Illinois Specific Model

National Certified Recovery Specialist (N.C.R.S.)

Study Guide

Foreword

The Illinois Association of Extended Care (IAEC) began in 1988 to unite extended care programs in the State of Illinois. Being a member of the national Association of Halfway House Alcoholism Programs (AHHAP), IAEC adapted the NCRS credential in 1994 and was granted permission from AHHAP to confer this credential to recovery professionals in the State of Illinois.

In 1999 the Illinois Alcohol and Other Drug Abuse Professional Certification Association (IAODAPCA), Illinois Association of Extended Care (IAEC), Illinois Alcoholism and Drug Dependence Association (IADDA), and the Illinois Department of Human Services (IDHS) Office of Alcoholism and Substance Abuse (OASA) began discussion about an Illinois specific NCRS. We are grateful to AHHAP for beginning the credential and allowing IAEC to develop an Illinois specific Certified Recovery Specialist (NCRS). We look forward to working with IAODAPCA, IADDA, and OASA in providing the Illinois model of the NCRS credential.

Respectfully submitted by:
Executive Committee of the Illinois Association of Extended Care

Introduction

Extended care facilities employ individuals who fill a unique role among health and human service professionals. Such practitioners work in a unique setting and utilize numerous approaches. They recognize the need to assure quality care to residents. Toward that end IAEC has designed this voluntary credentialing system for extended care professionals who provide services to adult alcohol and drug-involved individuals.

The demonstrated link between extended care and recovery has resulted in the development of this credentialing process. Individuals seeking this certification must be knowledgeable of both the recovery and substance abuse treatment systems.

IAEC realizes that extended care recovery professionals are educated in a wide range of disciplines including; criminal justice, addictions, social work, health, psychology, and other human service disciplines. The Extended Care Professional certification is designed to assess an individual's ability to provide support and direction to alcohol/drug involved individuals. It defines an extended care professional's role and function, thus distinguishing these individuals among other health and human service providers. The certification process is designed to accommodate and evaluate those who are both experientially trained, as well as those who are academically trained.

This process sets a baseline standard for professionals working in extended care settings when providing an array of services to alcohol/drug-involved residents. Such professionals are given recognition for meeting specific predetermined criteria. The purpose is to assure that quality services are available to adult alcohol/drug involved individuals. Certification provides a professional credential that can guide employers in selecting competent staff and sets the direction for further professional growth.

Definition and Setting

This certification process was developed for professionals working with the alcohol and other drug abuse (AODA) extended care populations. The setting in which the required number of work and supervised hours must be met is defined as: Any setting which provides case management services, service coordination, behavior management, or behavior shaping to alcohol/drug involved individuals.

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PRE-TEST

NAME:____________________ DATE:______________ RIGHT______

WRONG______

1. AODA is an acronym for:
    a. Administrative Office of District Attorney
    b. Ancient Order of Druids in America
    c. Alcohol and Other Drug Abuse
    d. American Overseas Diabetes Association

2. A written agreement with an external organization to supplement existing levels of care and to arrange for other specialty services not directly provided by the organization is a:
    a. Linkage Agreement
    b. Treatment Plan
    c. Utilization Review
    d. Revocation

3. A self-help support meeting is which of the following:
    a. A.A
    b. N.A
    c. C.A
    d. All of the above

4. Which of the following is the state law governing licensure for recovery homes?
    a. 2060.309
    b. 2060.205
    c. 2060.203
    d. 2060.509
    e. None of the above

5. An occurrence at a licensed facility that requires the services of the coroner and / or which renders the facility inoperable is considered which of the following?
    a. Transfer
    b. Incident
    c. Discharge
    d. Significant Incident

6. Residential extended care shall require staff to be on duty?
    a. 24 hours – 7 days per week
    b. Only when giving treatment
    c. 9:00 AM to 5:00 PM
    d. None of the above

(OVER)

SECTION 2

Resource Information

RECOVERY HOME SOCIAL MODEL HISTORY

The social model of alcohol recovery in California has evolved through several generations to what we know as the model of the 90's. Social model programs emphasize the process of learning through "doing" and "experiencing" and providing positive role models. The development and acceptance of the social model in California has been a dynamic process. It must continue to evolve to meet the needs of the people who seek its services. Nobody owns the social model, nobody created it, it is the legacy from many pioneers of the past, and is the hope for many alcoholics in the years to come.

The concept of social model in California is probably older than the State itself since the phenomenon of people helping others who have a like problem surely dates back to the dawning of civilization (as does the use of fermented substances to alter one's state of consciousness!).

In the 20th century, and the decade of the 30's in particular, significant events occurred which would influence and define the future social model. Prohibition ended in 1933, Alcoholics Anonymous was founded in 1935, and the National Council on Alcoholism was founded in 1937.

The roots of modern social model are in the mutual self-help concepts of Alcoholics Anonymous, (A.A.). Individuals struggling with early sobriety in A.A. often were temporarily homeless and in need of social support systems. Members of A.A. would often house newer members and act as guides by sharing their own experiences with the fledglings. Since Alcoholics Anonymous, according to its Traditions, could not be involved in support systems it became a movement of its own. When public support began to flow into these recovery homes, they became more formalized with program standards and facility licensing.

What exactly is social model? It tends to be elusive as it can be defined as a movement as well as a model for recovery, and the process of developing a social model program is itself a social model of process.

Some examples of social model include an Alcoholic Recovery Home which is a community based, peer-group oriented, residential facility that provides food, shelter, and recovery services in a supportive, non-drinking, drug-free environment for ambulatory and mentally competent alcoholics. Services provided include individual and group recovery planning, alcohol and recovery education, group support, recreational activities, information about and assistance in obtaining health, social, vocational and other community services. The home must be cheerful, warm and accepting and provide an environment within which the recovering alcoholic has the opportunity to make a positive change in life style. The major goal of a recovery home is to provide an environment in which men and women recovering from alcoholism will experience a sober, functioning life style and return to the community as responsible drug-free individuals. Another example is a non-residential Social Model Alcohol Program which is a community based program that provides a sober, supportive environment, offers services to persons with alcohol related problems and educates the surrounding community concerning such problems in order to reduce alcohol related problems including alcoholism.

Social model programs operate on the premise that experiential learning is the path to recovery. The program is structured so that opportunities to experience recovery and to observe and interact with persons who have experienced phases of recovery are available. The therapeutic relationship is between the person and the program, and the program is made up of all participants, volunteers, and staff. There is a reciprocal sharing between the individual and the program so that all give, and therefore, all receive. The program takes place in a positive sober environment wherein the individual feels comfortable and safe, and the program relies heavily on the larger community to provide additional health and social support services. The principals of Alcoholics Anonymous are stressed and involvement in A.A. early in recovery provides an opportunity for a life-time support system. Social model programs are extremely cost effective and are extremely outcome effective because of their ability to build strong and lasting social support systems.

Social model is a process, it is an attitude, it is a way of life.

STANDARDS
FOR

RESIDENTIAL RECOVERY HOMES
HALFWAY HOUSES
AND OTHER
SOCIAL MODEL RECOVERY PROGRAMS

Social Model Recovery Program Characteristics

Please Note: Residential Social Model Recovery Programs include Recovery Homes and Halfway Houses. The terminology will **differ** depending on the location of the program.

Social Model Recovery Programs are specifically community-based, designed systems of alcohol and other drug recovery services that are characterized by:

1. Provisions of a non-drinking, drug-free environment which encourages the development of life patterns conducive to sobriety and good health.
2. Encouragement of independence and personal responsibility on the part of the participants.
3. Encouragement of participants to develop interpersonal relationships and social skills.
4. Provisions of a peer group of participants to develop interpersonal relationships and social skills.
5. Establishment of opportunities for meaningful involvements or tasks and specific roles for participants.
6. Alcoholism and other drug addiction education and introduction to recovery resources for participants.
7. Informational **services** for alcoholics and other drug addicts and their families.
8. A program of non-drinking, drug free social interaction which may include parties, dinners, dances, picnics, etc.
9. A community educational resource for those providing services to alcoholics and other drug addicts.
10. Orientation and involvement of participants in appropriate **community** services.
11. Linkage to community services, i.e. vocational rehabilitation, hospitals, courts, social service departments, physicians, counseling agencies, Alcoholics Anonymous, Narcotics Anonymous and other self help programs.

SERVICE CHARACTERISTICS
OF THE VARIETY OF RECOVERY HOMES

A. Supportive Recovery Program: Services and programs are provided to recovering alcoholics and drug addicts' in need of a transitional stage to facilitate improvement of life styles and alleviate the need for alcohol and other drugs. Programs assist personal recovery and include social interaction tools such as: individual and peer group educational sessions, recreation programs, and personal recovery planning. Persons are also assisted in obtaining vocational employment training and other services.

B. Long Term Residency: This service is provided for alcoholics and drug addicts who require more time to assume self-sustained recovery. Residents are assisted in obtaining medical, dental and other social services. It also offers a structured life-adjustment and socialization program. Self-reliance and self-government are encouraged to the greatest possible extent. Work, recreation, and social activities are structured to expand personal potential. Medical and social services are obtained outside the facility. Whenever possible residents should be encouraged to make the transition to home or cooperative living arrangements. Length of stay is indeterminate.

C. Cooperative Living: Residents receiving this service have made positive life adjustments and are capable of sustaining a cooperative living arrangement. Persons must have a continuing income. Further recovery support may be obtained outside the facility (A.A., church, social clubs, etc.).

Services and programs are provided to alcoholics and drug addicts and their families who reside in the community and who are in need of support education and referral. The non-residential program services address alcohol and/or other drug-related problems at the individual, family and community levels.

RECOVERY HOME PROGRAM

A. The Recovery Home Program is an experiential environment where a variety of program activities are organized to support the natural process of recovery. Some of the activities are educational and analytical in nature focusing on internal realities and awareness of the stages of recovery. Others are reality-oriented tasks, work assignments and group involvements that offer opportunities for direct experiential learning and determine the nature of group interaction.

   This experiential knowledge is the basis of program authority. In the recovery home/halfway house the recovering persons learns by "doing" recovery, rather than by receiving help or "treatment".

B. In the home the learning relationship is between the person and the program as opposed to between the person and a "counselor". Rather than changing the individual (case management) the home staff manages the environment and provides tools in order to maximize recovery opportunities for individuals and serve as positive role models.

C. In the reciprocal learning process everybody both gives and receives help; the resident is at the same time consumer and provider of services.

D. The fundamental framework for the program is the dynamics and values of the self-help movement as expressed in the wisdom of the A.A. group. Along these lines the recovery home program focuses on the experience of surrendering and transformation of belief systems as the key to successful recovery.

E. The program also recognizes that alcoholism and drug addiction is part of a reciprocal relationship between the individual and the social context. Therefore, changes at the level of the individual are seen as able to effect the alcoholism and drug addiction at the level of society, and vice versa.

Comments/Examples:

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RESIDENT INVOLVEMENT

It is recommended that self-worth be promoted by involving the resident in home operation, household chores, and general duties of the home. Resident involvement must be considered as part of the recovery home program.

The resident must be encouraged to be a member of the home community with responsibility to this community. Resident involvement entails active participation with his/her new reference group as well as increased responsibility for making program decisions. This involvement during the primary recovery period may be limited to performing housekeeping or simple maintenance chores. As a resident's recovery progresses, additional opportunities may include meal and recreation planning, direction of renovation projects, participation in community activities, or assisting in policy decisions.

A progression schedule should be developed outlining resident responsibilities and opportunities for growth consistent with an individual's recovery progress. The formation of a resident council is encouraged. A council provides a method for residents to become involved in and responsible for decisions affecting their lives in the recovery program.

Resident involvement must be viewed as an investment in the program rather than an imposition.

Comments/Examples:

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SOCIAL, RECREATIONAL AND SPIRITUAL ACTIVITIES

Social model alcohol and drug program shall make provisions for social, recreational, and spiritual activities in accordance with the interests and abilities of the participants, including, but not limited to the following:

A. Participants shall be encouraged to join with other members of the program in various leisure-time activities designed to promote social relationships.
B. Participants, whenever possible, shall be encouraged to engage in community activities.
C. Programs should make spiritual resources available.

Attendance at religious services or A.A. or other "self-help" meetings held in the program shall be on a completely voluntary basis, unless otherwise specifically agreed in the participant agreement.

Comments/Examples:

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USE OF COMMUNITY SERVICES

A Social model alcohol and other drug program should be thought of as part of a network of services provided in the community. Therefore, the social model alcohol and other drug program should use all available existing community service resources to enhance its program, rather than duplicate them within the program.

Participants should be encouraged and aided in seeking needed medical care, social services, family, marital, vocational, legal counseling, and psychiatric evaluation and treatment in the community.

Comments/Examples:

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FOLLOW-THROUGH

The program staff should make continuous effort to maintain contact with former participants. Such contact aids the continued social, vocational, and general life adjustment of the participants.

Among the ways a program can maintain contact with former participants are the following:

Alumni Associations
Circulating a newsletter
Sponsoring annual or semi-annual get-togethers or outings
Using former participants as program volunteers
Mail and phone contacts

Comments/Examples:

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PARTICIPANT RECEPTION

All social model recovery programs will operate on a nondiscriminatory basis providing all recovery services in accordance with state and federal laws. In residential programs initial assessments will be performed to reinforce the environment of the home, referring individuals who are not appropriate for the program to appropriate resources as available, which may provide for their individual needs.

A Social Model Recovery Program may establish admission policies targeting specific populations such as members of religious, ethnic, gender, or special language needs and groups.
All admissions shall be voluntary.

RESIDENT AGREEMENT – RESIDENTIAL PROGRAMS

A. All residential programs shall have a written agreement with each resident. Such agreement shall be completed prior to or within seven (7) days after admission and shall be dated and signed by the Director or authorized representative and by the person admitted. The original of the completed agreement shall be retained and a copy shall be given to the resident.

B. The agreement shall specify:

   a. The services to be provided by the program.

   b. The fee for basic services and a list of charges for services not included in the basic rate.

   c. The conditions for modification of the agreement, including provisions for at least thirty (30) days prior written notice of any basic rate change.

   d. The conditions under which refunds will be made.

   e. The services shall at all times be provided without discrimination.

   f. Conditions under which the agreement may be terminated.

   g. That no person shall be summarily asked to leave except for specified reason.

   h. Conditions under which a person may be restricted to the program.

OBJECTIVES FOR STAFF

1. To provide safe, clean, sober living environment for residents.

2. To serve as a role model.

3. Teach residents to be self-sufficient (e.g. tell them where to look, or how to do, but do not do it for them).

Comments/Examples:

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BRIEF DESCRIPTION OF RECOVERY LEVEL FOR HOUSING

HALFWAY HOUSE - A licensed community-based residential facility that provides treatment services for adult alcohol and drug addicted clientele in a supportive, homelike environment. This level of care provides twenty-four hour on site coverage as a crisis management service, and a full treatment component as a crisis management service and a full treatment component provided by credentialed staff. The program emphasizes the use of community ancillary services and the securing of employment.

RECOVERY HOMES - A licensed community-based residential facility that either provides recovery services or peer interaction for adult alcohol and drug addicted clientele in a supportive, homelike environment. This level of care provides twenty-four hour on site coverage as a crisis management service provided by either credentialed staff or non-credentialed employees or volunteers. Most participants are fully able to care for self and are encouraged to seek employment as soon as possible in their recovery process.

SOBER HOUSE - A community-based residential facility that provides a homelike environment for adult alcohol and drug addicted clientele with no treatment component and emergency services provided when needed. Residents have sole responsibility for maintaining the residence and making rent payments, which are collected by the overseeing landlord or proprietor.

SANCTUARY - Provides board and lodging for adult alcohol and drug addicted clientele in the late stages of alcoholism. The typical client has repeated admissions to detoxification centers and a history of failure in traditional chemical dependency treatment programs. Sanctuaries provide long term housing for individuals who do not maintain continuous sobriety but want to and can live in permanent housing. Residents are active substance abusers but no alcohol/drugs are allowed on-site. Sanctuaries are a unique alternative that provide dignity and stability for the chronic alcoholic/substance abuser using a design that promotes remission of the disease and occasionally full recovery.

HALFWAY HOUSE

SUPPORT SYSTEMS

- Availability of specialized professional consultation and supervision
- Availability of a physician and/or emergency services by telephone twenty-four hours per day, seven days a week
- Access to more intensive levels of care as clinically needed

STAFF

- Appropriately trained addiction professional staff to provide supervision and training of technical staff and case management
- Facility approved technical staff

TREATMENT APPROACHES

- Scheduled clinical services to assess and address the individual needs of each client/patient. Such skilled treatment services may include but are not limited to psychotherapy, family therapy, individual and group therapy, education groups, occupational and recreational therapy

ASSESSMENTS/TREATMENT PLAN REVIEW

- Individual bio-psychosocial assessments an/or addenda are made on all clients/patients
- Individualized treatment plan includes problem formulation, treatment goals and measurable treatment objectives
- Treatment plan reviews are to be conducted at specified times as noted in the treatment plan or as required by accrediting or licensing bodies

DOCUMENTATION

- Progress notes in the client's/patient's record clearly reflect implementation of the treatment plan and the client's/patient's response to treatment.

RECOVERY HOME/THREE-QUARTER HOUSE
(Minimum required)

SUPPORT SYSTEMS

- Access to more intensive levels of care as clinically needed

STAFF

- Illinois Specific N.C.R.S. within two years and Facility approved technical staff

RECOVERY APPROACHES

- Peer interaction

ASSESSMENTS / RECOVERY PLAN REVIEW

- Recovery plan reviews are to be conducted at specified times as required by accrediting or licensing bodies

DOCUMENTATION

- Progress notes in the client's record to reflect progress and special incidents

SOBER HOUSE
(Minimum required)

SUPPORT SYSTEMS

- Access to more intensive levels of care as clinically needed

STAFF

- Facility approved technical staff

ASSESSMENTS / SOBER PLAN REVIEW

- Peer review

DOCUMENTATION

- Progress notes in client's chart to reflect progress and special incidents

SANCTUARY

SUPPORT SYSTEMS

- Large single and double rooms, communal bathrooms, laundry facilities
- Meals can be offered at an additional cost
- Information and referrals
- Self help group meetings
- Recreation/education programming
- Twenty-four hour supervision and assistance in responsible living at the residence

STAFF

- Facility approved technical staff

RECOVERY APPROACHES

- Does not impose structured services
- Emphasis on socialization/recreation
- Promoting employment
- Maintaining entitlement to income/health benefits
- Referrals to community social services
- Drug/Alcohol free section for those involved in a personal recovery program

DOCUMENTATION

- Progress notes in the client's record clearly reflect any change in progress

A BODY OF KNOWLEDGE

HALFWAY HOUSE ALCOHOLISM PROGRAMS ADMINISTRATION AND PROGRAMMING

Decision Makers

Decision makers are more readily responsive to accepting a situation, making an immediate assessment, and acting on their first evaluation of a situation. The more they do this, the more successful they are in being able to make the right responses. In other words, the more one practices decision making, the more accurate he is in his judgments. This is the intuitive quality that becomes highly developed among halfway house staffers. For theirs is a role of constant decision making.

The rule of practice makes perfect applies here. The key to why some develop this ability and others do not, is directly tied in with their willingness or unwillingness to accept risks. When working with people, there is always risks involved. One can minimize the risk, by minimizing the depth of the relationship. So the degree of involvement in one-to-one relationships with other staff and residents id dependent on how many risks the front liner is willing to accept. Accepting the risks has the potential for self harm.

***Nobody has the power to make anyone sober or relapse – you make your own decisions.*

Fortunately, most front-liners that work in halfway house alcoholism programs have complete acceptance of the risk factors. How do front-liners solve problems? And how do they do so expediently? Dr. Earl Rubington in the Status Reports, refers to the halfway house staff personnel (in particular, those who have achieved their own personal recovery from addiction) as "journeyman"; Individuals who act as guides to other recovering individuals, describing the "map" through, and to, a new way of life.

As journeymen or guides, one relies heavily on memory, landmarks, associations, and an inner sense of direction while traveling life's paths. So the front-liners, by virtue of their past experiences, their sense of inner direction, their ability to draw on familiar and associations, apply this knowledge, this knowing ability to present and unfamiliar with successful outcome. These people are invaluable and make great contributions as halfway house personnel.
Problem solving increases the further one goes on the recovery path. Each successful experience at solving a problem increases the chances of future

success in handling problems. The front-liners have learned this through their own recoveries and share this with newly recovering individuals.

Front-liners rely also on another known fact about dependent individuals. That is that they are people who "want...what they want, when they want it!" Why? Because, these people are extremely uncomfortable people on the inside! That is why they become addicted. Chemicals changed the way they felt and made them more comfortable.

Knowing this, the front-liners utilize the good and/or bad "reward system". Immediate responses to the recovering persons actions either enhances and encourages acceptable behavior, or stifles and discourages non-acceptable behavior. Thus behavior is modified or changed. In the halfway house setting, this goes on twenty-four hours a day and is reinforced by resident peers and other staff.

Consistency and immediate responses, help the recovering person to better assess his own behavior and actions. It also provides the basis for emulation of models. An outline is set forth here in an attempt to pin point the step-by-step responses of a front-liner in solving problem(s).

Front Line Problem Solving

A resident has a problem and comes to you for help:

- Hear the person out (just facts)
- Determine whether the problem is an emergency, or if there is time limit involved; act accordingly
- If an emergency, determine the first "must" or action to be taken
- If a non-emergency, help resident explore and initiate a "plan of action", but first......

When counseling a Resident

- It is important to explore all possible avenues of alternative responses to cope with the problem at hand.
- A guide, or map of alternative routes will assist the person in learning new ways of problem solving, other than drinking, taking pills, running away, procrastination, suicide, etc.

***Help the resident to make their own decisions.*

STAFF DIRECTION: Resident Choices

Problem

1. Do Something
2. Do Nothing
3. Wait (holding period)

Doing Something

1. Call
2. Write
3. Personal response
4. Seek professional advice
5. Follow professional advice

Doing Nothing

1. Avoid situation
2. Procrastinate
3. Pretend it didn't happen
4. Use a chemical solution
5. Sleep on it

Wait

1. Non-emergency, so there is time to plan actions.
2. Wait for deadline, timing is important.
3. It's not your problem, butt out!
4. Think on it, let anxiety build until you want to drink.
5. Contemplate suicide.

The above outline is appropriate when the resident comes to you. However, if you must go to the resident, another outline would be as follows:

Problem

1. Inappropriate behavior
2. Practicing addiction
3. Personal crisis

Staff Direct Approach
Emergency

1. Call resident to the office
2. Go to bedroom, etc. and find person
3. Wait for resident to return, meet at door

Staff In-Direct Approach

Non-emergency:

1. Leave message to see staff as soon as possible
2. Leave message with appropriate directions
3. Make appointment and/or appropriate referrals for resident

Meanwhile, reasoning:

1. Should this situation be handled in private?
2. Should this be handled by the group, by family?
3. Should this be referred to appropriate resource?
4. Is this an individual problem?
5. Is this a group problem?
6. Is this a community problem?
7. Should this problem be dealt with now?
8. Should this problem be dealt with later?
9. Should this problem be observed and allowed to complete its course, thereby solving itself or bring the situation to an either-or stage which can then be handled as a crisis.
10. Should resident be given a warning?
11. Should resident be terminated?
12. Should resident be appropriately referred, transferred to another agency or professional resource?

These outlines are only a sample of the thinking process that goes on inside the front-liner's mind while trying to make an "on-the-spot" decision, evaluation and immediate response to a given situation. How to choose, what to do, what to say, and when? Each and every individual will respond in his or her own way. Responses will be determined by past personal experiences, values, training and intuitive feeling.

Joint Committee on Administrative Rules

ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH
CHAPTER X: DEPARTMENT OF HUMAN SERVICES
SUBCHAPTER d: LICENSURE
PART 2060 ALCOHOLISM AND SUBSTANCE ABUSE TREATMENT AND INTERVENTION LICENSES
SECTION 2060.509 RECOVERY HOMES

Section 2060.509 Recovery Homes

Recovery Homes are alcohol and drug free housing components whose rules, peer-led groups, staff activities and/or other structured operations are directed toward maintenance of sobriety for persons who exhibit treatment resistance, relapse potential and/or lack of suitable recovery living environments or who recently have completed substance abuse treatment services or who may be receiving such treatment services at another licensed facility. In order to be called a Recovery Home, the home shall:

a) provide a structured alcohol and drug free environment for congregate living that shall offer regularly scheduled peer-led or community gatherings (self-help groups, etc.) that are held a minimum of five days per week and provide recovery education groups weekly;

b) have written linkage agreements with substance abuse providers in accordance with the provisions specified in Section 2060.329 of this Part;

c) establish a referral network to be utilized by residents for any necessary medical, mental health, substance abuse, vocational or employment resources, and maintain the confidentiality of client identifying information in accordance with 42 CFR 2 (Confidentiality of alcohol and drug abuse patient records);

d) establish a budget that specifies monthly operating expenses and demonstrates sufficient income to meet these expenses plus emergency reserve by providing documentation of access to a minimum sum equivalent to the total of two months of operating expenses;

e) comply with all applicable zoning and local building ordinances and the provisions specified in Chapter 26 (Lodging or Rooming Houses) of the National Fire Protection Association's (NFPA) Life Safety Code of 2000 (no later amendments or editions included) for any building housing 16 or fewer residents and with the

provisions specified in Chapter 29 (Existing Hotels and Dormitories) of the NFPA Life Safety Code of 2000 (no later amendments or editions included) for any building housing 17 or more residents;

f) maintain fire, hazard, liability and other insurance coverages appropriate to the administration of a recovery home;

g) employ at least one full-time Recovery Home Operator who is responsible for the daily operations at the Recovery Home (i.e., fiscal, personnel, rule compliance, etc.) who shall:

1) either:

A) hold clinical certification from IAODAPCA or receive that certification within two years after the date of employment; or

B) hold certification as a National Certified Recovery Specialist (NCRS) as specified by the Association of Halfway House Alcohol Programs (AHHAP), RR 2 Box 415, Kerhonkson NY 12446

C) have a minimum of 2000 hours of work experience or 4000 hours of volunteer experience in the field of substance abuse of which 1500 hours shall have been in direct Recovery Support Systems Services (i.e., Residential Extended Care Facility or Recovery Home); and

2) provide three letters of recommendation from substance abuse professional staff as defined in Section 2060.309 of this Part; and

3) provide a signed and dated acceptance of the Code of Ethics as established by the Illinois Association of Residential Extended Care Programs, Box 269180, Chicago, Illinois 60626, website: AHHAP.org; and

h) have on-site at least one Recovery Home Manager who oversees all Recovery Home activities under the direction of the Recovery Home Operator. Recovery Home Managers shall:

1) hold certification as a National Certified Recovery Specialist (NCRS) as specified by the Association of Halfway House Alcoholism Programs of North America, Inc. (AHHAP), RR2 Box 415 Kerhonkson NY 12446, or receive such certification within two years after the date of employment; or

2) hold certification from IAODAPCA or receive the certification within two years after the date of employment; or

3) have a minimum of 1000 hours of work experience or 2000 hours of volunteer experience in the field of substance abuse of which 750 hours shall have been in direct Recovery Support Systems Services (i.e.,

Residential Extended Care Facility or Recovery Home) and provide a signed and dated acceptance of the Code of Ethics as established by the Illinois Association of Residential Extended Care, Box 269180, Chicago, Illinois, 60626, website: AHHAP.org.

The Recovery Home Operator may also function as the Recovery Home Manager as long as the requirements for both positions are met.

(Source: Amended at 27 Ill. Reg. 13997, effective August 8, 2003)

Recovery Home Meetings
(Community, Peer Group, Recovery Education, A.A.)

The home must demonstrate that they provide a structured alcohol and drug free environment, offer regular scheduled peer-led or community meetings at least five times per week and provide recovery education groups weekly.

Recovery Home Linkage Agreements
(Referrals)

The linkage agreements ensure that the home has a method of obtaining any necessary written consent from the patient/client – a method ensuring continuity of client care.

The home must make the linkage agreements and referrals accessible to the client. This process is also subject to review by the Department (OASA).

Recovery Home Budget

An agency must have a budget that specifies monthly operating expenses, demonstrates sufficient income to meet these expenses, and have an emergency reserve of two months of operating expenses.

All receipts and/or bills are subject to review by the Department (OASA).

The home must also show evidence that it is 100% in compliance with having current fire hazard and liability insurance (payment procedures and expiration dates).

Joint Committee on Administrative Rules

ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH
CHAPTER X: DEPARTMENT OF HUMAN SERVICES
SUBCHAPTER d: LICENSURE
PART 2060 ALCOHOLISM AND SUBSTANCE ABUSE TREATMENT AND INTERVENTION LICENSES
SECTION 2060.417 ASSESSMENT FOR PATIENT PLACEMENT

Section 2060.417 Assessment for Patient Placement

An assessment shall be conducted prior to admission to any level of care. This assessment shall be an individual face-to-face service and shall include collection of demographic data as referenced in Section 2060.325(1) of this Part and:

a) For admission to Level 0.5, Early Intervention:

1) review of any specific conditions of court supervision or probation including any prior substance abuse screenings or evaluations conducted prior to admission (i.e., DUI); and

2) sufficient assessment to screen for, or rule out, substance related disorders.

b) For admission to Levels I-IV care:

1) an evaluation of the severity of the six dimensions established in the ASAM Patient Placement Criteria;

2) a recommendation for placement in Levels I-IV care as established in the ASAM Patient Placement Criteria;

3) a diagnostic impression of substance abuse and/or dependence as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) that shall be confirmed as a diagnosis by a physician.

c) Physician confirmation of diagnosis and initial patient placement:

1) the medical director shall define protocols and authorize procedures for confirmation of diagnosis or admission without diagnosis as specified in Section 2060.403(a) of this Part and initial patient placement in Levels I-IV care.

2) confirmation of diagnosis may be made by telephone or facsimile transmission if so authorized by procedure.

3) confirmation shall occur no later than 24 hours after admission for Level IV care, no later than 72 hours after admission for Level III care, and no later than 7 working days after admission for Level I and II care.

4) confirmation of diagnosis and admission is not necessary for Level 0.5 Early Intervention.

d) Prior to admission, or in the case of an intoxicated patient, as soon as stabilization occurs, basic information about treatment services shall also be provided and shall include the following:

1) the procedures and treatment services the patient will receive;

2) if possible, an introduction to the professional staff members who serve as the primary contact with the facility for the client;

3) the hours during which services are available;

4) the risks, side effects, and benefits of all medications prescribed by the organization's medical director or physicians working under his/her supervision or direction and experimental treatment procedures to be used;

5) the cost, itemized when possible, of services to be rendered;

6) any limitations placed on duration of services; and

7) the rules and regulations of the facility applicable to the patient's conduct.

e) A written, dated, and signed informed consent form shall be obtained from the patient, or the patient's legal guardian, and from family members who also participate, for use or performance of the following activities:

1) experimental medications;

2) hazardous on experimental assessment procedures;

3) recording on audiovisual equipment;

4) participation of the patient in research projects; and

5) testing for Human Immunodeficiency Virus (HIV).

(Source: Amended at 25 Ill. Reg. 11063, effective August 14, 2001)

ADMISSION CRITERIA FOR LEVELS OF CARE UNDER THE SIX DIMENSIONS

1. **Acute Withdrawal** - during the assessment or if a resident enters the building intoxicated/smelling of alcohol or displaying withdrawal symptoms from drugs or prescription medication – resident should be referred to detox.

   Signs that you may look for:

   a. Running eyes
   b. Running nose
   c. Dilated pupils
   d. Nodding
   e. Scratching
   f. Curving/twisting of the mouth
   g. Talking erratic
   h. Slurred speech

   Other signs to look for when assessing the potential resident:

   a. Facial expressions – frowns, eye contact
   b. Body language – twisting in the seat
   c. Constantly repeating rules and regulations (ex: thirty day restrictions, no visits, curfew, etc.)
   d. Eager to leave the treatment facility to come – not completing services

These are just visual signs that may assist you in assessing the level of care and the placement for a potential resident. Remember that every potential resident may not meet the level of care for residential housing.

Comments:

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2. **Biomedical** - Physical Problems that need to be addressed prior to admission.

Examples:

- Does that person appear to need direct medical attention? (daily nurse)
- Can the person self-administer their own prescription medication?
- Is the potential resident wheel-chair bound?

Review the list of prescription medications that the potential resident is taking and see if the medication will free them of any physical or psychiatric conditions that would prohibit participation in daily living activities.

Comments:

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3. **Emotional/Behavioral Conditions and Complications** – look to see if the potential resident is experiencing the following behaviors so that they may be referred to the appropriate services to meet their emotional and behavioral conditions.

Emotional symptoms that may interfere with daily living activities and/or recovery:

a. Depression
b. Compulsive behavior
c. Disruptive behavior
d. Violent acts
e. Danger to self or others
f. Suicidal thoughts/attempts
g. Personality disorders

Example: A person that suffers from two personality disorders. One way a person may be effected is cognitive, which means of the mind. They tend to perceive things in a different way (i.e. self, other people and events).

Comments:

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4. **Treatment Resistant/Acceptance** - In spite of the serious consequences, person continues to repeat the same behaviors (continues to use controlled substance, does not understand the relationship between substance use, life problems and improving their coping skills.

Signs to look for:

Does client resist or procrastinate when it comes to any of the following requirements?

a. Attend self-help meetings
b. Obtaining sponsor
c. Building a recovery network
d. Self-help home group

Comments:

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5. **Relapse Potential** – resident is unable to recognize relapse triggers, can't commit to continuance of care, continued substance use, imminent – possible danger to self and others.

How do we identify whether a resident is in a relapse mode?

a. Resident continues to go in the area that they used
b. Rationalizing the reason why
c. Not attending meeting
d. Does not have a sponsor
e. Late for all functions
f. Isolating
g. Attitude changes (defensive and anger)

Comments:

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6. The Recovery Environment

a. A resident that has resided in a toxic environment
b. At high risk of repeating physical and emotional abuse
c. The environment will not allow the resident to achieve long-term sobriety
d. Living in an environment where there is regular usage of alcohol and drugs
e. Resident has no permanent address – moves from relatives homes to friends homes
f. The environment in which the resident is or has resided has deteriorated their social/interpersonal network

Comments:

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INTAKE PROCESS

This portion is a piece of the intake process. It involves the following:

- Pre-Screening
- Assessment
- Placement
- Referral
- Continued Stay
- Crisis Intervention
- Discharge Planning

It is derived from **ASAM PPCII** and is used by anyone providing services for alcohol and substance abuse. The Rule 2060 governs treatment services in the state of Illinois.

Note: **IV Drug Users and Pregnant Women** are a priority by the State (OASA). During an assessment if it is determined potential resident is either one or both of these we can take them and possibly work toward finding them an appropriate level of care.

**Client cannot be denied services for HIV status nor their ability to pay. However, we do go by availability of beds.

Comments:

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INTAKE TRAINING

1. **Screening** – to see if person called the right place; that we are providing the right services for caller.

2. **Assessment** – determines move-in, are they appropriate for the facility? (Mental and physical disabilities, also may call for face to face).

   - If they are on meds, how do they pay for them?
   - Psych meds assessment – who is the doctor? Is client still seeing doctor?
   - Must have medical verification form
   - Signed release of information (Until you speak with therapist, do not commit to residency).

Comments:

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3. **Placement and Referral** – based on the answers to the above, we go to placement and referral. Either client is appropriate for services at your facility or the client must be referred to another agency.

4. **Continued Stay** – involves written review (Recovery Plan, progress notes or continued stay review form) of resident that actually moved-in.

   How well are they doing with:

   - recovery planners
   - sobriety
   - getting along with others, residents and staff

Comments:

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5. **Crisis Intervention** – deals with relapse, medical issues, mental break-downs. Tools to use – consequences, referrals, incident reports.

Note: Continued Stay Review and Crisis Intervention are Case Management Services.

Comments:

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6. **Discharge Plan** – this begins the day a client arrives. The Recovery Plan is a big part of the discharge plan. You should be planning and going over the day that the client will leave.

Comments:

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Joint Committee on Administrative Rules

ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH
CHAPTER X: DEPARTMENT OF HUMAN SERVICES
SUBCHAPTER d: LICENSURE
PART 2060 ALCOHOLISM AND SUBSTANCE ABUSE TREATMENT AND INTERVENTION LICENSES
SECTION 2060.329 REFERRAL PROCEDURE

Section 2060.329 Referral Procedure

a) Written procedures shall be established for the referral of patients to other providers for services that are not available within the organization and/or that are requested by the patient. These procedures shall include the following:

   1) the method of obtaining any necessary written consent from the patient for transfer of any relevant portion of the patient record and for communication regarding patient services with that provider;

   2) the method for ensuring continuity of patient care which shall include a written referral document that indicates the reason for the referral, provides information about any service received to date and any additional services needed or requested, specifies any necessary continued coordination between the providers and the time frame for any necessary follow-up reports; and

   3) the method by which a patient may request a referral.

b) Each organization shall have a written linkage agreement, specifying the above provisions, with any other provider that it routinely utilizes for referrals unless otherwise required by the Department.

c) All referrals made for treatment or intervention services as defined in this Part shall only be made to organizations licensed under this Part, to those individuals or organizations that are specifically exempted from licensure as specified in Section 15-5 of the Act or to similarly licensed and regulated organizations in other states.

Letter of Referral

Today's Date: ______________________________

Residents Name: ____________________________

Managers Name: ____________________________

Building Address: __________________________

Contact #: (   )__________________________

SAMPLE

Dear Personnel:

The above named person is being referred to your facility for detoxification. Our policy states that any resident found to be under the influence of any mood, or mind altering chemical is required to leave the facility.

This person is eligible to return to our facility ☐

This person is not eligible to return to our facility ☐

We greatly appreciate your continued support and services.

Sincerely,

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Program Manager

RELAPSE PROCEDURES

In cases of relapse, resident is immediately referred to appropriate detox facility. Managers should have a listing of referral sources.

1. Personal belongings should be secured at time of departure. Roommate and management must be present. If not present, resident's belongings must be bagged, labeled, dated and secured by staff.
2. Resident must be monitored at all times until time of departure.
3. In cases of violent or threatening behavior, manager should use discretion and call police if necessary. Don't jeopardize your safety. Avoid physical or verbal confrontations.

Comments/Examples:

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Returning From Detox

1. Residents who have proof of a detox stay may be allowed to return; those residents not having proof of detox stay are required to be out for at least 72 hours and must drop clean upon returning.

Comments:

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Detox Return Guidelines

1. Client relapses
2. Client referred to detox
3. Return based upon client profile.

   - If client has not been a problem in the past, makes meetings, etc., client may return.

   - If client has caused problems in the past, had consequences, been confrontational, does not make meetings, client should be given firm referral out.

Comments/Examples:

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Consequences

1. When client returns, based on treatment/relapse history, or lack thereof, client should be given a referral for an outpatient assessment. If outpatient is recommended, clients stay is contingent on his/her participation/completion of sessions.

2. If client has been exposed to treatment; client may be given recovery plan that includes the following: 90 meetings/90 days, 90 days no overnight, 30 days with a 6:00 p.m. curfew and 10 hours community service.

Comments:

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Notes:

Joint Committee on Administrative Rules

ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH
CHAPTER X: DEPARTMENT OF HUMAN SERVICES
SUBCHAPTER d: LICENSURE
PART 2060 ALCOHOLISM AND SUBSTANCE ABUSE TREATMENT AND INTERVENTION LICENSES
SECTION 2060.427 CONTINUING RECOVERY PLANNING AND DISCHARGE

Section 2060.427 Continuing Recovery Planning and Discharge

a) Organizations shall develop a continuing recovery plan for patients who are no longer actively receiving treatment in, or no longer require, an ASAM level of care.

b) The continuing recovery plan shall contain the following information as appropriate for individual patients:

1) a relapse prevention plan for patients who have obtained abstinence that also identifies actions to be taken if relapse should occur;

2) actions planned by the organization to support continuing recovery or reinitiation of active treatment services;

3) specific and measurable patient involvement in the event that accountability by the patient is required for any case management or monitoring organization (i.e., circuit courts, offices of probation, Office of the Illinois Secretary of State, parole officers, employers, etc.); and

4) community recovery support services that will maintain, support and enhance progress made in treatment.

The continuing recovery plan shall be completed prior to the patient discharge from all ASAM levels of care within the organization for any patient no longer meeting the criteria for continued active treatment.

c) Organizations shall develop discharge and exclusionary criteria consistent with customary clinical standards accepted within the community. After the patient is discharged from all treatment, a discharge summary shall be entered in the patient record within 15 days. This summary shall include:

1) the reason for discharge and the progress of the patient relative to each goal and objective in the treatment plan;

2) a prognostic statement of the patient's condition at discharge, including any continued use of prescribed medications; and

3) the patient's continuing recovery plan.

(Source: Amended at 25 Ill. Reg. 11063, effective August 14, 2001)

DISCHARGE SUMMARY CRITERIA

1. At the time of discharge resident does not indicate intoxication or any use of other non-prescriptions or prescription medicine and indicates no substance withdrawals.

2. The residents medical status is stable

3. The resident has exceeded all levels of care and is ready for independent living.

4. Resident recognizes their defeated relationship with alcohol and drugs and is attending A.A. meetings, working with sponsor and building a recovery network – resident requires a less structured environment.

5. Resident does not appear to be at any risk of relapse.

6. Resident has obtained permanent address at a safe and stable environment.

STEPS THAT ALLOW DISCHARGES

1. Remember if a resident is showing signs of intoxication, conduct a urine screen, if person is positive refer them to detox.

2. A resident can be discharged for medical conditions
   - Example: A resident must be free from physical or psychiatric conditions that would prohibit participation in daily living activities and functions.

3. Resident can be discharged for emotional behavior conditions/complications
   - Example: Resident can't stay sober
     Resident becomes a risk to self and/or others
     Resident will not follow directives

   This type of resident should be referred to a more intense level of care.

4. Resident requires a less structured environment.

5. Despite resident's previous attempts to remain sober, resident continues to repeat imminent danger to self.

Joint Committee on Administrative Rules

ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH
CHAPTER X: DEPARTMENT OF HUMAN SERVICES
SUBCHAPTER d: LICENSURE
PART 2060 ALCOHOLISM AND SUBSTANCE ABUSE TREATMENT AND INTERVENTION LICENSES
SECTION 2060.331 INCIDENT AND SIGNIFICANT INCIDENT REPORTING

Section 2060.331 Incident and Significant Incident Reporting

a) An incident is any action by staff or patients that led to, or is likely to lead to, an adverse effect on patient services because of a deviation from established patient care procedures.

b) Such incidents shall be documented immediately, in writing, by staff and such report shall be maintained at the facility for review by Department staff as necessary or during inspection.

c) A significant incident is any occurrence at the facility which requires the services of the coroner and/or which renders the facility inoperable.

d) A verbal report of any significant incident shall be given to the Department's Division of Licensing and Monitoring within 24 hours after its occurrence.

e) A written report of any significant incident shall be submitted within ten calendar days after the occurrence and, if applicable, a copy of any coroner's report shall be submitted within five calendar days after receipt of the written report.

POST-TEST

NAME:______________________________ DATE:________________________

RIGHT______

WRONG_____

1. AODA is an acronym for:
    a. Administrative Office of District Attorney
    b. Ancient Order of Druids in America
    c. Alcohol and Other Drug Abuse
    d. American Overseas Diabetes Association

2. A written agreement with an external organization to supplement existing levels of care and to arrange for other specialty services not directly provided by the organization is a:
    a. Linkage Agreement
    b. Treatment Plan
    c. Utilization Review
    d. Revocation

3. A self-help support meeting is which of the following:
    a. A.A
    b. N.A
    c. C.A
    d. All of the above

4. Which of the following is the state law governing licensure for recovery homes?
    a. 2060.309
    b. 2060.205
    c. 2060.203
    d. 2060.509
    e. None of the above

5. An occurrence at a licensed facility that requires the services of the coroner and / or which renders the facility inoperable is considered which of the following?
    a. Transfer
    b. Incident
    c. Discharge
    d. Significant Incident

6. Residential extended care shall require staff to be on duty?
    a. 24 hours – 7 days per week
    b. Only when giving treatment
    c. 9:00 AM to 5:00 PM
    d. None of the above

(OVER)

HELPFUL TERMS AND DEFINITIONS

1. "Act" means the Alcoholism and Other Drug Abuse and Dependency Act [20 ILCS 301].

2. "Admission" means what occurs after a patient has completed an assessment, received placement into a level of care, and been accepted for and begins such treatment.

3. "Adolescent" means a person who is at least 12 years of age and under 18 years of age.

4. "Adult" means a person who is 18 years of age or older.

5. "Alcohol and Drug Evaluation Report Summary" means the form, developed by the Office of the Secretary of State and required for use by the Illinois courts when granting judicial driving privileges, as defined in Section 6-201 of the Illinois Driver Licensing Law [625 ILCS 5/6-201].

6. "Alcohol and Drug Evaluation Uniform Report" means the form, mandated by the Department and produced from the DUI Services Reporting System (DSRS) that is required to report a summary of the DUI evaluation to the circuit court or the Office of the Secretary of State.

7. "Americans with Disabilities Act of 1990 (ADA)", 42 USC 12101, is the federal law requiring that public accommodations offer their services equally to persons without discrimination based on disabilities. An organization may not deny its services, offer unequal services or separate services, or have policies and procedures that have a discriminatory effect based on a disability, and shall remove barriers where possible and provide alternatives where not possible.

8. "ASAM Patient Placement Criteria" means the American Society of Addiction Medicine's Patient Placement Criteria for the Treatment of Substance-Related Disorders, Fourth Edition (ASAMPPC-2R), 4601 North Park Avenue, Upper Arcade Suite 101, Chevy Chase MD 20815 (2001, no later amendments or editions included).

9. "Assessment" means the process of collecting and professionally interpreting data and information from an individual and/or collateral sources, with the individual's permission, about alcohol and other drug use and its consequences as a basis for establishing a diagnosis of a substance use

disorder, determining the severity of the disorder and comorbid conditions and identifying the appropriate level and intensity of substance abuse treatment, as well as needs for other services.

10. "Associate Director" means the Associate Director of the Department of Human Services Office of Alcoholism and Substance Abuse (OASA).

11. "Authorized Prescriber" means a physician licensed to practice medicine in all its branches pursuant to the Medical Practice Act of 1987 [225 ILCS 60] or a physician under federal authority who issues prescriptions pursuant to 21 CFR 1301.25 (2000).

12. "Authorized Organization Representative" means the individual in whom authority is vested for the management, control and operation of all services at a facility and for communication with the Department regarding the status of the organization's licenses at that facility.

13. "CDC Tuberculosis Guidelines" means "Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Facilities", MMWR 1994 (no. RR13).

14. "Case Management" means 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.

15. "Chemical Test" means, in the context of intervention services, a breath, blood or urine test that measures the blood alcohol concentration (BAC) and/or drug concentration.

16. "Client" means a person who receives intervention services as defined in this Part.

17. "Clinical Services" means substance abuse assessment, individual or group counseling, and discharge planning. The organization may also determine that other specified activities require the services of a professional staff member.

18. "Continuing Recovery Plan" means a plan developed with the patient prior to discharge that identifies recommended activities, support groups, referrals and any other necessary follow-up activities that will support and enhance patient progress, to date.

19. "Continuum of Care" means a structure of interlinked treatment services (either offered by one organization or through linkage agreements with other

organizations) that is designed so a patient's changing needs will be met as that individual moves through the treatment and recovery process.

20. "Controlled Substance" means a drug or substance, or immediate precursor, that is enumerated in the Schedules of Article II of the Illinois Controlled Substances Act [720 ILCS 570] and in the Cannabis Control Act [720 ILCS 550]

21. "Department" means the Department of Human Services.

22. "Detoxification" means the process of withdrawing a person from a specific psychoactive substance in a safe and effective manner.

23. "Discharge" means the point at which the patient's treatment is terminated either by successful completion or by some other action initiated by the patient and/or the organization.

24. "Drunk and Drugged Driving Prevention Fund" means a special fund in the State Treasury created by Section 50-20 of the Alcoholism and Other Drug Abuse and Dependency Act out of which the Department may provide reimbursement for DUI evaluation and risk education services to indigent DUI offenders pursuant to this Part, and that it may also use to enhance and support its regulatory inspections and investigations.

25. "DUI" means driving while under the influence of alcohol, other drugs or combination thereof as defined in the Illinois Vehicle Title and Registration Law [625 ILCS 5/Ch. 2-5] or a similar provision of a local ordinance.

26. "DUI Evaluation" means the services provided to a person relative to a DUI offense in order to determine the nature and extent of the use of alcohol or other drugs as required by the Unified Code of Corrections [730 ILCS 5] and Section 6-206.1 of the Illinois Driver Licensing Law [625 ILCS 5/6-206.1].

27. "DUI Service Reporting System (DSRS)" means the computer software that shall be utilized to summarize all evaluation and risk education services statistics semi-annually and to produce the "Alcohol and Drug Evaluation Uniform Report" and other associated forms.

28. "Early Intervention" means services that are sub-clinical or pre-treatment and are designed to explore and address problems or risk factors that appear to be related to substance use and/or to assist individuals in recognizing the harmful consequences of inappropriate substance abuse.

29. "Facility" means the building or premises that are used for treatment and intervention services as specified in this Part.

30. "Good Cause" means conditions that would prevent a reasonable licensee from meeting one or more of the requirements of this Part.

31. "HIPAA" means the Health Insurance Portability and Accountability Act, 42 USC 1320(d) et seq. and the regulations promulgated thereunder at 45 CFR 160, 162 and 164 (Privacy and Security).

32. "Incident" means any action by staff or patients that led, or is likely to lead, to adverse effects on patient services.

33. "Indigent DUI Offender" means anyone who has proven inability to pay the full cost of the DUI evaluation or risk education service as determined through criteria established by the U.S. Department of Health and Human Services and published in the Federal Register and whose costs for such DUI services may be reimbursed from the Drunk and Drugged Driving Prevention Fund, subject to availability of such funds.

34. "Individual Counseling" means a therapeutic interaction between a patient and professional staff that includes but is not limited to the following: assessment of the patient's needs; development of a treatment plan to meet those identified needs; continual assessment of patient progress toward identified treatment plan goals and objectives; referral, if necessary; and discharge planning.

35. "Informed Consent" means a legally valid written consent by an individual or legal guardian that authorizes treatment, intervention or other services or the release of information about the individual, and that gives appropriate information to the individual so that he or she can authorize the service or disclosure with understanding of the consequences.

36. "Intervention" means activities or services that assist persons and their significant others in coping with the immediate problems of substance abuse or dependence and in reducing their substance use. Such services facilitate emotional and social stability and involve referring persons for treatment, as needed.

37. "Investigational New Drugs" means those substances that require approval by the U.S. Food and Drug Administration for trials with human subjects pursuant to 21 CFR 312 (2002).

38. "LAAM" means levo-alpha-acetyl-methadol that is a synthetic opioid agonist whose opioid effect is slower in onset and longer in duration (72 hours) than methadone and that is used in opioid maintenance therapy.

39. "Life Safety Code of 2000" means the National Fire Protection Association's Life Safety Code of 2000, National Fire Protection Association, 1 N. Batterymarch Park, Quincy MA 02269 (2000, no later amendments or editions included).

40. "Linkage Agreement" means a written agreement with an external organization to supplement existing levels of care and to arrange for other specialty services not directly provided by the organization.

41. "Methadone" means a synthetic narcotic analgesic drug (4,4-diphenyl-6-dimethylamino-heptanone-3-hydrochloride) that is used in opioid maintenance therapy.

42. "Mission Statement" means the reason for existence for the organization and/or specific setting or service.

43. "Opioid Maintenance Therapy (OMT)" means the medical prescription, medical monitoring and dispensing of opioid compounds (such as Methadone and LAAM) as a medical adjunct to substance abuse treatment.

44. "Off-Site Delivery of Services" means licensable services that are delivered at a location separate from the licensed facility.

45. "Organization" means any public or private agency, corporation, unit of State or local government or other legal entity acting individually or as a group that seeks licensure or is licensed to operate one or more substance abuse treatment or intervention services.

46. "Patient" means a person who receives substance abuse treatment services as defined in this Part from an organization licensed under this Part

47. "Person" means any individual, firm, group, association, partnership, corporation, trust, government or governmental subdivision or agency.

48. "Physician" means a person who is licensed to practice medicine in all its branches pursuant to the Medical Practice Act of 1987 [225 ILCS 60].

49. "Practitioner" means a physician, dentist, podiatrist, veterinarian, scientific investigator, pharmacist, licensed practical nurse, registered nurse, hospital, laboratory, or pharmacy, or other person licensed, registered, or otherwise permitted by the United States pursuant to 21 CFR 1301.21 and this State to distribute or dispense in accordance with Section 312 of the Illinois Controlled Substances Act [720 ILCS 510], conduct research with respect to, administer or use in teaching or chemical analysis, a controlled substance in the course of professional practice or research.

50. "Professional Staff" means any person who provides clinical services or who delivers intervention services as defined in this Part.

51. "Protected Health Information" means the health information governed by HIPAA privacy and security requirements set forth in 45 CFR 164.501.

52. "Psychiatrist" means a physician licensed to practice medicine in all its branches pursuant to the Medical Practice Act of 1987 [225 ILCS 60] and who meets the requirements of the Mental Health and Developmental Disabilities Code [405 ILCS 5].

53. "Recovery Home" means alcohol and drug free housing authorized by an intervention license issued by the Department, whose rules, peer-led groups, staff activities and/or other structured operations are directed toward maintenance of sobriety for persons in early recovery from substance abuse or who recently have completed substance abuse treatment services or who may still be receiving such treatment services at another licensed facility.

54. "Relapse" means a process manifested by a progressive pattern of behavior that reactivates the symptoms of a disease or creates debilitating conditions in an individual who has experienced remission from addiction.

55. "Residential Extended Care" (formerly halfway house) means residential clinical services for adults (17 year olds may be admitted provided that their assessment includes justification based on their behavior and life experience) or adolescents provided by professional staff in a 24 hour structured and supervised treatment environment. This type of service is primarily designed to provide residents with a safe and stable living environment in order to develop sufficient recovery skills.

56. "Revocation" means the termination of a treatment or intervention license, or any portion thereof, by the Department.

57. "Risk" means, in the context of intervention services, the designation (minimal, moderate, significant, or high) assigned to a person who has completed a substance abuse evaluation as a result of a charge for DUI that describes the person's probability of continuing to operate a motor vehicle in an unsafe manner. This assignment is based upon the following factors: the nature and extent of the person's substance use; chemical testing results; prior dispositions for DUI, statutory summary suspensions or reckless driving convictions reduced from a DUI; and any other significant dysfunction resulting from substance abuse or dependence.

58. "Secretary" means the Secretary of the Department of Human Services or his or her designee.

59. "Significant Incident" means any occurrence at a licensed facility that requires the services of the coroner and/or that renders the facility inoperable.

60. "Significant Other" means the spouse, immediate family member, other relative or individual who interacts most frequently with the patient in a variety of settings and who may also receive substance abuse services.

61. "Substance Abuse or Dependence" means maladaptive patterns of substance use leading to a clinically significant impairment or distress as defined in the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV), 1400 K Street NW, Washington, DC 20005 (1994, no later amendments or editions included).

62. "Support Staff" means any staff who do not deliver clinical or intervention services.

63. "Transfer" means the process that occurs when a patient can no longer receive services at an organization because the appropriate level of care is not available, or the movement of the patient from one level of care to another within an organization's continuum of care.

64. "Treatment" means a continuum of care provided to persons addicted to or abusing alcohol or other drugs that is designed to identify and change patterns of behavior that are maladaptive, destructive and/or injurious to health; or to restore appropriate levels of physical, psychological, and/or social functioning.

65. "Treatment Plan" means an individually written plan for a patient that identifies the treatment goals and objectives based upon a clinical assessment of the patient's individual problems, needs, strengths and weaknesses.

66. "Tuberculosis Services" means counseling the person regarding tuberculosis; testing to determine whether the person has been infected with mycobacteria tuberculosis to determine the appropriate form of treatment; and providing for or referring the infected person for appropriate medical evaluation and treatment.

67. "U.S. Drug Enforcement Administration rules and regulations pertaining to medical dispensary services" means 21 CFR 1301.71-1301.76, 1304, and 1307.2 (2000).

68. "Universal Precautions" means the following guidelines published by the U.S. Centers for Disease Control and Prevention:

- "Recommendations for Prevention of HIV Transmission in Health Care Settings", MMWR 1987; 36 (2s); and
- "Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and other Bloodborne Pathogens in Health Care Settings, MMWR 1988; 37 (no. 24).

69. "Utilization Review" means a quality protective function that attempts to ensure that the patient is receiving an appropriate level of services, in accordance with assessed clinical conditions. Utilization review activities focus primarily in four major areas:

- the appropriateness and clinical necessity of admitting a patient to a level of care;
- the appropriateness and clinical necessity of continuation of the initiated level of care;
- the initiation and completion of timely discharge planning; and
- the appropriateness and clinical necessity and timelines of support services.

Suggested Education Sources
(workshops and reading material)

Illinois Association of Extended Care (IAEC)

Illinois Alcohol and Other Drug Abuse Professional Certification Association (IAODAPCA)

Social Model Recovery

Illinois Licensure Rule 2060

IAEC Program Standards

ASAM Patient Placement Criteria II

Body of Knowledge

Slaying The Dragon

Loosening The Grip

A.A. World Services Approved Literature

For Purchasing Information Contact:

Illinois Association of Extended Care
1305 Wabash, Suite L
Springfield, IL 62704
(217) 698-3130
Website: www.iaec.info

TEST ANSWERS

1. c – 2060
2. a – 2060.103
3. d – AODA
4. d – 2060.509
5. d – 2060.103
6. a – 2060.401
7. a – NADAC Study Guide
8. a – IAEC Standards
9. b – IAEC Standards
10. e – IAEC Standards