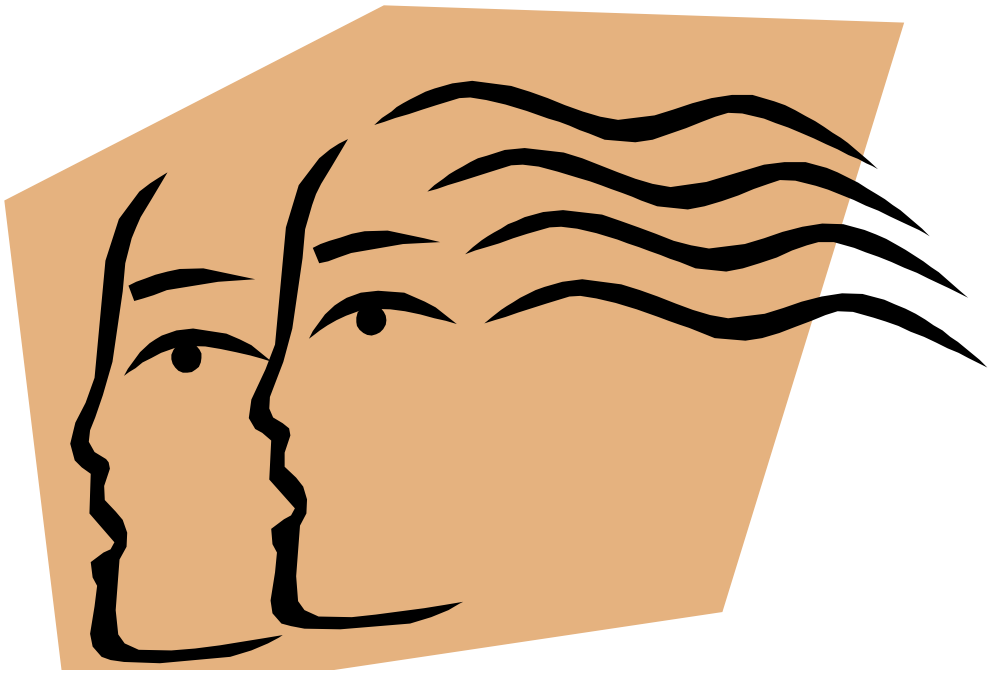
SAFETY and SOBRIETY:
Best Practices in
Domestic Violence and Substance Abuse

Domestic Violence/Substance Abuse
Interdisciplinary Task Force
of the
Illinois Department of Human Services

Safety and Sobriety:
Best Practices in Domestic Violence and Substance Abuse



Domestic Violence/Substance Abuse
Interdisciplinary Task Force
of the
Illinois Department of Human Services

July 2000

July 14, 2000

Dear Colleague,

The Illinois Department of Human Services is pleased to release *Best Practices For Domestic Violence and Substance Abuse Services*. This document will serve as an important tool for agencies when serving clients with both issues.

This manual is the result of years of work by the Domestic Violence/Substance Abuse Task Force. The Task Force, a committee of the Department's Domestic Violence Advisory Council, is a collaborative group linking service providers, administrators and researchers from the fields of domestic violence, substance abuse and criminal justice.

To create success for clients with both domestic violence and substance abuse issues, it is critical to provide comprehensive services which address their multiple needs. This manual outlines procedures that human service professionals can follow when they are facing clients with both domestic violence and substance abuse issues, and provides guidance for forging collaborations between agencies.

On behalf of the Department, I look forward to this manual being utilized by agencies across the state. With continued collaborations, we can help the families of Illinois achieve both sobriety and safety.

Sincerely,

Linda Reneé Baker
Secretary

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Dedication
Barbara Mills, 1947-1998

This document is dedicated to the memory of Barbara Mills. Barb, who died in 1998 shortly after the task force began its work, was co-chair of the task force, and was instrumental in its conception and development. She was that rare practitioner who had a solid background in both the substance abuse and domestic violence fields. She was Director of Agency Programming for DOVE, Inc., in Decatur, and was a certified alcohol and other drug abuse counselor. At the time of her death she was actively working to get certification for domestic violence counselors and advocates. She was a visionary who is missed by her friends, her community, and all who knew her.

Contents

Introduction

Safety and Sobriety: Best Practices in Domestic Violence and Substance Abuse

In December 1997, the Bureau of Domestic Violence Prevention & Intervention of the Illinois Department of Human Services convened an advisory group to discuss the frequently co-occurring problems of domestic violence and substance abuse. The 30 members of the *Domestic Violence-Substance Abuse Interdisciplinary Task Force* were drawn from the domestic violence and substance abuse practice and policy communities, academia, and government, including the DHS Office of Alcoholism and Substance Abuse.

In conjunction with the Illinois Family Violence Coordinating Council, and with the support of the Illinois Violence Prevention Authority, Illinois Department of Human Services, Illinois Coalition Against Domestic Violence, Illinois Alcohol and Other Drug Abuse Professional Certification Association, and a number of private sponsors, the first *Better Practices in Substance Abuse and Domestic Violence* conference convened in Bloomington in May 1998. This conference succeeded beyond anyone's expectations, drawing nearly 400 participants from across the spectrum of service providers and policy makers in the state. In June 1999, the second Best Practices conference was held in Springfield. The theme of that conference, and the title of this manual – Safety and Sobriety – was drawn from a keynote address by Theresa Zubretsky.

The task force has met for the past two years. While there are few areas where the task force could reach a true consensus, there are some key points about which we do agree:

- Substance abuse problems and domestic violence overlap and they often co-occur. However, substance abuse and domestic violence are different problems, and they require different interventions.

- There are multiple causes for both substance abuse and for domestic violence. There is little evidence that one problem causes the other.

- Active substance abuse by the perpetrator of domestic violence or active substance abuse by the victim of domestic violence threatens the safety of the victim.

- Domestic violence impairs the opportunity for addiction recovery and threatens sobriety.

- Regardless of setting, workers in all fields will be more effective if they consider the perspectives of safety, sobriety, and justice for the people with whom they work.

One of the tasks this group agreed to undertake is development of a best practices document which reflects the state of the art in substance abuse/domestic violence practice. The document is grounded in the 1997 booklet *Substance Abuse Treatment and Domestic Violence* published by the Center for Substance Abuse Treatment and distributed to participants at the 1998 conference.

The document you are reading was conceptualized as a brief, hands-on, Illinois-specific tool for

use by substance abuse professionals, the domestic violence community, and workers in other areas such as criminal justice, child welfare, and public assistance. The core sections of the document target four populations defined by the settings where they would first be encountered: (1) men in batterers' intervention programs, (2) men in substance abuse treatment programs, (3) women in domestic violence victim programs, and (4) women in substance abuse treatment. The task force believes these four settings — in addition to criminal justice, child protection, and public assistance — are the settings where the confluence between substance abuse and domestic violence can be most effectively addressed. Sections are added to address populations (cultural minorities, gays, and lesbians) and settings (child welfare, public assistance, and criminal justice) that could not be adequately addressed in the main sections.

This is only one of many ways to organize a document such as this, and we make no claim to it being the best way. Each of the four sections is designed for staff working in one of those settings. For example, the section on women in substance abuse programs targets addiction counselors working with women's treatment programs. The section assumes that addiction counselors do not need education in addictions, but are likely to need information about domestic violence. Specifically, they may need to learn about domestic violence as it affects practice with women currently receiving addiction treatment. The other three sections follow a similar pattern, targeting staff in batterers' intervention programs, addiction counselors in men's treatment programs, and domestic violence advocates.

There are a few things the reader should know about this document. First, it is not designed to be read cover-to-cover like a book. We believe the best way to use the document is to select the section best corresponding to the type of setting in which you work, then to read other sections as interest directs. Second, the document was developed by individuals working in a committee. Consequently, it has all the advantages and disadvantages of committee products. On the one hand, it lacks a single voice and may at times appear uneven or disjointed. On the other hand, it reflects a much broader base of opinion than most material you can read in this area. There are parts of the document which contradict other parts of the document. These contradictions reflect the disagreements between knowledgeable practitioners within and between their respective fields. Finally, where research exists to support a perspective, it is reflected in the document. However, there is little actual research to support practice in this area, so we depend heavily on the experience of practitioners to fill the knowledge gaps.

On behalf of the Domestic Violence-Substance Abuse Interdisciplinary Task Force, I welcome readers to join and contribute to the movement to link the domestic violence and substance abuse fields in a way that will enhance the safety and sobriety of the people who look to us for help.

Larry W. Bennett, Ph.D.
University of Illinois at Chicago

Note: The opinions expressed in this document are those of the Illinois Domestic Violence-Substance Abuse Interdisciplinary Task Force, and do not necessarily reflect the opinions or positions of the Illinois Department of Human Services or any of its constituent offices, bureaus, or programs. This document is not intended as legal advice and programs should consult with their own attorneys on all such matters.

Definitions

What is Domestic Violence?

Domestic violence as defined by the American Psychological Association (APA, 1996) is: "a pattern of abusive behaviors including a wide range of physical, sexual, and psychological maltreatment used by one person in an intimate relationship against another to gain power unfairly or maintain that person's misuse of power, control and authority." Domestic violence, simply stated, is an attempt to control the behavior of your partner. Abuse is a misuse of power that uses the bond of intimacy, trust, and dependency to make your partner, man or woman, feel unequal, powerless and unsafe. Domestic violence is a crime under the Illinois Domestic Violence Act (725 ILCS 5/112A-1)(750 ILCS 60/102).

What are Substance Abuse and Addiction?

Substance abuse is a destructive pattern of use of drugs including alcohol, which leads to clinically significant (social, occupational, medical) impairment or distress. Often the substance use continues in spite of significant life problems related to that use. When a person begins to exhibit symptoms of tolerance (the need for significantly larger amounts of the substance to achieve intoxication) and withdrawal (adverse reactions after a reduction of the substance), it is likely that the person has progressed from abuse to dependence, or addiction. Addiction is a primary, chronic disease with genetic, psycho-social, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic impaired control over drinking alcohol or using other drugs, preoccupation with drugs or alcohol, use of drugs or alcohol despite adverse consequences, and distortions in thinking, most notably denial. Addiction is a treatable disease and long-term recovery is possible.

– Adapted from definitions developed by the American Psychiatric Association and the American Society for Addiction Medicine

Best Practices: Addressing Substance Abuse In Domestic Violence Agencies

Common Perspectives

A significant number of women and children seen in domestic violence agencies suffer from substance abuse problems. A study of Illinois shelters reveals that as many as 42 percent of their clients abuse alcohol or other drugs (Bennett & Lawson, 1994). There are a number of reasons for this:

- Victims may begin or increase their use of alcohol/other drugs in response to domestic violence. Alcohol/other drugs may be used to medicate the physical and emotional pain of domestic violence or to cope with the fears of being battered.

- Alcohol/other drug use may be encouraged or even forced by the partner as a mechanism of control. Efforts at abstinence may be sabotaged.

- Factors related to victimization are low self-esteem, guilt, shame, powerlessness, depression, sexual dysfunction, and relationship dysfunction. All of these provide a foundation for the development of substance abuse.

A victim with a substance abuse problem is at increased risk because:

- Acute and chronic effects of alcohol/other drug use may prevent the victim from assessing the level of danger posed by the batterer.

- Under the influence, victims may feel a sense of increased power. Victims may erroneously believe in their ability to defend themselves against physical assaults, or their power to change the batterer.

- The abuse of alcohol/other drugs impairs judgement and thought processes so that victims may have difficulty with adequate safety planning. Alcohol/other drug use makes it more difficult for victims to leave violent relationships.

- Victims may be reluctant to contact police in violent situations for fear of their own arrest or referral to the Department of Children and Family Services.

- Use of alcohol/other drugs may increase involvement in other illegal activities.

- Victims may be denied access to shelters or other services due to substance abuse.

Response to Substance Abuse

Because there is a significant correlation between victimization and substance abuse, all domestic violence service providers need to address the issue of substance abuse. A formal screening for substance abuse should be included in the intake process. If victims are to remain free of violence, they should understand the impact substance abuse has on their safety.

Substance Abuse Screening

A substance abuse screening is an opportunity to begin discussing how substance abuse impacts safety. It is a preliminary step that determines the *likelihood* that an alcohol or drug problem

exists. Screening for substance abuse involves honest talk with individuals about their alcohol and drug use, observing their behavior, and looking for signs of use. A screening differs from an assessment. An assessment uses diagnostic instruments and processes to determine if the person is abusing, or is dependent on, alcohol or drugs. When screening for substance abuse, be sure to:

- Ensure privacy. The first step in screening is to insure that it occurs in private. *Children should not be present because they may repeat what they hear.*

- Communicate respect and trust. It is important to establish a respectful and trusting relationship. Assure victims that, except for safety concerns, anything discussed will be held in strictest confidence and will not jeopardize their ability to receive appropriate services.

- Observe behavior. Look for signs of alcohol or drug use.

Signs of Alcohol or Drug Use

- Smell of alcohol
- Signs of IV drug use (tracks)
- Unusual or extreme behavior
  - Nodding off
  - Overly alert
- Slurred or rapid speech
- Staggering
- Tremors
- Glassy-eyed/pupils dilated or constricted
- Unable to sit still
- Disoriented or confused for no apparent reason
- Argumentative, defensive, or angry at questions about substance use

- Ask questions. There are several recognized screening tools for alcohol or drug use included in the Appendix.

- Deal with denial. Denial is the most frequent response to questions about alcohol/other drug use. This is especially true for women not only because they are ashamed of their behavior, but also because they fear losing their children. When talking with a victim about alcohol/other drug use, ask open-ended questions. A victim may also find it easier to talk about their partner's use rather than their own. If this is the case, follow up with questions about the victim's use.

Intervention

What should come first: domestic violence counseling or substance abuse treatment? It is not a question of either safety or sobriety first, but rather safety *and* sobriety, since one is less likely without the other. The presence or threat of abuse often interferes with a victim's ability to achieve abstinence. Continued use of substances interferes with safety. If screening leads you to suspect that a person has an alcohol or drug problem, refer or arrange for an on-site assessment.

Linking persons to substance abuse programs requires the domestic violence staff to:

- Be informed about treatment options/ providers available in their community.

- Do cross-training with substance abuse programs to increase the awareness of both issues.

- Continue open dialogue and collaboration between agencies.

- Be willing to provide service options for victims who are substance dependent, whether they are in treatment or not. Ideally, victims should be referred to a

treatment provider sensitive to the issues of domestic violence. If the batterer is in treatment, avoid referring the victim to the same program. In rural areas, this may not be feasible, and advocates will have to be sure that the substance abuse provider understands that violence is an issue. (See section on confidentiality in the Appendix.)

Referral

- When referring an individual to a treatment provider for an assessment, the first concern should be safety. Will an assessment interview place the client or children at risk for further harm? What strategies can be employed to ensure safety?

- What assurance does the person need to follow through with the referral? Victims who have suffered from physical and/or sexual abuse and intimidation may be traumatized by the prospect of talking with a stranger about their use of illegal drugs or fear a drug test. What concerns does the person have about substance abuse treatment and how can they be addressed?

- What information does the person need to follow through with the referral? If the individual is referred to an off-site location, be sure the person understands where to go, who they will see, and how to get there.

- Another concern is what support the individual needs to keep the appointment. Is transportation or child care needed? Are there other barriers? The referral process necessitates developing a good working relationship with a treatment agency to jointly address the individual's needs.

- Victims of domestic violence should not be referred to programs that require conjoint counseling as part of substance abuse treatment.

- Many treatment providers do outreach; that is, they will attempt to visit the person at their home to engage them in treatment. If outreach will place the person or treatment provider staff at risk, it is important to convey that information to the provider.

Substance Abuse Assessment

When a person is referred to a substance abuse treatment provider, a counselor will use assessment techniques to characterize the problem and to develop a treatment plan. The Illinois Alcohol and Other Drug Abuse Professional Certification Association (IAODAPCA) evaluates counselor competency and grants recognition to those counselors who meet specified minimum standards. All treatment programs licensed by the Department of Human Services must have credentialed staff. The system identifies the functions, responsibilities, knowledge, and skill bases required by counselors in the performance of their jobs.

Assessment involves five important tasks:

- Aid in *diagnosis* of the problem.
- Establish the *severity* of the problem.
- Develop a *treatment* plan.
- Define a *baseline* which can be used to evaluate an individual's progress in treatment.
- Increase the individual's *motivation* to attend treatment.

A variety of methods may be used in assessing the individual, including medical examinations, clinical interviews, and formal instruments such as questionnaires. During

an assessment, information is gathered to determine which aspects of the individual's life are affected by alcohol/other drug use. Areas of assessment include alcohol and drug use, social and family relationships, psychological functioning, legal status, medical conditions, and employment and educational status. The goal is to determine if treatment is needed, and if so, the appropriate level of care. If the individual is given a DSM IV (or ICD-9) diagnosis, treatment is generally recommended.

In some settings, urine tests may be required. For domestic violence victims who have been sexually abused, the prospect of a urine drug test may be especially threatening. Drug tests are most commonly done to monitor treatment compliance rather than as part of the assessment.

Treatment

While abstinence may be a long-term goal for addiction programs, the immediate goals are to reduce use, improve the person's ability to function and minimize the effects of abuse on health and social functioning. Matching the person with the appropriate level of care ensures that the person receives the type of treatment corresponding to the person's use and their current level of functioning. Licensed treatment agencies in Illinois use ASAM (American Society of Addiction

Medicine) criteria to determine which treatment options and level of intensity are appropriate. In developing a treatment plan, the counselor evaluates:

- The person's level of intoxication, withdrawal potential and need for medication.
- The person's physical health.
- The person's emotional health and functioning.
- The person's acceptance or resistance to treatment.
- The potential for relapse and the recovery environment.

Treatment options vary and may include behavioral therapies such as counseling, psychotherapy, support groups or family therapy. Sometimes medications are given to suppress the withdrawal syndrome and drug craving or to block the effects of drugs. Treatment may include:

- Outpatient services (Level I).
- Intensive outpatient services, a structured program offered a minimum of 9 hours per week (Level II).
- Residential detoxification services (Level III.2).
- Residential rehabilitation (Level III.5).
- After-care programs.
- Referral to support groups such as Women for Sobriety, Alcoholics Anonymous, or Narcotics Anonymous.

Confidentiality

Unique confidentiality laws apply to almost all substance abuse treatment programs. The law prohibits the disclosure of any information that would identify a person as having been referred for, or having received treatment for, an alcohol or drug problem without the person's written consent. There are exceptions for mandated reports of child abuse, in certain medical emergencies or for court orders. A court may authorize a treatment program to disclose confidential patient information following a hearing at which good cause has been established and at which the patient and the treatment program have been represented. A subpoena, search warrant, or arrest warrant, even when it is signed by a judge, is not

sufficient, by itself, to require or permit a

program to release patient information.

Information protected by federal confidentiality laws may be disclosed if the client has signed a proper consent form. To be valid, the consent must be in writing and must specify:

- The client's name.
- The name of the program making the disclosure.
- The purpose of the disclosure.
- The name of the person/program that will receive the information.
- How much and what kind of information will be disclosed.
- A statement that the client may revoke the consent at any time, except to the extent that the program has already acted on it.
- The date, event or condition on which the consent expires.
- The signature of the client and the date of the signature.

Federal regulations also prohibit redisclosure of information; therefore, a domestic violence program may not disclose information received from a treatment agency without the person's consent. Federal regulations allow substance abuse treatment programs to disclose information to outside agencies that provide services to the treatment program — for example, laboratories, accountants or other professional services. When communication needs to take place on a regular basis, the treatment program enters into a *qualified service agreement.* The agreement specifies that the person or agency providing the service will abide by the federal confidentiality law. (See the Appendix for a more detailed discussion of confidentiality requirements.) A program should always consult its own attorney regarding the possible use of such an agreement.

Supporting Sobriety

Domestic violence agencies can support victims struggling with the issues of substance abuse in the following ways:

- Assist staff in dealing with their own beliefs, feelings, and prejudices about substance abuse. Provide ongoing training to enable staff to recognize the characteristics of substance abuse and to make appropriate referrals.

- Minimize blame and moral reprobation for use or relapse, which may further disempower the victim and empower the batterer.

- Inform/advise the victim and treatment provider of the risks of conjoint couples counseling sessions.

- While providing advocacy-based counseling for substance-abusing victims, help them recognize the role substance abuse plays. It can keep them tied to the abusive relationship, increase their risk of harm and impair their safety planning ability.

- Assist victims by helping them find an alternate means of empowerment as replacement for the sense of power induced by substances.

- Include plans for continued sobriety as part of the safety plan. Help the victim understand the ways the batterer may attempt to undermine sobriety before the victim exits the shelter or completes advocacy-based services.

- Encourage and facilitate linkage with substance abuse treatment resources and abstinence-based support groups.

- Remain cognizant of which local substance abuse programs and support groups provide the highest degree of physical and psychological safety for victims.

Best Practices: Addressing Domestic Violence In Substance Abuse Treatment for Women

Common Perspectives

The importance of addressing domestic violence in substance abuse treatment for women becomes evident when one sees the research. Women who abuse substances are more likely to experience domestic violence in relationships (Miller, Downs, & Gondoli, 1989). Women who experience domestic violence are more likely to misuse prescription drugs as well as alcohol (Stark & Flitcraft, 1988). One study found that of women in a drug treatment center, 90 percent had been physically assaulted and 95 percent had been raped (Stevens & Arbiter, 1995).

Substance-abusing women and women who have experienced domestic violence report similar experiences. Both may demonstrate:

- Isolation, shame, and guilt.
- Behaviors that others describe as bizarre or dysfunctional.
- Traumatization.
- Initial denial of the problem.
- Loss of support systems and fear of losing children as a result of admitting their problem.
- Low ego strengths.
- Magical thinking (a client's belief that the problem will simply go away as if by magic).
- Impairment of their ability to make logical decisions.
- Involvement in the criminal justice system, either as a victim or offender.
- Often seeking services only when in crisis.
- Several returns to the substance, or to a relationship where battering continues, before making a lasting change.

Interview Tips

All women in substance abuse treatment should be screened for domestic violence. When interviewing a client:

- Use caution and tact. Don't initially refer to the partner's behavior as domestic violence. Instead use language such as *inappropriate behavior*, *unhealthy behavior*, *behavior that is unsafe,* and possibly *abuse.*

- A woman might not feel safe disclosing information to you. She may disclose more about herself when she gains confidence and begins to trust you.

- Proceed sequentially from the least sensitive to the most sensitive topics. Use the early (least sensitive) part of the interview for relationship-building and the establishment of trust.

- Be careful about criticizing the partner. Battered women may care for their partners and may become defensive or shut down if the partner is criticized.

- Avoid labelling survival strategies or other behaviors as co-dependent.

- Get factual information. Often a woman will give vague answers to questions. Ask her to clarify her responses. For example, ask her to talk more about her experiences in relationships.

Domestic Violence Screening

There are formal domestic violence screening tools in the Appendix of this document. Key

questions which might lead to a formal screening include:

- What happens when you argue with your partner?
- How safe do you feel with your partner?
- How safe do you feel when you leave here?
- Can you tell me about a situation with your partner when yelling and screaming occurred?
- Can you tell me about a situation with your partner when things were destroyed?
- Can you tell me about a situation when your partner pushed, slapped, or hit you?
- How does your partner show respect to you?
- How does your partner attempt to control your alcohol or other drug use?
- Have your efforts to get clean and sober been sabotaged by your partner?

In addition to formal screening, counselors may notice:

- Bruises or other untreated physical injuries.
- Inconsistencies or evasiveness.
- Frequently missed appointments or partner waiting for her during counseling sessions.
- Reports that partner isolates her, prevents her from attending counseling or support groups, threatens her, or forces her to do things she does not want to do.
- Evidence or reports of child abuse.
- Reports of jealousy or statements beginning with "my partner won't let me."

Referral

If the screening indicates a probability of violence, refer the woman either to a shelter or to a provider who deals with domestic violence issues. (A list of domestic violence service providers is included in the Appendix.)

It is important to coordinate services as much as possible with the domestic violence advocate. Coordinate discharge planning, especially when discharging from a residential program. This coordination allows the woman to identify several options, such as staying at a shelter or staying with family or friends if it is unsafe to go home. Explain confidentiality regulations to domestic violence advocates when coordinating services, as well as the meaning of American Society of Addiction Medicine (ASAM) criteria. When serving a mutual client, it is also helpful for domestic violence and substance abuse service providers to present a united effort when advocating with other systems (e.g., Department of Children and Family Services).

Intervention

As substance abuse professionals know, women often have treatment issues that are different from men's. When domestic violence is added, this difference is magnified.

Safety issues can seriously affect the woman's ability to maintain sobriety. Make safety as well as sobriety a top priority. Treatment should focus on both issues. Develop relapse prevention plans that include safety planning and ways to cope if her partner gets violent.

When a woman is harmed, she may be more likely to use substances to cope. She may use alcohol or drugs to medicate physical and/or emotional pain. She may even be coerced into use by her partner — the abuser will often do whatever it takes to keep the woman under his control, including forcing use of substances and threatening her if she does not continue to use. Often her partner is using as well, and if she leaves to find a

more sober support network, there is increased risk to her safety.

Recognize that even though her relationship may be a trigger for continued use, it may also be unsafe for her to leave. Victims of domestic violence aren't so much choosing to stay in violent relationships as they are choosing when it is safe for them (and their children) to leave. For many victims, this may be never.

Discuss these issues in terms of the dilemmas they create. When addressing issues of noncompliance, counselors should take into account the batterer's ability to sabotage substance abuse treatment through threats or fear.

Couple or family counseling can be very dangerous for victims of domestic violence. DO NOT provide information to the partner. If the perpetrator finds out about disclosure of the violence or of substance use, the woman may be punished.

Domestic violence is not caused by substance abuse and is not merely a symptom of substance abuse. Domestic violence is an issue of *power and control,* however often people identify anger as a symptom. Battered women often blame themselves for the beatings they have suffered. Victims often believe they are being abused because of their substance use and some substance abuse counselors believe this as well. Therefore, it is important to stress that abuse is not the victim's fault. Counselors may need to address domestic violence and substance abuse with different interventions.

Confrontational techniques are often not effective with victims of domestic abuse. They can be interpreted by the woman as an extension of how the abuser treats her. Also, avoid language that implies there is something wrong with the victim or that she caused her own abuse. Some examples of words to avoid with these women are *codependency, enabling,* and *powerlessness.* It is important to avoid *codependency* and *enabling* because these concepts do not hold the batterer fully accountable for his behavior. In the domestic violence community, *codependency* is a term for a woman's adherence to the socially sanctioned roles of women, and is always inappropriate when applied to domestic violence victims.

Some 12 Step groups' concepts can pose problems for women. These include submission to a higher power referred to exclusively in male terms, emphasis on "character defects," limited emphasis on strengths, and discouragement from talking about the abuse that has happened to them.

Whenever possible, domestic violence victims should be referred to gender-specific treatment and support groups. Mixed groups may involve descriptions of male aggression directed toward female partners.

Victims respond best to gender-specific empowerment and self-discovery. They often desire and benefit from all-female support groups. They often feel there are not many options. Language focusing on empowerment may help her develop the tools to stay safe and sober. Emphasize strengths and healthy decision-making.

Best Practices: Addressing Substance Abuse

In Batterers' Programs

Overview

The incidence of substance abuse among men in batterers' programs is between 50 percent and 100 percent, depending on the proportion of the men who were referred by the criminal justice system (Bennett, 1995). Batterers referred through the courts are more likely to also be substance abusers than self-referred men. Men who are violent outside their families are more likely to have substance abuse problems than men who are violent only within their families. Alcohol or drug abuse does not *cause* the abusive behavior. However, for most batterers, alcohol and drug use may:

- ➜ Increase the risk that he will misinterpret his partner's behavior.
- ➜ Increase his belief that violent behavior is due to alcohol or drugs.
- ➜ Make him think less clearly about the repercussions of his actions.
- ➜ Reduce his ability to tell when a victim is injured.
- ➜ Reduce the chance that he will benefit from punishment, education, or treatment.

Victim safety

The most essential consideration is the safety of domestic violence victims. The interventions must account for the safety of victims whether they are in domestic violence programs or in substance abuse treatment.

Batterer screening

Because so many batterers are also substance abusers, all batterers should be thoroughly screened for substance abuse problems. A screening for substance abuse is a preliminary step that determines the probability of an alcohol or drug problem. Batterers' intervention programs screen for substance abuse through:

- Initial interviews. Program staff should ask established questions and be trained to interpret responses. Direct questioning about alcohol and drug use often makes substance abusers deny the importance or effect of alcohol or drugs in their lives. (Examples of screening questions and formal screening tools are in the Appendix.)

- Observations of behavior and interactions during the batterers' program. Lateness, fatigue, aggression, or the smell of alcohol point toward the need for formal alcohol and other drug assessment. Look for signs of alcohol or drug use. (See box.) Interactions with recovering alcoholics and addicts in the batterers' program are usually revealing, because recovering men can often identify substance abuse patterns in others. Exposure of batterers who are substance abusers to recovering alcoholics and addicts is one of the more compelling reasons for not excluding active substance abusers from batterers' programs.

- Existing records. The contract signed between the batterer and the program should include access to criminal justice, mental health, and medical records.

Signs of Alcohol or Drug Use

- Smell of alcohol
- Signs of IV drug use (tracks)
- Unusual or extreme behavior
  - Nodding off
  - Overly alert
- Slurred or rapid speech
- Staggering
- Tremors
- Glassy-eyed/pupils dilated or constricted
- Unable to sit still
- Disoriented or confused for no apparent reason
- Argumentative, defensive, or angry at questions about substance use

Refer for assessment. If screening reveals the possibility of substance abuse, the batterer should be referred for formal assessment (unless the evaluator has appropriate training and certification). Formal assessment of substance abuse problems should be conducted by specialists qualified by the Illinois Alcohol and Other Drug Abuse Professional Certification Association. If a probation officer is not actively involved in monitoring the batterer's progress, the batterers' program should assume the role of *case manager* during substance abuse assessment. The batterers' program should not regard the referral for assessment as a referral to another agency that will then assume responsibility for the case, since this has led to batterers "slipping between the cracks."

Evaluate abstinent batterers. Abstinent and recovering alcoholics and addicts will usually score positive on the Short Michigan Alcoholism Screening Test (SMAST), CAGE-D, and other screening tools. (Examples of such screening tools are in the

Appendix of this document.) Abstinent batterers with no observable supports for staying sober should be considered at high risk for relapse, and consequently, a safety risk.

Case manage active substance abusing batterers who accept alcohol and other drug intervention. Men who are assessed as abusing, or dependent on, alcohol or other drugs require integrated or parallel substance abuse and domestic violence programming. In cases where addiction impairs the man's ability to utilize the batterers' program, the batterer/addict may complete an initial phase of addiction treatment such as medical detoxification and engagement with a support program. He then continues in counseling and/or a support program while in the batterers' program. The batterers' program should receive regular reports from the substance abuse program about the man's progress in substance abuse treatment. This will require a Qualified Service Organization Agreement (see Appendix) or a two-way consent. Similarly, the batterers' program should also release to the substance abuse program (with the signed consent of the batterer) regular reports of attendance, participation, and compliance in the batterers' program.

Intervene with active substance abusing batterers who* refuse *alcohol and other drug intervention. When a batterer is also a substance abuser but does not understand or accept the situation, he should still be admitted into a batterers' program. He can then be referred to substance abuse treatment.

- Under the conditions of a court mandate, programs should communicate to probation officers or case managers that a man requires substance abuse treatment.

- The current or former partners of voluntary or non-court-referred batterers should be notified of his refusal to enter substance abuse treatment, along with the risk that such a refusal represents.

- Acceptance of an addiction treatment referral (including support group attendance) should be made a priority goal of the intervention program.

Integrate substance abuse and batterers' programs with caution. An integrated program provides domestic violence and substance abuse services under the same program, with differing degrees of integration. Integrated programs under substance abuse programs should actively utilize domestic violence programs as consultants and pay them for their services. They should also actively participate in the community's coordinated domestic violence council. Integrated programs under domestic violence agencies should actively utilize addiction program staff as consultants and pay them for their services. Sharing certain staff members across agencies may be an alternative to an integrated program. Programs that are not integrated (i.e., batterers' program and substance abuse program are in different settings) must utilize networking, case management, joint staffing, or some other means of ensuring continuity.

Safety and sobriety are interconnected. Lack of sobriety, either in victims or in batterers, increases the risk for further violence against victims. Lack of victim safety threatens the sobriety of both victim and batterer. However, abstinence and sobriety are not sufficient conditions for safety.

Best Practices: Addressing Domestic Violence In Substance Abuse Treatment for Men

Approximately half the men who batter their female partners have substance abuse problems. In one large treatment center in Chicago, which has been doing screening since 1997, a consistent pattern has emerged: 70 percent of funded clients (mostly indigent or below federal poverty-level incomes) and 92 percent of nonfunded male clients (mostly court-mandated for DUI or other non-domestic violence offenses) have used some level of violence in a primary relationship within the year prior to assessment (Haymarket Center, 1998). Counselors in addiction treatment programs for men may underestimate the number of men in their programs who use violence (Bennett & Lawson, 1994). Furthermore, the non-substance abusing female partner is often blamed for the actions of the substance abusing batterer. This practice includes labelling the woman as *co-dependent* or *an enabler.*

Domestic violence, like many other life problems which affect chemically dependent persons, has traditionally been viewed within the substance abuse treatment field as a manifestation of the dysfunction resulting from long-term use of psychoactive chemicals including alcohol. Until recently most counselors may have expected that abstinence alone would reduce the incidence of violence, and that sobriety (understood as an ongoing connection to community support in addition to abstinence) would eliminate it. In discussions with counselors who are involved in providing intervention services to men receiving alcohol and other drug addiction (substance abuse) treatment, the task force has been reminded of the importance of making treatment providers aware of the experience of women who are victims of domestic violence.

Violence does not always stop or even diminish when the batterer becomes abstinent, and when it does, an increase in other abusive and controlling behavior often replaces it.

Tips for Safety and Sobriety

Screen substance abuse clients for domestic violence. Make it clear that *all* program participants are screened for violence. It is important for victim safety that the man not believe the evaluator has been "tipped off" by his partner. (See Appendix for examples of screening and assessment tools.) If you identify a man as having used violence, do the following:

- Refer him to a batterers' intervention program as soon as possible.

- If you are doing his treatment plan, address violence in Dimensions 3, 5, and 6 (Emotional/Behavioral Issues, Relapse Potential, and Recovery Environment) of the American Society of Addiction Medicine's (ASAM) Client Placement Criteria.

- Use separate facilities to provide services to the batterer and his female victim if at all possible — unless staff and clients in men's and women's programs are distinctly separate. If this is not possible, at least schedule appointments at times when the perpetrator and victim are not likely to be in the facility at the same time or on the same day.

- If the client is under court supervision, contact his probation officer to request that batterers' intervention programming be added as a condition of probation.

- Recognize that violence does not always stop or even diminish when the batterer becomes abstinent, and when it does, an increase in other abusive and controlling behavior often replaces it.

- Do not provide him with family sessions or conjoint therapy. The *Illinois Protocol for Partner Abuse Intervention Programs* recommends the following criteria for conjoint intervention with batterers and victims:

  (a) The participant has been violence-free for six months.

  (b) A determination by the participant's counselor and abused women's advocates that it is appropriate — not automatic at a set time.

  (c) An affirmative desire by the victim, which must include provision for safety at the facility.

  (d) Separate screening of participant and victim.

  (e) A determination that the victim does not hold herself responsible for the abuse, and that she is aware of resources and knows how to use them.

  (f) An affirmative statement from the participant that he accepts full responsibility for his actions.

  (g) The joint arrangement must be able to be terminated at any time in the process. The person providing intervention must terminate any time it is determined to be unsafe to continue.

  (h) Victims must never be required to go for counseling as a condition of services for the participant. Services for men who abuse must never be contingent

upon the victim receiving services there or at a domestic violence victim services program.

In addition, talk with local courts and police regarding appropriate mandated sanctions for substance abuse clients who are found to be batterers. When courts mandate services, it empowers agencies to include batterer intervention as part of their treatment recommendations, even when the offense is not related to domestic violence (e.g., when a client is mandated to treatment for substance abuse after a DUI conviction).

Raising Awareness on Domestic Violence

Assess your own agency's tolerance toward the equality of women:

- Are women included in the decision-making processes of your agency?
- What are your agency's recruitment and promotion policies?
- Is there an equal partnership between male and female group co-facilitators?
- Is your agency actively involved in community networks that confront violence against women?
- Do staff exhibit supportive attitudes and beliefs about women and domestic violence?

Talk with local domestic violence service providers to get linkages going which include cross-training of staff. This will increase awareness of the issues on both sides and help in providing services across both agencies.

Screening and Referral

The incidence of family violence perpetrated by substance abusing men is sufficiently high that universal screening is necessary and should become not only the norm but should be seen as an essential part of the screening and assessment.

- Screening tools (see Appendix for examples) should be implemented in consultation with domestic violence professionals.
- These tools should include a clear explanation of what constitutes abuse, rather than just asking a general question about violence or abuse.

➜ If you do not have on-site batterer intervention services, you will need to establish a relationship with local batterers' intervention services.

➜ Make a Mutual Service Agreement or another linkage agreement (see Appendix for example) which establishes regular communication between substance abuse treatment providers and local domestic

violence programs. Linkage agreements should not be considered a substitute for regular direct communication between such programs.

Timing of Batterer Intervention

Some substance abuse counselors want to wait 90 days or longer to put clients in batterers' intervention services. However, violence is a powerful relapse trigger which can sabotage recovery in its earliest stages. For this reason, many service providers recommend beginning batterer services well before a client is discharged from primary substance abuse treatment. Remember: *Sobriety without accountability is unlikely.*

There are other concerns regarding partner abuse intervention during treatment and early recovery. Some of them are:

- ➜ Clients may be very resistant to the whole concept of treatment, and may not react well to the traditionally confrontational format of batterers' intervention.

- ➜ Clients are likely to be suffering neurological complications of long-term use of psychoactive chemicals, which may have an impact on their ability to function in a highly confrontational group.

- ➜ Clients may have significant cognitive and educational deficits. These can have an impact on their ability to take responsibility for their violence, as well as on the ability of the program to screen for problems that might suggest that a client is inappropriate for partner abuse intervention.

- ➜ Denial is an active dynamic in both substance abuse and domestic violence.

Clients must be individually assessed to determine readiness for partner abuse intervention groups. Carelessness in this area can easily foster bad outcomes by needlessly increasing client resistance and noncompliance.

Batterer Intervention and Relapse Prevention

Clients will respond better if the batterers' intervention is tied to the idea of relapse prevention. The process of relapse tends to be cyclical. The phases of the cycle may be related to the phases of the cycle of violence. Compare the two, and ask clients to identify experiences where an event in one cycle triggered an event in the other cycle for them. Stress to clients that violence-free life and sobriety are linked in a number of ways:

- In the Twelve Steps of Alcoholics/Narcotics/Cocaine Anonymous, inventory steps require admitting "to God, to ourselves and to another human being the exact nature of our wrongs." The "amend" steps require making a "list of persons we have harmed," and becoming "ready to make direct amends to them all." Accountability and responsibility can be framed in terms of these concepts.

- The A-B-C cognitive-behavioral approach of Rational Recovery and Rational Emotive Therapy asks clients to identify a relationship between their thoughts, feelings, and behaviors. Belief systems which exaggerate male privilege and demean women can be challenged in this context.

- Most religious traditions embrace some version of the Golden Rule: "Do unto others as you would have others do unto you." Stress the link between personal spirituality and relationships in ways which support equality and mutuality. Contrast concepts such as *serenity* and *centeredness* with violence, abuse, and chaotic family life. Relate *surrender* to giving up control of others' lives.

- Use tools such as the Cycle of Violence illustration and the Power and Control Wheel as concepts in treatment and relapse prevention.

Confidentiality and Other Legal Issues

Federal laws governing the confidentiality of client records and client-identifying information apply to alcohol and drug abuse treatment providers (see 42 CFR Part 2, and the similar Illinois rule in 77 Ill. Adm. Code 2060.319). Under these laws and the regulations implementing them, no client-identifying information can be disclosed without the client's written consent in a specific form. Exceptions are:

➜ Mandated reports of child abuse.

➜ Emergency medical care.

➜ Orders of a court of competent jurisdiction following a hearing *in camera* (in the judge's chambers) at which good cause has been established (and at which the client and the agency should be represented).

➜ Suicidal and homicidal threats.

See the relevant portion of the federal and state rule for specific language regarding the exceptions.

Potential problem areas include:

- *Caller ID and Star 69.* If your agency cannot place a total block on these services, you should block each call with

*(Star) 67. If this is not possible, anonymous calls will have to be placed from phones which cannot be traced to the agency.

- *Safety checks with partners*. Agencies must carefully limit the amount of information they convey, even with consent, to that which is necessary to assure partner safety.

➜ *Tarasoff situation (e.g., where consent has been revoked by a client who leaves an intervention group prior to completion).* Safety checks to partners must, again, be as limited as possible while assuring the goal of partner safety. If consent has been effectively revoked, contact must be made anonymously or only in the name of the victim-service program. ("We have information which leads us to believe that you may be in danger from your partner.")

➜ *Contracted providers of batterers' services*. Using their own agency's identity rather than the substance abuse treatment provider's identity may avoid the problems specific to the substance abuse-related federal confidentiality regulations.

➜ *Programs in hospitals or other institutions which are not primarily alcohol and drug abuse treatment providers*. Using the name of the larger institution rather than the specific name of the substance abuse treatment program is also an option for exercising duty to warn.

Qualified Service Organization Agreements

Qualified Service Organization Agreements (see Appendix for example) may be useful in communicating with a domestic violence program in some instances. In such an agreement, each agency states its understanding of and commitment to the protection of client information contained in the federal regulations and agrees to share such information as is necessary for the provision of the services in question. When such an agreement has been appropriately entered into, the program may share information with the Qualified Service Organization (QSO) as long as it pertains to the service which the QSO is providing. Further, the agency is not required to notify clients of the existence of the QSO Agreement. This may be a useful tool for agreements with victims' services organizations regarding safety checks. Note that in ordinary situations, this is not intended to replace consents, and that the QSO should not receive any more information than is necessary for it to perform the service which it has agreed to provide to the substance abuse treatment agency. The QSO is of course prohibited from redisclosing any information it does get unless it obtains a consent to do so from the client in question.

Reverse Confidentiality

Full disclosure and discussion of treatment planning and ancilliary services is the rule in substance abuse programs and reflects the need for transparency and genuineness in the therapeutic relationship. However, as a component of safety checks, programs may obtain reports from partners of men in treatment who are also receiving intervention services, and this information must remain confidential if the partner requests confidentiality. *Substance abuse providers need to be scrupulous about informing clients who are receiving batterers' intervention services of the fact that such reports will be accepted and will be kept in confidence if the victim requests it.*

Special Settings: Public Assistance (TANF)

The issues of substance abuse and domestic violence have important implications for welfare clients. On August 22, 1996, President Clinton signed the Personal Responsibility and Work Reconciliation Act ending open-ended entitlement for needy families. Aid to Families with Dependent Children (AFDC) was replaced by Temporary Assistance for Needy Families (TANF). The legislation creating TANF shifted welfare policy from economic security to stressing work and self-sufficiency. It establishes time limits and work requirements, and emphasizes personal responsibility.

Prevalence of Substance Abuse and Domestic Violence

There is a wide range of estimates of the prevalence of substance abuse and domestic violence among TANF families. Many studies lack common definitions, resulting in a wide range of estimates:

- Prevalence rates for substance abuse vary from 6.6 percent to 37 percent of the caseload (Olson & Pavetti, 1996). The general consensus is that 25 percent of TANF clients have substance abuse problems that are likely to interfere with their ability to get and keep a job (Young & Gardner, 1998).

- As more TANF clients go to work and leave the caseload, the percentage of TANF clients with substance abuse problems will likely increase. A study of 25 state programs by the U.S. Department of Health and Human Services found substance abuse to be among the most frequently identified functional impairments preventing clients from leaving welfare (U.S. Department of Health and Human Services, 1992).

- The estimates of women TANF recipients who experience domestic violence range from 20 percent to 80 percent. However, welfare reform demonstration projects from several states reveal lower rates of domestic violence than these estimates. In Illinois, less than 1 percent of the 57,985 clients screened as part of an employability review self-reported domestic violence (Illinois Department of Human Services, 1998). The disparity between the estimates and actual reports may be attributed to several factors. It may reflect a woman's reluctance to acknowledge that she is living with a man who may or may not be the father of her children. She may be reluctant to disclose for fear that financial and food stamp benefits will be reduced. She may also fear that disclosure may trigger child welfare involvement.

Implications for TANF Families

Time Limits

The focus of TANF is on transitional services. Federal law limits cash benefits to a maximum of five years in a lifetime. The law allows states to set limits at less than five years and to exempt 20 percent of the caseload from time limits. Illinois has established two time limits for TANF families:

- The time limit for all families is 60 months. Assistance received in other

states or in nonconsecutive months counts toward the time limit.

- However, families whose youngest child is age 13 or older are assigned to the Targeted Work Initiative and are limited to 24 months of cash assistance unless the adult is working. Adults who cannot find a job are given the opportunity to earn a TANF payment in a pay-after-performance program (Work First).

In Illinois, time limits began on July 1, 1997, with the implementation of TANF. Assistance received prior to this date does not count toward the time limits. Benefits paid under the following circumstances will come from state funds and will not count toward the time limits:

- Payments made to single-parent households when the adult is working 30 hours per week in a paid job.

- Payments made to families headed by a teen parent.

- Payments made to two-parent households if the adults are working a total of 35 hours per week.

- Payments made to single-parent households when the adult is attending an accredited post-secondary education program full time. The adult must maintain a cumulative 2.5 grade point average.

Work Requirements

Welfare reform places a greater emphasis on engaging TANF clients in work as quickly as possible.

- TANF requires most clients to work or participate in work-related activities. After 24 months of TANF, the adult must have a job or be taking part in work activities for the family to continue to receive cash assistance.

- The hours spent in substance abuse treatment and domestic violence counseling count toward meeting the work requirement.

Personal Responsibility

The TANF law stresses personal responsibility.

- Clients convicted of a felony crime after August 21, 1996, that involves possession, use, or distribution of a controlled substance are not eligible for cash assistance.

- Clients who are convicted of any other drug-related felony and don't enter treatment or an aftercare program will remain ineligible for two years.

- Clients who have additional children once they start receiving TANF benefits do not receive an increase in cash benefits.

- Clients must cooperate in establishing paternity and obtaining child support. A woman may receive an exemption from establishing paternity or obtaining child support if doing so will place her or her children at risk of harm.

- Clients must meet child support requirements, cooperate in work and training activities, cooperate in referral and treatment for substance abuse, and follow through on their service plan or face sanctions.

- Sanctions are imposed at three levels:

1. At the first level, the cash benefit is reduced by 50 percent. Benefits are restored as soon as the client cooperates.
2. At the second level, the cash benefit is reduced by 50 percent for three months. If by the fourth month the client has not cooperated, the entire cash benefit is stopped.
3. At the third level, the entire cash benefit is stopped for three months. The client must cooperate for benefits to be restored.

Need for Collaboration

Helping families struggling with poverty and domestic violence and/or substance abuse requires the coordinated efforts of TANF, domestic violence and substance abuse treatment agencies.

- The imposition of time limits on welfare receipt necessitates that service/ treatment plans incorporate the goal of employment.

- The reality of sanctions necessitates that DHS offices are informed of any circumstance that would keep a client from complying with a program requirement. Agencies need to communicate and work together to develop coordinated, rather than conflicting, service plans.

- The complexity of multiple problems often requires joint intervention. TANF policy requiring cooperation with a substance abuse treatment plan may be used to motivate a client. Supportive services such as child care and transportation are available to assist TANF clients with their service plan.

Special Settings: The Criminal Justice System

Common Perspectives

Although this best practice manual is targeted to direct service providers working in the substance abuse and/or domestic violence field, the collective authors of this manual concluded that the large number of domestic violence perpetrators involved in the criminal justice system necessitated the development of a separate chapter. This chapter is not sufficiently comprehensive to delineate all of the "best practices" within the intricacies of the criminal justice system; rather, it is intended to raise the general awareness of the system in its response to and treatment of the dual issues of domestic violence and substance abuse, and to encourage the system to undertake a more holistic approach to these dual issues.

A survey conducted by the American Correctional Association in 1990 found that more than half of female inmates report being victims of physical abuse and 36 percent report being victims of sexual abuse (that often occurred when they were adolescents or children).

The Illinois compiled statutes (ILCS), Chapter 750, defines domestic violence/abuse as "physical abuse, harassment, intimidation of a dependent, interference with personal liberty or willful deprivation," but does not include reasonable direction of a minor child by a parent or person in loco parentis. It also defines "family or household member" as inclusive of spouses, former spouses, parents, children, stepchildren and other persons related by blood or by present or prior marriage, persons who share or formerly shared a common dwelling, persons who have or allegedly have a child in common, persons who share or allegedly share a blood relationship through a child, persons who have or had a dating or engagement relationship, and persons with disabilities and their personal assistants.

Relationship Between Substance Use and the Crime of Domestic Violence

A National Institute of Justice study (1997), *Drugs, Alcohol, and Domestic Violence in Memphis*, indicates the following:

- 92 percent of domestic violence assailants had used drugs or alcohol during the day of the assault.
- 67 percent had used a combination of cocaine and alcohol.
- 45 percent of assailants were described as using alcohol, drugs, or both daily to the point of intoxication during the past month.
- 9 percent of assailants were either in treatment or had previously received treatment for substance abuse.
- 89 percent of victims were repeat victims of current assailants.
- 67 percent of assailants were on probation or parole at the time of assault.
- 72 percent of victims were female;

78
percent of assailants were male.
- 42 percent of victims used alcohol or drugs the day of the assault — 15 percent had used cocaine; about one half using cocaine reported being forced to by the assailant.

- 68 percent of the assault episodes included use of a weapon, primarily blunt instruments such as hammers, baseball bats, etc.
- 85 percent of the assaults were witnessed by children under the age of 18.
- 15 percent of the victims in the survey were younger than 18 years and most were assaulted after witnessing assaults on their mother.

Batterers' Services

In July 1998, NIJ published a research brief titled *Batterer Programs: What Criminal Justice Agencies Need to Know* (Healey & Smith). The highlights of the brief provide this information:

Batterer intervention programs were originally established in the late 1970s as feminists and others called attention to the victimization of women through domestic violence, grassroots programs sprang up, and service providers recognized that the offenders' behavior needed to be addressed. The requirement that batterers attend intervention programs as a condition of probation or as part of pretrial or diversion is fast becoming a part of the response to domestic violence in many jurisdictions. However, judges and probation officers often lack basic information about program goals and methods. This report, a summary of the full-length study, attempts to meet that need by presenting information about batterer intervention programs operating throughout the country. The interventions described were selected to represent the range of programming available and include the established or "mainstream" programs as well as innovative approaches.

All programs are structurally similar, proceeding from intake through assessment, victim contact, group treatment, and completion; but each program is based on one of several theoretical approaches to domestic violence. Most of the pioneers in intervention use the feminist model, which attributes the problem to societal values that legitimate male control. This model, exemplified in the "Duluth Curriculum," uses education and skills building to re-socialize batterers. The less common family systems interventions, based on the notion that violent behavior stems from dysfunctional family interactions, emphasize building communication skills within the family. Psychotherapeutic and cognitive-behavioral interventions are based on the belief that domestic violence is related to the offender's psychological problems and, as a result, emphasize therapy and counseling. The EMERGE and AMEND models represent a blend of the feminist

educational approach with more in-depth and intensive group work. Increased awareness of the diversity of the batterer population has given rise to the belief that more specialized approaches are needed. One trend reflects the idea that interventions should be based on various typologies or categories of batterers. Of these, the typologies that group offenders by their psychological factors may be less useful for criminal justice purposes than those that do so by degree of risk for dropping out or re-offending. Other specialized approaches are designed to enhance program retention of specific populations based on sociocultural characteristics such as poverty, race, ethnicity, nationality, gender, or sexual orientation.

Batterer intervention programs cannot deter domestic violence unless they are supported by the criminal justice system. Criminal justice responses to domestic violence should be coordinated to support batterer intervention. For example, the integrated criminal justice responses studied for this report included coordination among agencies; use of victim advocates throughout the system; designation of special, dedicated batterer intervention units; and provision of training for agency personnel. Probation officers have a key role as the critical link between the justice system and batterer interventions.

Victims' Perspective

Another NIJ study (Keilitz et. al., 1998), *Civil Protection Orders: Victims' Views on Effectiveness*, indicated the following:

- Effectiveness depends on how specific and comprehensive the orders are and how well they are enforced.

- Victims indicated that effectiveness depended on how accessible the courts are for victims and *how well-established the links are between public and private services and support resources for victims.*

- Violations of the protection order increase and *reported effectiveness decreases as the criminal record of the abuser becomes more serious.*

- Victims reported that the orders protected them against repeated incidents of physical and psychological abuse and were valuable in helping them regain a sense of well-being.

- The study confirmed a strong correlation between the severity and duration of abuse — the longer women experience abuse, the more intense the behavior is likely to become and the more likely women are to be severely injured by their abusers.

Recent Legislation

The following legislation, which became effective in Illinois on Jan. 1, 1999, enhances the criminal justice system's ability to respond to and deter further family violence:

- *First Degree Murder:* Amends the Criminal Code to state that a defendant, who is at least 18 years of age and who is guilty of first degree murder, is eligible for the death penalty when the victim had an

order of protection against the defendant.

- *Domestic Battery and Violation of Order of Protection:* Enhances a domestic battery and violation of order of protection charge from a Class A misdemeanor to a Class 4 felony if the defendant has a prior conviction for domestic battery or violation of order of protection.

- *Insurance:* Forbids a company issuing property or casualty insurance from using the fact that an applicant incurred bodily harm as the result of domestic violence as the sole reason for a rating, underwriting, or claims handling decision.

- *Elder Abuse:* Amends the Elder Abuse and Neglect Act to include a requirement that certain individuals report suspected elder abuse or neglect when it is believed that the elder is unable to seek help on his or her own.

Best Practices

The previously mentioned NIJ studies suggest the following:

- Screen and/or test assailants at the time of arrest for alcohol or drug intoxication.

- Detoxify arrested drug- or alcohol-dependent assailants prior to release from jail.

- Assess children who directly witness domestic violence to determine if services are needed.

- Allow domestic violence assault victims to swear out arrest warrants at the assault scene.

- Provide services for women whose self-esteem has been eroded by the manipulative and coercive behavior of a batterer.

- Safety planning must begin at the earliest point of contact with the victim and continue throughout the process.

- Accurate and complete information about the defendant (including previous arrests, substance abuse history, involvement with child protective services, and experience with batterer intervention) should be used to assist in making decisions concerning plea bargains, bail, and supervision and in fashioning the protection order.

- Reduce time between arrest and intervention program enrollment for batterers.

- Track participants more efficiently — practices currently involve referrals to a wide array of services.

- Centralized dockets created to handle domestic violence cases result in increased expertise, and access to all criminal justice system players and services.

- Opportunities for coordination by the criminal justice system include integrating batterer intervention with court-ordered substance abuse treatment.

- Program and sentencing options are needed for the full range of batterers, not just the low-risk male heterosexuals (the most common category).

- Further research is needed on the interactive aspects of domestic violence, such as use of criminal history information in crafting orders and counseling victims; effects and enforcement of specific terms of protection orders; and actions of police and prosecutors.

Special Settings: Child Welfare

Domestic violence and substance abuse increase the risk of child abuse and neglect. Either problem alone has the potential to destroy families; but when the two are combined, this potential increases significantly.

Domestic Violence and Child Maltreatment

Ninety-five percent of serious domestic violence is committed by men against women. These same men are also at high risk of physically abusing their children. Research has shown that children in homes where domestic violence occurs are at risk of becoming victims of violence themselves:

- Children whose mothers are battered are physically abused or neglected at a rate 15 times higher than the national average.

- Women and children are often victims of the same batterer. Studies have found that over half of the children of battered women have been physically or sexually abused by the same perpetrator as their battered mothers. Research on abused children similarly shows that nearly half of them have mothers who are battered.

- Lenore Walker's study of battered women found that one quarter had abused or neglected their children when they were being abused themselves. The same study also found that battered women were eight times more likely to hurt their children when they were being battered themselves than when they were living safe from violence.

- Even if they are not intentionally targeted for abuse, children in homes where women are being battered are sometimes injured while trying to intervene on behalf of their mothers, or when they are nearby while objects are thrown. Young children are sometimes hurt when their mothers are attacked while holding them.

- Because domestic violence is a pattern of behavior which escalates over time, it becomes increasingly likely that child witnesses of battering will eventually become victims of the same perpetrator.

- Domestic violence is the single major precursor to deaths occurring as the result of child maltreatment.

Even when children of battered women are not physically abused themselves, they still suffer the traumatic effects of witnessing violence between their parents or caretakers.
Whether or not they experience any physical
abuse, children from violent homes are at risk
for problems of adjustment:

- Children who witness domestic violence suffer effects similar to children who are themselves physically or sexually abused.

- The emotional effects of domestic violence on children include taking responsibility for the abuse, constant anxiety, guilt for not being able to stop the abuse, fear of abandonment, and lack of confidence.

- Children from violent homes may experience cognitive or language problems, developmental delay, stress-related physical ailments, and hearing and speech problems.

- Stress-related symptoms such as bed-wetting, hair pulling, frequent nightmares or night terrors are often present in children of battered women.

- Some children cope through regressive symptoms such as thumb-sucking or infantile temper tantrums.

- Even infants can be visibly upset by arguments between their parents.

In addition to these negative effects, children of battered women also experience the effects of having violent role models. They learn that violence is an appropriate way to manage stress, one that has few consequences from society:

- Many children begin to act out the violence they have seen at home. A study found that 47 percent of boys and 36 percent of girls from violent homes fell within the clinical range of behavior problems. Even when they are not physically abused themselves, child witnesses of domestic violence still show higher levels of behavior problems than children living in safe homes.

- Research shows that children from violent homes are more likely than other children to be abusive toward brothers and sisters.

- When tested, children from violent homes were more likely than their peers from nonviolent homes to indicate that violence is an acceptable way to resolve conflicts or express anger.

This modeling of violence continues into adulthood, and many children of battered women become batterers or victims themselves. Boys from violent homes are 15 times more likely than boys from non-violent homes to become abusers themselves. Research found that *witnessing* spouse abuse as a child was an even better predictor for becoming an abuser than experiencing physical abuse as a child. In this way, the cycle of violence continues.

Substance Abuse and Child Maltreatment

Substance abuse is closely linked to child abuse. At least 40 percent of child maltreatment cases involve the use of alcohol or other drugs, and that percentage could be as high as 75 percent. Studies suggest that at least 10 million children live in homes where the primary caretaker is addicted to alcohol or other drugs, and up to 675,000 children per year suffer serious abuse or neglect as the result of that substance abuse.

- Among psychoactive drugs, methamphetamine, cocaine, and PCP are only three of the substances that are capable of increasing the risk for violence due to drug-related irritability, hostility, suspiciousness, and psychosis.

- Alcohol, barbiturates, tranquilizers, and other sedatives, due to their disinhibiting effects, also increase the risk for aggressiveness and violence.

- Opiate use (e.g., heroin) may contribute to child neglect, while withdrawal from opiates is more likely to increase the

risk for abuse.

- The communities in which addicted women live with their children may also be a source of traumatic violence. In Illinois, some clients report that they live in what they perceive as a "war zone," and may resort to sleeping with their children on the floor of their home in order to avoid stray bullets from drive-by shootings.

Whether or not they are physically abused, children of substance abusers experience the effects of the chronic stress of living with an addicted parent. Young children of substance abusers may believe they caused the addiction, and older children may feel anxiety and guilt for not being able to control or cure it. Like children of batterers, children of substance abusers often grow up to repeat the pattern, becoming substance abusers themselves.

Safety and Sobriety

A common assumption within substance abuse treatment programs is that if the offending parent's alcohol or other drug use ceases, so will child maltreatment. This assumption, however, is based on the mistaken belief that the child abuse or neglect is entirely a product of substance abuse.

- *Child neglect appears to decrease when an addicted parent or caregiver achieves and maintains sobriety*. In some cases, child neglect is directly related to the effects of alcohol and other drugs and to the addict lifestyle, which is often chaotic and unpredictable.

- *Child abuse seems to decline minimally, if at all with sobriety.* The parent's sobriety can not be taken as an indication that all child maltreatment will stop.

- *A personal history of child abuse is also a risk factor for continued or renewed substance abuse as a means of "self-medicating" the feelings associated with such trauma.* Of adults in substance abuse treatment, nearly 70 percent of women and 12 percent of men were sexually abused as children. Substance abuse may often serve as the "anesthetic" which numbs the pain of being an adult survivor of child abuse. When this anesthetic action ceases as the result of sobriety, the individual's pain may be magnified, increasing the risk of child abuse. For this reason, therapy or counseling outside the realm of chemical dependency treatment may be required in order to minimize the risk of continued child abuse.

Ethics

The identified client within both domestic violence and substance treatment programs is the adult. However, such programs must take into account the importance of ensuring the safety of children within a home in which substance abuse or domestic violence is occurring.

- *Both substance abuse and domestic violence intervention programs are mandated to report child abuse and/or neglect.* Children from homes in which domestic violence has occurred should receive a thorough physical and psychological assessment.

- When appropriate, these children should be referred to a specialized support group such as those commonly found in domestic violence programs.

Training and Certification

At present, no agency within Illinois provides specific certification for domestic violence or child welfare professionals, although licensure for child welfare workers is likely to become a reality by the end of 2000. The Illinois Alcohol and Other Drug Abuse Professionals Certification Association (IAODAPCA) provides a wide range of certificates and levels of certification for substance abuse counselors, preventionists, assessment and referral specialists, and MISA (mentally-ill substance abuse) workers. Currently, training in the areas of domestic violence and child welfare are not requirements for such certification.

- Currently, the best solution to the issue of dual certification appears to be to continue offering cross-training opportunities to various professions, and to encourage continued dialogue and service planning between the various fields.

- Individuals who are chemically dependent, as well as those who are victims of domestic violence and child maltreatment, are frequently seen in hospital emergency departments and physicians' offices. Doctors, nurses, and social workers should be targeted for training in the screening of patients for substance abuse, domestic violence and child maltreatment.

- Colleges and universities should be encouraged to seek out opportunities for students majoring in human service fields to learn skills and gain experience in such diverse fields as addiction counseling, domestic violence intervention, and child welfare.

Special Populations: Racial and Ethnic Groups

Multicultural Sensitivity

Culture has been defined as "the shared values, norms, traditions, customs, art, history, folklore, and institutions of a group of people." It is formed by race, ethnicity, age, gender, sexual orientation, and geographical location. Culture shapes an individual's view of the world, their values, behavior, and way of life. It influences attitudes and affects how an individual responds to domestic violence and substance abuse services.

Culturally competent programs demonstrate sensitivity to and understanding of cultural differences. A culturally competent program:

- Understands the role of culture in shaping behaviors, values and institutions.
- Recognizes that cultural differences exist and have an impact on service delivery.
- Recognizes that diversity exists among the same racial and ethnic groups.
- Respects the unique, culturally defined needs of various client populations.
- Understands that people from different racial and ethnic groups and other cultural subgroups are usually best served by persons who are a part of or in tune with their culture.
- Trains staff to recognize and confront their own prejudices.
- Trains staff to assess and respond to an individual's communication style — for example, their preferred personal space, eye contact, language style, and the degree to which touching is appropriate.
- Provides written material in the appropriate language.
- Develops linkages with support systems representing the client's culture.

Ethnic and Racial Populations

Here are some points to consider in providing culturally competent services.

African American Women

- Some women may avoid maintaining eye contact because it is perceived as challenging. Others may reject deferential behavior and may be perceived as disrespectful or hostile. Assess the individual's communication style and avoid judging behavioral clues.

- Touching during conversations is generally reserved for close friends and family. Touching by a counselor may by considered intrusive or insincere.

- Questions of a personal nature, such as those related to sexual behavior, may be viewed as intrusive and indicative of stereotypical thinking. Staff should be aware that it may take some time before a person is willing to share personal information.

- Some women may be reluctant to report violence because of their community's negative experience with the police.

Asian/Pacific Island Women

- Be aware of and respect the diversity among the multiple racial and ethnic groups that comprise the Asian/Pacific community. There are more than 60 Asian/Pacific Islander groups, each with their own culture, language and ethnic identities.

- Various Asian/Pacific Islander groups have traditions for physical and emotional healing such as herbs or acupuncture that may be beneficial in treatment.

- Concepts of mental health or psychological well-being may be alien to cultures that assign identity and worth to harmonious relationships.

- Women may deflect eye contact as a sign of respect. Staring is considered impolite.

Hispanic/Latina Women

- Various Hispanic/Latina groups have their own traditions and cultures. It cannot be assumed that one approach will fit all.

- Recognize the importance of family in Hispanic/Latina culture. Be aware that the concept of family is broader than parents and children, and generally includes blood relatives, relatives by marriage, close family friends, and neighbors. When abuse exists, women may be reluctant to leave because of commitment to the family and fear of isolation.

Native American Women

- The Native American population consists of approximately 450 different groups with varying customs and some 250 languages. Acknowledgment of the cultural and religious beliefs, values and practices can empower and validate the Native American woman.

- Native American women owe their allegiance to their tribal laws over federal or state laws. Awareness of the Tribal Council's laws is helpful, particularly in counseling domestic violence victims.

- Native American women may experience feelings of isolation when living apart from the reservation. These feelings can be minimized by helping her build an adequate support system.

Immigrant Women

- Immigrant women are often vulnerable to domestic violence because of their immigration status and economic dependency. They may also be isolated because of language barriers and may face the added burden of racism.

- Immigrant women may not know American laws or may be misinformed by their batterer. The batterer may use the threat of deportation to control the woman. The Violence Against Women Act allows an immigrant woman to petition for legal residence. The provisions of the law are complicated, and professional assistance is recommended. Contact the Illinois Coalition Against Domestic Violence or the Poverty Law Center for assistance.

Men of Color

In groups composed primarily of European Americans, men of color may feel:

- Isolated — detached from familiar surroundings, culture, institutions and people.

- Uprooted — lacking familiarity with the system, dealing with hostility and messages of inferiority from the majority culture.

- Helpless — not functioning fully because of language barriers, lack of support systems, lack of education and skills.

- Powerless — lacking political and economic power, vulnerable because of immigration status and/or lack of documentation.

Studies have shown that men of color progress faster in treatment groups where they are the majority.

In partner abuse groups it is important to consider:

- Some men of color may argue that the society which disenfranchises them gives disproportionate power to women over men.

- The provider should be aware of the distinction between *acknowledgment* and *collusion* and take care to avoid the kind of negative bonding which can allow the man to internalize the message that his experiences justify his violence against women.

Special Populations:
Lesbian, Gay, Bisexual, and Transgendered People

Addiction and the Lesbian, Gay, Bisexual, or Transgendered Individual

Research on alcohol and drug addiction in the gay, lesbian, bisexual, or transgendered (LGBT) community is limited by a number of factors. Early research tended to concentrate on samples drawn from almost exclusively male patients of psychoanalysts and psychotherapists. The focus of the studies was often directed less toward treatment of alcoholism or addiction than toward "curing" homosexuality. Subsequent studies have focused on samples of people who are identified as gay because they are patrons of gay bars. The fact that in each of these groups rates of drug and alcohol use tended to be higher for what should have been obvious reasons skewed the resulting data. The rate of drug and alcohol abuse and addiction (often reaching 30 percent or higher) hypothesized in these samples was projected as a reasonable estimate for the population as a whole. There has been little research that recognizes the fact that most gay men and lesbians do not publicly acknowledge their orientation and are consequently overlooked in many studies.

One of the factors complicating the recognition and treatment of addiction in the LGBT community is the fact that bars do tend to be social centers in the community. For people who may be subject to hostility, violence, or arrest for making incorrect guesses or assumptions about another person's orientation, it is important to have a place where LGBT identity can safely be assumed. That place has usually been the gay and/or lesbian bar. In larger communities, this is less true now than it may have been previously, but it is still the case for many LGBT people. In some locales such venues are the only places where LGBT people can be relatively free of harassment and ridicule, and in a few states even these havens are subject to law enforcement and regulatory discrimination. It may be true for some people that the only gay men or lesbians they know are people whom they have met in gay or lesbian bars.

On the whole, people in the LGBT community are wary of mental health and substance abuse treatment because of the homophobic assumptions and practices which have been characteristic in the past (and which continue to be a problem in some institutions). Moreover, the "peer group" from whom LGBT people must seek support in treatment and in 12-Step and other self-help groups may reflect the generally homophobic attitudes of the larger culture, and may pose problems for the gay man or lesbian who is seeking sobriety. The encouragement of self-acceptance, which generally characterizes addiction treatment, has often hit a snag when a client discloses same-sex sexual attraction.

> While the incidence of LGBT alcoholism and addiction may have been overstated, there is certainly

little reason to believe that overall rates of addiction and substance abuse in the LGBT community are any lower than in the general community. Other research has shown that "sociocultural factors influence whether, how much, and why a person drinks" (National Institute on Alcohol Abuse and Alcoholism, 1978). Even assuming a similar distribution in the LGBT community of whatever factors may predispose people to addiction for genetic or biological reasons, the use of drugs and alcohol to medicate negative feeling states resulting from homophobia (both external and internalized) is likely to be higher in this population. Thus, those with such predisposing factors will be more likely to show symptoms of the disease, and to do so earlier.

Homophobia, Misogyny and Violence

Rigid conceptions of gender roles and attributes play a significant part in the dynamics of domestic violence. The expectation of male privilege is grounded in a belief that men are superior to women and that men have rights with regard to women which are not reciprocal. One of the effects of this attitude is to make male identity, and specifically heterosexual male identity, the norm. To be anything else is to be "less than."

In a sexist society it is not surprising that boys who find themselves attracted to other males, and wish the attraction reciprocated, may begin to internalize the gender role expectations that surround them and assume characteristics that the social framework characterizes as "feminine." Similarly, girls who are attracted to women may take on characteristics that might be seen as "masculine." Misogyny's relationship to homophobia can be inferred from the fact that adults see a girl who is considered a tomboy as "cute" far longer than they do a boy who is considered a sissy.

The threat to male privilege implied by homosexuality is that gender roles and their attendant privileges are not immutable — if he can give his up, perhaps mine can be taken away. If, as a man, I view women as sex objects in ways that depersonalize them, I am likely to respond with anger and fear to the thought that another man might regard me in the same way. If, as a man, I am defensive of male privilege, I may well feel threatened when confronted by another man who appears to have voluntarily surrendered that privilege. If I believe that being the object of a man's sexual interest is one of the things that defines the female and makes her "less than," then the attention of such a man is even more threatening to me.

Lesbians get less attention from the heterosexist position. The sexual attraction of one woman for another becomes useful in providing a label for women who reject or are indifferent to a particular man's advances. Whereas male-male sex is seen as repulsive and shameful, female-female sexual activity is seen as titillating or merely strange. Thus lesbians tend to become less visible, and are discounted by being trivialized (Nelson, 1988).

Homophobia and Men Who Batter

In many kinds of behavioral intervention or therapy with men, it is necessary to address homophobia as an isolating factor. Men in substance abuse treatment, for example, often need to confront homophobia as a factor that makes it more difficult for

them to self-disclose in groups of men or to confide fully in a sponsor. Many men come to realize that homophobia has made it difficult for them to seek and appreciate support from other men, including fathers and male siblings. In intervention with men who batter, however, homophobia and its relationship to misogyny play a more crucial role, and confrontation of homophobia is often a difficult and volatile aspect of the intervention process.

LGBT People of Color

Lesbians, gay men and transgendered individuals who are people of color experience what has been called "double trouble": they must deal with the effects not only of racism, but also of homophobia. For lesbians of color, this becomes a triple threat, as the effects of sexism must also be considered. People of color must deal with racism in the gay and lesbian community, whose emerging culture is heavily dominated by White men and women. At the same time, in struggling against racism, they must deal with the fear of homophobic retaliation in addition to their other vulnerabilities. These factors increase the isolation of the lesbian of color particularly, but also of the gay or transgendered person of color. The person of color who embraces a lesbian, gay, bisexual or transgendered identity is subject not only to homophobic attack, as are Whites, but also to racist attacks, which are not a concern for Whites (Kanuha, 1990).

Violence in Gay and Lesbian Relationships

There is evidence that battering occurs in gay and lesbian domestic partnerships at roughly the same rate as in heterosexual marriages or domestic relationships. One of the first studies of domestic violence in lesbian relationships found that 25 percent of those surveyed reported abuse in their committed relationships (Brand & Kidd). A 1990 study determined that 47 percent of lesbian couples had experienced repeated acts of violence. Of these couples, 10 percent to 20 percent experienced severe violence, defined as: two or more incidents of physical violence, including beating, choking, hitting, forced sex, mutilation or threats with a weapon (Coleman, 1990).

What we know about same-gender relationship violence is limited. According to a fact sheet distributed by Wingspan Domestic Violence Project in Tucson, this is because:

- Same-gender relationships are often not considered to be viable partnerships or families.

- In many states (Illinois is an exception), domestic violence law only protects partners of the opposite sex. Other types of domestic violence legislation, such as mandatory arrest, no-drop clauses, state prosecution and mandates for abusers or victims to attend programs that address domestic violence, may not apply to same-gender relationships.

- Fear of continued victimization by law enforcement, criminal justice, and social service helpers keeps LGBT people from seeking assistance, support, and safety.

- Limited official programs and resources further isolate same-gender couples in domestic violence situations.

- Many LGBT people lead double lives in which it would be a threat to job, status, family role, safety, and security to be open about their sexual or gender identity. When help is needed, fear of exposure may prevent them from taking action to stop the cycle of violence.

- With a few exceptions, the LGBT community generally avoids, denies, and ignores relationship violence. Victims and perpetrators are left without resources within their identified communities.

Intervention

Few resources are available for intervention in violent LGBT relationships. It is obvious that gay men would not be safe in an intervention group that was predominantly composed of heterosexual men. Of course, no woman should be included in a group for men who batter. In many communities, this makes group treatment of gay and lesbian batterers impossible, because it is unlikely that a sufficient number of gay men or lesbians to form an effective group would present for intervention at any one time.

In Chicago, the largest social service agency that serves the lesbian and gay community is currently referring identified perpetrators to individual therapy with selected psychotherapists. This is certainly not recognized as the intervention of choice. At present, there is only one support group for lesbian victims of domestic violence operating in Chicago. There are no groups that offer similar support to gay male victims. There are no services that specifically address the needs of transgendered people.

Special concerns

Concerns specific to LGBT identity also reduce the willingness of people affected by the problem to seek help. Anecdotal evidence is strong that such services, if they existed, would be used by only a small fraction of the LGBT community. Barriers to greater participation include the following:

- *Fears of being "outed" or exposed as homosexual*. In Illinois, except in Cook County and the cities of Champaign and Urbana, a gay, lesbian, bisexual or transgendered person can be discharged from or refused employment, evicted from or refused housing, and denied any public accommodation simply because of the person's sexual orientation. In fact, such discrimination is also legal on the basis of *perceived* or *suspected* orientation.

- *Low expectations of official response*. Many LGBT persons have experienced insults, harassment, and ridicule from police and other governmental authorities, and do not expect serious attention to their needs, including their needs for protection from violence. Many fear that taking action will result in retaliation by the perpetrator that will go unhindered by any official sanction.

- *Fear of other homophobic or heterosexist responses.* Both battered gay men and lesbians who batter challenge the assumptions that underlie the provision of services to both victims and perpetrators. Internalized homophobia leads many in the LGBT community to deny or minimize the existence of the problem, and disbelief,

ridicule or rationalization often greets discussion of the problem.

Initial Steps

While there are no easy solutions to this complex group of problems, there are steps communities and institutions can begin to take.

- *Name the problem.* Community groups, publications, and institutions within the LGBT community must acknowledge that gay men, lesbians, bisexuals and transgendered people batter their partners.

- *Make a commitment to a response.* Complex problems such as the incidence of violence in same-gender relationships often lead to situations in which nothing is done because so much needs to be done. An individual, a single community, or one institution cannot provide all that is necessary to address this, but each can do something. Programs can examine their attitudes toward LGBT clients, and can provide training designed to make staff sensitive to the particular needs of this community and its members. Community organizations and networks that have done so much to begin a coordinated response to intimate partner violence in opposite-sex couples can examine the opportunities for outreach to LGBT people.

- *Encourage research.* While there are few resources nationwide for this community, there are some. Further research is clearly needed to better understand the dynamics of same-sex domestic violence and the particular challenges it poses to intervention and safety planning efforts.

Within programs, there are steps that counselors and advocates can take to increase the effectiveness of their interactions with LGBT clients.

- Service providers should be aware that there is not one monolithic "gay subculture" or "gay lifestyle."

- As with any special population, an effort to be culturally sensitive begins with awareness of one's own attitudes. Advocates and counselors may wish to ask themselves:

  (a) Can I personally believe that gay is just as good as straight?

  (b) Can I personally conceive of a homosexual person living a happy life?

  (c) Do I conceal from myself attitudes of pity, condescension, and moral superiority toward LGBT people, attitudes which may cut me off from full communication with LGBT clients? (Schwartz, 1980).

- Become familiar with the resources available to LGBT clients in your community. For example, in Chicago, many LGBT persons may be unaware that more than 60 gay/lesbian or gay/lesbian-friendly religious organizations have services on a weekly or more frequent basis (*Out! A Resource Guide*, 1998). Many LGBT organizations for civic, political, philanthropic, and community organizing activities exist, which are places to seek friendship and support among people who are not focused on drinking. Many smaller communities may have some resources for LGBT clients of which the clients are unaware.

- Become familiar with referral sources for treatment such as the Pride Institute, Horizons Community Services and the Howard Brown Health Center, which may be able to suggest additional local resources. Obtain copies of the *Pink Pages* or *Out,* which are LGBT "yellow pages" publications issued on a semiannual basis.

- Be aware that there is a growing network of sobriety-based support for LGBT people such as special-interest A.A. and N.A. groups.

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APPENDIX

Screening Tools:
Alcohol and Other Drugs

Short Michigan Alcoholism Screening Test

NAME _____

Date of Birth _____

Date of Administration _____

SMAST

YES	NO		
( )	( )	1.	Do you feel you are a normal drinker? (By normal we mean you drink *less than* or *as much* as most other people.)
( )	( )	2.	Does your wife, husband, a parent, and/or other near relative ever worry or complain about your drinking?
( )	( )	3.	Do you ever feel guilty about your drinking?
( )	( )	4.	Do friends or relatives think you are a normal drinker?
( )	( )	5.	Are you able to stop drinking when you want to?
( )	( )	6.	Have you ever attended a meeting of Alcoholics Anonymous?
( )	( )	7.	Has drinking ever created problems between you and your wife, husband, a parent or other near relative?
( )	( )	8.	Have you ever gotten into trouble at work or school because of drinking?
( )	( )	9.	Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?
( )	( )	10.	Have you ever gone to anyone for help about your drinking? If YES, was this other than Alcoholics Anonymous or a hospital? (If YES, code as YES; if NO, code as NO.)
( )	( )	11.	Have you ever been in a hospital because of drinking? IF YES: Was this for (a) detox; (b) alcoholism treatment; (c) alcohol-related injuries or medical problems, e.g., cirrhosis or physical injury incurred while under the influence of alcohol (car accident, fight, etc.).
( )	( )	12.	Have you ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcoholic beverages?
( )	( )	13.	Have you ever been arrested, even for a few hours, because of other drunken behavior?

Michigan Alcoholism Screening Test (MAST) [1]

Answer Yes or No for each question as it applies to you.

Yes(0) No(2) 1. Do you feel you are a normal drinker?
Yes(2) No(0) 2. Have you ever awakened the morning after some drinking the night before and found you could not remember a part of the evening before?
Yes(1) No(0) 3. Does your wife (or do your parents) ever worry or complain about your drinking?
Yes(0) No(2) 4. Can you stop drinking without a struggle in one or two drinks?
Yes(1) No(0) 5. Do you ever feel bad about your drinking?
Yes(0) No(2) 6. Do friends or relatives think you are a normal drinker?
Yes(0) No(0) 7. Do you try to limit your drinking to certain times of the day or to certain places?
Yes(0) No(2) 8. Are you always able to stop drinking when you want to?
Yes(5) No(0) 9. Have you ever attended a meeting of Alcoholics Anonymous (AA)?
Yes(1) No(0) 10. Have you gotten into fights when drinking?
Yes(2) No(0) 11. Has drinking ever created problems with you and your wife?
Yes(2) No(0) 12. Has your wife (or other family member) ever gone to anyone for help about drinking?
Yes(2) No(0) 13. Have you ever lost friends or girlfriends/boyfriends because of drinking?
Yes(2) No(0) 14. Have you ever gotten into trouble at work because of drinking?
Yes(2) No(0) 15. Have you ever lost a job because of drinking?
Yes(2) No(0) 16. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?
Yes(1) No(0) 17. Do you ever drink before noon?
Yes(2) No(0) 18. Have you ever been told you have liver trouble? Cirrhosis
Yes(5) No(0) 19. Have you ever had delirium tremens (DTs), severe shaking, heard voices, or seen things that weren't there after heavy drinking?
Yes(5) No(0) 20. Have you ever gone to anyone for help about your drinking?
Yes(5) No(0) 21. Have you ever been in a hospital because of drinking?
Yes(2) No(0) 22. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was a part of the problem?
Yes(2) No(0) 23. Have you ever been seen at a psychiatric or mental health clinic, or gone to a doctor, a social worker, or clergy for help with an emotional problem in which drinking had played a part?
Yes(2) No(0) 24. Have you ever been arrested, even for a few hours, because of drunk behavior?
Yes(2) No(0) 25. Have you ever been arrested for drunk driving after drinking?

Various Alcohol and Other Drug Screening Questions [2]

[1] A score of 4 or more suggests evaluation by an AOD professional

[2] These are questions recommended by Dr. Kevin Downey, TASC

The following are examples of questions that batterers' programs may choose to utilize in their screening, depending on experience, type of batterers in the program, or characteristics of the man presenting for evaluation. Questions in **bold** type have been identified by men recovering from drug or alcohol problems as questions that are particularly important.

- Has a physician ever suggested that you quit or cut down on your drinking?
- **Has anyone in your family or close to you ever expressed concern about your drinking or drug use?**
- Have you ever missed school events for your children?
- Has any member of your family ever had a problem with drugs or alcohol?
- **Has anyone ever told you that when you drink or use drugs, you are a different person?**
- Have you ever been unable to remember parts of the night before when you were drinking?
- Have you ever done things to get alcohol or drugs that made you feel ashamed?
- **Have you tried to quit or cut down on alcohol on your own?**
- Have you been using more drugs or alcohol than normal?
- Have you ever thought about getting help or going into treatment?
- **Have you ever gone to counseling or self help (AA, etc.) to help with drinking?**
- Has your use of alcohol or drugs ever gotten you into trouble?
- **Have you ever gotten into a fight while using?**
- Are you a normal drinker?
- What is the most you have ever drank or used in a 24-hour period?
- **Do drugs or alcohol make you feel better?**
- **Do you ever wish that you didn't use alcohol or drugs?**
- How long have you been using drugs?
- How old were you when you got high or intoxicated on drugs or alcohol for the first time?
- Have you ever had a DUI?
- Do you like to drink before a party to relax or get ready?
- Do you look forward to certain times of the day because you know you can drink or use drugs?

Simple Screening Instrument For AOD Abuse
Self-administered Form[3]

Directions: The questions that follow are about your use of alcohol and other drugs. Your answers will be kept private. Mark response that best fits for you. Answer the questions in terms of your experiences in the past 6 months.

During the last 6 months:

1. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants.)
   _____ Yes _____ No
2. Have you felt that you use too much alcohol or other drugs?
   _____Yes _____ No
3. Have you tried to cut down or quit drinking or using alcohol or other drugs?
   _____Yes _____ No
4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors or a treatment program.)
   _____Yes _____ No
5. Have you had any health problems? For example, have you:
   ____ Had blackouts or other periods of memory loss?
   ____ Injured your head after drinking or using drugs?
   ____ Had convulsions, delirium tremens ("DTs")?
   ____ Had hepatitis or other liver problems?
   ____ Felt sick, shaky, or depressed when you stopped?
   ____ Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?
   ____ Been injured after drinking or using?
   ____ Used needles to shoot drugs?
6. Has drinking or other drug use caused problems between you and your family or friends?
   _____ Yes _____ No
7. Has your drinking or other drug use caused problems at school or work?
   _____ Yes _____ No
8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.)
   _____ Yes _____ No
9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?
   _____ Yes _____ No
10. Are you needing to drink or use drugs more and more to get the effect you want?
    _____ Yes _____ No

11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?

[3] Center for Substance Abuse Treatment (1994)

_____ Yes _____ No

12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone?

_____ Yes _____ No

13. Do you feel bad or guilty about your drinking or drug use?

_____ Yes _____ No

The next questions are about your lifetime experiences.

14. Have you ever had a drinking or other drug problem?

_____ Yes _____ No

15. Have any of your family members ever had a drinking or drug problem?

_____ Yes _____ No

16. Do you feel that you have a drinking or drug problem now?

_____ Yes _____ No

Scoring for the Simple Screening Instrument for AOD Abuse
Self-administered Form

Name/ID No.:_____ Date: _____

Place/Location:_____

Items 1 and 15 are not scored. The following items are scored as 1 (yes) or 0 (no):

____ 2	____ 5 (any items listed)	____ 8	___ 11	___ 14
____ 3	____ 6	____ 9	___ 12	___ 16
____ 4	____ 7	____ 10	___ 13	

Total score: _____ Score range: 0-14

Preliminary interpretation of responses:

Score	Degree of Risk for AOD Abuse
0-1	None to low
2-3	Minimal
>4	Moderate

CAGE-AID QUESTIONS [4]

		YES	NO
1.	Have you ever felt you ought to cut down or stop drinking or using drugs?		
2.	Has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?		
3.	Have you felt guilty or bad about how much you drink or use?		
4.	Have you been waking up wanting to have an alcoholic drink or use drugs?		

[4] Any positive response to a CAGE-AID indicates a possible problem and suggests further evaluation by an AOD professional.

GENERAL GUIDELINES FOR IDENTIFYING CLIENTS WHO MAY BE AFFECTED BY ALCOHOL OR OTHER DRUG USE

- **LOOK FOR CHANGE IN BEHAVIOR, ATTITUDE, OR APPEARANCE**
- **IDENTIFY BEHAVIOR WHICH DOESN'T SEEM RIGHT**
  - **Client can not stay awake**
  - **Client unable to sit still**
  - **Client is disoriented or confused for no apparent reason**
  - **Client laughs or cries at inappropriate time**
  - **Rapid shift in client's mood**
  - **Client's speech is slurred**
  - **Client's speech is rapid and loud, and it is difficult to follow his/her train of thought**
- **DO NOT AUTOMATICALLY ASSUME BEHAVIOR IS CAUSED BY ALCOHOL OR OTHER DRUG USE. RULE OUT OTHER CAUSES FIRST**
  - **Client is physically ill (e.g., flu)**
  - **Client is upset about some obvious problem (e.g., has been victimized by sexual partner or other person; client is concerned about her son's gang involvement)**
  - **Client's physician has recently prescribed new medication, particularly for psychiatric reasons**
- **DO NOT ARGUE WITH THE CLIENT REGARDING HIS/HER USE OF ALCOHOL OR OTHER DRUGS**

Common Signs/Symptoms of the Five Basic Abused Substances

Stimulants including speed, cocaine, caffeine, ephedrine, etc.	**Depressants** including barbiturates, minor tranquilizers, alcohol, opiates, etc.	**Hallucinogens** including LSD, acid, PCP, angle dust, wicki sticks, mushrooms, etc.	**Cannabis** also known as marijuana, pot, weed, reefer, dope, buds, etc.	**Inhalants** examples of what is commonly used: glue, gasoline, paint, etc.
Intoxication Characteristics:	**Intoxication Characteristics:**	**Intoxication Characteristics:**	**Intoxication Characteristics:**	**Intoxication Characteristics:**
dilated (large)pupils	slurred speech	pupils dilate(large)	increased appetite	dizziness
restlessness/excitement	drowsiness	fast heart rate	dry mouth	blurred vision
insomnia	staggering	sweating	fast heart rate	slurred speech
flushed face	impairment in attention or memory	blurring of visions	delusions	unsteady gait
increased urination	pupil constriction (small)	tremors	decreased body temperature	slowed reflexes
stomach problems	tremors	out of the ordinary behaviors	loss of coordination	muscle weakness
muscles twitching	smell of alcohol	hallucinations	panic	
rambling speech				
irregular heartbeat				
perspiration or chills				

Screening Tools:
Domestic Violence

Interview Questions

Please describe the FIRST incident of your violence or abuse in your most recent relationship.

Please describe the LAST (MOST RECENT) incident of your violence or abuse in your most recent relationship. (*Probe for description.)*

Please describe the TYPICAL incident of your violence or abuse in your most recent relationship. (*Probe for description.)*

Please describe the WORST incident of your violence or abuse in your most recent relationship. (*Probe for description.)*

Have you been the victim of violence or abuse in this relationship? (*Probe for description.)*

Did you see or hear your parents, or parent figures (grandparents, foster parents, etc.) being violent with one another when you were a child? (*Probe for description.)*

Were you physically or sexually abused by anyone as a child? (*Probe for description.)*

Trait Anger Scale

A number of statements that people have used to describe themselves are given below. Read the statements below and indicate how you *generally* feel by circling the appropriate number.

1 = Almost never
2 = Sometimes
3 = Often
4 = Almost always

	Almost Never	Sometimes	Often	Almost always
1. I have a fiery temper	1	2	3	4
2. I am quick tempered	1	2	3	4
3. I am a hotheaded person	1	2	3	4
4. It makes me furious when I am				

criticized in front of others	1	2	3	4
5. I get angry when I'm slowed down by others' mistakes	1	2	3	4
6. I feel infuriated when I do a good job and get a poor evaluation	1	2	3	4
7. I fly off the handle	1	2	3	4
8. I feel annoyed when I am not given recognition for doing good work	1	2	3	4
9. When I get mad, I say nasty things	1	2	3	4
10. It makes my blood boil when I am pressured	1	2	3	4

Sample Screening Questions

(Victim)

1. Within the past few years, have you been hit, slapped, kicked, pushed, shoved, or otherwise physically hurt by a family member, a person with whom you were in a relationship, or a care giver? ❑ Yes ❑ No

2. Within the past year, has anyone in your family, or anyone you have been in a relationship with forced you to participate in sexual activities against your will? ❑ Yes ❑ No

3. (If *yes* to either above): Are you afraid that the person who harmed you may do it again? ❑ Yes ❑ No

Sample Screening Questions (Perpetrator)

- Within the past few years, have you hit, slapped, kicked, pushed, shoved, or otherwise physically hurt a family member, a person with whom you were in a relationship, or a person to whom you were a care giver? ❑ Yes ❑ No

- Within the past year, have you forced anyone in your family, or anyone with whom you have been in a relationship, to participate in sexual activities against their will? ❑ Yes ❑ No

- (If *yes* to either above): Do you think that you may do it again? ❑ Yes ❑ No

Psychological Maltreatment of Women Inventory — Short Version

Richard Tolman, Ph.D.

Answer the following questions for your most recent relationship and during the time period of the last 12 months.

1 - NEVER 2 - RARELY 3 - OCCASIONALLY
4 - FREQUENTLY 5 - VERY FREQUENTLY

How often have you:

Called her/him names.	N	R	O	F	VF
	1	2	3	4	5
Swore at her/him.	N	R	O	F	VF
	1	2	3	4	5
Yelled and screamed at her/him.	N	R	O	F	VF
	1	2	3	4	5
Treated her/him like an inferior.	N	R	O	F	VF

	1	2	3	4	5	
Monitored her/his time and made her/him account for her/his whereabouts.	N 1	R 2	O 3	F 4	VF 5	
Used our money or made important financial decisions without talking to her/him about it.	N 1	R 2	O 3	F 4	VF 5	
Was jealous or suspicious of her/his friends.	1	N 2	R 3	O 4	F 5	VF
Accused her/him of having an affair with another man or woman.	N 1	R 2	O 3	F 4	VF 5	
Interfered in her/his relationships with other family members.	N 1	R 2	O 3	F 4	VF 5	
Tried to keep her/him from doing things to help herself/himself.	N 1	R 2	O 3	F 4	VF 5	
Restricted her/his use of the telephone.	N 1	R 2	O 3	F 4	VF 5	
Told her/him her/his feelings were irrational or crazy.	1	N 2	R 3	O 4	F 5	VF
Blamed her/him for my problems.	N 1	R 2	O 3	F 4	VF 5	
Tried to make her/him feel crazy.	N 1	R 2	O 3	F 4	VF 5	

Conflict Tactics Scale — Revised, Modified

Murray Straus, Ph.D.

During the last year, *how many times* has the person from whom you seek protection been *physically abusive* with you? Circle the "x" if he has done this prior to the past year. For example, if he had slapped you once six months ago,

but not before that, you would circle "1" for that item. If he slapped you two years ago, but not in the last year, you would circle "x". If he has slapped you two years ago and six months ago, you circle both "1" and "x".

0 Never in the past year
1 Once in the past year
2 2 times in the past year
3 3 to 5 times in the past year
4 6 to 10 times in the past year
5 11 to 20 times in the past year
6 More than 20 times in the past year
x Not in the past year, but he has done this prior to the past year

Frequency of:	0	1x	2x	3-5x	6- 10x	11-20x	more than 20x	before last year
(Circle the number that best reflects your answer)								
1. Threw something at you	0	1	2	3	4	5	6	x
2. Twisted your arm or hair	0	1	2	3	4	5	6	x
3. Pushed or shoved you	0	1	2	3	4	5	6	x
4. Grabbed you	0	1	2	3	4	5	6	x
5. Slapped you	0	1	2	3	4	5	6	x
6. Punched or hit you with something that could hurt	0	1	2	3	4	5	6	x
7. Wouldn't let you go to sleep or stay asleep	0	1	2	3	4	5	6	x
8. Forced you to have sex when you didn't want to	0	1	2	3	4	5	6	x
9. Choked you	0	1	2	3	4	5	6	x
10. Slammed you against the wall	0	1	2	3	4	5	6	x
11. Beat you up	0	1	2	3	4	5	6	x
12. Burned or scalded you on purpose	0	1	2	3	4	5	6	x
13. Kicked you	0	1	2	3	4	5	6	x
14. Hit or tried to hit you with something	0	1	2	3	4	5	6	x
15. Threatened you with knife, gun, or other weapon	0	1	2	3	4	5	6	x
16. Used knife, gun, or other weapon	0	1	2	3	4	5	6	x

As a result of domestic violence, have you had any of the injuries listed below? The first column is for injuries you have had *in the past year* as a result of domestic violence, and the second column refers to injuries you have had *at*

some point in your life as a result of domestic violence. Please include domestic violence from all partners in your answer.

Have you, *because of domestic violence . . .*	In the PAST YEAR	If NO, then EVER?
17. Had a sprain, bruise, or small cut	❒ Yes ❒ No	❒ Yes ❒ No
18. Felt physical pain that still hurt the next day	❒ Yes ❒ No	❒ Yes ❒ No
19. Passed out from being hit on the head	❒ Yes ❒ No	❒ Yes ❒ No
20. Went to a doctor	❒ Yes ❒ No	❒ Yes ❒ No
21. Needed to see a doctor, but didn't go	❒ Yes ❒ No	❒ Yes ❒ No
22. Had a broken bone	❒ Yes ❒ No	❒ Yes ❒ No

Lethality Scale – Modified

Jackie Campbell, Ph.D.

Does the perpetrator:

1. Call you obscene names?	❒ Yes	❒ No
2. Blame you for things that happen to him?	❒ Yes	❒ No
3. Have access to weapons?	❒ Yes	❒ No
4. Have suicidal ideas or attempts?	❒ Yes	❒ No
5. Have access to you?	❒ Yes	❒ No
6. Seem unwilling to stay separated from you (e.g., he tracks, stalks, or phones you)?	❒ Yes	❒ No
7. Make threats to you?	❒ Yes	❒ No
8. Have no desire to stop his violent behavior?	❒ Yes	❒ No
9. Get extremely upset or feel abandoned?	❒ Yes	❒ No
10. Get hostile, furious, or rageful?	❒ Yes	❒ No
11. Get extremely jealous and blame you for all sorts of behavior?	❒ Yes	❒ No
12. Threaten to kill pets (or kill pets)?	❒ Yes	❒ No
13. Damage property?	❒ Yes	❒ No
14. Been reported for child abuse?	❒ Yes	❒ No

SPOUSE ABUSE RISK ASSESSMENT

NAME_____ **DATE**_____

RISK FACTORS	LOW (L)	MODERATE (M)	HIGH (H)	COMMENTS
History of Abuse	No prior reports or injuries	Prior minor injuries	Subsequent incident or serious injury	
Substance abuse	None	Some use, non-contributing factor	Significant use, contributing factor	
Extent of physical injury	No medical treatment needed	Minor physical injuries/treatment	Major physical injury/hospitalization/injury during pregnancy	
Use of weapons	None	Weapons available, not used	Weapons used, or threat to use	
Emotional maltreatment	None/infrequent	Frequent/chronic	Threats of death or serious injury/stalking	
Location of Children	Known/no risk	Known/minimal risk	Unknown, or with perpetrator	
Forced sex	No evidence or allegation	Allegation with no evidence	Evidence of forced sex	
Family stressors	None	Minimal	Multiple	
Location of perpetrator	Known, no access to victim	Known, access to victim	Unknown, or at large	
Assault history	None	Infrequent/occasional episodes	Frequent/chronic episodes	
Fear of perpetrator	None	Minimal	Significant	
Safety plan	Appropriate	Vague	None	

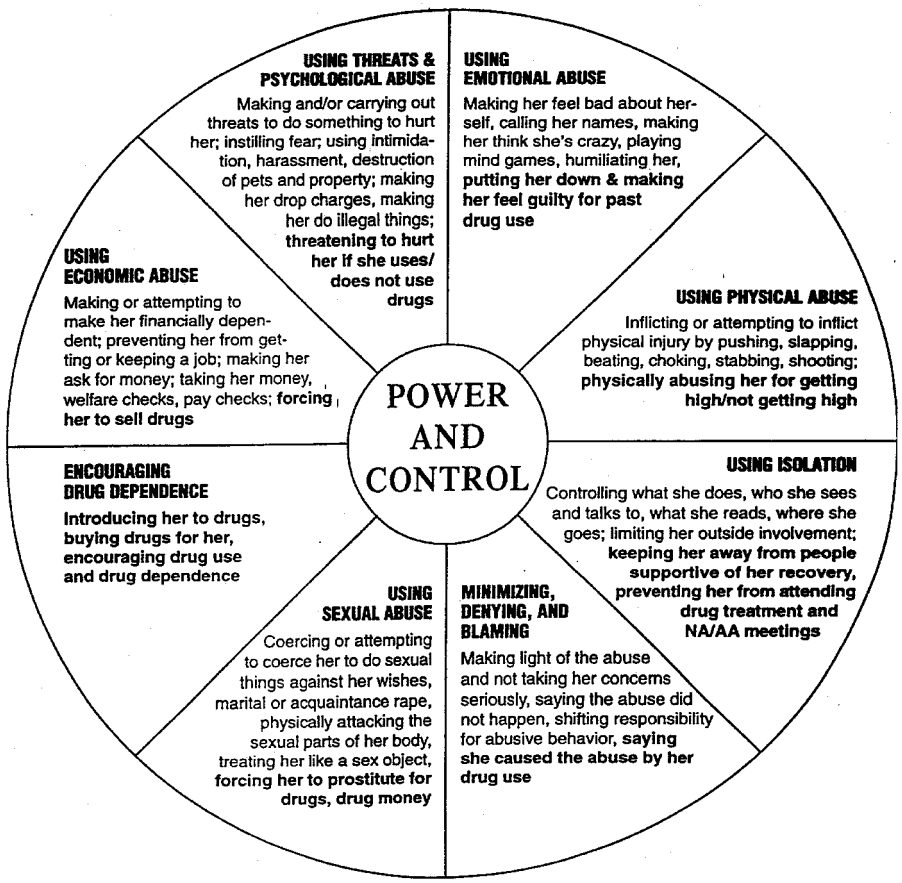
Any “H” must be thoroughly evaluated; the victim of the assessment and majority of “M”s require additional evaluation; advise

Warning/Protection Plan:

Power and Control Wheel

Domestic Abuse Intervention Project
206 West Fourth Street
Duluth, Minnesota 55806
218-722-4134

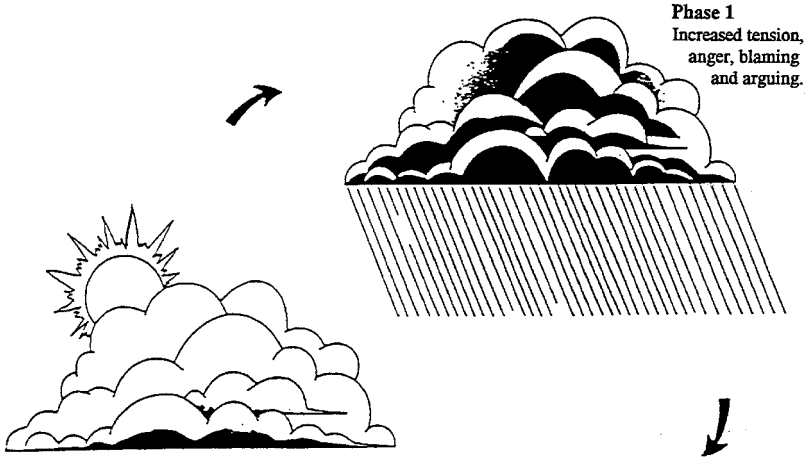
A Power and Control Model for Women's Substance Abuse



Adapted from: Domestic Abuse Intervention Project, Duluth, MN

-66-

Cycle of Violence



Phase 1
Increased tension, anger, blaming and arguing.

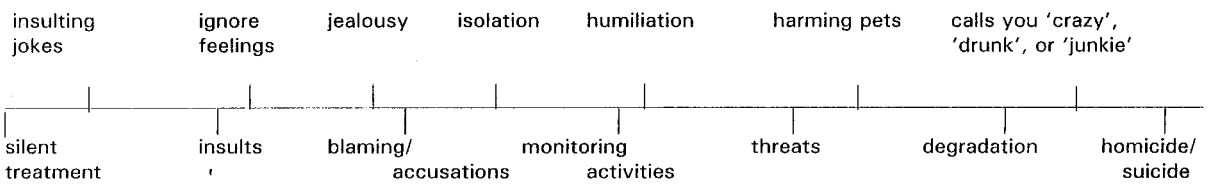
Phase 2
Battering-- hitting, slapping, kicking, choking, use of objects or weapons. Sexual abuse. Verbal threats and abuse.

Phase 3
Calm Stage (this stage may decrease over time). Man may deny violence, say he was drunk, say he's sorry and promise it will never happen again.

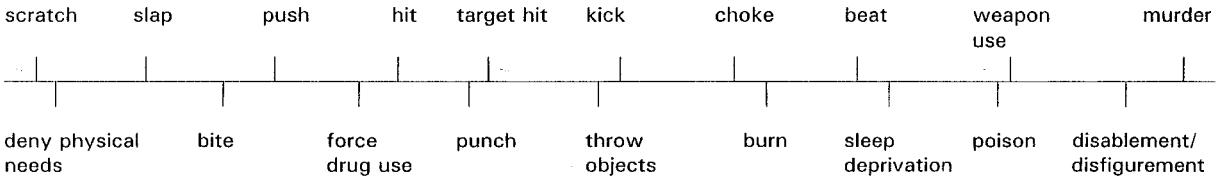
Manifestations of Violence

Abuse can occur in different forms. It can be physical, emotional, sexual, spiritual, social and/or economic. The lists below describe some of the tactics of abuse batterers use as they attempt to gain or maintain power and control over their intimate partners. Abuse does not always progress in regular steps as shown here. Sometimes the abuse may advance from pushing or hitting directly to more severe physical violence such as use of weapons. Although each relationship is unique, any type of abuse must be considered a serious cause for concern. Despite different circumstances, it is important to remember abuse can escalate (especially if intervention fails to occur). A coordinated community response holding batterers accountable for these abusive behaviors is essential as is a response acknowledging and respecting the rights of DV victims. **EXERCISE:** It is helpful for people to be aware of the tactics of domestic violence. Circle the type(s) of abuse you are now experiencing (or have experienced in the past). Notice if the violence is increasing in intensity, severity or frequency. Talk to a domestic violence advocate to develop or review your current safety plan or explore your options. Remember, domestic violence directed at you is never your fault (*even if you were drinking or using drugs*).

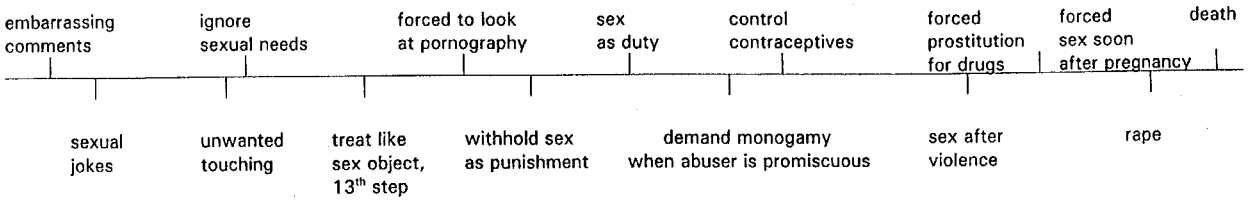
Emotional Abuse



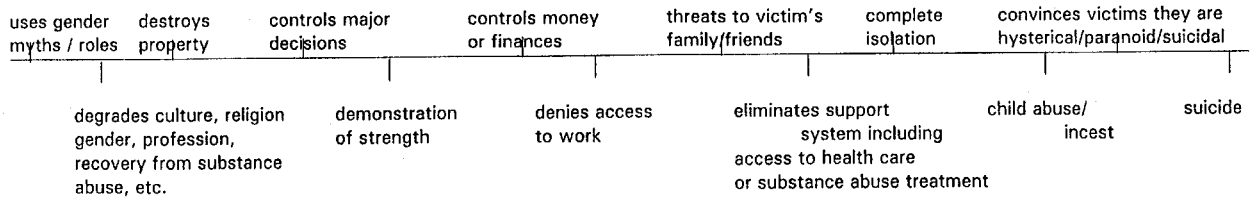
Physical Abuse



Sexual Abuse



Social / Environmental Abuse



Patricia J. Bland, M.A., CCDC
New Beginnings, Seattle

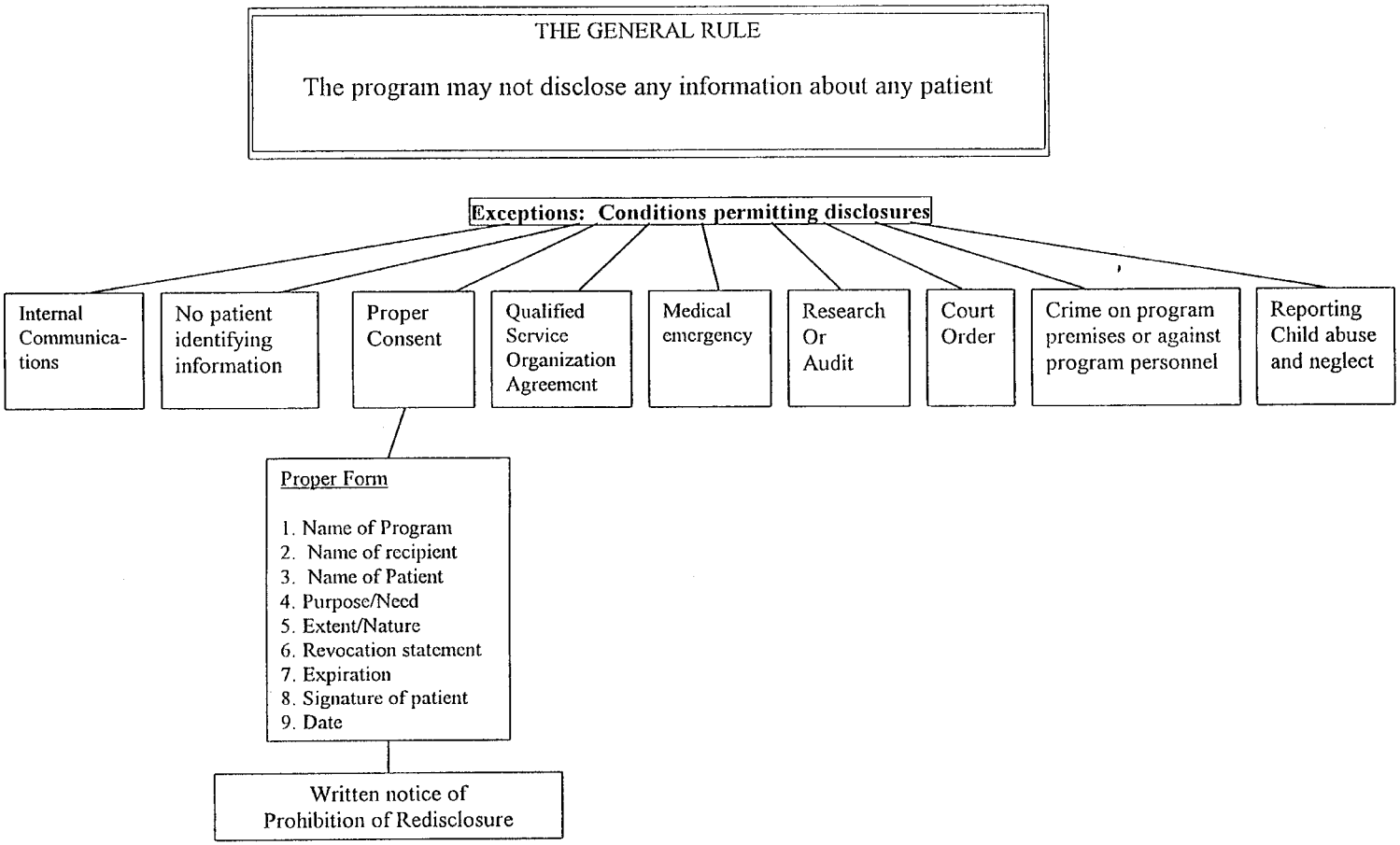
Confidentiality — Legal Protection

	ALCOHOL AND DRUG TREATMENT	DOMESTIC VIOLENCE VICTIMS' SERVICES
Applies to:	Programs in Illinois which provide treatment, diagnosis or referral for treatment of alcohol or other drug abuse or addiction, directly or indirectly supported by government or licensed by DHS.	All programs in Illinois which provide shelter, advocacy, counseling or case management services to victims of domestic violence.
What is prohibited?	Disclosure of any information regarding the presence in treatment, diagnosis, prognosis, treatment or condition of any person obtaining treatment for alcohol or other drug abuse or addiction. Confidential communications, such as therapy sessions, have an additional degree of protection.	Any information pertaining to the victim or the victim's presence in the shelter; communication between the victim and any counselor or advocate.
Can client consent to release of info? How?	Yes. Client must sign and date release, and the release form must satisfy nine conditions set forth in the statute.	Yes. Similar requirements for informed consent to release information.
Exceptions	1. Emergency medical care 2. Child abuse/neglect 3. Appropriately entered court order 4. Scientific research, management and financial audits.	1. Emergency medical care 2. Child abuse/neglect 3. "Duty to warn" - imminent harm to self or others
Can information be obtained by subpoena?	**ONLY** under very limited circumstances as defined in the statute and **ONLY** when subpoena is accompanied by court order which meets statute's requirements. Subpoena alone (even judicial subpoena) neither compels nor permits program to disclose client's presence.	Disclosure of client's presence in shelter, location of shelter, identity of advocates/counselors, records of communications can only be compelled by court order following hearing in judicial chambers to establish good cause. Note that protections are in state law — federal law gives little protection.
What about warrants?	Warrants cannot be served on clients unless accompanied by the same type of court order as mentioned above. Warrant alone neither compels nor permits program to disclose client's presence.	Similar protection under state law, but federal law is unclear – there is no comparable federal statute protecting domestic violence victims' privacy, confidentiality, or records.

The federal regulations specifically include programs funded "directly or indirectly" by federal funds. This includes all tax-exempt programs, programs in institutions which accept Medicare or Medicaid (even if the program itself does not), programs funded by state agencies which get a portion of their money from the federal government, and programs which receive direct federal funding in whole or in part. Illinois law also parrots the federal confidentiality protections for its licensees.

What laws or regulations spell these rights out?	Law: 42 U.S.C. §§ 290dd-2, 42 C.F.R. Part 2, incorporated in 77 Ill. Adm. Code 2060.319	750 ILCS 60-227 720 ILCS 5/45-2
What penalties are there for violations of the law?	$500 fine for first offense $5000 fine for <u>each</u> subsequent offense	Class A misdemeanor
Who enforces this?	United States Attorney, local law enforcement authority	Local law enforcement authority

CONFIDENTIALITY OF DRUG AND ALCOHOL PATIENT INFORMATION
(42 U.S.C. § 290dd-2; 42 C.F.R. PART 2)



Prohibition on Redisclosure of Information Concerning Client in Alcohol or Drug Abuse Treatment

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

Consent for the Release of Confidential Information (Sample)

I, _____, authorize
(Name of Patient)

_____
(Name or general designation of the program making the disclosure)

to disclose to_____the
(Name of the person or organization to whom disclosure is being made)

following information:_____
(Nature of the information, as limited as possible)

_____

_____

The purpose of the disclosure authorized herein is to:_____

_____
(Purpose of disclosure, as specific as possible)

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

_____
(Specification of the date, event or condition upon which consent expires)

Date: _____

_____
Signature of participant

_____
Signature of parent, guardian or authorized representative when required

_____
Signature of program staff (Witness — optional)

Sample Mutual Services (Linkage) Agreement

XYZ Addictions Treatment Center

The purpose of this document is to formalize the relationship between XYZ Addictions Treatment Center and the ABC Shelter. This cooperative and reciprocal arrangement will expedite referral, admission, and discharge of clients, allowing both agencies to serve clients better.

XZY Center will provide the following:

- Referrals of clients in need of safety planning, shelter and support
- Assessment services for substance abuse and chemical dependence
- Level I services for women
  Conventional outpatient services
- Level II services for women
  Intensive outpatient or partial hospitalization services
- Level III services for women
  Residential Treatment services
- Non-medical detoxification for women
- Case management services related to substance abuse treatment

ABC Center will provide the following:

- Referrals of clients in need of substance abuse treatment
- Assistance with safety planning for XYZ Center clients
- Shelter on a space-available basis for clients leaving substance abuse treatment
  who have been identified as victims of domestic violence
- Weekly support group for XYZ clients who have been identified as victims

Both parties to this agreement consent to abide by federal and Illinois standards regarding the confidentiality of client information, and to defend against efforts to obtain that information without the client's consent. Services will be provided under each party's usual arrangements for payment and/or funding and this agreement is not a guarantee that treatment slots or shelter beds will be available.

This agreement will become effective on the date both parties sign this agreement and may run uninterrupted for a period of one year from this effective date. Either party may terminate this agreement upon thirty days' written notice to the other party.

_____

_____

(Name of director, XYZ Center), Director (or other title)

Date

XYZ Center

_____

_____

(Name of Director, ABC Shelter), Director (or other title)

Date

ABC Shelter

(Note: Any such agreement should be reviewed by an attorney — it may be necessary to add further limiting language to make the limitations of the agreement clear.)

Qualified Service Organization Agreement (Sample)

XYZ Services Center ("the Center")
and
the_____
_____

_____
_____
_____
(Name of the Program)

("the Program") hereby enter into a

qualified service organization

agreement, whereby the Center

agrees to

provide_____

_____

_____

_____
_____
_____

_____
_____

_____
_____
(nature of services to be provided)

Furthermore, the Center:

1. Acknowledges that in receiving, storing, processing or otherwise dealing with any information from the Program about the patients in the Program, it is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and

2. Undertakes to resist in judicial proceedings any effort to obtain access to information pertaining to patients otherwise than as expressly provided for in the federal confidentiality regulations, 42 CFR Part 2.

Executed this _____ day of _____.

_____	_____
President	Program Director
XYZ Service Center	(Name of Program)
(Address)	(Address)

Domestic Violence Service Providers

ILLINOIS DEPARTMENT OF HUMAN SERVICES
DOMESTIC VIOLENCE SERVICE PROVIDERS

ALEDO Mercer County
Mercer County Family Crisis Center
110 N.W. 3rd Avenue
Aledo, Illinois 61231

Executive Director: Marla K. Reynolds
Office: 309/582-7233
Fax: 309/582-5675
Crisis: 309/582-7233
E-mail Address: mcfcc@winco.net

ALTON Madison County
Oasis Women's Center
P.O. Box 981
Alton, Illinois 62002

Executive Director: Margarette Trushel
Office: 618/465-1978
Fax: 618/465-0749
Crisis: 618/465-1978 or 800/244-1978
E-Mail Address: oasiswc@piasanet.com

Jersey County Program
Jerseyville, Illinois
Crisis: 618/498-4341 or 800/244-1978

AURORA Kane County
Mutual Ground, Inc.
P.O. Box 843
Aurora, Illinois 60507

Executive Director: Linda Healy
Office: 630/897-0084 Ext. 101
Fax: 630/897-3536
Associate Director: Paula Jo Hruby
Office: 630/897-8989 Ext. 103
Fax: 630/897-3536
Crisis: 630/897-0080
E-Mail Address: mground@mcs.net

Domestic Violence Coordinators:
Kelly Dahl - 630/897-0084 Ext. 108
Barb Solenberger - 630/897-0084 Ext. 112

Kendall County Program
Yorkville, Illinois
Crisis: 630/553-7445

BELLEVILLE St. Clair County
Women's Crisis Center of Metro East
P.O. Box 831
Belleville, Illinois 62222-0831

Executive Director: Jane Lee
Office: 618/236-2531
Fax: 618/235-9521
Crisis: 618/235-0892
E-Mail Address: jane@wccme.org

E. St. Louis Program
St. Mary's Hospital
Office: 618/875-7970

Randolph County Outreach
600 State Street, Room 305
Chester, Illinois 62233
Office: 618/826-5959
Fax: 618/826-2979
Crisis: 800/924-0096

Monroe County
Crisis: 800/924-0096

BLOOMINGTON McLean County
Mid Central Community Action, Inc.
923 East Grove Street
Bloomington, Illinois 61701

Executive Director: Donna Ferency
Office: 309/829-0691
Fax: 309/828-8811
E-Mail Address: comactn@ice.net

Countering Domestic Violence/Neville House
Program Director: Paula Dapkus
Office: 309/828-8913
Fax: 309/829-2425
Crisis: 309/827-7070
E-Mail Address: cdvnev@dave-world.net

CAIRO Alexander County
Cairo Women's Shelter, Inc.
P.O. Box 907
Cairo, Illinois 62914

Executive Director: E. Jeannine Woods
Office: 618/734-4357

Fax: 618/734-4367
Crisis: 618/734-4357
E-Mail Address: cwsi@midwest.net

Pulaski County Program
Mounds, Illinois
Massac County Program
Metropolis, Illinois
Union County Program
Jonesboro, Illinois

CANTONFulton County
Fulton - Mason Crisis Service
700 East Oak Street, Room 203
Canton, Illinois 61520

Executive Director: Martha Daly
Office: 309/647-7487
Fax: 309/647-8338
Crisis: 309/647-8311
E-Mail Address: martha@netins.net

Mason County Program
Havana, Illinois
Crisis: 309/543-6706 or 309/647-8311

CARBONDALEJackson County
The Women's Center, Inc.
406 West Mill Street
Carbondale, Illinois 62901

Acting Executive Director: Joey Gunn
Office: 618/549-4807 ext. 225

Shelter Program Director: Camille Dorris
Office: 618/529-2324
Fax: 618/529-1802
Crisis: 618/529-2324 or 800/334-2094 or 618/997-2277
E-Mail Address: wcac@midwest.net

Williamson County Program
Marion, Illinois
Office: 618/997-0949

CENTRALIAMarion County
People Against Violent Environments (PAVE)
P.O. Box 342
Centralia, Illinois 62801

Administrative Representative: Alice S. Snyder
Office: 618/533-7233
Fax: 618/533-7255
Crisis: 618/533-7233 or 242-7233 or 800/924-8444
E-Mail Address: pave@midwest.net

CHARLESTONColes County
Coalition Against Domestic Violence
P.O. Box 732
Charleston, Illinois 61920

Executive Director: Maureen Robinson
Office: 217/348-5931
Fax: 217/348-0722
Crisis: 888/345-3990
E-Mail Address: cadvchas@worthlink.net

CHICAGOCook County
Anixter Center
6610 N. Clark St.
Chicago, Illinois 60626-4062

Executive Director: Stuart G. Ferst
Office: 773/973-7900 Ext. 227
Fax: 773/973-5268
E-Mail Address: sferst@anixter.org

CHICAGO Cook County
Apna Ghar, Inc.
4753 North Broadway, Suite 518
Chicago, Illinois 60640

Executive Director: K. Sujata
Office: 773/334-0173
Fax: 773/334-0963
Crisis: 773/334-4663
E-Mail Address: info@apnaghar.org

CHICAGOCook County
Chicago Abused Women Coalition
PO Box 477916
Chicago, Illinois 60647-7916

Executive Director: Olga Becker
Office: 773/489-9081
Fax: 773/489-6111
E-Mail Address: cawc1997@mindspring.com

Greenhouse Shelter
Program Director: Beatris Burgos
Office: 773/278-4110
Crisis: 773/278-4566
TTY: 773/278-4114
Fax: 773/278-2616
E-Mail Address: cawcgreen@mindspring.com

Hospital Crisis Intervention Project
Coordinator: Kim Riordan
Office: 312/433-2390
Crisis: 312/633-5992
E-mail: cawchcip@mindspring.com

CHICAGOCook County
Family Rescue, Inc.
P.O. Box 17528
Chicago, Illinois 60617

Executive Director: Joyce Cowan
Program Services Director: Theresa DuBois

Office: 773/375-1918
Fax: 773/734-1245
E-Mail Address: familyrescue@mindspring.com

Shelter Program Director: Audrey Williams
Office: 773/375-1918
Fax: 773/375-8774
Crisis: 773/375-8400
Walk-In Program Director: Alta Tann
Office: 773/375-6863
Fax: 773/734-1245
Transitional Living Program Director: Daphyne Ball
Office: 773/667-0715
Fax: 773/667-1038
Domestic Violence Reduction Project
Coordinator: Ada Middleton
Office: 312/747-5493 or 5494
Fax: 312/747-5478

CHICAGOCook County
Friends of Battered Women and Their Children
2301 West Howard Street
Chicago, Illinois 60645

Executive Director: Mary Ruth Coffey
Office: 773/274-5232 Ext. 20
Fax: 773/274-2214
Crisis: 800/603-4357
E-Mail Address: afriendsplace@worldnet.att.net

CHICAGO Cook County
Healthcare Alternative Systems, Inc.
2755 W. Armitage Ave.
Chicago, Illinois 60647

Executive Director: Marco E. Jacome
Office: 773/252-3100
Fax: 773/252-8945
E-Mail Address: has@wwa.com

CHICAGOCook County
Healthy Families Chicago
3333 W. Arthington St.
Chicago, Illinois 60624

Executive Director: Kenneth W. Hicks
Office: 773/638-0111
Fax: 773/638-0110
E-Mail Address: None

CHICAGOCook County
Howard Area Community Center
7648 N. Paulina
Chicago, Illinois 60626

Executive Director: Roberta Buchanan
Office: 773/262-6622
Fax: 773/262-6645
E-Mail Address: None

CHICAGOCook County
Howard Brown Health Center
4025 N. Sheridan Rd.
Chicago, Illinois 60613

Executive Director: Eileen Durkin
Office: 773/388-1600
Fax: 773/388-8887
E-Mail Address: EileenD@howardbrown.org

CHICAGOCook County
Legal Assistance Foundation of Chicago
111 West Jackson - 3rd Fl.
Chicago, Illinois 60604

Executive Director: Sheldon H. Roodman
Office: 312/341-1070
Fax: 312/341-1041
E-Mail Address: sroodman@lafchicago.org

CHICAGOCook County
Metropolitan Family Services,
Family Violence Intervention Program
3843 West 63rd Street
Chicago, Illinois 60629

Program Director: Ida Anger
Office: 773/884-3310 ext. 314
Fax: 773/884-0003

CHICAGOCook County
Mujeres Latinas En Accion
1823 West 17th Street
Chicago, Illinois 60608

Executive Director: Norma Seledon
Program Director: Elena Sugano
Office: 312/226-1544
Fax: 312/226-2720
Crisis: 312/738-5358
TDD: 312/226-3350
E-Mail Address: mujereslatinas@mindspring.com

CHICAGOCook County
Neopolitan Lighthouse
P.O. Box 24709
Chicago, Illinois 60624

Executive Director: Crystal Bass-White
Office: 773/638-0228
Adm. Office Fax: 773/638-0323
Shelter Fax: 773/722-0007
Crisis: 773/722-0005
TTY: 773/826-2883
E-Mail Address: shelter@mcs.net

CHICAGOCook County
New Hope Community Service Center
2701 West 79th St.
Chicago, Illinois 60652

Executive Director: Brenda Golden
Office: 773/737-9555
Fax: 773/737-0401

CHICAGOCook County
Polish American Association
3834 N. Cicero Ave.
Chicago, Illinois 60641

Executive Director: Karen J. Popowski
Office: 773/282-8206
Fax: 773/282-1324
E-Mail Address: paa@polish.org

CHICAGOCook County
Pro Bono Advocates
28 N. Clark, Ste. 630
Chicago, Illinois 60602

Executive Director: Mary Trew
Office: 312/827-2420
Fax: 312/827-2425

CHICAGOCook County
Rainbow House, Inc.
20 E. Jackson Blvd., Suite 1550
Chicago, Illinois 60604

Executive Director: Deirdre Cutliffe
Office: 312/935-3430
Fax: 312/935-5071
E-Mail Address: rainbowhouse@ameritech.net

Rainbow House Residential Services Program
20 E. Jackson Blvd., Suite 1550
Chicago, Illinois 60604

Program Director: Kara Henner
Office: 773/762-6611
Fax: 773/762-7903
Crisis: 773/762-6611
TDD: 773/762-6802

Institute for Choosing Non-Violence
20 E. Jackson, Suite 1550
Chicago, Illinois 60604

Program Director: Anne Parry
Office: 312/935-3430

Community Resource Programs
20 E. Jackson, Suite 1550
Chicago, Illinois 60604

Program Director: Tonya Bibbs
Office: 312/935-3430
Fax: 312/935-5071

Crisis Intervention. Program . - Mt. Sinai Hospital Med. Ctr.
California Avenue at 15th Street, NR 620
Chicago, Illinois 60608

Outreach Co-ordinator: Shireen Virani
Office: 773/257-6090
Fax: 773/257-6099

Women's Resource Center
c/o Chicago Friends Meeting House
10749 S. Artesian Avenue
Chicago, Illinois 60655

Outreach Co-ordinator: Rita Ryan
Office: 773/238-5411
Fax: 773/238-3411

CHICAGOCook County
Southwest Women Working Together
4051 West 63rd St.
Chicago, Illinois 60629

Executive Director: Shelley Crump
Office: 773/582-0550
Fax: 773/582-9669
E-Mail Address: swwt@megsinet.net

CHICAGOCook County
Uptown Hull House
4520 North Beacon
Chicago, Illinois 60640

Executive Director: Margaret Luft
Office: 773/561-3500
E-Mail Address: mluft@hullhouse.org

Women's Counseling Center
4520 North Beacon
Chicago, Illinois 60640

Program Director: Maxine Florell
Office: 773/561-3500
Fax: 773/561-3507
E-Mail Address: hhaflore@wwa.com

Domestic Violence Court Advocacy Project
1340 South Michigan - Chambers 202
Chicago, Illinois 60605
Program Director: Heidi Kon
Office: 312/341-2754 or 312/341-2883
Fax: 312/341-2825
TDD: 312/341-2715
E-Mail Address: hhakon@wwa.com

CHICAGOCook County
Well Spring
7001 S. Laflin
Chicago, Illinois 60636

Executive Director: Karen Brewer
Office: 773/962-0784
Fax: 773/846-8983
E-Mail Address: wlspring@wwa.com

CHICAGOCook County
YWCA of Metro Chicago - Korean YWCA
180 N. Wabash, 3rd Fl.
Chicago, Illinois 60601

Executive Director: Audrey R. Peeples
Office: 312/372-6600
Fax: 312/372-4673
Crisis: 888/293-2080
E-Mail Address: YWCACHI@aol.com

DANVILLEVermilion County
Danville YWCA
201 North Hazel Street
Danville, Illinois 61832

Executive Director: Ellen Morris
Office: 217/446-1217
E-Mail Address: YDVShltr@soltec.net

Women's Alternative Shelter
Program Director: Sue Davis
Office: 217/446-1217
Fax: 217/443-6845
Crisis: 217/443-5566

DECATURMacon County
Dove, Inc.
788 East Clay
Decatur, Illinois 62521

Executive Director: Ray Batman
Office: 217/428-6616
E-mail Address: RBatman@doveinc.org

Domestic Violence Program
Program Director: Teri Ducy
Office: 217/428-6616 or 423-0950
Fax: 217/428-7256
Crisis: 217/423-2238
E-Mail Address: TDucy@doveinc.org

DeWitt County Program
111 South Quincy
Clinton, Illinois 61727
Coordinator: Rita Etherton
Office: 217/935-6619
Crisis: 217/935-6072

DEKALBDeKalb County
Safe Passage, Inc.
P.O. Box 621
DeKalb, Illinois 60115

Executive Director: Pam Wiseman
Office: 815/756-7930
Fax: 815/756-7932
Crisis: 815/756-5228
E-Mail Address: safepasag@aol.com

DES PLAINES Cook County
Lifespan
P.O. Box 445
Des Plaines, Illinois 60016

Executive Director: Denice Markham
Office: 312/408-1210 or 847/824-0382
Fax: 312/408-1223 or 847/824-5311
Crisis: 847/824-4454
TTY: 847/824-0189
E-Mail Address: lifespan@xsite.net

EFFINGHAM Effingham County
Effingham Victims Awareness Services (EVAS)
122 W. Jefferson
Effingham, IL 62401

Executive Director: Elaine Aderman
Office: 217/347-2273
Fax: 217/342-2411
Crisis: 800/755-3827
E-Mail Address: wings@xel.net

ELGIN Kane County
Community Crisis Center
P.O. Box 1390
Elgin, Illinois 60121
Executive Director: Gretchen Vapnar
Director of Client Services: Wendy DePatie
D.V. Program Coordinator: Sharon Burner
Office: 847/697-2380
Fax: 847/742-4182
Crisis: 847/697-2380
E-Mail Address: cccpeace@earthlink.net

EVANSTON Cook CountyYWCA Evanston/North Shore
1215 Church Street
Evanston, Illinois 60201

Executive Director: Christie Dailey
Office: 847/864-8445
Fax: 847/864-8498
E-Mail Address: christie@enteract.com

Shelter for Battered Women and Children
P.O. Box 5164
Evanston, Illinois 60204-5164

Program Director: Wendy Dickson
Office: 847/864-8445
Crisis: 847/864-8780
E-Mail Address: gpapirov@enteract.com

FREEPORT Stephenson County
YWCA of Freeport
641 West Stephenson Street
Freeport, Illinois 61032
Executive Director: Mary Freidag
Office: 815/235-9421
Fax: 815/233-2348

VOICES...Breaking the Silence
Program Director: Cindy Rackow
Office: 815/235-1681
Fax: 815/235-2348
Crisis: 815/235-1641
E-Mail Address: voices@aeroinc.net

Carroll County Program/CHOICES
PO Box 195
Mt. Carroll, IL 61053
Office: 815/244-1320
Fax: 815/244-1321
Crisis: 815/244-1320

JoDaviess County Program
CHOICES for Family/Peace and Justice
Program Director: Carrie-Altfillisch-Melton
901 Spring Street
Galena, Illinois
Office: 815/777-3681
Fax: 815/777-3682
Crisis: 815/777-3680
E-Mail Address: choices@galenalink.com

GALESBURGKnox County
Safe Harbor Family Crisis Center
P.O. Box 1558
Galesburg, Illinois 61401-1558

Executive Director: Connie L. Hartzell
Office: 309/343-7233

Fax: 309/343-3956
Crisis: 309/343-SAFE (7233)
E-Mail Address: safeharb@galesburg.net

GLEN ELLYNDuPage County
Family Shelter Service, Inc.
P.O. Box 3404
Glen Ellyn, Illinois 60138-3404

Executive Director: Karen H. Kuchar
Office: 630/469-5652
Fax: 630/790-6343
Crisis: 630/469-5650
TTY: 630/790-6344
E-mail Address: famsh@earthlink.com

GRANITE CITYBond County
Phoenix Crisis Center, Inc.
PO Box 1043 Nameoki Station
Granite City, Illinois 62040

Executive Director: Carolyn S. Burden
Office: 618/451-4267
Fax: 618/451-1008
E-Mail Address: CBurden@intecil.net

HARRISBURGSaline County
Anna Bixby Women's Center
213 South Shaw Street
Harrisburg, Illinois 62946

Executive Director: Barbara Wingo
Office: 618/252-8380
Fax: 618/252-1707
Crisis: 618/252-8389 or 800/421-8456
TTY: 618/252-8389
E-Mail Address: abixby@accessus.net

White County Program
Carmi Municipal Building
225 East Main - Room 6 & 7
Carmi, Illinois
Office: 618/384-2003
Crisis: 618/252-8389

HOMEWOODCook County
South Suburban Family Shelter, Inc.
P.O. Box 937
Homewood, Illinois 60430

Executive Director: Diane L. Bedrosian
Office: 708/798-7737
Fax: 708/647-6836
Crisis: 708/335-3028
E-Mail Address: LRFAMILY@Lincolnnet.net

JACKSONVILLEMorgan County
Crisis Center Foundation
446 East State Street
Jacksonville, Illinois 62650

Executive Director: Lynn Taylor Killian
Office: 217/243-4357
Fax: 217/245-9421
Crisis: 217/243-4357
E-Mail Address: ccf@fgi.net

Greene County Program
Roodhouse Police Department
Roodhouse, Illinois
Office: 217/589-4348
Crisis: 217/243-4357

Scott County Program
Scott County Courthouse Annex Building
Office: 217/742-3141
Crisis: 217/243-4357

JOLIETWill County
Guardian Angel Home
1550 Plainfield Road
Joliet, Illinois 60435

Executive Director: Sheila Schmitz
Office: 815/729-0930

Groundwork Domestic Violence Program
Program Director: Dorothy Kinsella
Office: 815/729-0930 Ext. 431
Fax: 815/744-6087
Crisis: 815/729-1228
E-Mail Address: GAH@Megsinet.net

Grundy County Program
Morris, Illinois
Crisis: 815/941-3267

KANKAKEEKankakee County
Kankakee County Coalition Against Domestic Violence/Harbor House
P.O. Box 1824
Kankakee, Illinois 60901

Director: Robin Savage
Office: 815/932-5814
Fax: 815/935-3551
Crisis: 815/932-5800
E-Mail Address: harbor@keynet.net

Iroquois County Office
100 East Walnut
Watseka, Illinois
Crisis: 815/432-3500
Fax: 815/432-3414

MACOMBMcDonough County
Western IL Regional Council - Comm. Action Agency
223 South Randolph Street
Macomb, Illinois 61455

Executive Director: Suzan Nash
Office: 309/837-3941

Victim Services Program
Program Director: Cynthia Stiffler
Office: 309/837-6622

Fax: 309/836-3640
Crisis: 309/837-5555
E-Mail Address: wirc@macomb.com

OAK PARK Cook County
Sarah's Inn
P.O. Box 1435
Oak Park, Illinois 60304

Executive Director: Faye Hegburg
Office: 708/386-3305
Fax: 708/386-3275
Crisis: 708/386-4225
TDD: 708/386-3687
E-Mail Address: sarahsinn@mindspring.com

OLNEY Richland County
Stopping Woman Abuse Now, Inc.
P.O. Box 176
Olney, Illinois 62450

Executive Director: Linda Bookwalter
Office: 618/392-3556
Fax: 618/392-5514
Crisis: 618/392-3556 or 888/715-6260 (toll-free)
E-Mail Address: four@wworld.com

PEORIA Peoria County
The Center for Prevention of Abuse
P.O. Box 3855
Peoria, Illinois 61612-3855

Executive Director: Martha Herm
Office: 309/691-0551

WomenStrength Domestic Violence Program
Program Director: Ruthanne Faught
Office: 309/691-0551
Fax: 309/691-0913
Crisis: 800/559-7233
E-Mail Address: cfpa@mcleodusa.net

Peoria County Program (DVO Only)
Office: 309/672-6074

Tazewell County Program (DVO Only)
Pekin, Illinois
Office: 309/346-6645

Tazwood Office
Office: 309/477-3066
Fax: 309/477-3068

Woodford County Program (DVO Only)
Office: 309/467-3212

PRINCETON Bureau County
Freedom House
P.O. Box 544
Princeton, Illinois 61356

Executive Director: Mary Carla Grube
Office: 815/872-0087
Fax: 815/879-3306
Crisis: 800/474-6031
E-Mail Address: freedom@theramp.net

Henry County Program Kewanee Hospital
Kewanee, Illinois
Crisis: 800/474-6031

QUINCY Adams County
Quincy Area Network Against Domestic Violence (QUANADA)
2707 Maine
Quincy, Illinois 62301

Executive Director: Marla Ferguson
Office: 217/222-0069
Fax: 217/222-4574
Crisis: 800/369-2287
E-Mail Address: quanada@rnet.com

Pike County Program
Pittsfield, Illinois
Crisis: 800/369-2287

ROCHELLE Ogle County
H.O.P.E. of Rochelle
P.O. Box 131
Rochelle, Illinois 61068

Executive Director: Connie Mershon
Office: 815/562-4323
Fax: 815/562-5756
Crisis: 815/562-8890
E-Mail Address: hopemail@rochelle.net

ROCK ISLAND Rock Island County
Family Resources
115 West 6th
Davenport, Iowa 52803
Vice President: Cheryl Goodwin
Office: 319/359-8216 (Bettendorf)
Fax: 319/359-5106 (Iowa)

Family Resources D. V. Advocacy Program
322 16th Street
Rock Island, Illinois 61201

Program Director: Chelsea Carter
Program Supervisor: Kelly Colebar
Office: 319-322-1200 or 309/793-7729
Fax: 309/793-7769
Crisis: 309/797-1777
TDD: 309-793-1443
E-Mail Address: vicserv@qconline.com

ROCKFORD Winnebago County

P.H.A.S.E., Inc.
319 South Church Street
Rockford, Illinois 61101-1316

President/CEO: Jared (Jeb) Kresge
Office: 815/966-1285
Fax: 815/962-7895

W.A.V.E. Domestic Violence Program
Vice President, Program Services: Karen Gill
Office: 815/966-1285
Crisis: 815/962-6102
E-Mail Address: Shirley.Phase@worldnet.att.net

Boone County Satellite
Belvidere, Illinois
Crisis: 815/962-6102

SPRINGFIELDSangamon County
Sojourn Shelter and Service, Inc.
1800 Westchester Blvd.
Springfield, Illinois 62704

Executive Director: Tami Silverman
Office: 217/726-5100
Fax: 217/726-8664
Crisis: 217/726-5200
E-Mail Address: sojcenter@aol.com
Logan County Program
Logan County Courthouse
Lincoln, Illinois 62656
Office: 217/732-8988
Crisis: 217/726-5200

Christian & Montgomery Counties Programs
Crisis: 217/726-5200

Menard County Program
118 East Jackson
Petersburg, Illinois 62675
Pager: 217/467-6435
Crisis: 217/726-5200

STERLINGWhiteside County
YWCA of the Sauk Valley
412 First Avenue
Sterling, Illinois 61081

Executive Director: Carol Fitzgerald
Office: 815/625-0333
Fax: 815/625-5308

COVE Domestic Violence Program
Program Director: Janice McCoy
Office: 815/625-0343
Crisis: 815/626-7277 or 288-1011
E-Mail Address: teams@cin.net

STREATORLaSalle County
ADV & SAS
P.O. Box 593
Streator, Illinois 61364

Administrative Office
510 North Bloomington Street
Streator, Illinois 61364

Exec. Director: Margaret Lauterjung
Office: 815/673-1552
Fax: 815/672-2084
Crisis: 800/892-3375
E-Mail Address: advsas@crtelco.com

Pontiac Office
110 West Water Street
Pontiac, Illinois 61764
Office: 815/844-0982
Fax: 815/844-1048

Ottawa Office
106 West Lafayette Street
Ottawa, Illinois
Office: 815/434-9650
Fax: 815/434-9652

SUMMITCook County
Des Plaines Valley Community Center
6120 South Archer Road, Box 10
Summit, Illinois 60501

Executive Director: Florence Forshey
Office: 708/458-6920
Fax: 708/458-2326
E-Mail:dvccmhsa@wwa.com

Constance Morris House (Shelter)
Program Director: Lynn Siegel
Office: 708/485-0069
Fax: 708/485-0160
Crisis: 708/485-5254
TTY: 708/485-5257
E-Mail: dvcccmh@wwa.com

TINLEY PARKCook County
Crisis Center for South Suburbia
7700 Timber Drive
Tinley Park, Illinois 60477

Executive Director: Patricia Bryant
Office: 708/429-7255
Fax: 708/429-7293
Crisis: 708/429-SAFE (7233)
TTY: 708/429-7284
E-Mail Address: dveltman@dls.net

TUSCOLADouglas County
BETHS Place
PO Box 462
Tuscola, Illinois 61953

Executive Director: Barbara Utterback
Office: 217/253-2555 or 217/253-4024
Fax: 217/253-6722
E-Mail Address: Lizzy844@aol.com

URBANAChampaign County

A Woman's Fund
1304 E. Main Street
Urbana, Illinois 61801
Executive Director: Debora Jones
Office: 217/384-4462

A Woman's Place D.V. Program
Program Director: Johnna Parker
Office: 217/384-4462
Fax: 217/384-4383
Crisis: 217/384-4390
E-Mail Address: awf@shout.net

WAUKEGAN Lake County
A Safe Place/
Lake County Crisis Center
P.O. Box 1067
Waukegan, Illinois 60079
Executive Director: Phyllis A. DeMott
E-Mail: pdemott@iconnect.net

Office: 847/249-5147
Fax: 847/336-5813
Crisis: 847/249-4450
TTY: 847/249-6557
E-Mail Address: safeplace@iconnect.net

WOOD DALE Dupage County
Hamdard Center for Health & Human Services
(Peoples Alliance for Progress)
355 N. Wood Dale Rd.
Wood Dale, Illinois 60191

Executive Director: Farzana F. Hamid
Office: 630/860-9122
Fax: 630/860-1918
Crisis: 630/860-9122
E-Mail Address: MHAMID8018@aol.com

WOODSTOCK McHenry County
Turning Point, Inc.
P.O. Box 723
Woodstock, Illinois 60098

Executive Director: Louisett Ness
Office: 815/338-8081
Fax: 815/338-8110
Crisis: 800/892-8900
E-Mail Address: TPOINTED@MC.NET

Office of Alcoholism and Substance Abuse Service Providers

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICE PROVIDERS

COUNTY	AGENCY	CITY		CONTACT	
ADAMS	Great River Recovery 428 South 36th Street	**Quincy**	62301	Hutmacher, Michael	217-224-6300
ALEXANDER	Delta Center, Inc. 1400 Commercial	**Cairo**	62914	Garnett, Frederico	618-734-2665
BOND	Bond County Health Department 503 South Prairie St	**Greenville**	62246	Barth, Maxine	618-664-1442
BOONE	P.H.A.S.E., Inc. 860 Biester Dr.	**Belvidere**	61008	Kresge, Jared L.	815-962-0871
BROWN	Brown County Mental Health Center 111 West Washington	**Mount Sterling**	62353	Wilson, Kathy	217-773-3325
BUREAU	North Central Behavioral Health 526 Bureau Valley Parkway	**Princeton**	61356	Block, Larry	815-875-4458
CARROLL	Sinnissippi Centers, Inc. 1122 Healthcare Drive	**Mount Carroll**	61053	Sarver, James	815-244-1376
CASS	Cass County Mental 121 East Second Street	**Beardstown**	62618	Cates, Donald	217-323-2980
CHAMPAIGN	LW's Place - Alcohol and Drug 605 North Neil Street	**Champaign**	61820	Mackey, James	217-356-4600
CHAMPAIGN	Prairie Center - Champaign 122 West Hill Street	**Champaign**	61824	Leary, Pat	217-356-7576
CHAMPAIGN	Prairie Center Health Systems, Inc. 718 Killarney Avenue	**Urbana**	61801	Leary, Pat	217-328-4500
CHAMPAIGN	T.A.S.C., Inc. 116 W. Main Street	**Urbana**	61801	Fesmire, Roy	217-344-4546

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICE PROVIDERS

COUNTY	AGENCY	CITY		CONTACT	
CHRISTIAN	Gateway Foundation / Taylorville Route 29 South	**Taylorville**	62569	Schwartz, Chuck	217-824-4004
CHRISTIAN	Triangle Center 320 North Western Ave.	**Taylorville**	62568	Knox, Stephen J.	217-824-7330
CLARK	Human Resources Center 1006 S. Sixth Street	**Marshall**	62441	Young, John W.	217-826-6212
CLAY	Southeastern/Clay Family 901 West Third	**Flora**	62839	Jackson, Glenn	618-662-2871
CLINTON	Community Resource Center 580 Eighth Street	**Carlyle**	62231	Duam, Denise	618-594-4581
COLES	C.E.A.D. Council 416 North 19th Street	**Mattoon**	61938	Irwin, Pamela	217-258-2968
COLES	C.E.A.D. Council 513 13th Street	**Mattoon**	61938	Irwin, Pamela	217-258-6018
COLES	C.E.A.D. Council 635 Division St.	**Charleston**	61920	Irwin, Pamela	217-348-8108
COLES	C.E.A.D. Council 8500 E. Co. Road 150N	**Lerna**	62440	Irwin, Pamela	
COLES	C.E.A.D. Council-women's 1501 1/2 18th Street	**Charleston**	61920	Irwin, Pamela	217-348-5444
COLES	Women's Chemical Dependency Project 726 4th Street	**Charleston**	61920	Irwin, Pamela	217-348-8108
COOK (CHICAGO)	Alcohol and Drug Assessment 721 N. LaSalle	**Chicago**	60610	Rizzato, Anthony	312-655-7530
COOK (CHICAGO)	Alternatives, Inc. 1126 West Granville	**Chicago**	60660	Gall, Judith M.	773-973-5400
COOK (CHICAGO)	Anixter Center 2001 North Clybourn	**Chicago**	60614	Ferst, Stuart	773-549-0208
COOK (CHICAGO)	Anixter Center 1706 N. Kedzie	**Chicago**	60647	Ferst, Stuart	773-227-8530
COOK (CHICAGO)	Anixter Center 1414 S. Fairfield	**Chicago**	60608	Furst, Stuart	773-522-2010
COOK (CHICAGO)	Association House of Chicago 1116 N. Kedzie Ave.	**Chicago**	60651	Maya, Dora	773-235-7703
COOK	Bobby E. Wright Comprehensive	**Chicago**	60612	Lang-	773-722-7900

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICE PROVIDERS

COUNTY	AGENCY	CITY		CONTACT	
(CHICAGO)	9 South Kedzie Ave.			Chappell, Lucy, Dr.	
COOK (CHICAGO)	Brass 340 East 51st Street	**Chicago**	60615	Mason, Eldoris J.	773-869-0300
COOK (CHICAGO)	Brass 8000 South Racine Ave.	**Chicago**	60620	Mason, Eldoris J.	773-994-2708
COOK (CHICAGO)	Caritas - Central Intake 140 North Ashland	**Chicago**	60607	Rybarczyk, Dennis	312-850-9411
COOK (CHICAGO)	Cathedral Shelter of Chicago 128 South Paulina	**Chicago**	60612	Gilchrist, Charles W.	312-997-2222
COOK (CHICAGO)	Cathedral Shelter of Chicago 1668 West Ogden Ave.	**Chicago**	60612	Gilchrist, Charles W.	312-997-2222
COOK (CHICAGO)	C.D.P.H. 1201 South Campbell	**Chicago**	60608	Williams-Lake, Constance	312-746-5905
COOK (CHICAGO)	Chicago Dept. Of Public Health 28 East 112th Place	**Chicago**	60628	Williams-Lake, Constance	312-747-7320
COOK (CHICAGO)	Chicago Dept. Of Public Health 4150 West 55th Street	**Chicago**	60632	Williams-Lake, C.	312-747-1020
COOK (CHICAGO)	Chicago Dept. Of Public Health 4314 South College Grove	**Chicago**	60653	Williams-Lake, Constance	312-747-0036
COOK (CHICAGO)	Chicago Dept. Of Public Health 5801 South Pulaski Ave.	**Chicago**	60646	Williams-Lake, Constance	312-744-1906
COOK (CHICAGO)	Chicago Dept. Of Public Health 641 West 63rd Street	**Chicago**	60621	Williams-Lake, Constance	312-747-7496
COOK (CHICAGO)	Community Counseling Center of 4753 North Broadway	**Chicago**	60640	May, Joanne	773-878-9999
COOK (CHICAGO)	Community Counseling Centers 4740 N. Clark Street	**Chicago**	60640	May, Joanne	773-769-0205
COOK (CHICAGO)	Cornell Interventions 140 North Ashland Ave.	**Chicago**	60607	Lissner, Arlene	312-850-9411
COOK (CHICAGO)	Cornell Interventions 2723 N. Clark Street	**Chicago**	60614	Lissner, Arlene	773-525-3250
COOK (CHICAGO)	Cornell Interventions 5700 S. Wood St.	**Chicago**	60636	Lissner, Arlene	773-737-4600
COOK (CHICAGO)	Cornell Interventions 5701 South Wood	**Chicago**	60636	Lissner, Arlene	773-737-4600

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICE PROVIDERS

COUNTY	AGENCY	CITY		CONTACT	
COOK (CHICAGO)	Counseling Center of Lake View 3225 North Sheffield Ave.	**Chicago**	60657	Groetzinger, Norman J.	773-549-5886
COOK (CHICAGO)	El Rincon 1874 N. Milwaukee Ave.	**Chicago**	60647	Rios, Rafael Jr.	773-276-0200
COOK (CHICAGO)	Erie Family Health Center 2750 West North Ave.	**Chicago**	60647	Land, Allen	773-489-6060
COOK (CHICAGO)	Erie Family Center, Inc. 1701 West Superior	**Chicago**	60622	Land, Allen	312-666-3488
COOK (CHICAGO)	Family Guidance Centers 809 West Monroe	**Chicago**	60607	Vlasaty, Ronald	312-421-0588
COOK (CHICAGO)	Family Guidance Centers, Inc. 310 W. Chicago	**Chicago**	60610	Vlasaty, Ronald	312-943-6545
COOK (CHICAGO)	Family Guidance Centers, Inc. 737 N. LaSalle	**Chicago**	60610	Vlasaty, Ronald	312-943-6545
COOK (CHICAGO)	Garfield Counseling Center 4132 W. Madison	**Chicago**	60624	Carter, Robert T.	773-533-0433
COOK (CHICAGO)	Gateway - Day Reporting Center 3026 South California Avenue	**Chicago**	60608	Schwartz, Chuck	
COOK (CHICAGO)	Gateway Foundation 3828 W. Taylor St.	**Chicago**	60624	Schwartz, Chuck	773-826-1916
COOK (CHICAGO)	Gateway Foundation 4301 W. Grand Ave.	**Chicago**	60651	Schwartz, Chuck	773-826-2279
COOK (CHICAGO)	Gateway Foundation Chicago 2615 W. 63rd St.	**Chicago**	60629	Schwartz, Chuck	773-476-0622
COOK (CHICAGO)	Gateway Foundation Substance Abuse 2700 S. California Ave.	**Chicago**	60608	Schwartz, Chuck	773-890-5667
COOK (CHICAGO)	Gateway Youth Care Foundation 3828 W. Taylor St.	**Chicago**	60624	Schwartz, Chuck	312-826-1916
COOK (CHICAGO)	H.R.D.I. 2311 E. 98th St.	**Chicago**	60617	Sleet, Marion G.	773-933-5570
COOK (CHICAGO)	H.R.D.I. - Harriet Tubman Women 11352 South State Street	**Chicago**	60628	Sleet, Marion G.	773-785-4955
COOK (CHICAGO)	H.R.D.I - Near West Prof. 2207 West 18th Street	**Chicago**	60608	Sleet, Marion G.	312-226-6989
COOK (CHICAGO)	H.R.D.I. West Pullman 33 East 114th St.	**Chicago**	60628	Sleet, Marion G.	773-660-4630
COOK (CHICAGO)	H.R.D.I. Women's Prof. 8731 S. Exchange	**Chicago**	60617	Sleet, Marion G.	773-374-8411

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICE PROVIDERS

COUNTY	AGENCY	CITY		CONTACT	
COOK (CHICAGO)	Habilitative Systems, Inc. 415 S. Kilpatrick St.	**Chicago**	60644	Dixon, Karen	773-261-2252
COOK (CHICAGO)	Haymarket Center 120 N. Sangamon St.	**Chicago**	60607	Soucek, Ray	312-226-7984
COOK (CHICAGO)	Haymarket Center O'Hare Outreach O'Hare Airport	**Chicago**	60666	Soucek, Ray	773-686-6480
COOK (CHICAGO)	Healthcare Alternative 1942 N. California Avenue	**Chicago**	60647	Valdez, Arturo	773-292-4242
COOK (CHICAGO)	Healthcare Alternative 1949 N. Humboldt Blvd.	**Chicago**	60647	Toch, Evelyn	773-252-2666
COOK (CHICAGO)	Healthcare Alternative 2755 W. Armitage Ave	**Chicago**	60647	Bances, Manvel J.	773-252-3100
COOK (CHICAGO)	Healthcare Alternative 4534 S. Western	**Chicago**	60609	Valdez, Arturo	773-254-5141
COOK (CHICAGO)	H.R.D.I. - Grand Boulevard 5401 S. Wentworth	**Chicago**	60609	Sleet, Marion G.	773-994-6074
COOK (CHICAGO)	H.R.D.I. Health Center 6241 S. Halsted St.	**Chicago**	60636	Sleet, Marion G.	773-994-6075
COOK (CHICAGO)	Intervention Instruction, Inc. 321 North LaSalle	**Chicago**	60610	Kilbane, Patricia	312-467-7100
COOK (CHICAGO)	Intervention Instruction, Inc. 432 N. Clark St.	**Chicago**	60610	Kilbane, Patricia	312-467-7100
COOK (CHICAGO)	Jefferson Park DUI 5243 N. Elston Ave.	**Chicago**	60630	Maletz, Sonja	773-286-1484
COOK (CHICAGO)	Kedzie 1706 N. Kedzie	**Chicago**	60647	Schwartz, Chuck	773-227-2158
COOK (CHICAGO)	Latino Treatment Center 2608 West Peterson Avenue	**Chicago**	60659	Pujals, Ernest	773-465-1161
COOK (CHICAGO)	L.S.S.I. - Belmont 5825 W. Belmont Ave.	**Chicago**	60634	Bruggeman, Steve	773-637-0487
COOK (CHICAGO)	L.S.S.I. - Devon I 1758 W. Devon Ave.	**Chicago**	60660	Bruggeman, Steve	773-764-4350
COOK (CHICAGO)	L.S.S.I. - Kenmore Outpatient 5517 North Kenmore Ave	**Chicago**	60640	Bruggeman, Steve	773-275-7962
COOK (CHICAGO)	L.S.S.I. - Men's Residence 1640 West Morse Ave	**Chicago**	60626	Bruggeman, Steve	773-338-5105

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICE PROVIDERS

COUNTY	AGENCY	CITY		CONTACT	
COOK (CHICAGO)	L.S.S.I. - Men's Residence So 7843 South Essex Ave	**Chicago**	60649	Bruggman, Steve	773-933-0666
COOK (CHICAGO)	L.S.S.I. - Mt. Greenwood 3220 West 115th Street	**Chicago**	60655	Bruggeman, Steve	773-881-1900
COOK (CHICAGO)	Near North Health Serv. 1276 N. Clybourn	**Chicago**	60610	Mills-Thomas, Bernice	312-337-1073
COOK (CHICAGO)	Near South Family Counseling Center 407 South Dearborn	**Chicago**	60605	Bettison, John	312-922-1566
COOK (CHICAGO)	New Age Services Corp. 1330 South Kostner	**Chicago**	60623	Denman, Bobby	773-542-1150
COOK (CHICAGO)	Polish American Assoc. 3834 N. Cicero Ave.	**Chicago**	60641	Popowski, Karen	773-282-8206
COOK (CHICAGO)	Polish American Addictions 6500 W. Archer Ave.	**Chicago**	60638	Fahrberger, Visia	773-586-9511
COOK (CHICAGO)	Polish American Substance Abuse 4440 N. Milwaukee	**Chicago**	60630	Tym, Anna	773-777-7885
COOK (CHICAGO)	S.E.A.D. Council 8640 S. Chicago Ave	**Chicago**	60617	Zyvert, Gregory R.	773-731-9100
COOK (CHICAGO)	Substance Abuse Services, Inc. 2101 S. Indiana Ave.	**Chicago**	60616	Reynolds, A. Doris	312-808-3210
COOK (CHICAGO)	T.A.S.C., Inc. 1500 N. Halsted St.	**Chicago**	60622	Fesmire, Roy	312-787-0208
COOK (CHICAGO)	T.A.S.C., Inc. 2240 W. Ogden Ave.	**Chicago**	60612	Fesmire, Roy	312-738-8933
COOK (CHICAGO)	T.A.S.C., Inc. 1100 S. Hamilton	**Chicago**	60612	Fesmire, Roy	312-666-7339
COOK (CHICAGO)	T.A.S.C., Inc. 2600 S. California Ave.	**Chicago**	60608	Fesmire, Roy	773-376-0950
COOK (CHICAGO)	The Anixter Center 3220 W. Armitage	**Chicago**	60647	Ferst, Stuart	773-235-3161
COOK (CHICAGO)	The McDermott Center Haymarket 4910 South King Drive	**Chicago**	60615	Soucek, Raymond	773-548-7598
COOK (CHICAGO)	The McDermott Center Haymarket 750 W. Montrose	**Chicago**	60613	Soucek, Raymond	773-334-4388
COOK (CHICAGO)	The McDermott Center Haymarket 932 W. Washington	**Chicago**	60607	Soucek, Ray	312-226-7984

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICE PROVIDERS

COUNTY	AGENCY	CITY		CONTACT	
COOK (CHICAGO)	The Women's Treatment Center 140 North Ashland Ave.	**Chicago**	60607	Oates, Jewell Dr.	312-850-0050
COOK (CHICAGO)	The Woodlawn Organization 1447 East 65th Street	**Chicago**	60637	May, Orlando E.	773-288-5840
COOK (CHICAGO)	Woodlawn Holistic Outpatient 1445 E. 65th Street	**Chicago**	60637	May, Orlando E.	773-493-6116
COOK (CHICAGO)	Youth Outreach Services 4751 N. Kedzie Avenue	**Chicago**	60625	Velasquez, Rick	773-478-4500
COOK (CHICAGO)	Youth Outreach Services 5910 West Division	**Chicago**	60651	Velasquez, Rick	773-379-3600
COOK (CHICAGO)	Youth Outreach Services 6417 W. Irving Park Road	**Chicago**	60634	Velasquez, Rick	773-777-6377
COOK (CHICAGO)	Youth Service Project, Inc. 3942 West North Ave.	**Chicago**	60647	Abbate, Nancy M.	773-772-6270
COOK (SUBURB)	Alexian Brothers-Lake Cook 901 Biesterfield Road	**Elk Grove Village**	60007	Vaughan, T.J.	847-882-1600
COOK (SUBURB)	Aunt Martha's 233 Joe Orr Road	**Chicago Heights**	60411	Wood, Warren	708-754-1044
COOK (SUBURB)	Bremen Youth Services 15350 Oak Park Ave.	**Oak Forest**	60452	Sebek, Donald	708-687-9200
COOK (SUBURB)	Des Plaines Valley Community Center 6120 S. Archer Rd.	**Summit**	60501	Forshey, Florence W.	708-458-0230
COOK (SUBURB)	Family Guidance Centers, Inc. 1689 Elk Blvd.	**Des Plaines**	60016	Lofy, Joseph	847-827-7517
COOK (SUBURB)	Foundation I 15400 South Page	**Harvey**	60426	Kyles, James	708-339-8861
COOK (SUBURB)	Grateful House Intensive 412 South Wesley	**Oak Park**	60302	Piper Voss, Janet	708-848-6969
COOK (SUBURB)	Guildhaus 13317 Old Western Ave.	**Blue Island**	60406	King, John L.	708-385-1608
COOK (SUBURB)	Guildhaus 2413 Canal St.	**Blue Island**	60406	King, John L.	708-385-3228
COOK (SUBURB)	Intervention Instruction, Inc. 10220 S. 76th Avenue	**Bridgeview**	60455	Kilbane, Patricia	708-947-6706
COOK (SUBURB)	Intervention Instruction, Inc. 1500 Maybrook Sq.	**Maywood**	60153	Kilbane, Patricia	312-865-6338
COOK	Intervention Instruction, Inc.	**Markham**	60426	Kilbane,	708-210-4483

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICE PROVIDERS

COUNTY	AGENCY	CITY		CONTACT	
(SUBURB)	16501 S. Kedzie Parkway			Patricia	
COOK (SUBURB)	Intervention Instruction, Inc. 2121 Euclid Street	**Rolling Meadows**	60008	Kilbane, Patricia	847-818-2885
COOK (SUBURB)	Intervention Instruction, Inc. 5600 Old Orchard Rd.	**Skokie**	60077	Kilbane, Patricia	847-467-7100
COOK (SUBURB)	L.S.S.I. - Elgin Center I 675 Varsity Drive	**Elgin**	60120	Bruggeman, Steve	847-741-2600
COOK (SUBURB)	Leyden Family Service 10001 W. Grand Ave.	**Franklin Park**	60131	Clasen, Douglas	847-451-0330
COOK (SUBURB)	L.S.S.I. - Palatine 4811 Emerson Avenue	**Palatine**	60067	Bruggeman, Steve	847-397-0095
COOK (SUBURB)	North Suburban Counseling Center 9933 N. Lawler Ave.	**Skokie**	60077	Rosenthal, Scott	847-676-0113
COOK (SUBURB)	Norwood Park Township 4600 N. Harlem Ave.	**Hardwood Heights**	60656	Santoro, Donna	708-867-6886
COOK (SUBURB)	Omni Youth Services 1111 West Lake Cook Road	**Buffalo Grove**	60089	Wells, Harry	847-537-8871
COOK (SUBURB)	Omni Youth Services 16 N. Arlington Hgts. Rd.	**Arlington Heights**	60004	Wells, Harry	847-253-6010
COOK (SUBURB)	Omni Youth Services 222 East Dundee Road	**Wheeling**	60090	Wells, Harry	847-541-0199
COOK (SUBURB)	Peer Services, Inc. 906 Davis St.	**Evanston**	60201	Mahoney, Kate	847-492-1778
COOK (SUBURB)	Proviso Family Services 1414 Main Street	**Melrose Park**	60160	Smith, Melvin	708-681-2324
COOK (SUBURB)	Proviso Family Services 1820 S. 25th Street	**Broadview**	60154	Smith, Melvin	708-681-2324
COOK (SUBURB)	Proviso Family Services 723 S. Boulevard	**Oak Park**	60302	Smith, Melvin	708-660-0638
COOK (SUBURB)	Renz Addiction Counseling Center Two American Way	**Elgin**	60120	Skogmo, Jerry	847-742-3545
COOK (SUBURB)	Renz Addiction Counseling Center 7431 Astor Ave.	**Hanover Park**	60103	Flynn, Diane	630-837-6445
COOK (SUBURB)	S.S.C.A.S.A. - Outpatient Services 1909 Checker Square	**East Hazel Crest**	60429	Sandusky, Allen	708-957-2854

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICE PROVIDERS

COUNTY	AGENCY	CITY		CONTACT	
COOK (SUBURB)	Substance Abuse Operations 308 South 5th Avenue	**Maywood**	60153	Crick, Mary	708-343-1275
COOK (SUBURB)	The McDermott Center Haymarket 1990 E. Algonquin Rd.	**Schaumburg**	60173	Soucek, Raymond	847-397-5340
COOK (SUBURB)	The Way Back Inn 104 Oak Street	**Maywood**	60153	Lieggi, Frank	708-345-8422
COOK (SUBURB)	The Way Back Inn 201 S. 2nd Ave.	**Maywood**	60153	Lieggi, Frank	708-345-8422
COOK (SUBURB)	YMCA of Metropolitan Chicago 3801 W. 127th St.	**Alsip**	60803	Fryklund, Janice	708-385-6700
COOK (SUBURB)	Youth Outreach Services 10125 W. Grand Ave.	**Franklin Park**	60131	Velasquez, Rick	847-455-8445
COOK (SUBURB)	Youth Outreach Services 1633 N. 37th Avenue	**Melrose Park**	60160	Velasquez, Rick	708-343-6869
COOK (SUBURB)	Youth Outreach Services 2614 W. St. Charles Rd.	**Bellwood**	60104	Velasquez, Rick	708-547-8730
COOK (SUBURB)	Youth Outreach Services 6117 W. Cermack Rd.	**Cicero**	60650	Velasquez, Rick	708-795-4747
COOK (SUBURB)	Youth Outreach Services 723 S. Boulevard	**Oak Park**	60302	Velasquez, Rick	708-660-0638
DEKALB	Ben Gordon Community 12 Health Services Drive	**Dekalb**	60115	Graves, James	815-756-4875
DEWITT	DeWitt County Human Services 1150 Route 54 West	**Clinton**	61727	Lietz, Cheryl	217-935-9496
DUPAGE	Breaking Free 800 West 5th Avenue	**Naperville**	60563	Phelps, Don	630-355-2585
DUPAGE	Cornell Interventions 11 South 250, Rt. 83	**Hinsdale**	60521	Lissner, Arlene	630-325-5050
DUPAGE	Cornell Interventions 11 South 250, Rt. 83	**Hinsdale**	60521	Lissner, Arlene	630-325-5050
DUPAGE	Cornell Interventions 4450 Lincoln Highway	**St. Charles**	60175	Lissner, Arlene	630-584-0506
DUPAGE	Guidance Center of Memorial 183 N. York Rd.	**Elmhurst**	60126	Guistolise, Paul	630-941-4577
DUPAGE	Healthcare Alternative Systems, Inc.	**Glen Ellyn**	60137	Jacome,	630-858-7400

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICE PROVIDERS

COUNTY	AGENCY	CITY		CONTACT	
	799 Roosevelt Rd.			Marco	
DUPAGE	Serenity House, Inc. 891 South Route 53	**Addison**	60101	Tews, Henry	630-620-6616
DUPAGE	T.A.S.C., Inc. - Area 10 799 Roosevelt Rd.	**Glen Ellyn**	60137	Fesmire, Roy	630-858-7400
EDGAR	Human Resources Center 118 E. Court St.	**Paris**	61944	Young, John W.	217-465-4118
EDWARDS	Southeastern Edwards Family 254 S. 5th St.	**Albion**	62806	Jackson, Glenn	618-445-3559
EFFINGHAM	Heartland Human Services 1200 N. Fourth St.	**Effingham**	62401	Compton, Cheryl	217-347-7058
FAYETTE	Community Resource Center 421 W. Main St.	**Vandalia**	62471	Daum, Denise	618-283-4229
FAYETTE	Gateway Foundation Rt. 51 North, Box 500	**Vandalia**	62471	Schwartz, Chuck	618-283-4170
FRANKLIN	Franklin - Williamson Human 902 West Main Street	**West Frankfort**	62896	Bailie, Wendy	618-997-5336
GALLATIN	Egyptian Public and Mental Health 112 E Main St.	**Ridgeway**	62979	Garnett, Frederica	618-272-4691
GREENE	The Wells Center Rural Route 1	**Roodhouse**	62082	Carter, Bruce	217-243-1871
GRUNDY	Grundy Co. Health Dept. 1320 Union St.	**Morris**	60450	Goggins, Jackie	815-941-3404
HANCOCK	Hancock County Mental Health 607 Buchanan Street	**Carthage**	62321	Knowles, David W.	217-357-3176
HENDERSON	Bridgeway, Inc. Rural Health Facility	**Oquawka**	61469	Swanson, Vivienne	309-867-2626
HENRY	Bridgeway A.D.A.P.T. Services 114 North East Street	**Cambridge**	61238	Swanson, Vivienne	309-937-2417
HENRY	Bridgeway, Inc. 137 East College	**Kewanee**	61443	Swanson, Vivienne	309-852-4331
IROQUOIS	Iroquois Mental Health Center 908 E. Cherry	**Watseka**	60970	Haldeman, Charles F.	815-432-5241
JACKSON	Gateway Youth Care - Carbondale	**Carbondale**	62901	Schwartz,	618-529-1151

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICE PROVIDERS

COUNTY	AGENCY	CITY		CONTACT	
	1080 East Park Street			Chuck	
JACKSON	Recovery and Addictions Program 604 East College Street	**Carbondale**	62901	Freitag, Karen	618-529-5353
JACKSON	T.A.S.C., Inc. 18 North 10th St.	**Murphysboro**	62966	Fesmire, Roy	618-565-1900
JACKSON	Wells Center/Illinois Youth Center P.O. Box 1507	**Murphysboro**	62966	Carter, Bruce	618-684-8500
JASPER	Jasper County Health Department 106 East Edwards St.	**Newton**	62448	Clark, Joel	618-783-4154
JASPER	Southeastern/Jasper Family 902 West Jourdan	**Newton**	62448	Jackson, Glenn	618-783-8615
JEFFERSON	Jefferson County Comprehensive P.O. Box 1000	**Ina**	62846	Baumgarten, Jean	618-437-5300
JEFFERSON	Jefferson County Comprehensive Services Rte. 37 North, Box 428	**Mount Vernon**	62864	Baumgarten, Jean	618-242-1511
JERSEY	Tri-County Counseling Center 220 East County Rd.	**Jerseyville**	62052	Schaffner, Carol A.	618-498-9587
KANE	Association for Individual Dvlpmt. 400 North Highland Avenue	**Aurora**	60506	O'Shea, Lynn	630-859-1291
KANE	Breaking Free, Inc. 120 Gale St.	**Aurora**	60506	Moran, Michael	630-897-1003
KANE	Breaking Free, Inc. 1329 North Lake St.	**Aurora**	60506	Moran, Michael	630-847-5610
KANE	Breaking Free, Inc. 250 W. Downer Place	**Aurora**	60506	Moran, Michael	630-895-0670
KANE	Community Counseling Center 400 Mercy Lane	**Aurora**	60506	Hegy, Elaine M.	630-897-0584
KANE	Family Guidance Centers, Inc. 751 Aurora Ave.	**Aurora**	60506	Lofy, Joseph M.	630-801-0017
KANE	H.R.D.I. 34 W. 826 Villa Maria Road	**St. Charles**	60174	Sleet, Marion G.	312-441-9009
KANE	Latino Treatment Center 54 South Grove Ave.	**Elgin**	60120	Pujals, Ernest T.	847-695-9155

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICE PROVIDERS

COUNTY	AGENCY	CITY		CONTACT	
KANE	Opportunity House/Community 469 North Lake Street	**Aurora**	60506	Hegy, Elaine M.	630-859-1870
KANE	Renz Addiction Counseling Center 309 Walnut St.	**St. Charles**	60174	Flynn, Diane	630-513-6886
KANE	Renz Addiction Counseling Center 211 West Main Street	**Carpentersville**	60110	Flynn, Diane	847-428-3340
KANKAKEE	Aunt Martha's Outpatient Adult 355 N. Schuyler	**Kankakee**	60901	Wood, Warren	815-937-0100
KANKAKEE	Duane Dean Prevention 700 East Court St.	**Kankakee**	60901	Eckstein, Dewana	815-939-0125
KANKAKEE	Riverside Medical Center 411 West Division St.	**Manteno**	60950	Simone, James	815-468-3241
KENDALL	Kendall County Health and Human Services 500A Countryside Center	**Yorkville**	60560	Johnson, Cheryl	630-553-9100
KNOX	Bridgeway A.D.A.P.T. 2323 Windish Drive	**Galesburg**	61401	Swanson, Vivienne	309-344-2323
LA SALLE	Gateway Foundation P.O. Box 38, LaSalle Co. Highway #3	**Sheridan**	60551	Schwartz, Chuck	815-496-2311
LA SALLE	North Central Behavioral Health 207 East Spring St.	**Streator**	61364	Miskowiec, Don	815-673-3388
LA SALLE	North Central Behavioral Health 2960 Chartres Street	**Lasalle**	61301	Miskowiec, Don	815-224-1610
LA SALLE	North Central Behavioral Health 727 Etna Rd.	**Ottawa**	61350	Miskowiec, Don	815-223-0160
LAKE	Cornell Interventions 26991 Anderson Rd.	**Wauconda**	60084	Lissner, Arlene	847-526-0404
LAKE	Gateway Youth Care Foundation 25480 W. Cedarcrest Lane	**Lake Villa**	60046	Schwartz, Chuck	847-356-8205
LAKE	Lake County Health Department 121 East Grand Ave.	**Lake Villa**	60046	Schanding, David	847-356-0055
LAKE	Lake County Health Department 24647 N. Milwaukee Ave.	**Vernon Hills**	60061	Schanding, David	847-362-7494
LAKE	Lake County Health Department 3001 Green Bay Road	**North Chicago**	60064	Johnson, Ruth	847-689-4320
LAKE	Lake County Health Department 3012 Grand Avenue	**Waukegan**	60085	Schanding, Dave	847-360-6729

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICE PROVIDERS

COUNTY	AGENCY	CITY		CONTACT	
LAKE	Lake County Health Department 423 E. Washington	**Round Lake Park**	60073	Schanding, David	847-360-6770
LAKE	Lake Villa Gateway Foundation, Inc. 25480 W. Cedarcrest Lane	**Lake Villa**	60046	Darcy, Michael	708-356-8205
LAKE	N.I.C.A.S.A. 2031 Dugdale	**North Chicago**	60064	Merwin, John	847-785-8660
LAKE	N.I.C.A.S.A. 2900 North Main Street	**Prairie View**	60069	Merwin, John	847-634-6422
LAKE	N.I.C.A.S.A. - Bridge House 3016 Grand Ave.	**Waukegan**	60085	Merwin, John	847-662-4124
LAKE	N.I.C.A.S.A. 1113 Greenwood Ave.	**Waukegan**	60087	Merwin, John	847-244-4434
LAKE	N.I.C.A.S.A. 31979 N. Fish Lake Rd.	**Round Lake**	60073	Merwin, John	847-546-6450
LAKE	Omni Youth Services 157 East Main	**Lake Zurich**	60047	Wells, Harry	847-540-0680
LAKE	Omni Youth Services 2900 North Main St.	**Prairie View**	60069	Wells, Harry	847-634-9360
LAKE	Omni Youth Services 505 East Hawley St.	**Mundelein**	60060	Wells, Harry	847-949-1020
LAWRENCE	Southeastern Illinois Counseling 1501 Olive	**Lawrenceville**	62439	Jackson, Glenn	618-943-3451
LEE	L.S.S.I. - Dixon 1247 N. Galena Ave.	**Dixon**	61021	Bruggeman, Steve	815-288-6655
LEE	Sinnissippi Centers, Inc. 325 Illinois Route 2	**Dixon**	61021	Sarver, James R.	815-284-6611
LIVINGSTON	Gateway Foundation, Inc., Dwight I-55 & Route #17	**Dwight**	60420	Schwartz, Chuck	815-584-2806
LIVINGSTON	Institute for Human Resources 310 E. Torrance	**Pontiac**	61764	Ronaldson, Joe	815-844-6109
LOGAN	Gateway Foundation Lincoln 1098 1350th St.	**Lincoln**	62636	Schwartz, Chuck	217-735-5411
MACON	Chestnut Health Systems 2130 N. 27th Street	**Decatur**	62526	Sender, Alan	217-423-0750
MACON	Geoffrey M. Geoghegan 151 N. Main St.	**Decatur**	62525	Knabe, Diana	217-362-6293
MACON	St. Mary's Treatment Center	**Decatur**	62521	Marshall,	217-464-2500

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICE PROVIDERS

COUNTY	AGENCY	CITY		CONTACT	
	1800 East Lakeshore Drive			Gloria	
MACOUPIN	Macoupin Co. Mental Health Center 100 North Side Square	**Carlinville**	62626	Kleinlein, Ann m.	217-854-3166
MADISON	Alcoholic Rehabilitation 1313 21st Street	**Granite City**	62040	Divine, Drew	618-877-4987
MADISON	Chestnut Health Systems 2148 Vadalabene Dr.	**Maryville**	62062	Sender, Alan	618-288-3100
MADISON	Chestnut Health Systems, Inc. #50 Northgate Industrial Drive	**Granite City**	62040	Sender, Alan	618-877-4420
MADISON	Community Counseling Center 2615 Edwards St.	**Alton**	62002	Sloan, Debra	618-462-2331
MADISON	T.A.S.C., Inc. 103 Plaza Court	**Edwardsville**	62025	Rodriguez, Pamela	618-656-7672
MARION	Community Resource Center 101 S. Locust Street	**Centralia**	62801	Daum, Denise	618-533-1391
MARION	Community Resource Center 1325 C West Whitaker	**Salem**	62881	Daum, Denise	618-548-2181
MCDONOUGH	Bridgeway, Inc. 440 North Lafayette	**Macomb**	61455	Swanson, Vivienne	309-837-4876
MCHENRY	Comprehensive Behavioral 503 N. Front St.	**McHenry**	60050	Austin, Lisa	815-344-8860
MCHENRY	Family Service & Community Mental 115 N. Main St.	**Algonquin**	60102	Schmiege, Barbara	847-385-6400
MCHENRY	Family Services & Community Mental 5320 W. Elm St.	**McHenry**	60050	Schmiege, Barbara	815-385-6400
MCHENRY	The Advantage Group 422 Tag Way	**Crystal Lake**	60014	Owens, M. Patrice	847-516-0500
MCLEAN	Chestnut Health Systems - Central 1003 Martin Luther King Jr. Drive	**Bloomington**	61701	Sender, Alan	309-827-6026
MCLEAN	Chestnut Health Systems - Central 702 West Chestnut	**Bloomington**	61701	Sender, Alan	309-827-6026
MONROE	Substance Abuse Alternatives 988 N. Illinois Rt. 3	**Waterloo**	62298	Singer, Robert	618-939-4444
MONTGOMERY	Gateway Foundation Interstate 55 & Route 185	**Hillsboro**	62049	Schwartz, Chuck	217-532-6961

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICE PROVIDERS

COUNTY	AGENCY	CITY		CONTACT	
MONTGOMERY	Montgomery County Route 185, P.O. Box 128	**Hillsboro**	62049	Dugger, Mark	217-532-2001
MORGAN	Gateway Foundation Jacksonville R.R. # 4 Box 28C	**Jacksonville**	62650	Schwartz, Chuck	217-245-1481
MORGAN	The Wells Center 1300 Lincoln Avenue	**Jacksonville**	62650	Carter, Bruce	217-243-1871
OGLE	Sinnissippi Centers, Inc. 125 S. 4th	**Oregon**	61061	Sarver, James	815-732-3157
OGLE	Sinnissippi Centers, Inc. 417 North 6th St.	**Rochelle**	61068	Sarver, James	815-562-3801
PEORIA	Human Service Center 3420 North Rochelle	**Peoria**	61604	Boyle, Michael G.	309-671-8040
PEORIA	Human Service Center Outpatient 228 N.E. Jefferson	**Peoria**	61654	Boyle, Michael G.	309-671-8000
PEORIA	T.A.S.C., Inc. 1520 N.E. Adams	**Peoria**	61603	Fesmire, Roy	309-673-3769
PEORIA	White Oaks Center 3400 New Leaf Lane	**Peoria**	61614	Boyle, Michael G.	309-693-6900
PEORIA	White Oaks Knolls 2101 West Willow Knolls Road	**Peoria**	61614	Boyle, Michael G.	309-689-3074
PEORIA	White Oaks Welfare Initiative 1701 W. Garden St.	**Peoria**	61605	Murphy, Thomas P.	309-692-6900
PERRY	Perry Co. Counseling 1016 S. Madison St.	**Du Quoin**	62832	Venskus, John R.	618-542-4357
PERRY	Wells Center P.O. Box 470	**Duquoin**	62832	Carter, Bruce	618-542-5738
PIATT	Piatt County Mental Health 1921 N. Market	**Monticello**	61856	Lochbaum, Susan	217-762-5371
PIKE	Counseling Center of Pike County 121 S. Madison	**Pittsfield**	62363	Norris, Kelly J.	217-285-4436
POPE	Wells Center - Dixon Springs P.O. Box 103	**Grantsburg**	62943	Carter, Bruce	618-949-3311
RANDOLPH	Human Service Center 10257 State Route 3	**Red Bud**	62278	Hoyle, Susan	618-282-6233

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICE PROVIDERS

COUNTY	AGENCY	CITY		CONTACT	
RANDOLPH	Human Service Center 800 Servant Street	**Chester**	62233	Hoyle, Susan	618-826-4547
RANDOLPH	Human Service Center 104 Northtown Drive	**Sparta**	62286	Wells, W. Theo	618-443-3045
RICHLAND	Southeastern Illinois Family 504 Micah Drive	**Olney**	62450	Jackson, Glenn	618-395-4306
ROCK ISLAND	Rock Island County Council 1607 John Deere Road	**East Moline**	61244	Schroeder, Thomas	309-792-0292
ROCK ISLAND	Robert Young Center 2701 17th Street	**Rock Island**	61201	Freda, Michael	309-793-2121
ROCK ISLAND	T.A.S.C., Inc. 2525 - 24th St.	**Rock Island**	61201	Fesmire, Roy	309-788-0816
SALINE	Egyptian Public 112 U.S. Highway 45 North	**Eldorado**	62930	Peyton, Billy	618-273-3326
SANGAMON	Gateway Springfield Center 2200 Lake Victoria Drive	**Springfield**	62703	Schwartz, Chuck	217-529-9266
SANGAMON	Gateway Youth Care Foundation 2200 Lake Victoria Drive	**Springfield**	62703	Schwartz, Chuck	217-529-9266
SANGAMON	Mental Health Centers of Central Illinois 319 E. Madison	**Springfield**	62701	Allen, Brian	217-523-2217
SANGAMON	T.A.S.C., Inc. 3 Old Capitol Plaza West	**Springfield**	62701	Fesmire, Roy	217-544-0842
SANGAMON	Triangle Center 120 N. 11th St.	**Springfield**	62703	Knox, Stephen J.	217-544-9858
SCHUYLER	Schuyler Counseling 127 South Liberty	**Rushville**	62681	Wilson, Francis M.	217-322-4373
SHELBY	C.E.A.D. Council 155 S. Morgan St.	**Shelbyville**	62565	Irwin, Pamela	217-774-5566
ST. CLAIR	Cornell Interventions 302 N. 5th Street	**East St. Louis**	62201	Otis, Don	618-271-4542
ST. CLAIR	Cornell Interventions 950 Kings Highway	**East St. Louis**	62202	Lissner, Arlene	618-394-2200
ST. CLAIR	Center for Addictions Rehabilitation 913 Martin Luther King Drive	**East St. Louis**	62201	Ray, Delores S.	618-482-7385

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICE PROVIDERS

COUNTY	AGENCY	CITY		CONTACT	
ST. CLAIR	Gateway Foundation Caseyville 600 Lincoln	**Caseyville**	62232	Schwartz, Chuck	618-345-3970
ST. CLAIR	Gateway Foundation 7 N. High Street	**Belleville**	62220	Schwartz, Chuck	618-234-9002
ST. CLAIR	Mid-America Behavioral Healthcare #5 Executive Woods Court	**Swansea**	62226	Brown, Karen	618-235-8100
ST. CLAIR	T.A.S.C., Inc. 218A West Main St.	**Belleville**	62220	Fesmire, Roy	618-277-0410
STEPHENSON	Sojourn House, Inc. 565 North Turner Avenue	**Freeport**	61032	Bombard, Brenda J.	815-232-5121
TAZEWELL	Tazwood Center for Human Services 1421 Valle Vista Boulevard	**Pekin**	61554	Kuhn, John	309-347-5522
TAZEWELL	Tazwood Center for Human Services 3223 Griffin Ave.	**Pekin**	61554	Kuhn, John	309-347-5579
TAZEWELL	Tazwood Mental Health Center, Inc. 100 N. Main St.	**East Peoria**	61611	Kuhn, John	309-694-6462
TAZEWELL	Tazwood Mental Health Center, Inc. 1618 Valle Vista	**Pekin**	61554	Kuhn, John	309-347-1614
UNION	The Fellowship House 800 N. Main St.	**Anna**	62906	Spurlock, Norma	618-833-4456
VERMILION	New Directions Treatment Center 101 W. North Street	**Danville**	61832	Fontenot, Chester J.	217-442-9026
VERMILION	Prairie Center for Substance Abuse 3545 N. Vermilion	**Danville**	61832	Leary, Pat	217-477-4500
WABASH	Southeastern/Wabash Family Counseling 311 West Fifth Street	**Mt. Carmel**	62863	Jackson, Glenn	618-262-7473
WARREN	Bridgeway A.D.A.P.T. Services 219 Euclid Street	**Monmouth**	61462	Swanson, Vivienne	309-734-9461
WAYNE	Southeastern/Wayne Family Counseling Center 407 North Basin	**Fairfield**	62837	Jackson, Glenn	618-842-2125
WHITE	Egyptian Public and Mental Health 307 East Cherry	**Carmi**	62821	Garnett, Frederica	618-382-7311
WHITESIDE	L.S.S.I. - Sterling 1901 1st Avenue	**Sterling**	61081	Bruggeman, Steve	815-626-7333
WHITESIDE	Sinnissippi Centers, Inc. 2611 Woodlawn Rd.	**Sterling**	61081	Sarver, James R.	815-625-0013
WILL	Cornell Interventions 1611 W. Jefferson St.	**Joliet**	60431	Lissner, Arlene	815-730-7521

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICE PROVIDERS

COUNTY	AGENCY	CITY		CONTACT	
WILL	Cornell Interventions 404 W. Boughton Rd.	**Bolingbrook**	60440	Lissner, Arlene	630-759-5750
WILL	Gateway Foundation Kankakee Route 102, Warner Bridge Road	**Manteno**	60950	Schwartz, Chuck	815-476-9568
WILL	Stepping Stones, Inc. 1621 Theodore St.	**Joliet**	60435	Lauridsen, Paul	815-744-4647
WILL	Stepping Stones, Inc. Short Term 1621 Theodore St.	**Joliet**	60435	Mclenighan , Peter	815-744-4654
WILL	T.A.S.C., Inc. 16 W. Van Buren	**Joliet**	60432	Fesmire, Roy	
WILL	The Joliet Counseling Center 54 North Ottawa Street	**Joliet**	60432	Talarico, David J.	815-723-7575
WILL	Will County Health Department 407 West Jefferson Street	**Joliet**	60435	Troiani, Joseph	815-727-5065
WILLIAMSON	Franklin-Williamson Human Services 1305 W. Main St.	**Marion**	62959	Bailie, Wendy	618-997-5336
WINNEBAGO	Comprehensive Behavioral Services 401 W. State St.	**Rockford**	61101	Austin, Lisa	815-965-7979
WINNEBAGO	L.S.S.I. - Rockford 119 N. Wyman Street	**Rockford**	61101	Bruggeman, Steve	815-965-6300
WINNEBAGO	P.H.A.S.E., Inc. 319 South Church Street	**Rockford**	61101	Kresge, Jared	815-962-0871
WINNEBAGO	Rosecrance on State 420 E. State St.	**Rockford**	61104	Eaton, Phillip	815-967-8722
WINNEBAGO	Rosecrance, Inc. 1505 N. Alpine Road	**Rockford**	61107	Eaton, Phillip	815-399-5351
WINNEBAGO	Rosecrance, Inc. 3815 W. Harrison St.	**Rockford**	61104	Eaton, Phillip	815-391-1000
WINNEBAGO	T.A.S.C., Inc. 119 N. Church St.	**Rockford**	61101	Fesmire, Roy	815-965-1106
WOODFORD	Tazwood Mental Health Center, Inc. 109 E. Eureka	**Eureka**	61530	Kuhn, John	309-467-3770

COUNTY	AGENCY	CITY	CONTACT

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