ivl.com/mayo/library/htm/mental.htm](http://www.mayo.ivl.com/mayo/library/htm/mental.htm)
14. Medscape: [www.medscape.com/Home/Topics/MentalHealth/MentalHealth.html](http://www.medscape.com/Home/Topics/MentalHealth/MentalHealth.html)
15. The Mining Company (Mental Health Page): <http://home.miningco.com>
16. National Clearinghouse for Alcohol and Drug Abuse Info: [www.health.org](http://www.health.org)
17. National Mental Health Services Knowledge Exchange Network:  
[www.mentalhealth.org](http://www.mentalhealth.org)
18. Web of Addictions: [www.well.com/user/woa](http://www.well.com/user/woa)
19. Substance Abuse and Mental Health Services Administration:  
[www.samhsa.gov](http://www.samhsa.gov)
20. Steps: <http://205.186.239.2:80/steps/index.html>
21. 12-Step Cafe': [www.12steps.org](http://www.12steps.org)
22. Recovery On-Line: <http://recovery.netwiz.net/index.html>
23. Substance Abuse Policy: [www.ncadd.org](http://www.ncadd.org)
24. On-Line AA Resources: [www.casti.com/aa/](http://www.casti.com/aa/)

\*\*Inform clients of your specific website if available

## SESSION VI

### COUNTERMEASURES

#### GOAL:

To enable participants to assess the behaviors that led to the DUI arrest, and to identify alternatives to drinking and driving. To introduce the psychological, physical, and financial losses experienced by those impacted as victims or offenders of DUI.

#### OBJECTIVES:

1. Participants will be able to identify attitudes/behaviors that lead to problematic drinking.
2. Participants will develop action plans to prevent further arrests for DUI.
3. Participants will recognize the consequences of re-arrest for DUI as well as for Driving on a Suspended License.
4. Participants will understand the adverse effects of DUI on victims.
5. Participants will know the process for re-gaining their driving privileges.

#### RESOURCES NEEDED:

1. 12 Hour Recall Handout
2. Counter measure/Action Plan Handout
3. Victim Impact Panel or approved video
4. Steps to Completion of DUI Educational/Treatment Component

#### OUTLINE:

1. Review major points of treatment resources as discussed in session five.
  - a. Identify goal of treatment given the progressive nature of the disease process.
  - b. Review relapse signs.
  - c. Identify at least two community-based or region-based treatment resources.

2. Use 12 Hour Recalls, completed in class by participants, to look for similarities in their behaviors at the time of their arrests for DUI. Process similarities in each section (what they were doing, who they were with, how much and what they drank, reason for drinking, cause of arrest, and B.A.C.)
3. Discuss likelihood of participants' re-arrest unless they learn individualized alternatives to drinking and driving.
  - a. Include in discussion, possible reasons for increased probability of re-arrest, such as:
    - 1) Police are familiar with their car, now
    - 2) They have more to lose if re-arrested
    - 3) The places/people they go to/hang out with
4. Identify countermeasures to drinking and driving:
  - a. Discuss only two 100% safe alternatives to drinking and driving: not drinking or not driving.
  - b. Discuss need for individuals to develop and implement an action plan that will work for them, giving general ideas (i.e. taxi, designated driver, staying home, having someone drop off and pick them back up, walking, staying where they are, i.e. with friend, at a party, etc., limiting drinks to one an hour, etc.)
  - c. Have each participant complete an action plan.
  - d. Using examples from class participants, discuss pros and cons of each idea presented. Remind participants that using abstinence as a #1 action plan alternative is often only a temporary reaction to the DUI, and generally, unless they have been practicing abstinence for an extended period of time, this alternative is not a viable option.
  - e. Discuss responsible drinking.
5. Review DUI laws for multiple offenses (two, three or more) and the penalty for being caught driving on a suspended license.
6. Victim Impact Panel or approved video
  - a. Present a panel comprised of contacts in the community (a local Mothers Against Drunk Driving chapter could be utilized) who will discuss how a DUI affected them personally. The panel should discuss economic losses suffered by victims or offenders, death or physical injuries suffered by victims or offenders, psychological injuries suffered by victims or offenders, changes in the personal welfare or family relationships of victims or offenders, and other information

related to the impact of alcohol or drug-related offenses on victims or offenders.

- b. If a panel is unavailable, show appropriate victim impact video. Discuss the film, covering the points outlined in step a.
7. Review what participants need to do to complete the DUI Safety and Treatment Program and to regain their licenses:
    - a. Must have completed all 6 sessions of the DUI educational component.
    - b. Must have completed treatment goals.
    - c. Must complete an exit interview (ensure that these are scheduled to be completed in timely fashion).
    - d. Must take care of financial obligations for treatment.
    - e. Must have completed mandatory license-suspension time.
    - f. Must pay a re-instatement fee to DMV (provide DMV telephone # and address).
    - g. Generally, must have taken care of any old fines that DMV may have on their record as unpaid.
    - h. Address questions re: procedure, such as whether they can go to Charleston to get their license, roughly the time lapse between completion of class and receipt of license, etc.
  8. Administer Post Test
  9. Schedule Individual, separate, Follow up Reassessment Session/Exit Interview, and Client Satisfaction Survey

## APPROVED VIDEOS

### Session #1

Drinking and Drugs: Driving Under the Influence (AIMS Media)  
Yeah, but...  
DUI: Choices and Consequences  
DUI Every 15 Minutes (AIMS Media)

### Session #2

Medical Aspects of Chemical Dependence (Hazelden)  
Fetal Alcohol Syndrome and Effects (AIMS Media)  
Alcohol and the Body  
Marijuana and the Mind  
Born Drunk  
Drug Babies  
Alcoholic Blackouts and the Brain  
Teen Files: The Truth About Alcohol (AIMS Media)  
Teen Files: The Truth About Drugs (AIMS Media)  
Alcohol and the Mind

### Session #3

Chalk Talk on Alcohol – Revised  
Nicotine Addiction (GMC)  
The Hijacked Brain  
Symptoms of Alcoholism  
The Social Drinker and the Antisocial Driver  
The Disease of Alcoholism - Update

### Session #4

Soft if the Heart of a Child (Hazelden)  
The Enablers (Johnson Institute)  
Family Roles  
Family Dynamics of Chemical Dependency  
Alcohol and the Family: The Breaking Point  
Enabling: Masking Reality (Johnson Institute)

## **Session #5**

Hope: Alcoholics Anonymous  
The 12 Steps of AA (Gerald T. Rogers Productions)  
The Intervention (Johnson Institute)  
Relapse  
Just Call me Crash (Drunk Busters)  
Alcohol: The Addiction, The Solution

## **Session #6**

Crossing the Line (AIMS Media)  
Drink and Deadly  
Drinking and Driving  
Blurred Lines (AIMS Media)  
The Victims  
Sentenced for Life  
Straight Talk About a #1 Killer (Ohlmeyer)  
Drink and Driving: The Toll, the Tears  
The Crash (Drunk Busters)  
Left Behind (Drunk Busters)  
Choices (Drunk Busters)

**PRE/POST TEST**

**West Virginia DUI  
Safety and Treatment Program  
Pre/Post Test**

Name: \_\_\_\_\_  
Date: \_\_\_\_\_  
Score: \_\_\_\_\_

Mark T (True) or F (False) beside these statements:

- \_\_\_\_\_ 1. How much a person drinks determines whether he or she is alcoholic.
- \_\_\_\_\_ 2. Penalties for Knowingly Permitting DUI with One's vehicles are identical to the Driving Under the Influence Penalties.
- \_\_\_\_\_ 3. When chemical dependency exists within a family system not everyone feels the effects.
- \_\_\_\_\_ 4. The goal of treatment is to learn to live comfortably without addictive substances.
- \_\_\_\_\_ 5. One of the most helpful, effective interventions of chemical dependency is active involvement in self-help support groups such as 12-Step, AA and NA.
- \_\_\_\_\_ 6. Addiction to any mood altering chemical is progressive and can be fatal.
- \_\_\_\_\_ 7. Alcohol and other drug dependencies are considered to be diseases in the same way cancer and diabetes are considered diseases.
- \_\_\_\_\_ 8. Genetic predisposition has been proven to be a factor in alcoholism.
- \_\_\_\_\_ 9. Alcohol acts as a depressant on the central nervous system.
- \_\_\_\_\_ 10. Use of marijuana (cannabis) causes an altered state of perception and impaired memory and physical coordination.

**MULTIPLE CHOISE:** Circle the correct answer:

11. Having to drink more alcohol now than use used to in order to feel the effects is called:
- a. Intoxication
  - b. Tolerance
  - c. Blackouts
  - d. Loss of Control

12. Cirrhosis is a disease of the:
- a. Central nervous system
  - b. Intestines
  - c. Liver
  - d. Heart
13. The inability to recall events in which you were involved while you were drinking alcohol is called:
- a. Passing Out
  - b. Blackouts
  - c. Intoxication
  - d. Preoccupation
14. Alcohol affects your:
- a. Central Nervous System
  - b. Liver
  - c. Heart
  - d. All of the above
15. Alcohol is a/an
- a. Drug
  - b. Physically dependent
  - c. Psychologically dependent
  - d. All of the above
16. Which is an effective way of sobering up?
- a. Drinking black coffee
  - b. Taking a cold shower
  - c. Letting time pass
  - d. Exercise

17. Studies suggest that driving performance may be impaired when Blood Alcohol Concentrations are as low as:
- a. .01
  - b. .04
  - c. .08
  - d. .10
18. Twelve ounces of beer, five ounces of wine, and 1 ½ ounces of 80 proof liquor all contain:
- a. Different kinds of alcohol
  - b. About the same amount of alcohol
  - c. Different amounts of alcohol
  - d. All of the above
19. The penalty for second offense DUI in the State of West Virginia is:
- a. A misdemeanor
  - b. Punishable by confinement in a regional jail
  - c. Loss of driver's license for one year and interlock for 2 years
  - d. All of the above
20. Which of the following is the most abused drug in the United States?
- a. Marijuana
  - b. Heroin
  - c. Alcohol
  - d. Cocaine
21. What part of the body oxidizes alcohol?
- a. Lungs
  - b. Kidneys
  - c. Liver
  - d. Pancreas

22. Which of these affects the way a person might act while drinking?
- a. How much a person drinks
  - b. A persons drinking experience
  - c. The mood they were in before they started drinking
  - d. All of the above
23. The combined effects of mixing alcohol and other drugs, increasing the effects of both is called:
- a. Potentiation
  - b. Overdose
  - c. Blackouts and passing out
  - d. Withdrawal
24. An individual who reacts to the symptoms of alcoholism in a way to shield the alcoholic from experiencing consequences is:
- a. Enabling
  - b. Scapegoating
  - c. Overprotecting
  - d. Defending
25. Late stage symptoms of alcoholism are:
- a. Reverse tolerance, loss of job, family and friends, and physical dependence
  - b. Preoccupation, blackouts, and guilt
  - c. Increased tolerance, loss of interest and personality changes
  - d. None of the above.

**PRE/POST TEST KEY**

**West Virginia DUI  
Safety and Treatment Program  
Pre/Post Test**

Name: \_\_\_\_\_  
Date: \_\_\_\_\_  
Score: \_\_\_\_\_

**KEY**

Mark T (True) or F (False) beside these statements:

- \_F\_** 1. How much a person drinks determines whether he or she is alcoholic.
- \_T\_** 2. Penalties for Knowingly Permitting DUI with One's vehicles are identical to the Driving Under the Influence Penalties.
- \_F\_** 3. When chemical dependency exists within a family system not everyone feels the effects.
- \_T\_** 4. The goal of treatment is to learn to live comfortably without addictive substances.
- \_T\_** 5. One of the most helpful, effective interventions of chemical dependency is active involvement in self-help support groups such as 12-Step, AA and NA.
- \_T\_** 6. Addiction to any mood altering chemical is progressive and can be fatal.
- \_T\_** 7. Alcohol and other drug dependencies are considered to be diseases in the same way cancer and diabetes are considered diseases.
- \_T\_** 8. Genetic predisposition has been proven to be a factor in alcoholism.
- \_T\_** 9. Alcohol acts as a depressant on the central nervous system.
- \_T\_** 10. Use of marijuana (cannabis) causes an altered state of perception and impaired memory and physical coordination.

**MULTIPLE CHOISE:** Circle the correct answer:

11. Having to drink more alcohol now than use used to in order to feel the effects is called:
- B** a. Intoxication
  - b. Tolerance
  - c. Blackouts
  - d. Loss of Control

12. Cirrhosis is a disease of the:

- C**
- a. Central nervous system
  - b. Intestines
  - c. Liver
  - d. Heart

13. The inability to recall events in which you were involved while you were drinking alcohol is called:

- B**
- a. Passing Out
  - b. Blackouts
  - c. Intoxication
  - d. Preoccupation

14. Alcohol affects your:

- D**
- a. Central Nervous System
  - b. Liver
  - c. Heart
  - d. All of the above

15. Alcohol is a/an

- D**
- a. Drug
  - b. Physically Dependent
  - c. Psychologically Dependent
  - d. All of the above

16. Which is an effective way of sobering up?

- C**
- a. Drinking black coffee
  - b. Taking a cold shower
  - c. Letting time pass
  - d. Exercise

17. Studies suggest that driving performance may be impaired when Blood Alcohol Concentrations are as low as:

- B**
- a. .01
  - b. .04
  - c. .08
  - d. .10

18. Twelve ounces of beer, five ounces of wine, and 1 ½ ounces of 80 proof liquor all contain:

- B**
- a. Different kinds of alcohol
  - b. About the same amount of alcohol
  - c. Different amounts of alcohol
  - d. All of the above

19. The penalty for second offense DUI in the State of West Virginia is:

- D**
- a. A misdemeanor
  - b. Punishable by confinement in a regional jail
  - c. Loss of drivers license for one year and interlock for two years
  - d. All of the above

20. Which of the following is the most abused drug in the United States?

- C**
- a. Marijuana
  - b. Heroin
  - c. Alcohol
  - d. Cocaine

21. What part of the body oxidizes alcohol?

- C**
- a. Lungs
  - b. Kidneys
  - c. Liver
  - d. Pancreas

22. Which of these affects the way a person might act while drinking?

- D**
- a. How much a person drinks
  - b. A persons drinking experience
  - c. The mood they were in before they started drinking
  - d. All of the above

23. The combined effects of mixing alcohol and other drugs, increasing the effects of both is called:

- A**
- a. Potentiation
  - b. Overdose
  - c. Blackouts and passing out
  - d. Withdrawal

24. An individual who reacts to the symptoms of alcoholism in a way to shield the alcoholic from experiencing consequences is:

- A**
- a. Enabling
  - b. Scapegoating
  - c. Overprotecting
  - d. Defending

25. Late stage symptoms of alcoholism are:

- A**
- a. Reverse tolerance, loss of job, family and friends, and physical dependence
  - b. Preoccupation, blackouts, and guilt
  - c. Increased tolerance, loss of interest and personality changes
  - d. None of the above.

**AGREEMENT OF UNDERSTANDING**



STATE OF WEST VIRGINIA  
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Earl Ray Tomblin  
Governor

Bureau for Behavioral Health and Health Facilities  
350 Capitol Street, Room 350  
Charleston, West Virginia 25301  
Telephone: (877) 215-2522 Fax: (304) 558-3275

Michael J. Lewis, M.D., Ph.D.  
Cabinet Secretary

AGREEMENT OF UNDERSTANDING FORM: CLIENT/PROVIDER  
REGISTRATION

An enrollment fee of four hundred dollars (\$400.00) is required for enrollment and participation in the DUI Safety and Treatment Program. This registration fee entitles me to all services provided in the DUI Safety and Treatment Program which include the following: Assessment/Enrollment Interview, the Education Component, and a Reassessment Session. I understand that the \$400.00 will not cover the costs for any additional treatment I may be assessed as needing. The costs for treatment will be based on the Center's sliding fee schedule, based upon federal poverty guidelines specific to income and family size. If I decide to discontinue participation in the Program, I understand that my enrollment fee will not be refunded and must be repaid should I re-enroll after one year's time.

ATTENDANCE:

Each class of the DUI Safety and Treatment Program is mandatory and must be attended. If for some reason I am unable to attend a class, I will contact the instructor prior to the class. It will be my responsibility to see that the instructor is notified. Failure to do so will result in immediate withdrawal from the current Educational Program.

1. If one session is missed, and if it is an excused absence, I will be required to make up the same class in another Educational Component Cycle offered by the behavioral health care center.
2. If I am absent for more than one session, I will be required to repeat the entire Educational Component. I will be required to enroll by a specific date set by the DUI Coordinator and for this privilege of re-enrollment, I will be assessed an additional registration fee of one-hundred (\$100.00) dollars.

ALCOHOL/DRUG FREE ATTENDANCE:

All participants attending the Educational Component must be alcohol-free and not under the influence of drugs. I understand that I will be asked to submit to a breathalyzer test or urine screen at any time during the Program.

## APPEAL PROCESS

If I wish to appeal my recommended course of treatment, I understand that I can have my case reviewed by an appeal board. This appeal board will consist of individuals responsible for provision of services within the DUI Safety and Treatment Program but not involved in my initial assessment. The procedure for making an appeal is as follows:

1. I can obtain a DUI Appeal Form from my service provider.
2. I will complete and return this form to my service provider within three (3) days.
3. The Appeal Board should render a decision regarding my appeal within 21 days.
4. Channel of Appeal is made through the behavioral health care provider's DUI Coordinator, Substance Abuse Coordinator, Clinical Director, and/or Executive Director.
4. Final Appeal is made to the State DUI Program Coordinator, DUI Safety and Treatment Program, Division Of Motor Vehicles, and only after completing the initial channels of appeal. The decision rendered shall be made within 10 days of receipt, with consultation with the DUI/Substance Abuse Coordinator of the behavioral health care provider and considered final.

I understand that a majority vote of these three appeal board members will constitute the board's final recommendation to the West Virginia Division of Motor Vehicles. I fully understand that my completion of this Program does not automatically assure that my license will be reinstated by the Division of Motor Vehicles, and that, under the law, the DHHR is responsible for the final consideration of licensing reinstatement and may require additional treatment and/or other considerations before such reinstatement is made.

This certifies that I fully understand and agree to abide by the policies of the DUI Safety and Treatment Program contained in this form.

---

Participant's Signature

Date

**CONSENT FOR RELEASE OF INFORMATION**



STATE OF WEST VIRGINIA  
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Earl Ray Tomblin  
Governor

Bureau for Behavioral Health and Health Facilities  
350 Capitol Street, Room 350  
Charleston, West Virginia 25301  
Telephone: (304) 558-0627 Fax: (304) 558-2230

Michael J. Lewis, M.D., Ph.D.  
Cabinet Secretary

**CONSENT FOR THE RELEASE OF CONFIDENTIAL ALCOHOL OR DRUG TREATMENT INFORMATION**

I, \_\_\_\_\_, authorize  
*(Name of Patient)*

\_\_\_\_\_  
*(Name of general designation of program making disclosure)*

**To disclose to WV DHHF / DUI Unit all classes and treatment.**  
**The purpose of the disclosure authorized is to reinstate license.**

I understand that my records are protected under state and federal laws and regulations including federal regulations governing Confidentiality of Alcohol Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: One year.

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Signature of parent, guardian or authorized  
Representative when required*

**PROHIBITION ON REDISCLOSURE OF INFORMATION CONCERNING CLIENT IN ALCOHOL OR DRUG ABUSE TREATMENT**

This notice accompanies a disclosure of information concerning a client in alcohol /drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**STAFF MEMBER INFORMATION AND QUALIFICATION**



STATE OF WEST VIRGINIA  
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

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Governor

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350 Capitol Street, Room 350  
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Michael J. Lewis, M.D., Ph.D.  
Cabinet Secretary

**SAFETY AND TREATMENT PROGRAM  
STAFF MEMBER INFORMATION AND QUALIFICATIONS**

Complete this form for each staff member who provides DUI services. An individual's social security number is solicited for the purpose of verifying his/her identity and related personal information required under these regulations. This form shall be used for individuals providing the educational and/or treatment components.

PROGRAM NAME: \_\_\_\_\_

PROGRAM ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ FAX NUMBER: \_\_\_\_\_

STAFF QUALIFICATION DATA:

NAME: \_\_\_\_\_

JOB TITLE: \_\_\_\_\_

COLLEGE/PROFESSIONAL SCHOOL: \_\_\_\_\_

GRADUATE SCHOOL: \_\_\_\_\_

OTHER SCHOOL: \_\_\_\_\_

YEARS OF ADDICTIONS TREATMENT AND/EDUCATION EXPERIENCE: \_\_\_\_\_

Document your work experience, training, license(s), and certification(s) including C.A.C., C.C.A.C. and/or C.C.S. to demonstrate compliance with standards set forth for the DUI Safety and Treatment Program, as applicable. (attach copies of credentials and additional pages as necessary)

\_\_\_\_\_  
STAFF MEMBER SIGNATURE: DATE

\_\_\_\_\_  
DUI COORDINATOR SIGNATURE: DATE

(Signature verifies that the individual has completed the necessary training/supervision requirements as indicated in the standards.)

**DUI SAFETY AND TREATMENT APPEAL PROCESS FORM-**  
**SAMPLE**



**ASAM GUIDELINES CHART**

In order to assist the participant and the clinician during the assessment process when a participant requires either the Intervention/Treatment Component or the Intensive Care Component, the following chart is offered based upon the West Virginia Model for the Treatment of Psychoactive Substance Abuse Disorders. This has been developed as uniform admission, continued stay, and discharge criteria in conjunction with the American Society of Addiction Medicine's Patient Placement Criteria II-R.