

Illinois Substance Abuse Plan

Illinois
Partnerships
In
Prevention
and
Recovery

2003-2007

Year One
September
2003.



Rod R. Blagojevich, Governor

Carol L. Adams, Ph.D. , Secretary

Theodora Binion Taylor, Associate Director

PAGE LEFT BLANK INTENTIONALLY

ACKNOWLEDGEMENTS

The Department of Human Services, Office of Alcoholism and Substance Abuse and the Division of Community Health and Prevention, Bureau of Substance Abuse Prevention would like to acknowledge the dedication, time and effort that the members of the Subcommittee on Planning and Budget contributed to the development of this State Plan. We would also like to acknowledge and thank those individuals that have joined these planning and development efforts through their participation on the Subcommittee Workgroups.

Subcommittee on Planning and Budget

Jay Meyer – Chair

Karel Ares	Michael Flora	Peter McLenighan
Mike Bach	Michael Fonda	Pam Rodriguez
Jean Baumgarten	Judy Fried	Allen Sandusky
Angela Bowman	Russell Hagen	Dave Schanding
Bruce Carter	Pam Irwin	Jean Schram
Anthony Cole	Glenn Jackson	Marion Sleet
Tim Cramer	Marco Jacome	Rick Velasquez
David Deopere	Kate Mahoney	Ron Vlasaty
Martin Doot, M.D.	Don Malec	Sharon Zahorodnyj

Addressing Work Force Issues Work Group

Rick Velasquez, Co-Chair	Laurie Call, Co-Chair
Karel Ares	Andrea Tarble
Marla Chrisagis	Ron Vlasaty
Glenn Jackson	Eve Weinberg
Bill Johnson	Kerry Whipple
Peter McLenighan	Melanie Whitter

Connecting Services and Research Work Group

Pam Rodriguez, Co-Chair	Tim Cramer, Co-Chair
Maria Bruni	Mary Ellen Mate
Bruce Carter	Joel Warmolts
Beth Epstein	Beth Welbes
Pam Irwin	

**Improving and Strengthening the Prevention and
Treatment Systems through Accountability Work Group**

Dave Schanding, Co-Chair

Jean Schram, Co-Chair

Karel Ares
Lori Baker
Kim Fornero
Pam Irwin
Beth Johnson

Jay Meyer
Lillian Pickup
Joel Warmolts
Beth Welbes

Reducing the Prevention and Treatment Gap Work Group

Angela Bowman, Co-Chair

Sara Moscato, Co-Chair

Mike Bach, Co-Chair

Lori Baker
Anthony Cole
David Deopere
Martin Doot, M.D.
Kevin Downey
Michael Flora
Kim Fornero

Glenn Jackson
Kate Mahoney
Jeff May
Jay Meyer
Susan Moses
Teresa Perdieu
Lillian Pickup

Reducing the Stigma and Changing Attitudes Work Group

Jean Baumgarten, Co-Chair

Allen Sandusky, Co-Chair

Daphne Baille
Deb Brisino
Brendan Foster
Stacy Greco
Karen Jerczyk

Don Malec
Tari Marshall
Susan Moses
Ron Vlasaty
Kerry Whipple

Our friend Jean Baumgarten passed away suddenly in August 2003. The Subcommittee on Planning and Budget and its Work Groups would like to acknowledge the dedication and tireless effort given by her to the Subcommittee, the Reducing the Stigma and Changing Attitudes Work Group, the many other workgroups and committees, the field of alcoholism and substance abuse and the Office of Alcoholism and Substance Abuse.

**Meeting the Needs of Illinois Residents
Illinois Plan for Substance Abuse
2003 - 2007
Year One - 2003**

I. IDHS/DASA Legislative Mandate and Organizational Structure.

The Illinois Department of Human Services, Division of Alcoholism and Substance Abuse (IDHS/DASA) was created by the Illinois General Assembly through enactment of House Bill 963, revised in 1985 in Public Act 85-965 and incorporated into Illinois Revised Statutes 1987 Chapter 111½ paragraph 6351 et seq., and recodified in July 1996 through House Bill 2632, effective July 1, 1997. The mandate given to IDHS/DASA begins with the below legislative declaration:

The human suffering and social and economic loss caused by the illness of alcoholism, addiction to controlled substances, the use of cannabis, and the abuse and misuse of alcohol and other drugs are matters of grave concern to the people of the State of Illinois. It is imperative that a comprehensive and coordinated strategy be developed through the leadership of a State agency and implemented through the facilities of federal and local government and community-based (which may be public or private, volunteer or professional) to empower individuals and communities through local prevention efforts and to provide intervention, treatment, rehabilitation and other services to those who misuse alcohol or other drugs (and, when appropriate, the families of those persons) to lead healthy and drug-free lives and become productive citizens in the community.

The human, social, and economic benefits of preventing alcohol and other drug abuse and dependence are great, and it is imperative that there be interagency cooperation in the planning and delivery of alcohol and other drug abuse prevention, intervention, and treatment efforts in Illinois.

IDHS/DASA Illinois SSA Responsibilities - The following major functions of IDHS/DASA, as the Illinois Single State Authority (SSA) for alcohol, tobacco, and other drug (ATOD) issues, are specified as part of this enabling legislation. The third of these organizational functions relates specifically to the development of an annual State plan.

(1) Design, coordinate and fund a comprehensive and coordinated community-based and culturally and gender-appropriate array of services throughout the State for the prevention, intervention, treatment, and rehabilitation of alcohol and other drug abuse and dependency that is accessible and addresses the needs of at-risk or addicted individuals and their families.

(2) Act as the exclusive State agency to accept, receive and expend, pursuant to appropriation, any public or private monies, grants or services, including those received from the federal government or from

other State agencies, for the purpose of proving an array of services for the prevention, intervention, treatment and rehabilitation of alcoholism or other drug abuse and dependency. Monies received by the Department shall be deposited into appropriated funds as may be created by State law or administrative action.

(3) Coordinate a statewide strategy among State agencies for the prevention, intervention, treatment and rehabilitation of alcohol and other drug abuse and dependency. This strategy shall include the development of an annual State plan for the provision of an array of services for education, prevention, treatment, relapse prevention, and other services and activities to alleviate alcoholism and other drug abuse and dependency. The plan shall be based on local community-based needs and upon data including, but not limited to, that which defines the prevalence of costs associated with the abuse of and dependency upon alcohol and other drugs. This comprehensive State plan shall include identification of problems, needs, priorities, services and other pertinent information, including the needs of "minorities and other specific populations" may include, but shall not be limited to groups such as women, children, intravenous drug users, persons with AIDS or who are HIV infected. African Americans, Puerto Ricans, Hispanics, Asian Americans, the elderly, persons in the criminal justice system, persons who are clients of services provided by other State agencies, persons with disabilities and such other specific populations as the Department may from time to time identify. In developing the plan, the Department shall seek input from providers, parent groups, associations and interested citizens.

Beginning with State fiscal year 1996, the annual comprehensive State plan developed under this Section shall include an explanation of the rationale to be used in ensuring that funding shall be based upon local community needs, included but not limited to, the incidence and prevalence of, and costs associated with, the abuse of and dependency upon alcohol and other drugs, as well as upon demonstrated program performance.

The annual comprehensive State plan developed under this Section shall contain a report detailing the activities of and progress made by the programs for the care and treatment of addicted pregnant women, addicted mothers and their children established under this Act.

(4) Lead, foster and develop cooperation, coordination and agreements among federal and State governmental agencies and local providers that provide assistance, services, funding or other functions, peripheral or direct, in the prevention, intervention, treatment or rehabilitation of alcoholism and other drug abuse and dependency.

II. Central IDHS/DASA Planning Principles.

The following ATOD prevention and treatment service system principles guided the development of this Illinois State Plan.

- The Illinois ATOD service system shall be developed based upon the belief that ATOD addictions are preventable and treatable diseases. A service system that encourages the addressing of ATOD-related problems prior to, or early in their progression, will be relatively more effective in preventing and treating these diseases, and more cost efficient.**
- Prevention services are critical to both the short and long-term reduction of ATOD-related problems and conditions, and to improvements in the general health and well-being of Illinois' individual residents, families, and communities.**
- A comprehensive and coordinated continuum of care and services is required to substantially impact the long-term abstinence and recovery of ATOD addicted individuals. This continuum of care and services must be responsive to the unique, specific, and varied needs and characteristics of individuals, families, racial/ethnic groups, other special populations, and local communities.**
- The Illinois ATOD treatment service system should allow for an appropriate response to any individual seeking ATOD services regardless of level of dysfunction. The system must also be capable of responding to the functional needs of the individual as they change during the recovery process, through the availability of appropriate levels of care and services.**
- Comprehensive and appropriate ATOD service delivery is enhanced through the development and implementation of written policies and procedures that govern both provider and individual responsibilities and participation in the treatment process. The content and implementation of these policies and procedures should be consistent with other Illinois service system principles.**
- The Illinois ATOD service system should be structured so as to minimize or eliminate financial, cultural, geographic, and other types of factors that serve as barriers to service access.**
- The Illinois system should reflect a balanced distribution of services and resources among and between IDHS regions, DASA networks, and population groups. This balanced system should be responsive to the needs and characteristics of racial/ethnic groups, youth, females and males, criminal justice clients, individuals with co-existing mental health problems, TANF recipients, child welfare agency-involved parents, and other priority populations.**
- IDHS regions, DASA networks, and population groups with demonstrated gaps between assessed needs and available resources, should be given relative priority in future service enhancements and resource allocations.**

- The Illinois system should be based upon IDHS regions and DASA networks. The ATOD services provided through this system should be community-based and reflective of the specific local needs and characteristics of each region and network. DASA network boundaries should be reviewed periodically to assess the extent to which they facilitate an equitable and appropriate distribution of available resources.

Description of Planning Process

As mentioned previously, the Division of Alcoholism and Substance Abuse (DASA) is an organizational unit within the Illinois Department of Human Services (DHS). IDHS/DASA has the two primary organizational functions of *Program Compliance* and *Program Services* as they apply to Illinois' publicly funded ATOD treatment system. A valuable source of input into IDHS/DASA's performance of these organizational functions is provided through the Illinois Advisory Council on Alcohol and Other Drug Dependency.

Illinois Advisory Council and Committees - The State legislation that created IDHS/DASA includes the establishment of the Illinois Advisory Council on Alcoholism and Other Drug Dependency. The specified powers and duties of the Council include the following.

- Advise the Department on ways to encourage public understanding and support of the Department's programs.
- Advise the Department on the formulation, preparation and implementation of the comprehensive State plan for prevention, intervention, treatment, and relapse prevention of alcoholism and other drug abuse and dependency.

The Illinois Advisory Council on Alcoholism and Other Drug Dependency has members representing the fields of health care, criminal justice, and social service, the legislature and general public. The council's committees provide advice and counsel to the department on substance abuse issues. The Council's Planning Committee was established to assist in fulfillment of the Council's responsibility in regard to providing advisory input into IDHS/DASA's annual Illinois State Plan.

Development of 2003-2007 Illinois State Plan

A decision was made to pattern the development of the five year 2003-2007 Illinois State Plan to be consistent with focus areas contained within the *National Treatment Plan* developed through the U.S. Department of Health and Human Services, Substance Abuse Services Administration, Center for Substance Abuse Treatment (CSAT). The Council's Planning and Budget Subcommittee was charged with providing valuable guidance in development of the content of the 2003-2007 State Plan. The Planning and Budget Subcommittee's membership includes representation across the range of Illinois geographic areas and service provider organizations. Members met during the first six months of 2003 to develop the structure of goals and objectives for this initial year of the *Bridging the Illinois Prevention, Intervention, and Treatment Gap for Alcoholism and*

Other Drug Addiction Services Plan. Members of this Subcommittee volunteered to participate on the following work groups.

- Reducing Stigma and Changing Attitudes
- Reducing the Gap in Services
- Workforce Development
- Connecting Services and Research
- Accountability

Each work group was asked to develop goals, objectives, and action steps that were intended to address key issue areas in their particular focus area. The CSAT *National Treatment Plan* served as guidance in the selection of work group focus areas, however issues considered to be of primary importance to Illinois were the basis for identification of workgroup planning areas. The workgroups continued on in development of an Implementation Plan including timelines and responsible parties that will serve as both a supplement and a progress report regarding this plan.

III. Illinois Planning Committee Focus Area Plans.

Provided below is a summary of goals, objectives and action steps developed by each of the five Illinois State Plan work groups. Committee members continue work on the action steps contained within the Implementation Plan.

Issue Area I - Reducing Stigma and Changing Attitudes Workgroup.

Goal 1: Raise awareness and influence change in attitudes of the general public in regards to the prevention, prevention, treatment and recovery fields.

Objective 1: Promote non-stigmatizing language for prevention, treatment and recovery.

Objective 2: Facilitate and support efforts to build the capacity of the recovery community to participate in the public dialogue about prevention, early intervention, addiction, treatment and recovery.

Goal 2: Promote dignity and reduce stigma and discrimination against people in alcohol and other drug prevention, treatment, or recovery programs by encouraging respect for their rights in a manner similar to people who have suffered and overcome other illnesses and/or participated in similar services.

Objective 1: Support initiatives that promote the reduction in discrimination and stigma in employment, healthcare, insurance and other areas that decrease the discriminatory affect upon the individuals with the disease of addiction.

Objective 2: Advocate for classification of addiction as a disease in legislation, regulations and administrative policies.

Issue Area II – Reduce the Gap in Services.

Goal 1: *Identify the gaps in services in Illinois.*

Objective 1: Develop a reliable database of services delivered by substance use prevention, intervention, treatment and extended care facilities/programs in Illinois.

Objective 2: Develop and implement a methodology for data analysis that permits multi-variant analysis and identification of need for services, relating prevalence data to data on services delivered.

Goal 2: *Close the gap in services.*

Objective 1: Increase access and enhance inter-system linkages. Emphasize the benefit of multiples systems working together to ensure that appropriate, effective prevention, intervention, treatment and extended care services are available to all individuals and communities.

Objective 2: Support national, statewide and community specific campaigns that challenge social norms and standards.

Objective 3: Enhance collaboration between prevention, intervention, treatment and extended care providers.

Objective 4: Resource allocation and financing - Increase total fiscal (i.e., Federal, State, local and private) and human resources available for substance use disorder prevention, intervention, treatment and extended care.

Objective 5: Develop a standard insurance benefit for substance use disorders that provides for a full continuum of appropriate and continuing care to meet the needs of person with substance use disorders.

Issue Area III – Workforce Development.

Goal 1: *Ensure that an adequate number of competent workers enter the substance abuse prevention and treatment fields to meet the demands in identified and specific cultural and geographical areas, program specialties, and administrative functions.*

Objective 1: Gather data to understand and communicate the real-time workforce needs throughout the state.

Objective 2: Increase the desirability of careers in ATOD treatment and prevention.

Objective 3: "Open the Door" to new entry-level career opportunities within the ATOD prevention and treatment fields.

Objective 4: Develop structures to promote the recruitment of volunteers in prevention and treatment fields.

Objective 5: Ensure availability of accredited training and academic degree programs for counselors, physicians, nurses, and prevention specialists.

Goal 2: Ensure that an adequate number of qualified, competent staff is maintained in the prevention and treatment fields to meet the needs of diverse individuals and communities.

Objective 1: Develop a system for collecting data that reliably identifies workforce needs pertaining to professional development, emerging trends, gaps in knowledge and workforce satisfaction.

Objective 2: Provide training to improve management and supervisory best practices.

Objective 3: Identify strategies to appropriately compensate the prevention and treatment workforce for their education level, skills and experiences.

Objective 4: Streamline continuing education by developing reciprocal continuing education agreements.

Objective 5: Foster leadership within the ATOD prevention and treatment fields.

Goal 3: Ensure that all levels of staff demonstrate the skills and knowledge to deliver high-quality prevention and treatment services to diverse individuals and communities.

Objective 1: Develop an organized strategy to provide training that is based on the most current research available and that meets the minimum standard competencies of the workforce.

Objective 2: Ensure that organizations are using performance management systems that outline, measure, and reward staff competencies in addition to knowledge and productivity.

Objective 3: Promote collaborative cross training that increases competencies in mental health, juvenile justice, and child welfare issues and services and their relation to ATOD prevention and treatment.

Objective 4: Identify processes that will ensure continued competency as the field evolves.

Issue Area IV – Connecting Services and Research.

Goal 1: *Establish and maintain a research initiative that is the result of a state government, university, community, consumer, and service provider collaboration.*

Objective 1: Promote and support research and data collection efforts consistent with state and federal performance and outcome measures.

Objective 2: Create active linkages with a variety of agencies, organizations, communities and consumers around Illinois to focus on relevant knowledge development.

Objective 3: Create a statewide system, linking the service delivery system and the research community.

Objective 4: Support research and evaluation studies of new and innovative service delivery technology.

Goal 2: *Eliminate barriers to utilization of evidence-based programming.*

Objective 1: Identify and address barriers, including but not limited to funding constraints, community and consumer input, and replicability of research in applied settings.

Objective 2: Create and use efficient and effective research and data gathering efforts.

Goal 3: Encourage, develop, and implement practices that assist provider agencies to develop internal positions and/or competencies within their workforce to collaborate with researchers, influence research designs, and support internal utilization of quality research within the organization.

Objective 1: Enlist state and federal support to assist providers in adoption and integration of research findings into clinical practice

Objective 2: Provide administrative, prevention professional, counselor and clinical supervisor training on application of knowledge and evidenced-based practices gained through research

Objective 3: Assist providers in implementing and maintaining needed changes through use of proven change management strategies

Goal 4: Define and adopt a system of evidence-based prevention, treatment and continuing care program management.

Objective 1: Use small-scale pilot studies that are relevant to the array of Illinois provider and consumer issues.

Objective 2: Create active linkages with state agencies, community and provider organizations to focus on knowledge application

Objective 3: Enhance prevention and treatment infrastructure to enable implementation and evaluation of evidence-based practices

Issue Area 5 – Accountability.

Goal 1: Improve organizational business management systems at the community provider and state agency levels.

Objective 1: Ensure adequate standards of governance and in leadership boards including knowledge, skill sets and composition.

Objective 2: Review current standards, monitoring procedures and training to assess degree to which they exist and are appropriate, relevant and consistently administered.

Objective 3: Improve Management Information Systems for clinical support and management functions at the local and state levels.

Objective 4: Review interest in/feasibility for low-interest bond funding for organizations to address capital improvement investments, infrastructure development, facility improvement.

Page is Blank by Design

V. Nature and Extent of ATOD Problems - Nationwide.

A study completed in 1998 estimated that the total costs to U.S. society during 1992 from alcohol and other drug abuse were \$246 billion.¹ Of these total costs, \$148 billion was attributed to alcohol abuse and alcoholism and the remaining \$98 billion was attributed to drug abuse and dependence. Another study concluded that the total costs to society from alcohol and other drug abuse increased from the estimated \$246 billion in 1992 to in excess of \$276 billion in 1995.² Considering inflation and population growth, it is certainly reasonable to assume that the total economic costs to our society from alcohol and other drug abuse approached \$300 billion during 2002. The following are ATOD-related conditions and factors that contribute to these substantial nationwide costs.

Health Care Costs

- Alcohol and other drug use has been implicated as a factor in many of this country's most serious and expensive problems, including violence, injury, child and spousal abuse, HIV/AIDS and other sexually-transmitted diseases, teen pregnancy, school failure, motor vehicle accidents, escalating health care costs, low worker productivity, and homelessness.³
- The range of medical consequences associated with alcohol and other drug abuse and dependence are well-documented.^{4,5} A large part of the national health care bill is for alcohol and other drug-related medical expenses. For example, 25 to 40% of all Americans in general hospital beds (exclusive of maternity and intensive care beds) are being treated for complications of alcoholism. The total

¹ Harwood, H. et al. (1998). *The Economic Cost of Alcohol and Drug Abuse in the United States, 1992*. Prepared by the Lewin Group for the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism. Available online at www.nida.nih.gov/EconomicCosts/index/html.

² Harwood et al. (1998). *The Economic Costs of Alcohol and Drug Abuse in the United States 1992*. U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse, NIH Publication Number 98-4327, September 1998.

³ *Center for Substance Abuse Prevention's Discussion Paper on Preventing Alcohol, Tobacco, and Other Drug Problems, 1993*.

⁴ National Institute on Alcohol Abuse and Alcoholism (NIAAA) (2000). *10th Special Report to the U.S. Congress on Alcohol and Health*. U.S. Department of Health and Human Services (USDHHS). Washington, DC.

⁵ Office of National Drug Control Policy (ONDCP) (2001). *The Economic Costs of Drug Abuse in the United States, 1992-1998*. Washington, DC; Executive Office of the President (Publication No. NCJ-190636).

costs of health care expenditures during 1998 for alcohol-related problems was estimated at \$26.3 billion and total health care expenditures for drug-related problems during 2000 was estimated to be \$14.9 billion.

- In a study of one large metropolitan hospital, 28% of all admissions to intensive care units (ICUs) were related to alcohol, tobacco, and other drug (ATOD) problems (9% alcohol, 14% tobacco, and 5% other drugs). The ATOD-related admissions were more severe than the other 72% of admissions, requiring an average of 4.2 days in ICU versus an average of 2.8 days for the remainder of admissions, and also more expensive - about 63% greater than the average cost for other ICU admissions.
- Health care costs related to substance abuse are not limited to the abuser. Children of alcoholics average 62% more hospital days than other children. These increased hospital days result from 24% more inpatient admissions and 29% longer stays when admitted.
- At least 1 of every 5 dollars Medicaid spends on hospital care and 1 in every 5 Medicaid hospital days are attributable to substance abuse.
- Substance abuse is one of the leading causes of premature death in the U.S.⁶ Among the conditions alcohol and other drug use have been associated with are breast cancer⁷, liver disease⁸, weakened immune⁹ and cardiovascular¹⁰ systems, and accidents and fatal injuries.¹¹
- Alcohol is the drug most frequently used by 12 to 17 year-old, and the one that causes the most negative health consequences. More than 4 million adolescents under the legal drinking age consume alcohol in any given month. Alcohol-related motor vehicle accidents are the number one killer of teens in our

⁶ Horgan C, Skwara, K.C., & Strickler, G. (2001). Substance Abuse: *The Nation's Number One Health Problem*. New Jersey: The Robert Wood Johnson Foundation.

⁷ Smith-Warner, S. et al. (1998). Alcohol and breast cancer. *Journal of the American Medical Association* 279: 535–40.

⁸ Dufour, M.C., Stinson, F.S., & Caces, M.F. (1993). Trends in cirrhosis morbidity and mortality: United States, 1979–1988. *Seminars in Liver Disease* 13.

⁹ Cook, R.T. (1998). *Alcohol abuse, alcoholism, and damage to the immune system — A review. Alcoholism: Clinical and Experimental Research* 22: 1927–42.

¹⁰ York, J.L., & Hirsch, J.A. (1997). Association between blood pressure and lifetime drinking patterns in moderate drinkers. *Journal of Studies on Alcohol* 58: 480–5.

¹¹ Felson, D.T., Kiel, D.P., Anderson, J.J., & Kannel, W.B. (1988). Alcohol consumption and hip fractures: The Framingham Study. *American Journal of Epidemiology* 128: 1102–10.

country. Alcohol use also is associated with homicide, suicides, and drowning - the other three leading causes of death among our nation's youth.

Violence and Crime

- **Crime and violence are clearly related to alcohol and other drug abuse. Each year in this country, there are about 1.1 million arrests for illicit drug law violations, 1.4 million arrests for driving under the influence, 480,000 arrests for liquor law violations, and 704,000 arrests for drunkenness. The total of these alcohol and other drug arrests annually account for over one-third of all arrests in this country.¹²**
- **The impaired judgment and violence induced by alcohol contribute to alcohol-related crime. Rapes, fights, and assaults leading to injury, manslaughter, and homicide often are linked with alcohol because the perpetrator, the victim, or both were drinking. The total annual economic costs of ATOD-related crime are over \$60 billion.¹³**
- **Alcohol is a key factor in up to 68% of manslaughters, 62% of assaults, 54% of murders/attempted murders, 48% of robberies, and 44% of burglaries.¹⁴**
- **Over 60% of men and 50% of women arrested for property crimes (Burglary, larceny, robbery), who are voluntarily tested, test positive for illicit drug use.**
- **In 1987, 64% of all reported child abuse and neglect cases in New York City were associated with parental alcohol and other drug abuse.¹⁵**

ATOD-Related Problems in the Workplace

- **Workplace ATOD-related problems cost U.S. companies over \$100 billion each year.¹⁶ Employees who abuse alcohol and other drugs are: far less productive,**

¹² U.S. Department of Justice, Bureau of Justice Statistics (1992). *Drugs, Crime, and the Justice System: A National Report*. Washington, DC.

¹³ Institute for Health Policy, Brandeis University (1993). *Substance Abuse: The Nation's Number One Health problem: Key Indicators for Policy*. The Robert Wood Johnson Foundation.

¹⁴ U.S. Department of Health and Human Services, National Institute on Alcohol Abuse and Alcoholism (1987). *Alcohol and Health: Sixth Special Report to Congress on Alcohol and Health from the Secretary of Health and Human Services*.

¹⁵ Chasnoff, I.J. (1988). *Drugs, Alcohol, Pregnancy and Parenting*. Northwestern University Medical School, Department of Pediatrics and Psychiatry and Behavioral Sciences. Hingham, MA, Kluwer Academic Publishers.

¹⁶ U.S. Department of Labor (1992). *Working Partners: Confronting Substance Abuse in Small Business*. National Conference Proceedings Report.

use up to three times as many sick days, are more likely to injure themselves or others, and are five times more likely to file workman's compensation claims.^{17,18}

- **Up to 40% of industrial fatalities can be linked to alcohol consumption and alcoholism.**
- **Approximately 70% of illicit drug users are currently employed.¹⁹**

V. Nature and Extent of ATOD Problems - Illinois.

IDHS/DASA has conducted a series of CSAT-funded needs assessment studies that document the severity of the impacts of substance abuse within Illinois. The following are some of the findings from these studies.

Mortality²⁰

- **Over 5,500 deaths among Illinois residents each year, over 5% of all deaths, are directly or indirectly related to the use of alcohol and other drugs.**
- **From 9,000 to 10,000 Illinois residents die each year from accidental injuries. About 40% of these deaths are related to the use of alcohol.**
- **Each year, about 18,000 Illinois residents die from conditions that are related to the use of tobacco products. These tobacco-related deaths account for about 17% of annual total deaths among Illinois residents.**
- **The annual Illinois statewide economic costs associated with alcohol, other drug, and tobacco-related mortality is in excess of \$3.5 billion.**

¹⁷ U.S. Department of Labor (1991). *What Works: Workplaces without Drugs*.

¹⁸ National Council on Alcoholism and Drug Dependence, Inc. (May 1992). *NCADD Fact Sheet: Alcohol and Other Drugs in the Workplace*.

¹⁹ U.S. Department of Health and Human Services, National Institute on Drug Abuse (1991). *National Household Survey on Drug Abuse*.

²⁰ Illinois Department of Alcoholism and Substance Abuse. *Illinois Indicators of Alcohol, Tobacco and Other Drug Abuse: Comparisons, Consequences, Risk Factors (1996)*. DASA Needs Assessment Series Report 96-001.

Health Care²¹

- Nearly 10% of discharges from Illinois general hospitals each year involve diagnoses that are either 100% attributable to, or are related to the use of alcohol. These alcohol-involved hospital discharges have total annual charges in excess of \$1 billion.
- Each year about 40,000 discharges from Illinois general hospitals involve diagnoses that are 100% attributable to other drug use, with total annual charges in excess of \$300 million.
- Medicaid is substantially over represented as the reimbursement source for Illinois general hospital alcohol and other drug-involved discharges.
- While the estimated economic health care impacts of alcohol and other drug abuse as determined from review of diagnostic records are substantial, the actual costs are much higher due to under diagnosis. For example, although research indicates that 75% of cancers of the esophagus are attributable to alcohol use, less than 5% of discharges from Illinois general hospitals that have esophageal cancer diagnoses also have alcohol-specific diagnoses.
- Each year about 10% of discharges from Illinois general hospitals involve conditions related to the use of tobacco products with total annual charges in excess of \$2 billion.

VI. Need for ATOD Treatment Services in Illinois.

Documentation of the need for substance abuse treatment in Illinois is provided from the findings of several CSAT-funded studies conducted by IDHS/DASA.

Illinois Adult Household Surveys. IDHS/DASA conducted CSAT-supported surveys of the Illinois adult population in 1990, 1994, and 1998 to measure alcohol, tobacco, and other drug use.^{22, 23, 24} Stratified random samples of 4,897, 4,644, and 8,282 were

²¹ Illinois Department of Human Services, Division of Alcoholism and Substance Abuse (1996). *Illinois Hospital Discharges with Alcohol, Tobacco, and Other Drug Abuse-Related Conditions during 1993*.

²² Johnson, T.P., & Barrett, M.E. (1992). *Substance Use in the Adult Population of Illinois: 1990*. Chicago: Illinois Department of Alcoholism and Substance Abuse.

²³ Bruni, M., & Gillespie, S. (1996). *Illinois household survey on alcohol, tobacco, and other drug abuse, 1994: Prevalence and need for treatment*. Chicago: Division of Alcoholism and Substance Abuse.

interviewed by telephone in those years, respectively. Using the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)* criteria²⁵ for diagnoses of substance abuse and dependence, 9% of the 1994 sample was found to be in need of alcohol or drug treatment, with 15% of men and 3.6 percent of women needing treatment services. Of the respondents with a positive diagnosis of substance abuse, a majority (90%) needed treatment only for alcohol abuse, less than 5% needed treatment for drug problems only, and 6% required treatment services for both alcohol and drug abuse.

Preliminary estimates from the Illinois Household Study of adults aged 16 and above completed in late August of 2003 indicate a current adult treatment need for the past year of 16.4%. Preliminary estimates from this survey are found in the below table.

Percentage of Respondents Meeting DSM-IV Criteria for Substance Abuse/Dependence

Demographics	Alcohol Problem	Drug Problem	Alcohol or Drug
Total	15.5%	3.1%	16.4%
Regions			
Chicago	16.1%	4.0%	17.6%
Suburban Cook	12.9%	2.0%	13.2%
Northwest Illinois	16.6%	1.4%	17.1%
South Collar Counties	18.8%	2.4%	19.2%
North Collar Counties	16.4%	3.5%	17.3%
West Central Illinois	16.2%	3.6%	17.8%
East Central Illinois	16.5%	3.6%	16.9%
Southern Illinois	14.3%	2.2%	14.3%

Illinois Population-Specific Prevalence Studies. IDHS/DASA has conducted several CSAT-funded needs assessment studies that estimate prevalence of need for substance abuse treatment within selected population groups. Each of these studies used DSM-III-R criteria in estimating prevalence of need for treatment.

- **Arrestees.** To examine the substance use patterns and treatment needs of adults coming into contact with the criminal justice system in Illinois, IDHS/DASA conducted a study that involved interviews conducted with 993 arrestees in 1995.²⁶ Approximately 43% of the male and 59% of the female arrestees met the

²⁴ Cho, Y.I., Johnson, T.P., & Pickup, L. (2000). *Illinois Household Survey on Alcohol, Tobacco, and Other Drug Use, 1998*. Chicago: Illinois Division of Alcoholism and Substance Abuse.

²⁵ American Psychological Association (APA) (1987). *Diagnostic and Statistical Manual of Mental Disorders* (3rd edition, revised). Washington, DC: Author.

²⁶ Swartz, J.A. (1996). *Results of the 1995 Illinois Drug Use Forecasting Study*. Chicago: Illinois Criminal Justice Information Authority.

DSM-III-R dependency criteria for any drug, with 45% of all the subjects classified as being drug dependent at some time in their lives.

- Probationers. An IDHS/DASA CSAT-funded needs assessment study involved a sample of 627 Illinois adult probationers who were interviewed to assess prevalence of alcohol and other drug use and substance treatment needs in 1999 and 2000.²⁷ Approximately 43% of interviewed Illinois probationers were diagnosed as being in need of alcohol or drug treatment in the preceding 12 months.**
- Inmates. Another IDHS/DASA CSAT-funded needs assessment study focused on a population at another level of the criminal justice system. This study involved a sample of 630 inmates entering the State of Illinois correctional system at four sites during 1994. Based on DSM-III-R criteria for alcohol and drug abuse/dependence, 55.8% of male and 62.2% of female inmates were diagnosed as being in need of alcohol or drug treatment at some point in their lives.**
- Homeless Persons. Other IDHS/DASA CSAT-funded studies have developed prevalence of treatment need among non-criminal justice populations. During October and early November 1990, 481 randomly selected homeless adults were interviewed at 36 facilities serving homeless persons in Cook County.²⁸ A total of 43.3% of the homeless interviewed were classified as being in need of treatment for alcohol or drug abuse.**
- Mental Health Clients. Three hundred (300) inpatient and 302 outpatient clients of service providers funded by the Illinois Department of Human Services, Office of Mental Health (IDHS/OMH) were interviewed between June 1999 and February 2000.²⁹ Over half of inpatients (55.6%) and slightly less than half of outpatients (48.4%) interviewed had alcohol or other drug treatment need.**
- Medicaid Recipients. In an effort to more precisely identify patterns of alcohol and other drug use among the Illinois Medicaid population and associated treatment needs, 1,382 Medicaid recipients were interviewed between January**

²⁷Lurigio, A. et al. (2000). *Alcohol, Tobacco, and Other Drug Use among Adult Probationers in Illinois: Prevalence and Treatment Need, 2000*. Chicago: Illinois Division of Alcoholism and Substance Abuse.

²⁸ Johnson, T.P., & Barrett, M.E. (1991). *Homelessness and substance use in Cook County*. Chicago: Survey Research Laboratory, University of Illinois at Chicago.

²⁹ Cho, Y.I., Johnson, T.P., Hart, H., Kelly-Wilson, L., & Pickup, L. (2000, September). *Alcohol, Tobacco, and Other Drug Use among Illinois Office of Mental Health Clients: Prevalence and Treatment Need, 2000*. Chicago: Illinois Division of Alcoholism and Substance Abuse.

1998 and June 1999.³⁰ Compared to the 1994 Illinois household survey, lifetime prevalence rates among Medicaid recipients were higher in all substance use categories except alcohol. Twelve percent (12%) of respondents were found to be in need of treatment, which was 3 percentage points higher than was found in the general household sample in 1994. Copies of these studies can be found at <http://www.srl.uic.edu/publist/oasa/oasa.htm> .

VII. State of Illinois Current Resources and Continuum of Care

IDHS/DASA administers and supports a statewide comprehensive community-based specialty system of Illinois substance abuse treatment provider organizations. These organizations collectively provide services that are representative of a broad continuum of care. State of Illinois publicly funded substance abuse treatment services are licensed, funded, administered, and monitored through IDHS/DASA. As the Illinois SSA for alcohol and drug services IDHS/DASA is responsible for coordinating the efforts of all state programs dealing with problems associated with substance abuse.

The Illinois Continuum of Care

The Illinois publicly funded substance abuse treatment system is designed to provide a community-based network of services for screening, assessment, intervention, and the referral and treatment of individuals with diagnosed substance abuse and dependency conditions. The Illinois system offers a broad range of treatment alternatives to address the needs of referred clients. Selected Illinois system funding modalities of relevance to this application are briefly described below. The Illinois continuum of care also includes halfway house and recovery home services. The level designations associated with the below service categories reflect those contained in the American Society of Addiction Medicine *Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised* (ASAM PPC-2R)³¹ which all IDHS/DASA licensed providers are required to use in formulating all admission, continuing stay, and discharge decisions.

- *Case Management* - Substance abuse case management augments clinical services provided to patients, through the provision, coordination, or arrangement of ancillary services designed to support a specific patient's substance abuse treatment with the goal of improving clinical outcomes.

³⁰ Cho, Y.I., Johnson, T.P., Farrar, I.C., & Pickup, L. (2000, April). *Alcohol, Tobacco, and Other Drug Use by Medicaid Recipients in Illinois: Assessment of Treatment Need*. Chicago: Illinois Division of Alcoholism and Substance Abuse.

³¹ American Society of Addiction Medicine (ASAM) (2001). *Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition Revised (PPC-2R)*. Chevy Chase, MD: ASAM.

- ***Community Intervention*** - Services are provided within the community rather than within the treatment setting and include crisis intervention and case finding to identify individuals in need of specialized services.
- ***Level 0.5 Early Intervention (EI)*** - Services are early treatment and are designed to explore and address problems factors that appear to be related to substance use and/or to assist individuals in recognizing the harmful consequences or inappropriate substance use.
- ***Level I Outpatient (OP)*** - Non-residential substance abuse treatment consisting of face-to-face clinical services for adults or adolescents. The frequency and intensity of such treatment shall depend on patient need but shall be a planned regimen of regularly scheduled sessions that average less than nine hours per week. Outpatient methadone and other pharmacological opioid management services are included in this modality.
- ***Level II Intensive Outpatient (OR)*** - Non-residential substance abuse treatment consisting of face-to face clinical services for adults or adolescents. The frequency and intensity of such treatment shall depend on patient need but shall be a planned regimen of scheduled sessions for a minimum of nine hours per week.
- ***Level III.2 Detoxification (DX)*** - Detoxification consists of the process of withdrawing a person from a specific psychoactive substance in a safe and effective manner and using face to face clinical services to engage the individual in additional treatment services.
- ***Level III.5 Residential Rehabilitation (RR)*** - Residential substance abuse treatment consisting of clinical services for adults or adolescents. The frequency and intensity of such treatment shall depend on patient need but shall, except in residential extended care, include a planned regimen of clinical services for a minimum of 25 hours per week. Inpatient care, with the exception of residential extended care (as defined in 2060), requires staff who are on duty be awake 24 hours per day, seven days per week.

Major Funding Streams

The table below provides information in regard to State of Illinois alcohol and drug service expenditures for state fiscal years 2000 and 2001 by major revenue sources. These revenue source totals include, with the exception of Medicaid, funds in support of prevention services. It can be seen that the major source of revenue in support of Illinois alcohol and drug services is state general revenue funds, and that there was an over 15% increase in funds from this source from FY2000 to FY2001. State general funds represented 48.6% of combined funds for these two fiscal years. There was a 16.5% increase in Medicaid funds from FY2000 to FY2001.

Summary of Illinois Alcohol and Drug Service Expenditures by Revenue Source: FY2000 and FY2001		
Revenue Source	FY2000	FY2001
State General Revenue Funds	\$100,133,193	\$115,324,054
Other State Funds (e.g. Youth Alcoholism and Substance Abuse Prevention Fund, Drunk and Drugged Driving Prevention Fund, Drug Treatment Fund, Youth Drug Abuse Prevention Fund, and Local Funds)	\$4,551,914	\$5,805,182
SAPT Block Grant Funds	\$61,143,781	\$63,976,687
Other Federal Funds (CSAT categorical, CSAT Needs Assessment and Demonstration Grants)	\$10,101,049	\$9,451,718
Medicaid Funds	\$33,424,192	\$38,942,730
TOTAL	\$209,354,129	\$233,500,371

Provider Regional Networks

The treatment provider organizations that are licensed and funded by IDHS/DASA are located throughout the State of Illinois. Primarily for planning purposes, provider organizations are grouped according to 20 regional networks that consist of 3 groupings of Cook County's 31 suburban townships, 3 groupings of the City of Chicago's 77 community areas, and 14 groupings of the remaining 101 Illinois counties. Networks 3, 4 and 5 consist of groupings of the 77 City of Chicago community areas. Networks 6, 7 and 8 consist respectively of groupings of Cook County suburban northern, western, and southern townships that surround the City of Chicago and make up the remainder of Cook County.

Counselor Certification

The Illinois Alcohol and Other Drug Abuse Professional Certification Associations, Inc. (IAODAPCA), a private board, grants counselor certification in Illinois. IAODAPCA is a member of the International Certification Reciprocity Consortium (ICRC) and has been in existence since 1991. The 1996 amendments to 2060 require counselors working in all Illinois licensed alcohol and drug treatment programs to be certified, unless licensed by another discipline such as licensed social workers. Uncertified counselors may be hired, but they must attain certification within 2 years of the date of hire. Certification is based on counselor competency and a combination of supervised work experience and/or training, and passing a written examination. There are six classifications and four levels of counselor certification available. Maintenance of certification is in part based on meeting a continuing education requirement. To-date, IAODAPCA has certified over 6,200 counseling professionals. The majority of these certified counselors are currently employed in the Illinois publicly-funded system.

Training and Technical Assistance

IDHS/DASA regularly provides or sponsors training and technical assistance activities for alcohol and drug program staff and other interested parties. Needs in this area are assessed primarily on the basis of legislative developments, program requests and identification of needs, drug use trends, contractual and licensure requirements, joint agency projects, site visit reviews, and implementation of best practice models. IDHS/DASA training activities are approved for continuing education credits. The following are examples of recent IDHS/DASA training and technical assistance activities. The Illinois MISA Institute, established through a FY1999 funding initiative, has trained over 500 professionals in MISA basic skills, psychopharmacology, and integrated treatment processes. IDHS/DASA, in partnership with GLATTC, is working on building a consortium of academic institutions, state agencies, and treatment organizations in Illinois, Ohio, and Wisconsin to improve the practice standards of alcohol and drug abuse treatment professionals. The FY2000 IDHS/DASA Youth Initiative included the provision of two major training events for youth treatment providers. Several regional ASAM PPC-2R trainings were held by IDHS/DASA during 2001. Trainings on Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates have also been provided.

Illinois Service Planning, Funding and Administrative Functions

It was noted above that State of Illinois publicly funded substance abuse treatment services are licensed, funded, administered, and monitored through the Illinois Department of Human Services, Division of Alcoholism and Substance Abuse (IDHS/DASA). Key among IDHS/DASA responsibilities are the following: 1) Design, coordinate, license, fund and monitor community-based services throughout the state for the treatment of addictive disorders; 2) Coordinate a statewide strategy among state agencies for the prevention, intervention, treatment and rehabilitation of alcohol and other drug abuse and dependency; 3) Establish policy related to substance abuse treatment; 4) Promulgate regulations to provide appropriate standards for publicly and privately funded programs as well as for levels of payments to government funded programs providing alcohol and other drug abuse treatment services; 5) Provide information to the general public regarding addictions, including public awareness campaigns on gambling and substance abuse; 6) Promote, conduct, assist or sponsor basic clinical epidemiological and statistical research into alcoholism and other drug abuse and dependency; and 7) Coordinate the annual preparation and submission of the department's application for Substance Abuse Prevention and Treatment Block Grant award.

***Fiscal Management-* IDHS/DASA and the DHS Office of the Budget (DHS/OB) share responsibility for substance abuse intervention and treatment budgeting. The Illinois Office of the State Comptroller is responsible for issuing and maintaining State-level fiscal policy and for recording SAPT Block Grant obligations and expenditures in the Statewide Accounting and Management System. The IDHS Office of Fiscal Services (IDHS/OFS) is responsible for issuing and maintaining department-level fiscal policy. IDHS/DASA is responsible for procuring program services. Disbursements to**

providers require approval from the IDHS Office of Clinical Administrative and Program Support (IDHS/OCAPS), IDHS/DASA, and IDHS/OFS. IDHS/OSC is responsible for issuing checks to providers. IDHS/OCAPS is responsible for recording SAPT Block Grant obligations and expenditures through the IDHS Consolidated Accounting and Reporting System (CARS). The IDHS Office of Contract Administration and the IDHS/DASA Bureau of Management Operations share responsibility for ensuring compliance with SAPT Block Grant fiscal issues. The Illinois Office of the Auditor General is responsible for performing the Single State Audit.

Procurement Management - Illinois alcohol and other drug treatment fund allocation decisions made by the IDHS/DASA Associate Director are based on SAPT Block Grant requirements, consultation with other management staff, service priorities, and historical patterns of contract/grant funding. The IDHS Secretary, General Counsel, and Budget Manager must sign off on all contracts over \$250,000. Funds are distributed to service provider organizations through grants-in-aid and fee-for-service contracts. During FY2003, IDHS/DASA contracted with 154 provider organizations, which includes 14 Medicaid-only providers. When additional funds do become available, IDHS/DASA management staff utilize needs assessment study findings and related information and data in making allocation decisions. IDHS/DASA management staff either approach specific providers in regard to targeted geographic areas or client populations, or issue a call for proposals from interested providers for development of identified program and service expansion. For example, in FY2001 an additional \$9 million in state general revenue funds were granted to IDHS/DASA for new programming, called initiative programs. These initiatives included: services for medically indigent males who do not qualify for Medicaid; enhanced services for adolescents involved in the criminal justice system; and, expanded services for women recently released from correctional facilities.

Provider Contracts Management - Contracts issued through IDHS/DASA specify that all individuals who receive fund-supported services must meet established income eligibility requirements. There is no Illinois law that stipulates that either federal or state funds should be spent first. IDHS/DASA contracts specify that "...the provider shall utilize funding from IDHS/DASA as the payer of last resort."

Program Licensure/Accreditation - IDHS/DASA licensure regulations are stated in the Illinois Administrative Code Title 77, Chapter X, Subchapter d, Part 2060 (hereinafter referred to as "2060"). All Illinois programs engaged in alcohol and drug treatment that receive public funds are required to be licensed. Monitoring site reviews of licensed programs are conducted periodically, and in the case of any issued complaints or indicated questions. Regulations specific to written program policies and procedures, professional staff qualifications and supervision, client management and service delivery, service documentation and reporting, physical facilities, and life safety are included in 2060.

Assessment and Utilization Management - IDHS/DASA licensed providers are required by 2060 to apply ASAM PPC-2R criteria in formulating all admission, continuing stay, and discharge decisions. Licensed provider organizations may choose their own

assessment tools and procedures, as long as they yield the information needed to apply ASAM PPC-2R criteria and the data required for submission through the Office's Automated Reporting and Tracking System (DARTS). Regulations in 2060 mandate regular assessment of the appropriateness and clinical necessity of client admissions, continuing stay decisions, and discharges.

Admission Priorities - Consistent with SAPT Block Grant regulations and Illinois state policies, IDHS/DASA funding contracts specify that the following client populations shall be given priority consideration for available treatment resources: pregnant injecting drug users, pregnant and post-partum women, injecting drug abusers (who are at high risk for HIV infection) and known HIV-infected persons, persons eligible for Temporary Assistance for Needy Families (TANF), Illinois Department of Children and Family Services (DCFS) referrals, other women and children, and specific criminal justice system referrals.

IDHS/DASA Cost Modalities - The table below provides IDHS/DASA established FY2003 rates that are used to reimburse or calculate earnings for major cost modalities.

IDHS/DASA FY2004 Service Reimbursement Rates			
Service	Unit of Service	Code	Rate
Level I (Individual)	Quarter Hour	OP	\$58.56 - per hour \$14.64 - per quarter hour
Level I (Group)	Quarter Hour	OP	\$22.12 - per hour \$5.53 - per quarter hour
Level II (Individual)	Quarter Hour	OR	\$58.56 - per hour \$14.64 - per quarter hour
Level II (Group)	Quarter Hour	OP OR	\$22.12 - per hour \$5.53 - per quarter hour
Level III.1	Daily	HH	\$62.97
Level III (Detoxification)	Daily	DX	Provider Specific
Level III.5	Daily	RR	Provider Specific
Sanctuary	Daily	SN	\$45.29
Recovery Home - Adult	Daily	RH	\$45.29
Recovery Home - Adolescent	Daily	RH	\$115.0
Case Management	Quarter Hour	CM	\$45.32 - per hour \$11.33 - per quarter hour
Psychiatric/Diagnostic	Per Encounter/Day	-	\$76.64
Opioid Maintenance Therapy	Weekly	OP	\$82.86 (< 105 patients) \$66.29 (> 104 patients)

IDHS/DASA FY2004 Service Reimbursement Rates

Service	Unit of Service	Code	Rate
Early Intervention (Individual)	Quarter Hour	EI	\$58.56 - per hour \$14.64 - per quarter hour
Early Intervention (Group)	Hourly	EI	\$22.12 - per hour \$5.53 - per quarter hour
Community Intervention	Hourly	CHI	\$44.20 - per staff hour \$5.53 - per quarter hour
Child Domiciliary Support	Daily	CRD	\$47.29
Toxicology	Per Test	TOX	As specified in exhibit
HIV Counseling and Testing -Direct Service	Quarter Hour	HVD	\$58.56 - per hour \$14.64 - per quarter hour
HIV Counseling and Testing -Indirect Service	Quarter Hour	HVI	\$45.32 - per hour \$11.33 - per quarter hour

IDHS/DASA Average Costs per Episode - The below table provides results from a calculation of Illinois per served individual costs for major service modalities based on FY2002 service and funding data. This data includes both adults and youth. Current Illinois modality individual average costs compare quite favorably to comparable modality cost bands disseminated by CSAT.

Illinois FY2002 Average Individual Costs by Service Modality - Adult Clients					
Modality	Individuals	Medicaid Costs	Contract Costs	Total Costs	Episode Average
Early Intervention	23,031	0	3,424,758	3,424,758	\$148.70
Case Management	14,997	0	6,545,707	6,545,707	\$436.40
Level I (OP)	41,644	3,182,919	14,484,582	17,667,501	\$424.25
Level I (OP-Meth)	8,383	0	20,426,088	20,426,088	\$2,436.60
Level II (OR)	11,270	2,542,865	9,687,375	12,230,240	\$1,085.20
Level III.2 (DX)	14,015	1,230,103	18,966,223	20,196,426	\$1,441.05
Level III.5 (RR)	12,900	28,232,548	45,291,972	73,524,520	\$5,699.60
Res. Aftercare (SN,HH,RH)	16,038	9,690,017	51,135,717	60,825,734	\$3,792.60

VIII. "Gap in Services"

Extent to which Resources are Insufficient to Meet Need.

Evidence of the extent to which current Illinois publicly-funded substance abuse treatment resources are insufficient to meet the need for these services can be obtained through comparison of the level of currently provided services with prevalence of need estimates presented earlier in this section. Since the majority of IDHS/DASA needs assessment studies have focused on adult populations, this gap analysis likewise focuses on adults. As part of its monitoring and planning activities, IDHS/DASA develops a data book that summarizes client service data reported via the Office's Automated Reporting and Tracking System (DARTS). All provider organizations that have a funding contract with IDHS/DASA and/or are Medicaid-certified to deliver substance abuse treatment and/or intervention services are mandated to report through DARTS. This system includes the full federal Treatment Episode Data Set (TEDS).

The IDHS/DASA FY2002 Data Book provides a snapshot of the types and levels of publicly funded substance abuse intervention and treatment services provided in Illinois during this twelve-month period, and the individuals to whom these services were provided. The below table from this most recent databook provides a duplicated count of adults served in the Illinois publicly-funded system during State Fiscal Year 2002 by cost modality. Totals do not sum due to coding errors and differences with which individuals are represented across service modalities. In considering the below table it should be noted that this data is to some extent reflects a duplicated client count. The duplicated client count results from data being reported as the total number of services, by modality, that were provided to clients within a treatment episode regardless of the fiscal year during which they first entered treatment. A treatment episode refers to the period of service(s) between the beginning of treatment services for a drug or alcohol problem, and the termination or discharge from those services. In the below the count of persons within modality is an unduplicated count, but a single individual may be represented in multiple modalities, yielding a duplicated count when modality are summed to yield the 119,300 total. For example, during a single treatment episode, an individual client might receive services in the detoxification, residential, outpatient and case management modalities. Such a client would be represented four times in the service data provided below. The race/ethnic breakdown of served clients during FY2002 was: White, non-Hispanic/Latino - 43.7%; African American - 43.4%; Hispanic/Latino - 9.8%; Other - 3.1%

FY2002 Duplicated Count of Clients by Illinois Cost Modality								
	Total	DX	OP	OR	RR	RA	CM	EI
Total	119,300	18,134	41,668	11,544	12,993	4,034	14,297	16,630
Male	79,867	12,492	28,239	6,766	7,086	2,678	11,097	11,509
Female	39,433	5,642	13,429	4,778	5,907	1,356	3,200	5,121

Presenting service data in the above manner is necessary to provide a description of the total levels and types of services provided by the Illinois system. However, a duplicated count has some limitations in assessing need for services since prevalence estimates are generally produced as individuals. Thus, a duplicated count will yield an overestimate of the extent to which current resources meet assessed need for services. A separate analysis was run which determined that 76,435 unduplicated individuals are represented in the combined intervention and treatment services that were provided through the Illinois system during FY2002. The number of unduplicated individuals provided services through the publicly funded Illinois system has remained fairly constant over the past few years. The assessment of need provided earlier in this section concluded that an estimated 975,000 adult Illinois residents are in need of alcohol and drug treatment. Applying the number of individuals served during FY2002, this yields a penetration rate of 7.8% for that 12-month period. IDHS/DASA State Plans have consistently included a stated goal that a service system that is capable of at least a 15% annual penetration rate into the population in need is required to be optimally responsive to the alcohol and other drug service needs of Illinois residents. On this basis, there is a concluded need that the service capacity of current Illinois system resources needs to be nearly doubled.

It is also worth noting results from another CSAT-funded needs assessment that applied a multiple capture-recapture probability model to DARTS data with the purpose of estimating the number of Illinois residents who are "susceptible" to admission to the State's publicly funded treatment system.³² This study concluded that there are approximately 750,000 Illinois residents who fit this categorical description. This estimate, which was derived from a methodology quite different from those used in other Illinois prevalence studies, is nevertheless quite comparable. The somewhat lower estimate derived from this study can be attributed to the primary focus on individuals who would be likely to make use of the publicly-funded system. An updated replication of this study may well yield a higher prevalence estimate given the decreased availability of private alcohol and drug treatment services in Illinois. Another aspect of this prevalence study is that it included prevalence estimates by IDHS/DASA regional network.

IDHS/DASA Waiting List - Evidence of the extent to which current Illinois resources are insufficient to meet the demand for treatment is also provided from provider organization waiting list that is maintained by IDHS/DASA. Each IDHS/DASA funded provider is required to report on a daily basis, the number and characteristics of assessed individuals who are waiting for an available treatment opening, by service modality. This information is reported through the IDHS/DASA Internet-linked Capacity Management System. As an example of current demand for services, on June 11, 2003, a total of 712 individuals were on treatment wait lists maintained by Illinois providers.

³² Illinois Department of Human Services, Division of Disability and Behavioral Services, Division of Alcoholism and Substance Abuse (IDHS/DASA) (1996). *Illinois Alcohol and Other Drug Abuse Prevalence Estimation Study*.

IX. Illinois ATOD Service System-shaping Factors.

The development of a meaningful and potentially effective Illinois State Plan for ATOD prevention and treatment services cannot be accomplished without identification and assessment of the various external factors that serve to influence and shape this system.

ATOD-related Federal Agencies. An assessment of these external factors must begin with discussion of the several federal government agencies that significantly impact both the structure of state and local level ATOD service systems, and the funding support made available to these systems.

- *Center for Substance Abuse Prevention* - The Office for Substance Abuse Prevention (OSAP) was created through the federal Anti-Drug Abuse Act of 1986. In 1992, the Center for Substance Abuse Prevention (CSAP) was established as the successor to OSAP as one of three centers within the new Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services. *CSAP's Mission is to provide national leadership in the federal effort to prevent alcohol, tobacco, and illicit drug problems.*

In 1987, OSAP assumed responsibility for the National Clearinghouse for Alcohol and Drug Information (NCADI). This clearinghouse maintains copies of numerous documents developed through various federal substance abuse agencies. During this same year, OSAP funded 130 *High Risk Youth* grants in 42 states. In 1989, OSAP funded 20 demonstration grants for *Pregnant and Postpartum Women and Their Infants* in 14 states. During the following year, OSAP funded the first set of five year grants in its *Community Partnership Demonstration Program*.

In 1993, the *Division of Workplace Programs* was transferred to CSAP, and new enabling legislation assigned the Center with responsibility for monitoring State prevention plans within the SAPT Block Grant program. The Office of Managed Care was established within CSAP in 1996 to develop and coordinate new initiatives and integrate prevention programs and related behavioral health activities into managed care systems.

- *Center for Substance Abuse Treatment* - The Center for Substance Abuse Treatment (CSAT) was created in 1992 with CSAP and the Center for Mental Health Services as the three centers within SAMSHA. CSAT has the congressional mandate to expand the availability of effective treatment and recovery services for alcohol and drug problems. CSAT initiatives are structured around the philosophy that for most individuals, substance abuse treatment and recovery services are most effectively provided through a community-based, coordinated system of comprehensive services. CSAT initiatives are designed to support the nation's substance abuse treatment effort to provide specific services, evaluate treatment effectiveness, and utilize evaluation results to enhance treatment and recovery approaches.

CSAT administers the SAPT Block Grant which is the primary tool used by the Federal Government to support State substance abuse prevention and treatment programs. While the SAPT Block Grant provides Federal support to addiction prevention and treatment services nationally, the program is designed to empower States to develop local solutions to experienced addiction-related problems. The SAPT Block Grant program, and its importance to Illinois are described below.

The *State Systems Development Program* (SSDP) is administered through CSAT as a coordinated strategy to assist the State in developing and managing ATOD abuse treatment services that will meet SAPT funding requirements, increase the level of federal and State accountability for programs funded, and improve the quality of the services provided. Included among the SSDP components is the *Statewide Needs Assessment Program*. Illinois was among the first 13 States that received funding under this SSDP component. Results of Illinois' family of CSAT-funded needs assessment studies are provided later in this document. CSAT's *Treatment Improvement Protocols (TIPS)* which are state-of-the-art protocols for the treatment of ATOD abuse and dependence represent a second SSDP component.

CSAT also has funded or funds a range of substance abuse demonstration and discretionary programs, to include the following: *Target Cities Program; Critical Populations Program; Criminal Justice Programs; Programs for Women, Their Infants and Children; Treatment Outcome and Performance Pilot Studies (TOPPS); Treatment Capacity Expansion (TCE); Treatment Capacity Expansion and HIV Services (TCE/HIV)* and, *HIV/AIDS Outreach for Substance Abusers Programs*. Illinois has received several funding awards through these CSAT demonstration programs.

- *National Institute on Alcohol Abuse and Alcoholism* - The National Institute on Alcohol Abuse and Alcoholism (NIAAA) was created by the U.S. Congress in 1970 as one of 18 institutes that comprise the National Institutes of Health (NIH), the principal biomedical research agency of the Federal government. NIH is a component of the Public Health Service within the U.S. Department of Health and Human Services (DHHS). NIAAA supports and conducts biomedical and behavioral research on the causes, consequences, treatment, and prevention of alcoholism and alcohol-related problems.
- *National Institute on Drug Abuse* - The National Institute on Drug Abuse (NIDA) was established in 1974, and in 1992 became part of NIH as the Federal focal point for research, treatment, prevention and training services, and data collection on the nature and extent of drug abuse. NIDA's mission contains the following two major components: the strategic support and conduct of research across a broad range of disciplines; and, ensure the rapid and effective dissemination and use of the results of that research to significantly improve drug abuse and addiction prevention, treatment, and policy. NIDA presently

supports over 85 percent of the world's research on the health aspects of drug abuse and addiction.

- ***Office of National Drug Control Policy*** - The Anti-Drug Abuse Act of 1988 (P.L. 100-690 as amended) established the Office of National Drug Control Policy (ONDCP) to set national drug control priorities and objectives, coordinate the activities of over 50 Federal drug control agencies, and prepare a consolidated Federal drug control budget. In 1994, the Violent Crime Control and Law Enforcement Act (P.L. 103-322) expanded ONDCP's responsibilities to include providing budget guidance to Federal drug control agencies and evaluating the effectiveness of Federal drug control activities.

ONDCP's authority to conduct performance evaluation is in its authorization language set out in 21 U.S.C. 1502 (b) and (d). These responsibilities and powers relate in part to coordinating and overseeing the implementation of the National Drug Control Strategy and conducting performance audits and evaluations of National Drug Control programs. Statutory language appearing at 21 U.S.C. 1504 (a) and (b) and 21 U.S.C. 1507 provides additional authority related to Strategy Goals and Objectives, assessments of Federal drug control efforts, and projections of priorities for supply reduction and demand reduction.

Legislative and Policy Influences

A range of legislative and policy related factors exert influence upon the structure and extent of State and local level ATOD service systems. Foremost among these influences is the legislation that determines the level of federal funding support allocated to these systems.

- ***SAPT Block Grant*** - As mentioned above, the Substance Abuse Prevention and Treatment (SAPT) Block Grant is the primary vehicle for transferring funds to the states for the purpose of addressing substance abuse problems. Each year, over \$1 billion in federal funds are allocated to States through the SAPT Block Grant Program. These funds are allocated directly to the States according to a formula legislated by Congress. States then distribute these funds within their jurisdictions based upon need. The SAPT Block Grant although relatively stable the last few years, has been targeted for budget cuts. Although the need for treatment across the nation far surpasses available resources, increases in the Block Grant have been minor. Block Grant funds are allocated to states based on a formula. In FY99 the formula was revised, decreasing the proportion of funds several states receive including, Illinois.

Since FY95, the Block Grant has functioned with an expired authorization. This is significant in that many of the provisions of the Block Grant require updating. The federal government and Congress are moving toward converting the SAPT Block Grant to a "Performance Partnership Grant" when the Block Grant is re-authorized. Under such a grant format, states would not only be required to provide services but also demonstrate the impacts of these services.

Of the SAPT Block Grant funds dispensed to each State annually, Congress has specified that 20 percent be allotted for prevention of alcohol, tobacco and other drug abuse. SAPT Block Grant "set asides" were established for programs targeting special populations, such as services for women, especially pregnant and postpartum women and their substances-exposed infants, and in certain States, for screening for exposure to the HIV.

The SAPT Block Grant also includes a "maintenance of effort" provision that requires States to maintain their current resources for substance abuse services, as well as for HIV and tuberculosis services to patients in substance abuse treatment. The consequence of not monitoring state funds is a dollar for dollar loss of federal funds.

***Welfare Reform* - One of the most significant public policy changes of the past decade was the passage of the *Personal Responsibility and Work Opportunity Reconciliation Act of 1996*. Also known as "Welfare Reform" this law replaced the former Aid for Dependent Children (AFDC) program with Temporary Assistance for Needy Families (TANF) on July 1, 1997. The intent of the Act is to move people off welfare and into work. With the passage of this legislation, welfare is no longer an entitlement, but includes a five-year life-time limit on benefits. It was intended that by the year 2002, 50 percent of the clients receiving welfare must be engaged in work or work-related activities. One other provision of welfare reform relates to the ineligibility of those convicted of drug felonies. In Illinois, this provision has been revised by State law to disallow persons convicted of drug-related felonies for two years if they are not in treatment or an aftercare program.**

Welfare Reform has driven the need to change how Illinois delivers human services to clients. Jobs must be created, people educated and trained for employment and barriers removed that prevent people from working. One such barrier is the use and abuse of alcohol and other drugs. National estimates indicate that at least 600,000 women receiving public assistance require treatment for alcohol and other drug-related problems, other national estimates indicate that as many as 1,000,000 women may need treatment. It can be safely assumed, that the need for treatment among the TANF population in Illinois is significant.

In addition, because adults will only be able to receive federal welfare assistance for a maximum of five years during their lifetime, Illinois must improve the ability of its residents to be economically self-sufficient. The alcoholism and substance abuse service system has been actively involved in the assessment of TANF and other welfare clients for many years. These activities have been increased through the Illinois' Welfare Pilot Projects, increased service capacity for TANF clients, and the joint training of DHS local office and DASA-funded treatment provider organization staff. The State has placed a great deal of emphasis on identifying and treating substance abuse among TANF clients. As this effort becomes more successful, increased capacity pressures on the

treatment system will occur. The end result, will be clients ability to gain and retain employment.

Synar Legislation - In July 1992, the U.S. Congress enacted the Alcohol, Drug Abuse and Mental Administration Reorganization Act (P.L. 103-321), which includes an amendment (Section 1926) aimed at decreasing access to tobacco products among individuals under 18 years of age. Named for its sponsor, Congressman Mike Synar of Oklahoma, the Synar Regulation requires States to enact and enforce laws prohibiting any manufacturer, retailer, or distributor from selling or distributing tobacco products to individuals under 18. The goal of the amendment is to reduce the number of successful illegal purchases by minors to no more than 20 percent in each State within a negotiated timeframe.

The Synar Regulation requires that each State annually conduct random, unannounced inspections of a sample of Tobacco vendors to assess their compliance with the State's access laws. Each State must submit an annual report to the Secretary of Health and Human Services describing that year's enforcement activities, the extent to which the State reduced availability of tobacco products to minors, and a strategy and timeframe for achieving and inspection failure rate of 20 percent or less of outlets accessible to minors. A noncompliant State may lose up to 40 percent of its Federal SAPT Block Grant funds.

The Illinois Liquor Control Commission (ILCC) was delegated responsibility for administration and monitoring of tobacco control efforts within Illinois. Previously a state-level cabinet agency, during 2003 the Commission was placed within the Illinois Department of Revenue. Consistent with IDHS/DASA's enabling legislation regarding collaboration with other State agencies, the Office participates with the Commission, the Illinois Department of Public Health (IDPH), and the Illinois State Police (ISP) on an Illinois tobacco control planning and oversight committee. As part of its tobacco control responsibilities, the Commission coordinates annual unannounced inspections of a sample of tobacco product vendors s mandated by the Synar Amendment. This annual vendor survey is designed and conducted in consultation with IDHS/DASA, and IDHS/DASA provides a report of each year's survey results as part of Illinois' annual SAPT Block Grant application. The results of this survey indicate that Illinois has made impressive progress in complying with Synar Amendment requirements.

In 1994, the first year of the annual tobacco vendor inspections, 67% of 493 selected Illinois vendors offered to sell tobacco products to the youth volunteers. This rate was consistent with research results that were reported at that time. For 1995, the "failure" rate decreased to 53% of inspected vendors. In 1996, the "failure" rate decreased again to 41% of the 550 vendors inspected. ILCC's 1997 annual vendor survey resulted in 26.1% of inspected vendors agreeing to sell to minors, and the recently completed 2003 statewide annual survey resulted in a "failure" rate of 16.5%. This "failure" rate from the most recent ILCC

statewide survey is below the 20% target rate for States, but was an increase from the "failure" rate of 13.9% obtained in the 2002 survey.

Government Performance and Results Act - More and more policy makers, funders and the general public not only want to know what services were provided, but what was the result of those services. At all levels information on outcomes is sought. At the federal level, the Government Performance and Results Act of 1993 (GPRA) was enacted to increase the focus on the results from government programs and activities. GPRA requires that DHHS plan, budget, and be accountable for the results of programs that the Department administers and funds. The intent of the Act is to improve program performance by considering performance information in decision-making and by involving a range of stakeholder groups. DHHS's implementation of GPRA is based upon a performance-based approach. GPRA strives to answer these important questions:

- What are Americans getting from the money spent?
- What are federal programs and organizations trying to achieve?
- How can the effectiveness of these activities be determined?

As a result of GPRA, States are being asked for substantial amounts of information through the SAPT Block Grant. GPRA is the driving force for converting the Block Grant into a performance partnership grant. At the state level, the need for this information is just as great. Public Act 86-1415 requires the Illinois Comptroller to define financial reporting requirements for Illinois State Agencies. Annually, the Service Efforts and Accomplishments (SEA) Report is completed to provide information on the service efforts, costs, and accomplishments of the agency or its major programs and services.

Service outcome data collection requires a shift in thinking not only among those requiring the information, but among those collecting it. Appropriate steps must be taken to assure the accuracy and consistency of collected data. Outcomes monitoring systems also must be adapted or created to accept, manage, and process this data. This process of systems development often involves controversial and expensive steps. However, not taking these steps is fast becoming unacceptable. The steps being taken by Illinois to move in the direction of service outcome data-collection and reporting are discussed later in this plan.

Parity for Substance Abuse - Addiction to alcohol and other drugs is a disease, that not only effects the poor, but those with moderate and high incomes. In many cases those with no financial means have better access to treatment than those with moderate incomes and no or inadequate health care coverage. Health care coverage plans often lack sufficient reimbursement for substance abuse treatment. Although legislation has been introduced over the last few years to provide parity for ATOD treatment with other forms of health care treatment, there has not been enough support in Congress to create such a law. One of the major reasons for this lack of support are the costs associated with adequate

coverage of these services. However, studies are referenced in this Plan that document the substantial cost savings to society that are derived through ATOD treatment. The savings related to parity would far outweigh the costs of providing treatment. SAMSHA has released a report stating that parity for ATOD treatment would increase private insurance premiums by only 0.2%.

State Priorities

For many years, Illinois has focused its attention on clients who are involved in multiple human service systems. These clients tend to have complicated problems that are very expensive if untreated. In addition to the federal priorities of pregnant women, women with children and injecting drug users the State also focuses on the mentally ill, TANF clients and those involved with the criminal justice and DCFS systems. By focusing on these populations, admissions to state hospitals, jails and prisons can be reduced; rates of employment can be increased; and incidents of abuse and neglect of children can be reduced.

Prevention and early intervention, particularly for youth has simultaneously been a focus of the state. A strong prevention system, with the means to intervene early when problems occur, ultimately improves the quality of peoples lives, reducing the reliance on other state systems.

Focus on Professionalism - The State and Illinois' ATOD treatment system take their mission very seriously. In 1996, Illinois became the first State to require American Society for Addiction Medicine (ASAM) patient placement criteria as a requirement of licensure (Rule 2060). In doing so, it has attained a new level of professionalism by matching patients to particular levels of care based on a nationally recognized protocol. ASAM has moved the field from an “outdated” approach of serving patients through categorical programs to individualized treatment-matching. ASAM places clients based on the following six dimensions.

- Acute intoxication and/or Withdrawal Potential.
- Biomedical Conditions and Complications.
- Emotional/Behavioral Conditions and Complications.
- Treatment Acceptance/Resistance.
- Relapse Potential.
- Recovery environment.

At the same time Illinois ATOD treatment licensure was being changed to include ASAM, the rule was also amended to include professional standards for staff providing direct service to patients. All direct service staff must hold clinical certification as a Certified Alcohol and Drug Counselor from the Illinois Alcoholism and Other Drug Abuse Professional Certification Association (IAODAPCA); or be a licensed professional counselor or licensed clinical professional counselor pursuant to the Professional Counselor and Clinical Professional Counselor Licensing Act; or be a physician licensed to practice

medicine in all its branches pursuant to the Medical Practice Act of 1987; or be a licensed psychologist pursuant to the Clinical Psychology Practice Act; or be licensed as a social worker or licensed clinical social worker pursuant to the Clinical Social Work and Social Work Practice Act. This requirement will go a long way in assuring quality care of patients.

Increased Emphasis on Outcomes Monitoring - For the past several years, there has been mounting pressure on Single State Authorities (SSAs) to answer tough questions about the performance and effectiveness of treatment programs. To be specific, performance and outcome monitoring is being stressed by licensing and accrediting entities such as the Commission on Accreditation of Rehabilitation Facilities (CARF), the Rehabilitation Accreditation Commission, and the Joint Commission on Accreditation of Healthcare Organizations, among other groups. In addition, there has been a growing interest, on the part of the federal government, for data from the SSA's on program performance and client outcomes. GPRA and performance measurement systems being developed by ONDCP and the National Association of State Alcohol and Drug Abuse Agencies (NASADAD) further reflect the increased importance being placed on outcomes monitoring.

With the growing emphasis on the standardized collection of performance and outcome information, it is expected that efforts to measure program performance and client outcomes will expand beyond the individual, time-limited studies used in the past to large, on-going information systems involving most, if not all, of the providers in the publicly-funded treatment system. Illinois' experience with Target Chicago, the I-STOP study, and the CSAT-funded TOPPS II project have allowed our State to remain at the forefront of state-level program and client outcome evaluation.

X. Current State of ATOD-related Research.

A goal of the Illinois State Plan concerns improved transfer of findings from ATOD-related research to the design and delivery of ATOD prevention and treatment services. The steps to achieve this goal must begin with an assessment of major learning gained through ATOD research. Most ATOD-related research is funded through either NIAAA or NIDA. Reflective of the distinct missions of these two federal agencies, funded research studies often focus on either alcohol or other drugs. In many cases however, to include the conclusion that addiction satisfies the criteria of a "disease" and indicated components of effective treatment approaches, the findings of these studies can be extended to both alcohol and other drugs.

Summary of Addiction Etiology Research- Alan Leshner, M.D., former Director of NIDA summarized research findings developed over the past 25 years in regard to the physiological mechanisms of ATOD addiction.

The reality, based on 25 years of research, is that drug addiction is a brain disease - a disease that disrupts the mechanisms responsible for generating, modulating, and controlling our cognitive, emotional, and social behavior.

Dr. Leshner continued by describing how differently many within our society respond to individuals with diseases of the heart or kidneys, even though these conditions may have also been the result of individual vulnerabilities from a genetic perspective, combined with behaviors of excess, such as eating too much fat. In contrast, many individuals respond to malfunctions of the brain by equating it with being different, eccentric, or "crazy." Prior to recent research findings, many could not understand why someone with depression was emotionally and physically paralyzed, or why a person with schizophrenia heard voices or saw apparitions. In the absence of knowledge to the contrary, these conditions were often attributed to causes ranging from being "weak-willed" to poor parenting.

Modern science has demonstrated that depression and schizophrenia are physical diseases of the brain that manifest themselves through behavior, as do all brain diseases and disorders including autism, stroke, obsessive-compulsive disorders, mania, anorexia, and ATOD addictions. ATOD addictions alter the functioning of the brain and changes the mind. The brain of an individual addicted to alcohol or other drugs is quantitatively different in several ways from that of someone who is not addicted. These differences include gene expression, glucose utilization, and responsiveness to environmental cues. What is perhaps most critical, is that ATOD addictions result in change to the brain's limbic system that produce uncontrollable, compulsive ATOD-seeking and use behaviors, which is the essence of the disease of addiction.

On the purpose of research into addiction, Enoch Gordis, M.D., former Director of NIAAA, concluded: "Alcohol research has one fundamental purpose, to develop the knowledge necessary to effectively prevent and treat alcohol abuse and alcoholism and the consequences of these illnesses." This statement can be expanded to include drugs other than alcohol. The major conceptual advances in ATOD research are: the acceptance of ATOD addiction as a disease; the demonstration that a significant portion of vulnerability to addiction is inherited; the application of neuroscience to understanding alcohol and other drug use and the phenomena of addiction; the study of "mental processes" involved in ATOD use, abuse, and dependence; new insights into how ATOD use damages organs; the demonstration that ATOD prevention can be studied rigorously; and, new approaches to ATOD treatment.

The implications for research as it applies to ATOD treatment issues have been summarized by the below statements of the directors of NIAAA and NIDA. Once again, these statements apply to both alcohol and other drugs.

The principle goal of alcoholism treatment is to help alcoholics maintain sobriety. Research progress has been made in developing both behavioral strategies and medications, such as naltrexone, to help achieve this goal. These two classes of treatment strategies are not competitive. Rather, research suggests that pharmacologic agents may be combined with verbal therapy to improve treatment outcomes.

Combinations of pharmacological; and behavioral treatments for addictive disorders appear to be more beneficial than either component alone. This is true of other diseases as well. For example, cholesterol levels can be

dramatically reduced through a regimen that combines diet and exercise with cholesterol-lowering drugs. In treating patients with high cholesterol and other chronic conditions, the health professional must determine the best combination of therapies to meet the health needs of the patient, based on access to services, costs, severity of illness, and other risk factors.

These advances in ATOD science and research have profound implications for the practice of addiction medicine, the ATOD treatment system for addicted patients, and our societal response to these problems. First of all, ATOD addictions are diseases of the brain that have effective methods of treatment and prevention. Insurance companies, managed care organizations, and government funding sources must reflect on the resources that support ATOD treatment in comparison to illnesses of the heart, lungs, kidneys, and other organs and physical systems. Several new medications have been developed to control cholesterol levels leading to the optimism of actually reversing blockages in coronary arteries. Physicians prescribe these medications to their patients as soon as they become available since they are eager to prevent heart disease. On the other hand, relatively few medications have been developed in the treatment of ATOD addictions, and physicians are often reluctant to prescribe them to their addicted patients. And, many addicted individuals receive behavioral care and support assistance within separate systems with limited coordination and access to needed medical services.

AOD Prevention Research - In more than 20 years of drug abuse research, important principles have been identified for prevention programs in the family, school, and community. Researchers have tested these principles in long-term drug abuse prevention programs and have found them to be effective.³³ Prevention programs should be designed to enhance "protective factors" and move toward reversing or reducing known "risk factors." *Protective factors* include strong and positive bonds within a prosocial family; parental monitoring; clear rules of conduct that are consistently enforced within the family; involvement of parents in the lives of their children; success in school performance; strong bonds with other prosocial institutions, such as school and religious organizations; and adoption of conventional norms about drug use. *Risk factors* include chaotic home environments, particularly in which parents abuse substances or suffer from mental illnesses; ineffective parenting, especially with children with difficult temperaments or conduct disorders; lack of mutual attachments and nurturing; inappropriately shy or aggressive behavior in the classroom; failure in school performance; poor social coping skills; affiliations with deviant peers or peers displaying deviant behaviors; and perceptions of approval of drug-using behaviors in family, work, school, peer, and community environments.

Prevention programs may target a variety of drugs of abuse, such as tobacco, alcohol, inhalants, and marijuana or may target a single area of drug abuse such as the misuse of prescription drugs. Prevention programs should include general life skills training

³³ Pentz, M.A. (In Press). Costs, benefits, and cost effectiveness of comprehensive drug abuse prevention. In W.J. Bukoski, ed. *Cost Effectiveness and Cost Benefit Research of Drug Abuse Prevention: Implications for Programming and Policy*. NIDA Research Monograph.

and training in skills to resist drugs when offered, strengthen personal attitudes and commitments against drug use, and increase social competency (e.g., in communications, peer relationships, self-efficacy, and assertiveness).

Prevention programs for children and adolescents should include developmentally appropriate interactive methods, such as peer discussion groups and group problem solving and decision making, rather than didactic teaching techniques alone. Prevention programs should include parents' or caregivers' components that train them to use appropriate parenting strategies, reinforce what the children are learning about drugs and their harmful effects, and that open opportunities for family discussions about the use of legal and illegal substances and family policies about their use. Prevention programs should be long-term (throughout the school career), with repeat interventions to reinforce the original prevention goals.

Family-focused prevention efforts have a greater impact than strategies that focus on parents only or children only. Community programs need to strengthen norms against drug use in all drug abuse prevention settings, including the family, the school, the workplace and the community. Schools offer opportunities to reach all populations and also serve as important settings for specific subpopulations at risk for drug abuse, such as children with behavior problems or learning disabilities and those who are potential dropouts. Prevention programming should be adapted to address the specific nature of the drug abuse problem in the local community. Prevention programs should be age-specific, developmentally appropriate, and culturally sensitive. Effective prevention programs are cost-effective. For every \$1 spent on drug use prevention, communities can save \$4 to \$5 in costs for drug abuse treatment and counseling.

The following are critical areas for prevention planners to consider when designing a program:

- **Family Relationships** - Prevention programs can teach skills for better family communication, discipline, and firm and consistent rulemaking to parents of young children.
- **Peer Relationships** - Prevention programs focus on an individual's relationship to peers by developing social-competency skills, which involve improved communications, enhancement of positive peer relationships and social behaviors, and resistance skills to refuse drug offers.
- **The School Environment** - Prevention programs also focus on enhancing academic performance and strengthening students' bonding to school, by giving them a sense of identity and achievement and reducing the likelihood of their dropping out of school. Most curriculums include the support for positive peer relationships (described above) and a normative education component designed to correct the misperception that most students are using drugs.
- **The Community Environment** - Prevention programs work at the community level with civic, religious, law enforcement, and governmental organizations and enhance antidrug norms and prosocial behavior through changes in policy or

regulation, mass media efforts, and community-wide awareness programs. Community-based programs might include new laws and enforcement, advertising restrictions, and drug-free school zones - all designed to provide a cleaner, safer, drug-free environment.

AOD Treatment Research - Research findings support the efficacy and effectiveness of various forms of ATOD treatment, and the need for treatment to be comprehensive in nature. *Project Match* funded by NIAAA demonstrated the effectiveness of the following ATOD treatment approaches when used either as the primary treatment method or as aftercare with ATOD patients: Twelve Step Facilitation Therapy, Cognitive-Behavioral Coping Skills Therapy, and Motivational Enhancement Therapy. Studies that resulted in Food and Drug Administration (FDA) approval of naltrexone for the treatment of alcoholism provided evidence of the effectiveness of medication use in combination with counseling. Methadone treatment studies have likewise demonstrated that client outcomes can be improved if counseling is combined with medication distribution.

The implications of ATOD research to the design and implementation of treatment are profound. The team of professionals who care for addicted individuals and their families need a broad range of characteristics and skills, and team members need to represent a multi-disciplinary group professionals. Among these characteristics is the desire and ability to remain current in the ATOD research literature. Numerous additional insights into the dynamics of addiction and treatment are expected to be derived from ATOD research during the next few years. The effective application of these research findings within ATOD treatment practice, will require dedicated professionals who are willing to learn new skills, challenge old beliefs, and change how they interact with their patients/clients.

Since most of the effective ATOD treatment approaches are proving to be a combination of medications and counseling therapies, teams of ATOD treatment professionals will need to include both medical and counseling staff. Traditional "drug-free" programs are already moving to comprehensive approaches through which medications are routinely used to prevent relapse, while patients participate in *Twelve Step Facilitation and relapse prevention therapies* - Viewing ATOD addictions as chronic rather than acute illnesses has moved the ATOD treatment community to accept the responsibility for monitoring the outcomes of treatment, and supporting the gains of rehabilitation with case management services that span several years. This comprehensive and long-term perspective of treatment and continuing care, with on-going refinement based upon research findings, will result in improved outcomes for ATOD treatment patients.

XI. Major Barriers to Persons Accessing Needed Services in Illinois.

The 2002 National Survey on Drug Use and Health (NSDUH) (formerly the National Household Survey on Drug Abuse (NHSDA)) estimated that 22.0 million U.S. residents

can be classified with alcohol and/or other drug abuse or dependence.³⁴ It was further estimated that during the 12 months prior to the survey 2.3 million persons received alcohol or other drug treatment services through "specialty" substance abuse facilities. This estimated annual penetration rate of 10.4% is somewhat higher than similar estimates obtained through Illinois prevalence studies. This might be attributed to the nature of this national survey.

In considering the findings of surveys such as the NSDUH and other studies such as the needs assessment studies conducted by IDHS/DASA, one should be aware of the numerous sources of error that can systematically bias population estimates derived from survey research. These include sampling error, coverage error, measurement error, and nonresponse error.³⁵ Each may influence the accuracy of survey findings *within* any studies and may artificially inflate or decrease differences *across* studies. One example related to measurement error is of particular importance with household surveys such as the NHSDA: it is generally understood that self-reported substance use behaviors are underreported in epidemiologic surveys and that a variety of factors are associated with the quality of self-reported information regarding substance use.³⁶ Considerable research suggests that survey respondents may be more willing to report illicit or stigmatizing behaviors, such as alcohol and other drug use, when provided the opportunity to do so using more private means of data collection.³⁷ In addition, telephone surveys are believed to produce greater underreporting of drug use than do other methods, particularly self-administered questionnaires that do not require direct reporting of these behaviors to an interviewer^{38,39}. Consequently, the population estimates of illicit drug use derived from surveys such as the NHSDA are most likely underestimates. If such is the case, somewhat more than 16.6 million U.S. residents are in need of treatment and the percentage of those in need in treatment who are receiving treatment is actually less than the estimated penetration rate of 9.0%. In effect, it is most likely that the national treatment gap is greater than what is estimated on the basis of the NSDUH.

³⁴ Substance Abuse and Mental Health Services Administration. (2003). *Overview of Findings from the 2002 National Survey on Drug Use and Health* (Office of Applied Studies, NHSDA Series H-21, DHHS Publication No. SMA 03-3774). Rockville, MD.

³⁵ Groves, R.M. (1989). *Survey Errors and Survey Costs*. New York: Wiley.

³⁶ Harrison, L., & Hughes, A. (1997). *The Validity of Self-reported Drug Use: Improving the Accuracy of Survey Estimates*. Rockville, MD: National Institute on Drug Abuse.

³⁷ Tourangeau, R., & Smith, T. (1996). Asking sensitive questions: The impact of data collection mode, question format, and question context. *Public Opinion Quarterly* 60, 275-304.

³⁸ Aquilino, W.S. (1994). Interview mode effects in surveys of drug and alcohol use: A field experiment. *Public Opinion Quarterly* 58, 210-240.

³⁹ Johnson, T.P., Hougland, J.G., & Clayton, R.R. (1989). Obtaining reports of sensitive behavior: A comparison of substance reports from telephone and face-to-face interviews. *Social Science Quarterly* 70, 174-183.

In any event, it can be reasonably concluded that the majority of individuals in our country with alcohol and other drug abuse and dependence disorders will never receive any assistance for their problems during their lifetimes. Several barriers and factors contribute to this major gap in access to needed services, that have well-documented positive client outcomes. Briefly discussed below are major barriers that exist not just in Illinois, but throughout the country.

- ***Missed Opportunities*** - The varied impacts of alcohol and other drug abuse and dependence result in affected individuals becoming involved in several societal systems, often before they become involved in the specialist treatment system. The numerous physical health effects of alcohol and other drug abuse and dependence referenced earlier in this section result in affected persons making substantial use of general hospital and other primary health care services. Despite the sizeable representation among patients in these settings who present with alcohol and other drug-related conditions, as cited earlier in this section, there is a general lack of sufficient screening, intervention, and treatment referral services provided to these patients.⁴⁰ As would be the case with any disease that goes undiagnosed and unaddressed, because of this missed opportunity the alcohol and other drug using behaviors of these patients often continues with the resultant physical and other effects progressing to more serious and chronic levels.

- ***System Resource Limitations*** - Documentation is provided in this plan in regard to the limited extent to which the Illinois publicly funded alcohol and other drug treatment system can accommodate the number of persons in our State who are in need of such services. Even if efforts are implemented to increase referrals to treatment, various resource limitations restrict the Illinois system's ability to respond to any such increase in referrals. Two system resource limitations seem to require primary attention. One of these limitations relates to provider organization physical facility resources. Many Illinois provider organizations lack the appropriate physical facility space to accommodate a substantial increase in referrals. A second limitation pertains to the need to expand and upgrade the current ATOD clinician workforce in Illinois. At present, there is a lack of a sufficient number of qualified and experienced ATOD treatment clinicians who would be available to provide the treatment services that would be needed by an increased number of referred individuals.

- ***Coverage Limitations*** - Barriers to persons in need receiving substance abuse treatment in regard to cost limitations, originate from two major perspectives. The first pertains to limited and decreasing funding from private sources. A recent study found that private funding in support of substance abuse treatment

⁴⁰ National Center on Addiction and Substance Abuse at Columbia University (CASA) (2000). *Missed Opportunity: National Survey of Primary Care Physicians and Patients on Substance Abuse*. Available online at www.casacolumbia.org/usr_doc/29109.pdf.

decreased by 28% from 1990 to 1994.⁴¹ Over this time period there was an increase in public support of treatment in specialty settings, primarily due to increases in Medicaid spending. Medicaid support of ATOD treatment within Illinois also increased during this period, but has recently been subject to decreases. Decreases in private spending in support of ATOD treatment since 1990 are primarily associated with reductions in substance abuse treatment benefits in private medical insurance plans. This trend has led to recent calls for parity for substance abuse coverage among health benefits. Although there have been concerns about the impacts of parity for substance abuse services on health premiums, it has been estimated that this would result in only about a 0.2% increase in premiums.

- From a second perspective, some coverage limitation issues originate from within the public funding stream. As noted above, current IDHS/DASA cost modalities correspond to the categories that CSAT uses to track GPRA data reporting. The delivery of the majority of services represented by these modalities are "site-bound." That is, they must be delivered in facilities that are licensed by IDHS/DASA. There is of course a need to ensure that client services are delivered in appropriate and accessible facilities that satisfy certain life safety codes. However, it may be appropriate to expand the types of sites in which certain reimbursable services can be provided. Notable exceptions apply to the delivery of screening and brief intervention services. Illinois' approach to addressing these cost limitation issues are discussed in the following section.
- *Lag in Implementation of Evidence-Based Practices* - Researchers have made substantial strides in identifying a variety of approaches and practices that have demonstrated effectiveness in the prevention and treatment of AOD-related disorders. However, there is currently an approximate 17 year lag time between the publication of such evidence-based approaches and practices in the professional literature, and their actual implementation. Although there is substantial evidence of the effectiveness of current ATOD prevention and treatment services, a more expeditious implementation of evidence-based practices could only serve to increase the efficiency and effectiveness of current programs.
- *Stigmatization* - It is important to note that each of the above barriers to persons accessing needed substance abuse services exist to the extent that they do, because of the stigma that remains associated with the disease of alcohol and other drug addiction.
- *Need for Balanced Approach* - Attempts to address any of the barriers to closing the gap in available ATOD prevention and treatment services must include consideration of potential unintentional affects these attempts might have that

⁴¹ Dayhoff, D.A., Urato, C.J., & Pope, G.C. (2000). Trends in funding and use of alcohol and drug abuse treatment at specialty facilities, 1990-1994. *American Journal of Public Health* 90(1): 109-111.

would serve to increase the seriousness of other factors that represent barriers to this goal. For example, focusing solely on increased identification and referrals of individuals in need of addiction treatment services without considering the impacts of increased referrals on an already fully-utilized publicly-funded provider system is likely to only increase the size of wait lists for treatment.

XII. CSAT *National Treatment Plan Initiative.*

CSAT's *National Treatment Plan* initiative began in the fall of 1998, with the purpose of moving the field toward a working consensus on..."how best to improve substance abuse treatment, and then to pursue action to effect needed change." Primary purpose is to develop recommended guidelines and actions that over time will improve the effectiveness of substance abuse treatment. Expert panels met between April 1999 and February 2000. Public comments were sought through field publications, a dedicated website, and public hearings were held from July through November 1999. Input from these various sources resulted in a series of guidelines and recommendations that are organized according to the following five areas: Closing the Treatment Gap; Reducing Stigma and Changing Attitudes; Improving and Strengthening Treatment Systems; Connecting Services and Research; and, Addressing Workforce Issues. Below are some key recommendations within each of these areas.⁴²

Closing the Treatment Gap

Develop a plan to create a nationwide expectation for alcohol and drug treatment such that no matter where in the human services, health, or justice system an individual appears, his or her alcohol or drug problem will be appropriately identified, assessed, referred, or treated.

Increase total resources available for substance abuse treatment (i.e. Federal, State, local, and private) to reduce associated health, economic, and social costs.

Facilitate cross-system consensus on critical data elements to measure quality of care and treatment outcomes.

Reducing Stigma and Changing Attitudes

Based on the results of marketing research, develop and implement a social marketing plan designed to change the knowledge, attitudes, and beliefs of individuals and institutions to reduce stigma and its negative consequences.

Promote the dignity and reduction of stigma and discrimination against people in treatment for or in recovery from alcohol and other drug addiction by encouraging the

⁴² Substance Abuse and Mental Health Services Administration (SAMHSA) (2000). *Changing the Conversation: Improving Substance Abuse Treatment, The National Treatment Plan Initiative.* Department of Health and Human Services, Center for Substance Abuse Treatment. Rockville, MD.

respect for their rights in a manner similar to people who have suffered from and overcome other illnesses.

Improving and Strengthening Treatment Systems

Treatment plans should be based on an individual's needs and should respond to changes in need as he or she progresses through stages of treatment. Evidence-based practices should guide screening, intervention, assessment, engagement, individual and group therapies, aftercare, and relapse prevention so that the individual enters at an appropriate level of care, becomes engaged in services, and progresses through a continuum of care.

Treatment programs, payors, and regulators should promote organizational cultures that improve the quality, effectiveness, and efficiency of services through the adoption of best business practices for program management and operations. These should include effective governance and leadership for the board of directors and senior management; management and operation of human resources, marketing, and finance; information and data management operating systems; and capital and facilities.

Connecting Services and Research

This panel recommended the establishment of a system designed to connect services and research, which would be supported and maintained through CSAT.

Addressing Workforce Issues

Advocate for competency-based career ladder opportunities in addiction treatment settings.

Advocate for all health and human service-related accrediting and certifying/re-certifying agencies to require education and competence in addition, and inclusion of addiction questions on all credentialing exams.

Establish standards for didactic, clinical, and experiential education and training of addiction professionals and other health and human service providers.

XII. Illinois Efforts to Achieve *National Treatment Plan* Recommendations.

The State of Illinois is strongly committed to participation in efforts to achieve the CSAT *National Treatment Plan* recommendations. This commitment goes beyond the decision to modify the format of the Illinois State Plan for substance abuse services to be consistent with that of the *National Treatment Plan*. The following represent several examples of how Illinois is attempting to respond to the recommendations made within the Plan's five focus areas.

Closing the Treatment Gap

- Illinois is engaged in several efforts to both quantify and describe the substance abuse treatment gap in our State. Much of this work consists of needs assessment studies conducted by IDHS/DASA that are supported by CSAT State

Treatment Needs Assessment Program (STNAP) funding. As noted previously in this State Plan, based on these studies it is estimated that nearly 900,000 Illinois residents are in need of substance abuse treatment. However, the current Illinois publicly-funded system is capable of serving less than 10% of those in need on an annual basis. It is a planning goal for Illinois to have a publicly-funded treatment system that is capable of annually serving at least 15% of those in need.

- **Although current budgetary constraints limit similar actions in the near future, in recent years IDHS/DASA has issued new funding initiatives that target treatment gaps within specific populations and geographic areas. Population funding initiatives have targeted youth, victims of domestic violence, and men with an emphasis on family reunification. IDHS/DASA established a satellite office in Marion, Illinois as a first step to addressing the need for expanded services in rural areas in the southern portion of our State.**
- **Illinois continues to pursue various sources of funding to help address the gap in treatment services within our State. For example, IDHS/DASA, units of local government, and community-based organizations in our State have been quite successful in applying for CSAT funding to expand services through the *Targeted Capacity Expansion (TCE)* and *Targeted Capacity Expansion and HIV/AIDS Services (TCE/HIV)* initiatives. IDHS/DASA has had an excellent track record of sustaining Illinois TCE and TCE/HIV projects, either completely or in part, following the termination of CSAT funding.**
- **Illinois has a commitment to conduct studies that document the effectiveness of treatment. Findings from the Illinois Statewide Treatment Outcomes Project (ISTOP), conducted through IDHS/DASA, were released in September 2001. This is the largest and most comprehensive study of substance abuse treatment outcomes conducted in Illinois to-date. A total of 1,210 treatment clients were interviewed six months after they entered treatment. Clients reported significant reductions in alcohol and other drug use, medical problems, and mental health problems. Clients also reported significant reductions in illegal activities and improvements in employment status. Findings from the ISTOP Study can be obtained from the IDHS/DASA website.**
- **Illinois is one of 19 states that participated in the CSAT Treatment Outcomes and Performance Pilot Studies II (TOPPS II) Project. IDHS/DASA staff made a presentation of summary client treatment outcome findings at the final TOPPS II meeting held last month in Bethesda, Maryland. Illinois TOPPS II Project findings are quite similar to those obtained through the ISTOP Study, providing more compelling evidence of the effectiveness of substance abuse treatment.**

Reducing Stigma and Changing Attitudes

- **IDHS/DASA initiated a "Treatment Works" public awareness campaign in the Fall of 2001. A major goal of this campaign was to reduce the stigma that still too often must be faced by persons who seek and receive substance abuse**

treatment services. This campaign made use of posters, billboards, bus cards, and radio and TV PSAs that get out the message that..."Treatment Works."

- For each of the last three September has been proclaimed as "Recovery Month" in our State. This year IDHS Secretary Carol L. Adams, Ph.D. hosted a special event on September 3 at the James R. Thompson Center in Chicago that kicked off Recovery Month in Illinois. Various events were held throughout the month to stress the message that treatment works and to highlight the strides and accomplishments made by persons in recovery.
- To coincide with last year's Recovery Month activities in Illinois, in late September of 2002 IADDA issued results from a public opinion poll that sampled the perception of Illinois registered voters regarding various addiction-related issues. Eighty-five percent of respondents agreed with the statement: "Drug and alcohol addiction is a public health problem that is handled better by prevention and treatment programs than by the criminal justice system." From 95% to 85% of respondents also agreed with statements that addiction is a pervasive illness that affects all segments of our society, and that the chemistry of the brain changes over time during the course of addiction. Fifty-three percent of respondents said that they have an immediate family member or close friend who has or had a substance abuse problem. Perhaps of interest in helping us design future public awareness campaigns, 70% of respondents stated that personally knowing someone in recovery, or hearing the personal stories of "everyday" people in recovery were for them, the most compelling types of evidence of the effectiveness of treatment. Although we need to continue to conduct well-designed and rigorous substance abuse treatment client outcome studies, only 15% of the persons surveyed indicated that for them such studies was the most compelling form of evidence. The personal stories of celebrities and famous persons who are in recovery was the least compelling form of evidence among the survey respondents.
- We feel that the recovery community can be valuable partners in helping to reduce substance abuse problems, especially in regard to reducing stigma and changing attitudes. Results from the IADDA opinion poll cited above indicate that the testimony of members of the recovery community can be an influential factor in affecting the beliefs of the general public regarding the nature and effects of substance abuse. To help forge our relationship with the recovery community, IDHS/DASA awarded continuation funding support to the Illinois-based Recovery Communities United, Inc. (RCU). RCU was one of the 19 organizations awarded CSAT Recovery Community Support Program funding in Federal Fiscal Year 1998.

Improving and Strengthening Treatment Systems

- Illinois has a long history of working with provider organizations in improving and strengthening the publicly-funded substance abuse treatment system in our State. Reflective of recommendations in the National Treatment Plan, IDHS/DASA licensure regulations have for several years included the

requirement that an individualized treatment plan be developed for clients admitted to substance abuse treatment.

- IDHS/DASA-licensed providers are also required to use the American Society of Addiction Medicine (ASAM) patient placement criteria as an objective means of assessing clients and referring them to the most appropriate level of care, based upon their individual needs and characteristics.
- IDHS/DASA licensure regulations have for several years also included physical facility requirements that include compliance with standards mandated by the Americans with Disabilities Act.

Connecting Services and Research

- IDHS is committed to the implementation of best practices in all areas of human service design and delivery. DASA is presently considering the development of best practices in the delivery of domestic violence and methadone maintenance services. DASA staff consistently include evidence-based best practices in the development of applications for funding to expand treatment services.
- IDHS/DASA has partnered with the DHS Office of Mental Health in awarding a contract to the University of Chicago, Center for Psychiatric Rehabilitation, to manage the Illinois MISA Institute. The Illinois MISA Institute is a key part of a broader initiative that is designed to expand and improve the services that are available to mentally-ill substance abusers in our State. Included among the services provided by the Illinois MISA Institute is maintenance of a resource center that is a source of training and support materials for treatment. The consideration of evidence-based best practices is an important factor in structuring the services available through the Illinois MISA Institute. More information about this organization is available at its website: illinoismisainstitute.org.
- IDHS/DASA is also a participant in the CSAT-funded Practice Improvement Collaboratives Project coordinated through the Illinois TASC. Several IDHS/DASA-licensed provider organizations are involved in this Project's studies that involves the implementation of research-based best practices.

Addressing Workforce Issues

- Illinois is also taking a regional approach on workforce issues. During the summer of 2003, a committee to address workforce development issues was initiated among IDHS/DASA, Single State Agency directors from Wisconsin, Ohio, Michigan, and Indiana, GLATTC, and the Illinois Alcohol and Other Drug Abuse Professional Certification Association (IAODAPCA). The certification and credentialing organizations within these other Midwestern states have also been invited to participate.

- In July 2002, GLATTC hosted a symposium with representatives from the Great Lakes states to outline a strategy to address various workforce development issues. Future directions and action steps were identified in the following workforce development issue areas: certification and reciprocity, surveying the field, public and legislative education, and motivating the field.

Related Illinois Efforts - Illinois is engaged in several other efforts that are designed to help close the existing gap in services, increase public awareness of AOD-related issues, improve the quality of services that are provided to those in need, and assist in the support of provided services. A sample of these additional efforts are summarized below.

Childcare Study Group - IDHS/DASA currently provides in excess of \$4 million to community-based providers for childcare services while a parent receives either residential or outpatient substance abuse treatment. This is a significant commitment to support services. A Study Group was established to review childcare as defined by IDHS/DASA. Site visits have been completed at 18 programs, and the information collected has driven the next step of the process. Two subgroups are currently determining categories and contracting conditions for childcare services, and establishing funding concepts and service reporting protocols. The goal of the group is to have a complete childcare plan to guide the FY2004 contracting process.

Web-based Reporting - IDHS/DASA is working in partnership with CSAT, other states, and IDHS MIS staff to upgrade the Illinois substance abuse treatment data reporting systems to a Web-based "real-time" contracting, clinical/capacity management and patient data reporting system. CSAT began national web-based efforts several years ago. These efforts have afforded Illinois the opportunity to upgrade its system in a cost effective and timely manner. IDHS/DASA has pursued federal funds to support these efforts and to maximize its minimal resources. It has been apparent for some time that changes must be made to the substance abuse data systems. Funding requirements necessitate a transition to data systems that will support multiple real-time analysis functions for budgeting, contract and systems development, state and federal performance management. Substance abuse treatment data must accommodate changes required by Health Insurance Portability and Accountability Act (HIPAA) data reporting and transactions coding, and Federal Block Grant Performance Partnership and Paper Work Reduction requirements.

The Health Insurance Portability and Accountability Act - The Health Insurance Portability and Accountability Act of 1996 (HIPAA) creates a system for regulating the use, disclosure and electronic transfer of health information. IDHS/DASA determined that its payment for treatment services renders it a health plan and therefore a covered entity under HIPAA. It is likely that many if not all of the providers licensed by IDHS/DASA are also independently covered entities, because they directly provide services that are considered "health services" under HIPAA. Each provider must conduct its own analysis to determine its status and is responsible for its own compliance with HIPAA. IDHS/DASA has jointly sponsored a number of training events for funded providers over the past two years in order to assist them in HIPAA related transitions and to assure the minimal disruption to patient services in Illinois.

IDHS/DASA formed a HIPAA team, provided staff training, and conducted a "compliance gap analysis."

Federal Competitive Grant Awards - IDHS/DASA has been awarded more than \$12.5 million dollars since 1998 in competitive grants from the U.S. Department of Health and Human Services. They include:

- High Risk Latino Injecting Drug Users (\$2.2 million)
- Expanded Services for Minority Injecting Drug Users (\$1.3 million)
- Women's Recovery Home and Intensive Outpatient Services (\$1.34 million)
- Traumatic Brain Injury (\$1.3 million)
- Expanded Sub. Abuse Outpatient Services for Hispanic Clients (\$1.42 million)
- Needs Assessments/Data Development (\$1.875 million)
- Treatment Outcomes and Performance Pilot Studies (TOPPS II) (\$1.5 million)
- Homeless Services Integration Project (\$1.8 million)
- I-STOP, Treatment Outcome Study on the Effectiveness of Substance Abuse in Illinois.

In October of 2001, a treatment outcome study was completed on the Effectiveness of Substance Abuse Treatment in Illinois. This was the largest, most comprehensive study of treatment outcomes collected by the State to date. Nearly 2,000 adult clients receiving various levels of care were recruited from 40 treatment programs across the state. Data was collected for the study from the fall of 1998 through the end of August 2000. The baseline data was collected by the staff at the participating programs while the follow-up data was collected by phone six months after the clients were assessed and accepted into treatment. The study's results were positive. It is clear that clients participating in treatment services in Illinois experience substantial reductions in alcohol and other drug use as well as a reduction in criminal activity. In addition, clients also experience dramatic improvements in employment, physical and mental health, and relationships with family and others. The study also found specific areas of client histories and problems that may have important implications for treatment programs. The results of this outcome study were published in hard copy and are currently available on the Internet at: <http://www.state.il.us/agency/dhs/indexasanp.html>.

Illinois TOPPS II Study - The Illinois TOPPS II (Treatment Outcomes and Performance Pilots Study) Project was supported by a grant to IDHS/DASA from the U.S. Center for Substance Abuse Treatment (CSAT). The major purpose of this study was to provide information that would lead to the development of a statewide system for monitoring publicly-funded substance abuse treatment client outcomes. Through this study substance abuse treatment client information was collected at admission (T1), discharge (T2), and 9-month post-admission follow-up (T3). The data was transmitted to IDHS/DASA through an Internet-linked MIS. Study data collection ended in May 2002, with the collection of T3 (follow-up) data from 635 adult clients. Analyses found several statistically significant changes among the interviewed clients from treatment admission to 9-month post-admission follow-up. Clients reported significant reductions in alcohol and other drug use, improved employment status and living arrangements, decreased involvement in illegal activities, and improved relations with family members. They also reported great of satisfaction with the treatment they received.

Treatment Works Media Campaign - IDHS/DASA has worked with the IDHS Office of Communications, and the media department at the University of Illinois-Springfield to launch a media campaign promoting the effectiveness of substance abuse treatment. This campaign, which began in November 2001, communicated to people in Illinois through bus signs, billboards, and television and radio public service announcements that substance abuse *Treatment Works!* This campaign also provided the public with a toll-free number for information or help. During February and March 2002, two posters displaying the same art work and information as that used on the billboards and bus signs were mailed to numerous locations throughout the State.

Youth Initiative - Recommendations generated at community forums and a conference on adolescent treatment framed the new Youth Initiative programs around the state. The funded programs have redirected alcohol and substance abuse treatment services to non-traditional settings that are more conducive to youth involvement. This has resulted in increased collaboration with local middle and high schools, and a new treatment mind set geared towards youth specific services. In addition, peer networking/collaboration are promoted to establish a strong infrastructure for the delivery of substance abuse services targeted to youth.

Criminal Justice Juvenile Community Court and DOC Initiative - In an effort to strategically address the substance abuse treatment needs among juvenile offenders, DASA focused on two different criminal justice populations in Illinois: 1) delinquent youth under the wardship of community court systems, and 2) youth exiting Department of Corrections (DOC) youth center treatment programs. The Criminal Justice Juvenile Community Court and DOC Initiative expanded the current infrastructure of juvenile court through additional criminal justice interface services to systematically assess substance abuse treatment needs and a process to match the clinical need with the appropriate clinical intervention. Additionally, it attaches clinical re-entry management at Warrenville, Harrisburg, and St. Charles Youth Centers to engage and assess the continuing substance abuse treatment needs of the youthful offenders in preparation for release to the community. It provides tracking of the clinical progression of the probationer/parolee through linkages with a wide range of dedicated community-based substance abuse treatment services throughout the duration of probation/parole.

Criminal Justice Female Initiative - A focus has also been placed on women exiting Illinois Department of Corrections (IDOC) institutional treatment programs, and those women currently within the parole system in the community. IDHS/DASA has partnered with IDOC to implement a variety of substance abuse treatment services. The designated point of entry is within the correctional center and follows the female inmate from the institution to the community. The Criminal Justice Female Initiative attaches clinical re-entry management at Decatur Correctional Center to engage and assess the continuing substance abuse treatment needs of the adult female inmates in preparation for release to the community. It provides tracking of the clinical progression of the parolee through linkages with a wide range of dedicated community-based substance abuse treatment services throughout the duration of the managed supervised release period.

Domestic Violence Substance Abuse Treatment - A need has been recognized for specialized substance abuse treatment services for women who are victims of domestic violence. Four pilot sites support a comprehensive linkage of services to facilitate a safe environment for recovery. Medical evaluation, diagnosis and treatment, emergency shelter, childcare, legal advocacy and individual and group counseling are among the facets of pilot programs. Formal protocols were developed using the research based "Best Practices for Domestic Violence and Substance Abuse Services" manual. The manual was the result of work by a collaborative group of treatment providers, administrators and researchers from the fields of domestic violence, substance abuse, and criminal justice.

Department of Children and Family Services (DCFS) Initiative - The DASA/DCFS initiative, inclusive of the nationally recognized Project SAFE model, continued expansion to include a recovery home where women, who are DCFS involved, may reside with their small children while working to regain full custody. Nearly 75% of the recovery home participants completed work toward family reunification. A model of treatment delivery providing substance abuse education, individual and family counseling, specialized women's groups, skill building and self help groups, Project SAFE was increased to 24 locations statewide. Co-location has also placed substance abuse treatment clinicians in 3 DCFS field offices to perform assessments, diagnose substance abuse problems of clients, and make referrals for treatment.

Temporary Assistance For Needy Families (TANF) - The movement to integrate substance abuse treatment into the public assistance delivery system and fully support Welfare-To-Work was expanded to a full continuum of services treatment to TANF clients statewide. Currently, substance abuse treatment clinicians are out stationed in 61 IDHS field offices to perform assessments, diagnose substance abuse problems of clients, and make referrals for treatment. This integrated referral process is supported by treatment programs offering intensive case management including life skills, health education, job search and parenting skills. The addiction counseling is augmented with sober housing, child care, and transportation services.

Problem and Compulsive Gambling Initiative - The Problem and Compulsive Gambling Initiative is designed to assist the State in understanding the nature, scope and impact of compulsive gambling in Illinois and to provide treatment avenues for addressing compulsive gambling problems. Approximately 300 provider staff have been trained through the initiative and training continues. Additionally, a public awareness campaign produced radio spots and videos to raise awareness of risks associated with problem gambling. The program also contains an outreach and speakers bureau, which has concentrated on senior programs and high schools. The program also completed a study of prevalence of gambling problems in non-clinic youth in the City of Chicago. Treatment at seven sites statewide began in FY 2002.

Male/Family Reunification Project - Community-based programs for males needing substance abuse treatment, but who lack the individual financial resources, have no adequate private insurance, and do not fall within one of IDHS/DASA's priority treatment populations were significantly expanded in FY 2001. This initiative provides

gender sensitive services and requires participating agencies to provide or have access to parenting, domestic violence training and employment services for all men served. In this initiative, IDHS/DASA contracted with 28 substance abuse treatment providers throughout the State to provide a variety of substance abuse treatment services constituting the full continuum of treatment services to the target population.

Methamphetamine Initiative - For the past few years Illinois has been plagued, like many other mid-western states, with the growth of methamphetamine production and use. To address the current methamphetamine problem that is especially serious in rural Illinois, IDHS/DASA developed specific programming to treat this growing phenomenon. Community-based agencies are meeting the increased demand for treatment services with IDHS/DASA support. The project also resulted in the development of a resource and training manual for the treatment of the abuser of methamphetamines and/or other high intensity drugs, and in implementation of four training workshops throughout the State.

Aging Pilot - IDHS/DASA and the Illinois Department on Aging developed a pilot program, Daybreak, which is intended to serve substance abusing adults, aged 60 and older. The pilot is based in Peoria and involves collaborative efforts between the local area aging network, including public health nurses, aging case managers, social workers and substance abuse professionals. The inter-disciplinary team visits the elderly in their homes and at nursing facilities. Aging network workers are provided with substance abuse awareness training via workshops. Development of a video for volunteers and other staff unable to attend the workshops has also supported the effort.

Integrated MISA Treatment and Case Management Services - The Integrated MISA program is a collaborative system of care among community mental health agencies, substance abuse treatment providers and state mental hospitals. It is designed for persons who are clinically diagnosed with co-occurring mental illness and substance use. The program provides coordination and provision of services to MISA clients to enable each to attain the highest level of functioning and to circumvent avoidable psychiatric hospitalization and chemical relapses. The MISA program consists of 23 IDHS/DASA funded programs in 27 sites. Approximately 5000 clients were served over the past year. The agencies developed standardized screening and assessment protocols for admitting clients to treatment. IDHS/DASA also funds the Illinois MISA Institute, which has one of the premier dual diagnosis web sites in the country. The MISA Institute also provided training for over 2000 treatment providers in the past year.

Driving Under The Influence (DUI) Programs - Beginning in 1999, changes were made in DHS to return oversight of all DUI programs to DASA and efforts began to revitalize the program and increase visibility and credibility with the Illinois courts and the Secretary of State, the main recipients of the services delivered by licensed DUI providers. Through use of specialized funding contained within the Drunk and Drugged Driving Prevention Fund, DUI program monitoring has increased dramatically. New enhancements will soon be made to DUI reporting software that will allow for electronic billing and better collection of data relative to the DUI offender profile.

Rural Outpost - As a part of the effort to enhance substance abuse treatment services in rural Illinois, DASA opened a satellite office in Mt. Vernon, Illinois. Staff work closely

with providers in that regional area to provide technical assistance, interpret policy, and facilitate better client service.

Capacity Management (CAPMAN) - All DASA contracted service providers are required to report available service capacity by level, and by service delivery site, every day. This data is a required component of the federal block grant application. Prior to October 1999, this data was provided to DASA through a dial up modem connection. The daily response rate under the dial up system was under 60%. An Internet-based reporting system was developed in 2000, and fully implemented in 2001. IDHS/DASA funded providers with access to the Internet connect to the CAPMAN web site and transmit daily reports directly to the CAPMAN web server database. The daily provider response rate is over 87% and system availability is 99%. Participating providers can also query the system regarding available slots to ensure referral to prompt and appropriate client/treatment matching. This system will be updated and integrated into the upcoming Web-based reporting system.

Standardized Monitoring Tool - In FY2001, IDHS/DASA began the process of developing a new inspection protocol. The charge was to develop a comprehensive weight based inspection tool that could quantify provider compliance to state and federal guidelines as well as contract conditions. After a series of developmental meetings between DASA staff and a group of community treatment providers, a comprehensive tool was developed and agreed upon. For the first time, the tool provided a written standard for compliance to improve internal consistency among inspectors. The weighting was used to increase the amount of variance in compliance data by taking into account the relative importance of each individual rule. Weighting allows more of an emphasis to be placed on health, safety, and welfare risk to patients. IDHS/DASA compliance monitors used the new inspection tool during all FY 2002 site visits. IDHS/DASA management has been able to use the new scoring protocol to make decisions concerning continued or increased funding for contracted providers, licensure sanctioning, and overall system evaluation.

Technical Assistance - IDHS/DASA has established a significant mechanism to support the field in interpretation of policy and identification of training needs as well as trends and issues for review by upper management. It is the Help Desk. Designated staff receive and respond or disseminate all questions from consumers and providers regarding Administrative, State, and Federal Rules, Contracts, DARTS, DUI/DSRS, Payments, Medicaid, Licenses, Audits, and etc. They identify, catalog, and report systemic and individual problems occurring in the DASA system, and recommend solutions and forward suggestions for improvement. This Help Desk service to consumers and providers was cited as a significant best practice during a recent federal technical assistance review. Once a need for technical assistance is identified, work begins with the provider to develop a corrective action plan with detailed tasks, time lines, and evidence of compliance. An individual at the provider agency is responsible for the each task, and the implementation of policies, procedures, and/or self studies that will assist a provider to reach and maintain compliance. Technical assistance is most often provided to address underutilization, compliance monitoring, DARTS reporting problems, and attention to special populations.

Who are these voices and faces of
success?

They are young people, men and
women of all ages, people who are just
like you and me. These are just some of
those stories.

"VOICES AND FACES"



**Participants at the Dekalb County Partnership for a Safe, Active
and
Family Environment Education/Sports Action Group**

“Voices and Faces of Success”



This five-year plan and its updates will again celebrate the countless success stories of participants in state-supported substance abuse services. Letters, pictures and stories are contributed from participants across Illinois. Some choose to share their story, some choose to send their pictures and include their names. Others write anonymously. All are a celebration of the success of their participation in prevention, intervention or treatment services and the system that provides them. The young people highlighted here provide examples of prevention activities. People of all ages in recovery who have chosen to share their stories serve as examples of success of many others in treatment.



Indian Creek Middle School Project Reduces Office Referrals

For the past two years, as a result of a grant from the Illinois Violence Prevention Authority, The DeKalb County Partnership for a Safe, Active and Family Environment (DCP/SAFE) has been working with Indian Creek Middle School students, faculty and parents using Social Norms Prevention to reduce bullying in the school. Below is an overview of the percent of reduction in office referrals between the 2002 and 2003 school year. Dramatic changes were seen in these 7 of the ten areas evaluated.

INFRACTION	
Verbal Harassment	-33%
Physical Contact	- 9%
Lunch Time Inappropriate Behavior	-25%
Disrespectful Behavior - Student	-95%
Verbal Threats	-50%
Fighting	-66%
Expulsions (physical violence; weapon)-	None
('03)	

VOICES AND FACES OF SUCCESS PREVENTION

VOICES AND FACES

Let me tell you about the most beautiful thing I have ever seen. No, it wasn't a monument or a landmark. It wasn't a rainbow or a waterfall. Not a canyon or a cliff. And no, not even a moonbeam or a constellation. It was seven hundred some hands, two for each person, waving in the air, and one very brave girl grooving to their beat. The most beautiful thing I have ever seen was a wordless act of kindness, sensitivity, and acceptance. And I was moved to tears.

When Melissa Manak, a hearing impaired participant, had the guts to get up on stage and dance at the talent show to music she couldn't hear in front of kids she didn't know, I was already awed and touched beyond belief. I clapped my hands to the beat in the usual fashion, before noticing that the rest of the room had quieted. I glanced behind me to see an ocean of waving palms, a sign language clap. Participants, PALS, and staff alike were all on their feet, arms extended, "clapping" to the music. And Melissa just danced her heart out, signing Leanne Rimes's words to the audience as she went, and only occasionally glancing at her interpreter for cues.

I, however, was paralyzed. And for once, speechless. Moments later, as I sat there bawling, friends asked if I was okay. "I'm just so happy," I managed through the tears.

Just when you think that the world is full of ugliness and selfishness, when the news makes you shudder and people make you cringe, when you wish that your children didn't have to grow up here, someone shows you that there is still kindness out there in the world—that for every bit of ugliness inside of us all, there's twice as much beauty, twice as much love. For me, that person was Melissa Manak—an extraordinary young woman who possesses courage and strength in abundance, and, most of all, girl's got rhythm.

Thank you Melissa, and thank you ITI, for reminding me that there's a whole lotta good hiding out there, and you never know where it might show up. You have changed my life and opened my eyes. You have given me a remarkable gift—hope. And I am more grateful than words can express. Turns out, guys, this camp is pretty great.

Love always,
Corinne

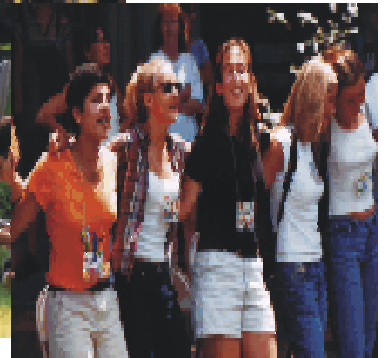


Prevention activities
Around the state



DeKalb County Partnership for a Safe, Active and Family Environment (DCP/SAFE)

Pictures from the Illinois Teen Institute (ITI) and Operation Snowball, Inc. (OS) award winning alcohol and other drug use prevention programs focusing on leadership development to empower youth to lead drug-free lives. The programs provide opportunities for youth and adults to work together in a spirit of cooperation to plan implement and evaluate community-based alcohol and other drug prevention programs. The programs are part of the IADDA (Illinois Alcoholism and Drug Dependence Association) family.

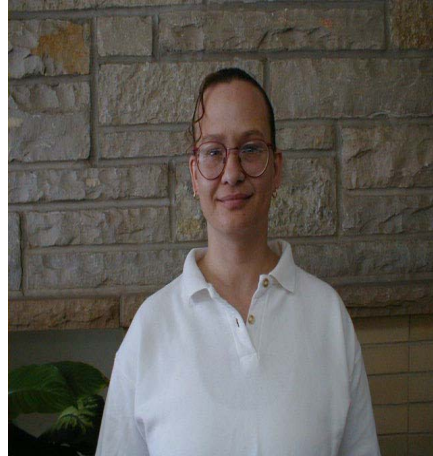


VOICES AND FACES of TREATMENT AND RECOVERY

Voices and Faces

My name is Teresa Stoll. I am a 40-year old female whose substance abuse and alcohol usage began 20 years ago. I started "socially" after high school. After my first pregnancy, age 23, I resumed use and by age of 26 my addiction became apparent. As a direct effect of my prolonged use, I lost custody of four children, developed an extensive criminal history and became estranged from my family. My first attempt at treatment was August 2001 during incarceration. LCHD's Substance Abuse Program sponsored AA meetings, lead by Karen Cox at Lake County Jail. Upon release, I attended LCHD Intensive Out Patient Treatment daily for 6 weeks. I successfully completed the program and still continue to attend AA/CA "women only" meetings at the LCHD's ATP Center. I received a grant and completed job training through IETC and was awarded a Governor of Illinois's Personal Achievement Award in October 2002. I was placed at the City of North Chicago by the Lake County

Urban League and received an Outstanding Achievement Award from the Mayor in December 2002. I remain



alcohol and drug free which I directly attribute to (1) God, who continues to guide my spirit, (2) my fiancée who give me constant love and support, (3) LCHD programs and regular attendance at meetings and church services, and (4) remembering what my life used to be like and never wanting to return to that world of unhappiness. **Teresa.**

The term recovery at this stage in my life has taken on more meaning than I ever thought it would. It isn't just a word anymore it is an accomplishment. Even more than an accomplishment it is a homecoming. By this I mean it is a return to self, to myself before I chose to walk down a destructive path. Recovery to me is a new beginning, a second chance, a chance to right the wrongs in my life. In other words, a chance to truly enjoy life. **Andre.**

Growing-up in an alcoholic family, Julie started drinking at 13. For the next 35 plus years she was in inpatient treatment at least twenty times, with various outpatient programs scattered over the years. At most, she would



remain sober three or four months, with an occasional year of abstinence. Her family gradually deteriorated, with her husband finally "giving-up" on her three years ago. Julie's last eleven inpatient treatments were at ATP. She describes these as giving her hope as well as the education/tools needed to make sobriety possible. She says that without the support, acceptance and empathy shown by the program staff time and time again, she would never have been able to make up her mind to take care of herself, no one else, and entered recovery about two years ago. Since then she has seen her family become closer than ever, her marriage is strong, she became an ATP volunteer on a regular basis, and, as her picture indicates, is now her husband's partner in running the family business. **Julie.**

Patrick was raised on the North Shore,



growing-up with an alcoholic father. Pat started drinking at 13 and continued for the next 32 years. During that time he was in inpatient treatment 25 times, 13 of them at ATP. He would do well during treatment, but had difficulty putting what he learned into practice. He looks at his treatment experiences as having kept him alive, since the various facility staffs had more confidence in his ability to stay sober than he had in himself. His life changed on 9/11-calling this experience his spiritual awakening. He was in a bar that morning, with a gun, planning his suicide. As he watched 9/11 unfold on TV, he feels God spoke to him, saying the "whole world has just changed-and you can change." He stopped drinking, admitted himself for the last time to ATP, went on to 6 months at Gateway. Looking back, he realized that on 9/11 he overcame the fears he had of facing what had happened in his life and had lost the anger he had held on to. These past two years he has been back to work, very involved in the Oxford House movement, and became a program volunteer at ATP. The picture shows him helping with the relapse prevention group. **Patrick.**

RESIDENTIAL CARE AND RECOVERY

Voices and Faces

My stay in the Extended Residential Care and Recovery home gave me the time and support I needed to change my life. I am 46 years old. I drank heavily all of my adult life and used other drugs including crack. When I entered treatment a year and a half ago, I had no job, DCFS had taken custody of my kids, and I had been in jail because of multiple DUI's. In spite of all of this, no matter what happened in my life as a result of my using, it was never enough to make me stop. It was around Christmas time. I was drinking with my girlfriend and we had a big fight. I had no place to go so I called my brother who suggested I go into treatment. I agreed to go and ended up in Stepping Stones short term residential program. When I completed this, my counselor recommended Extended Residential Care. I really didn't want to go but I didn't have anywhere else to go. During my 3 months in Extended Care and my year in the Recovery Home with the help and support of others I learned how to face problems and deal with them in a positive way without alcohol or other drugs. I got a job my second week in Extended Care. I am still working for the same company and was promoted

to supervisor. I also began to have supervised visits with my 2 year old daughter Candice. While I was in the Recovery Home, DCFS approved weekend overnight visits. Arrangements were made for me to have a private room where Candice spent the weekend with me. I now have a home of my own where Candice and I are living together. Soon my older daughter Paige is going to start visiting on the weekends and hopefully will be able to come live with us. I am getting a lot of rewards. I have a full time job, a place of my own and my family. I look forward to the future. I know I have a lot of support in my life and people who genuinely care about me. **Mike B.**

I live with the addict/alcoholic that will forever reside within me. During the course of coming in and out of the room I had no problem admitting that I'm an addict/alcoholic, I just couldn't accept the fact. Through trial and error I realized yesterday and (just as important) I realize today, I am not perfect and I do not have to pick up entrapping myself in a bar or bottle of lonely depression and anger. Today God, The fellowship of AA, and recovery homes are spiritually and consistently reminding me---so long as there's a breath of life in me, there's HOPE. **Anonymous.**

First I want to thank God for saving my life and giving me another chance. Before I came here I didn't know anything about anything. About how I could stay sober one day at a time the staff taught me things that I thought I

Voices

could never be taught to do. And they were just some simple suggestions listen, don't mess with it and it won't mess with you, and go to meetings. I thought I had to get high in order to go to parties, but they showed me that I could enjoy myself and have a nice time at parties without any drugs when I arrived here they welcomed me and showed me that I could live a better life as long as I don't pick up that first one. Since I have been here my life has changed. I thank God for this program and the staff and the men and women who are trying to find a better way to live. **Anonymous.**

Living in a half-way $\frac{3}{4}$ house has been an oasis providing safety security and hope for me to be rehabilitated. I have learned greater tolerance and acceptance through various apartment mates and residents. I live in a fortunate time where I can seek safety from my inner drive of self-destruction to finding solutions that free my mind and soul I now realize I have been my worst enemy. But together I have the support of others here I now have more serenity and opportunity to be of service to others and myself. **Ronald.**

Voices

Well the way I look at what makes recovery so different is that you have to deal with a lot of different things like your self when your clean like other people not being able to do what you want when you want to do it having to follow rules having to stop doing things that we were used to doing like getting high, tripping off staying out all night not being

responsible dealing with life on life terms so to me recovery is so different now because I see things for what there worth and not for what its not and what I get out of that is BS is BS and real is real you can make this stuff good or bad or happy or sad its up to you to make the call good or bad or happy or sad and with that note I'll keep coming back. **Lamond.**

I came here homeless and hopeless. I thought I'd live the rest of my life in shelters or mental institutions. The people here are more than just men sharing the same house. They are friends, something that I really never had before. **Paul.**

Faces

Recovery first everything else second. **Anonymous**

It keeps me clean and sober, it gives me a clear thought of thinking, ways of being humble, keeping me out of trouble, venturing out to different places, around different people, real people, people about recovery. Change my life, helps me to get positive things back straight with my people and kids. They respect me better, than they used to. Allows me to be the man I used to be, and prove that I can be trusted again. Set good examples for other people, while they're still in their addiction, hoping they will be willing to change their life again. Getting me back to be responsible. Gave me the opportunity to know I don't have to drink or use again. **Kenneth.**

I think living in a recovery home is a privilege. It gives me a chance to be in a place where I would be able to put together the new found coping skills in learning about the AA and NA programs. It also still provides me with more standard living environment. It will only work if the person is willing to change. I'm willing today, to take a honest look at me, and my life. It gives me an opportunity to start anew.

Vincent.

My stay here has inspired me because this is my first time in recovery. It's given me a chance to realize that there is another way of living life on life's terms. This has given me and provided me with a understanding of life without drugs/alcohol it has affected me as well as others giving me input, of the do's and don'ts my stay here has provided me with utilization of taking heed to people that has been in the same predicament as me. When I leave here I will be able to live again. Make better decisions and choices so that I will not experience those consequences of jail and institutions. This is a structured program that's put great emphasis on my life. It's better, I'm better, and I will continue to get better one day at a time. **Anonymous.**

What this program has done for me is just a blessing. I've been in treatment before, but it wasn't for me, and it was nothing like this one. I came here on my own and there's not a day being here that I regret. Safe Haven has so much to offer, and I'm taking advantage of this blessing. Since I've been here I'm learning a lot about

myself. I've had a place of mine, I'm learning to put my priorities in order, I'm learning to be responsible, and take responsibility for my actions. I'm learning acceptance, something I had a problem with. I'm learning how to be productive again and to have patience. I'm just learning how to live again and this program is teaching me all of that. I'm very content with myself right now and I know as long as I want this it will work. The miracle is happening. There's something I might not think is fair but that's where acceptance kicks in. I know now it's part of my recovery. I'm learning to love myself again. Thank God for this beautiful program.

Kim.

Faces

What treatment means to me. It means a world of difference to me, it has made my life much cleaner and sober, all my feelings of hopelessness and loneliness has passed away and everything seems new now. I have turned inconsistent behavior, like anger, confusion and just having a bad attitude into love, a piece of mind and self worth. This is a good program and it is a blessing to me in my life. I have learned how to love myself all over again. The staff are great people that God has sent to work with people like myself. They teach me how to cope with life on it terms. I have gained weight and met a lot of new people. The apartment I live in is very nice and clean, it's a big step up from living on the streets.

Anonymous.

I'm so grateful for this recovery home I'm in I would not trade it for anything in the world!! **William.**



LETTERS

TO WHOM IT MAY CONCERN

To Whom It May Concern:

I am approaching my one-year clean. This is one of my biggest accomplishments in my life. When I sit down and think of my stay at Monarch, a lot comes to my mind.

I have been at the house now for ten months and plan on staying for another year. I had first sobered up in rehab when I told my probation officer I needed help with my drug problem. My stay at Alpine was for twenty-eight days. I had successful discharge from Alpine when I was seventeen and had my eighteenth birthday at Monarch. The first month and a half here I petitioned and moved up to General, the second level in the house. At this same time my discharge was successful from my probation due to my reports, my Primary Counselor gave my officer. When I reached my fifth month at Monarch, I was ready to petition for Pre-mentor, the third level at the house.

Monarch has taught me about the twelve step program and we attend meetings at least three times a week. Working these steps have worked on my character defects. I apply these steps to my everyday life. In addition, working the steps I had created successes in my life. I was recently

employed at Family Dollar in Rockford. I am looking forward to my senior year of high school at Auburn. If I was home I know I would not have the opportunity I have had living here. In this past year, I have built strong relationships with the girls in the house, the staff and my family. I am confident in my future and looking forward to starting college.

Now, I travel around the Chicagoland area, and publicly speak. The pressures at school can get hard, but I know I have a safe home to come too. While working my recovery I know I am not alone and have obtained a sponsor. My tools of recovery and self-esteem are built up more everyday. I am currently working towards Mentor, the highest level at the house. My goal before I leave Monarch is to be a Mentor and be mentally and financially stable to be successful in society. **Melissa.**

To Whom It May Concern:

The Monarch Houses saved my life. I don't know any other way to say it. I truly believe I would not have made it if it were not for this home and all the help that it offers. The people here believed in me until I could believe in myself. When I came into the Monarch House I had no idea who I was. I had no self esteem. I had no clue what it meant to live life on life's terms. They helped me find all this within myself. I know who I am today and I want to discover more. Today because of the Monarch House I can stand up in front of a group of people say I am Elaine and I am an addict and feel no shame and

then tell my story I hope that it can help someone else. Today, because of the Monarch home I can deal with what ever comes up in my life and know that I don't have to use drugs any more. I can survive without them. I have learned coping skills. I learned that as long as I don't give up and to get out of my own way I can do anything, even stay clean. I didn't think it was possible for me to stay clean when I first got here, but with the help of these people I now know I can.

When I got to the home I was not speaking to my mom. Now my mom I go to family sessions and talk on the phone on a regular basis and she comes to visit me also.

This house has given me so much I can't even begin to explain how much it has help me. I am grateful.

Elaine C.

To Whom It May Concern:

The Monarch House gave me another chance to be somebody in the life. It helped me build relationships with people, especially my family. Being in this house has taught me responsibility, by keeping me on a schedule with school, meetings, and chores. I have passed my classes in school, and will be a junior next year. I also maintained good attendance. I have learned to express my feelings and am more assertive now. I feel like I can accomplish anything I set my mind to. I am grateful for the Monarch House and recovery, otherwise I would not be the person I am today. **Christina.**

To Whom It May Concern:

I came into the Monarch House after a 7-month stay at a long-term inpatient treatment center. Probation, my mom, and the courts decided that it would be best for me to continue treatment since three days before I was supposed to go home, I relapsed on my drug of choice, which is crystal meth.

My attitude was not positive when I got to the house. I was very secretive and

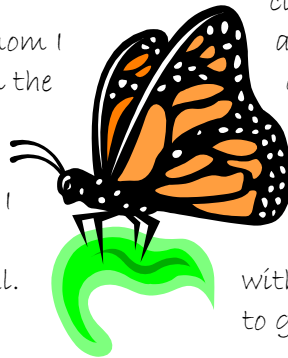
closed-minded for a while. My addiction still had a strong grip on me at that point. I did not want to get rid of my using friends. I did not like going to meetings. I did not want to share my feelings with anyone. I just was not ready to give up my old lifestyles,

although I was sober.

Everything most positive recovering addicts try to

practice the most is everything I was trying so hard to push away. I could handle my using. If they would just watch and give me the chance to show them, they would see that I could do it.

At some point, something clicked for me, I gave recovery a chance. I believe that if it was not for the structure of the house and their determination for me to succeed, there are few possibilities of where I would be right now: miserable and using, in jail, or dead. But I had people who showed me how to live a healthier and happier life, a life that had meaning and goals. I learned



Monarch butterflies are known for their long migrations and impressive wing spans.

beneficial habits and behavioral skills that I know will help me tremendously in the future.

In the program they say, "Fake it 'til you make it" and I did. Because even though I finally starting to see what I needed to do, it was not easy to practice the principles that have been shown to me through the Monarch House and the program. However, as time went on, practicing the principles became easier and I realized I was doing this for me, not for anyone else. I got less worn out, less overwhelmed. I felt like I was accomplishing something for the first time in my life. It was a very different feeling and so I decided to hold onto it for as long as I could and I guess I knew that it meant continuing with working the twelve steps. I now know how to be assertive with anyone. I practice acceptance and patience daily now. I was able to get my grades up in school, maintain positive relationships with family, friends, and people in recovery. I have never been able to do these things before and I think I owe a lot of that to the Monarch House program. **Sincerely, Eleana.**

Upon coming to "This recovery home", my purpose was to seek a safe environment. As I had been clean for 12 months, nine of those spent in the penitentiary and three, of those at my sister's house which was not a safe environment. What I found here was a whole lot more. First of all I found people like me, people who understood me. I was giving a sound plan of action of which I followed, I was given instructions and direction of which I

didn't always willingly accept, believing that I knew a better way. But the structure, the meetings, time spend with my God while here, somehow I found myself listening and trusting intelligent and spiritually sound years, instead listening to myself knowing my 30 years of failure. Here I learned to put God and recovery first which has been very expedient to my growth as a person and My recovery as a alcoholic/addict. Today, because this recovery home has played a very vital role in my recovery, I have 25 1/2 months clean, a decent job with benefits, some people even rust me and look to me for advise, some for things they need. Sometimes I get stressed, sometimes angry, I don't always do the right things, but with God's help I haven't used and don't have a desire to use.

My transition back into society as a law abiding, tax paying citizen is evident to me, and those close to me. I am confident, but cautious, exuberant, but now I count the cost, I know my glass is half full, but aware that it's half empty also. I know that away from here won't be as smooth, and as I continue to grow in my recovery. Three things I know": I have my tools, i.e. meetings, sponsor, God will never leave me or forsake me and A Safe Haven will be here! **Fred.**

I am the sum of my whole
Every bit I pick up along the
Way is part of the creation of me

I have been in 3 treatment centers in my life and it is safe to say that this has changed my life. Recovery has not

just helped me today it has saved my life. And on a daily basis the counselors show me how I can continue to stay sober just take it one day at a time and make meetings. Today I have been in this program 25 days and I am able to identify with myself I can honestly say I am learning who I am. It is refreshing to be able to live like a human being and live with people where are as sick as I am and that they try to help each other take it one day at a time. This allows you to grow in your own pace. If they ask is that you follow the rules of the house take it one day at a time and keep it simple. Not every one knows how to live life and life terms or even to keep things simple. I was one of those people and I have been taught through this program, that recently how to do just that. Staff makes it less hard as they can and it's not hard at all just follows directions and lessons the rest will fall into place. God plays a major part in all of how I haven't been for this Grace and Mercy would not be able to say no to the things I feel today so my thanks to God first to a better way to live and I thank Safe Haven because they help me to see the light at the end of the tunnel. That's what Recovery Means to me today Sobriety.

A Safe Haven provides an environment where you can work on your recovery treatment, a chance to fit back into society. Join the workforce. They give you structure through rules. Why? People need rules to live the way they are suppose to. The rules are very simple; There's no doubt about the recovery home. If it

weren't here I'd still be using drugs I know this. Upon being here through speakers, classes groups I'm sure I'll be a person that keeps my sobriety. My sobriety is very important to me working. I've seen it with my own eyes. The staff here are just like I was. And today you can't tell they've worn the shoes I wear. They care, they try to help other addicts. They extend their hands and heart. I've see clients leave here with jobs with the help of staff members. I've seen clients come back and give it away. Addicts helping addicts. They are needed in all communities (Recovery Homes). I have no doubts about where my life is going. I have choices to make. Today I've made a choice to go further in recovery. As a matter of fact I'm going to be a substance abuse counselor. It that's winned up with God. Then that's what I'm going to do. I shall be an advocate for substance abuse, and I'll start where my drug use ended. The Cook County Jail. They need me. The program is not hard, it's for those who want to change. Before coming here I was a complete total wreck, a full blown addict. Before the TASC program I was using drugs selling and making crack. Getting arrested was the greatest thing that ever happened to me. I knew I was tired of the drugs, tired of the jails, tired of the life I was living tired of the same cycle. I wanted to quit but had not knowledge on how to. I received a blessing I was granted the TASC program 28 days of I.O.P. But I knew truly that 28 days wasn't enough for a 20 year addicts such as myself. So I informed the caseworker at TASC that I needed more than 28

Voices and Faces

days. She got on the phone and called here. They had an empty bed open. That was three months ago. The program is the 120 days: I'm in my last 30 days. To me A Safe Haven is just what it's name is. It's a place where I've found Hope. Hope that lets me know that I can be sober and live a productive life like I once did before I start using drugs. A normal life. While using nothing, Nothing I did was normal. I'm not a bad person I have a lot of skills, seamstress, cosmetologist, certified restaurant manger. So why can't I be a member of the normal people club? There's isn't any reason I just needed another chance. I've have that. E.

For an ex-offender, the path of re-entry into society is filled with lengthy processes, extensive paperwork and dead-ends, including denied access to public housing and jobs because of a criminal record. One of the biggest challenges individuals face is the lack of an established support system when they are released from the correctional facilities.

"Coming to Winners Circle (Winners' Circle is a peer-led support group designed to address the special needs of ex-offenders who are in recovery from severe and persistent alcohol and other drug-related problems. For many, the label of "addict" further compounds the stigma of "criminal" inspired me to do things, to go to school, to share what I've done, where I've been, and how (Winners' Circle is a peer-led support group designed to address the special needs of ex-offenders who are in recovery from severe and persistent

alcohol and other drug-related problems). I got here. Pain shared is pain lessened." Jackie

"I always had the assumption that I did that [planned out everything] but now in my recovery I praise God for all I am. My 61 days in prison were a blessing for me because of my six cell mates who were all races, all ages, all appearances, all experiences but they were all spiritual. "Tammy you ain't even planned your recovery part yet" Those were the last words one of them said to me [before I was released]. This is not just fun for me. When I saw "leadership" it meant business to me. This is all preparing me for what I want to do. The other night I told my daughter for the first time that I used drugs. She said she didn't know."

Tammy

"It moves God when I reach out to somebody else. He didn't clean me up to help me. He cleaned me up to help others." Michorn

"This changed my whole life. I can just say...woo! It opened doors in myself - I know what I can do - I can accomplish. I know my life from this point on has a purpose and a plan. I owe it all to this retreat and now to Restoring Citizenship and Winners' Circle. I'm gonna stay in this. This is what I do now." Tammy (again)

Glossary of Abbreviations

AIDS: Acquired Immune Deficiency Syndrome

ASAM PPC-2R: American Society of Addiction Medicine, Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised

ATOD: Alcohol, Tobacco and Other Drugs

CAPMAN: Capacity Management System

CARF: Commission on Accreditation of Rehabilitation Facilities

CARS: Consolidated Accounting and Reporting System

CM: Case Management

CSAP: Center for Substance Abuse Prevention

CSAT: Center for Substance Abuse Treatment

DARTS: Office's Automated Reporting and Tracking System

DCFS: Department of Children and Family Services

DHHS: Department of Health and Human Services

DSM III-R: Diagnostic Statistical Manual of Mental Disorders, Third Edition, Revised

DUI: Driving Under the Influence

DX: Detoxification

EI: Early Intervention

GLATTC: Great Lakes Addictions Technology Transfer Center

GPRA: Government Performance and Results Act

GRF: General Revenue Fund

HH: Halfway House

HIPAA: Health Insurance Portability and Accountability Act

HIV: Human Immunodeficiency Virus

IADDA: Illinois Alcohol and Drug Dependence Association

IAODAPCA: Illinois Alcohol and Other Drug Abuse Professional Certification Association

ICU: Intensive Care Unit

IDHS/DASA: Illinois Department of Human Services, Division of Alcoholism and Substance Abuse

IDOC: Department of Corrections

ILCC: Illinois Liquor Control Commission

IOP: Intensive Outpatient

ISTOP: Illinois Statewide Treatment Outcomes Project

MISA: Mentally Ill Substance Abusers

NASADAD: National Association of State Alcohol and Drug Abuse Agencies

NCADI: National Clearinghouse for Alcohol and Drug Information

NHSDA: National Household Survey on Drug Abuse

NIAAA: National Institute on Alcohol Abuse and Alcoholism

NIDA: National Institute on Drug Abuse

NIH: National Institutes of Health

NSDUH: National Survey on Drug Use and Health

OB: Office of the Budget

OCAPS: Office of Clinical Administrative and Program Support

OFS: Office of Fiscal Services

ONDCP: Office of National Drug Control Policy

OP: Outpatient

OR: Outpatient Rehabilitation (also specified as Intensive Outpatient)

OSAP: Office of Substance Abuse Prevention

RCU: Recovery Communities United

RH: Recovery Home

RR: Residential Rehabilitation

SAMHSA: Substance Abuse and Mental Health Services Administration

SAPT: Substance Abuse Prevention and Treatment (federal block grant designation)

SEA: Service Efforts and Accomplishments

SN: Sanctuary

SSA: Single State Authority

STNAP: State Treatment Needs Assessment Project

TANF: Temporary Aid to Needy Families

TCE: Treatment Capacity Expansion

TCE/HIV: Treatment Capacity Expansion and HIV/AIDS Services

TEDS: Treatment Episode Data Set

TOPPS: Treatment Outcomes and Performance Pilot Studies