



Testimony of Melody M. Heaps, President

Little Hoover Commission
Public Hearing on Alcohol & Drug Abuse Treatment
Thursday, September 26, 2002

Expanding Treatment with Existing Resources and Opportunities

Members of the Commission, good morning. My name is Melody Heaps and I'm the founder and president of TASC, Inc. in Illinois. TASC is a statewide non-profit organization that diverts drug-involved criminal offenders out of the justice system and into treatment, through a system similar to Proposition 36. We've been in business for over 25 years, and as most of our funding comes from state and federal funding streams, we have a constant interest in what is happening around the country and at the federal level related to drug policy and funding for those policies.

I've had a chance to review the testimony from the two prior hearings on this subject, much of it from people we consider to be long-time friends and cohorts in the drug policy arena. I first want to commend the Commission for your dedication to this issue and for the quality of people you've had testify. Much of what I would have like to have said today has already been said by the people who have come before me, and so what I'd like to do is give you my perspective as someone who not only runs an agency dependent on public funding streams, but also as someone who has been involved in state and national drug policy for 25 years. I'll be highlighting three key concepts:

- 1. A national perspective on funding for drug treatment.**
- 2. A brief overview of existing funding opportunities and challenges.**
- 3. The need for global thinking in funding and programmatic strategies.**

One of the themes that you'll hear me reiterate today is that it is possible to make existing funding strategies more efficient, serving greater numbers of people. But this only half of the equation. The simple truth is that drug use and addiction need to be viewed by policymakers as major public health issues, and if states want to adequately address these issues, they're going to have to prioritize funding for demand reduction programs at a level appropriate for the seriousness and pervasiveness of drug use in our communities. In Illinois, for example, despite the continued increase in the number of drug-involved cases coming through our justice system, over the last 4-5 years human service providers have received the equivalent of a 2% cost of living adjustment. In the same time period we've built two new prisons and doubled the number of parole officers. The demand for treatment continues to far outstrip the supply, and if states want to reverse this trend, the money needs to support the policy.

National Perspective

The Robert Wood Johnson Foundation categorizes drug use as the number one health problem in America. The problems associated with drug use and its attendant consequences can be traced back several decades to the heroin epidemic prevalent among soldiers returning from VietNam in the late 60s and early 70s, and the subsequent inundation of heroin into urban centers. What we began to see with this population was a level of addiction that affected not only the user, but also their community. Drug use

stimulated the addiction, which stimulated the need for more drugs, which led to crimes committed for money to buy more drugs. It was here that the link between drug use and crime was forged.

Out of this problem, the Nixon Administration funded several demonstration programs known as TASC, or Treatment Accountability for Street Crimes. These programs used a model of intensive case management to identify offenders with drug problems, accurately assess their level of treatment need, divert them out of criminal justice processing, yet hold them accountable for completion through justice sanctions. I helped bring one of these demonstration programs to Cook County, Illinois, home to the largest unified court system in the country, and once the demonstration ended, I worked with the state to annualize the program in the state budget.

Other TASC programs, in various shapes and sizes, have emerged out of the same national model and there are now over 120 TASC programs around the country. TASC in Illinois is the largest, and is the only single statewide entity. In many ways TASC could be considered a precursor to drug courts, which are now blossoming all over the country. In fact, in many jurisdictions, the TASC offender management model is an integrated part of the drug court milieu.

We incorporated TASC as a non-profit entity in Illinois in 1976, and have since expanded our services to reach every criminal courtroom in the state. We were able to pass legislation that mandated treatment alternatives for drug-related crimes, an early version of Prop 36, and we now have state administrative rules that establish us as the singular entity to manage assessment and referral services for the statewide court system and the statewide parole system.

As we moved into the eighties, we began to see that the model of case management we were using was applicable to other publicly-supported populations, and so we've made great inroads into the juvenile justice system, the child welfare system, the welfare-to-work system, and many others. We now have over 350 staff statewide, and serve over 30,000 clients in our array of programs. And I'm especially proud that our executive and management staff have been tapped by a number of state and federal entities to participate in policy planning and strategy at the highest levels.

Our growing role working with Illinois' public systems has afforded us the opportunity to affect systemic changes in the way treatment is managed in Illinois. Most important is our ability to develop a network of quality service providers who are accountable for providing effective services for specific client populations – be they criminal offenders, juvenile delinquents, mothers who have lost custody of their children, etc. This in turn has led to collaboration and cross-training opportunities that allow the public systems and the treatment systems to learn from each other, ultimately enhancing the ability of both to effectively meet the needs of the client population and restore them to self-reliance.

As I said earlier, almost all of our funding comes from public sources, so every year we pay close attention to state and federal budgets, and with every change of administration we hold our collective breath waiting to see what the priorities will be. Over the years, I've noticed several trends that I believe have contributed to the current state of drug policy in America.

- **Fragmented, Programmatic Funding Streams.** The current process of funding drug treatment programs has become routine – a state or federal entity will release an RFP for a specific program for a specific population, and commit a certain dollar figure to it. This process has completely fragmented our local treatment strategies and thrown our local treatment community into a state of administrative disarray, effectively eliminating any economies of scale. It has also created hopelessly narrow attempts at solving systemic problems. Case in point – the recent federal Serious and Violent Offender Re-entry Initiative. For the first time, key federal agencies have combined to address common priorities for a

common population. In total, \$100 million is devoted to this project nationwide. On its face, it seems like a broad-based, systemic approach, but in application it clearly isn't. Each state will get at the most \$2 million, and with the scope of services to be provided, in Illinois we're expecting to serve only about 200 clients. This in a state with over 200,000 people under some form of justice supervision. This piecemeal strategy simply does not hold promise for long-term systemic solutions.

- **Community Assessment and Collaboration.** One of the difficulties in measuring the effectiveness of any given program is that most communities or jurisdictions don't have an accurate assessment of the scope or depth of the local drug use problem or an accurate assessment of the local resources that are available for treatment programs. Without this baseline understanding, the ability to measure progress is limited. Ultimately this is an issue that requires interagency or interdepartment or intersystem collaboration on a local level. Thorough examinations of local strengths and weaknesses are the only adequate foundation for local strategies, and the examination process encourages disparate systems to work together to develop cohesive solutions.

The good news in both of these areas is that, through my work with the federal government, I understand that they are making a concerted attempt to unify funding strategies and encourage local partnerships. Until such time as that happens, the current funding landscape is like a giant Rubik's cube, where every policy turn results in a different picture and different implications for drug treatment, and very few people can make sense of it all.

Use of Funding Sources

Knowing that there will never be enough funding to support treatment for every person in every state who needs it, policymakers need to be creative in determining not only funding *sources*, but also funding *strategies*. As I've suggested, the federal government is taking steps to present a more unified funding strategy, and I believe it is imperative that states do the same.

I'd also like to applaud the work of my co-panel member Victor Capoccia and the Robert Wood Johnson Foundation. More than any other private foundation, they've organized their priorities to take a hard look at many of the bigger picture concerns. In addition to funding programs, they support projects that really explore the issues, and solutions, related to systems of care for drug-involved populations. They are as actively involved in policies related to drug treatment, and unraveling barriers to treatment, as they are in the delivery of the services themselves. This two-pronged approach is a model that states and other jurisdictions could benefit from.

There are two considerations related to funding that I believe are important to raise:

- **Systems for High-Need Clients.** If we hope to reverse the trend of drug users becoming hopelessly entrenched in our public systems, we need to develop specialty systems of care management targeted at those clients that cause the greatest drain on public resources. These are the chronic users with years of drug involvement and addiction, and with a panoply of ancillary issues including criminal activity, loss of custody of their children, joblessness, occasionally homeless, and more prevalent recently, concurrent mental illness. Certainly we can continue to promote programs that deliver appropriate levels of intervention to less involved users and generally have higher success rates, but I don't believe that we'll be able to effect significant change in drug use if we don't develop systems that can manage the needs of the core group of chronic users. I'll discuss this issue in depth momentarily.

- **Parity.** Insurance parity for substance abuse treatment is an issue that continues to be hotly debated in policy circles. Obviously, we members of the treatment field believe that addiction is a health issue and parity is key to unlocking a plentiful pot of resources to encourage and support treatment, without significant added expense to plan purchasers. But the issue must be accompanied by a recognition of the clinical nature of drug use. There are several facets of the drug treatment experience – the saliency of coercion in treatment entry, determination of level of need, the chronic nature of addiction, the prevalence of mental illness – that place drug treatment outside the traditional managed care context. Treatment benefits must be tied to evidence-based practices and protocols and measurements of effectiveness. I believe that insurance benefits represent a mostly untapped source of funding for treatment, but our clinical understanding of drug use and addiction must be employed in determining benefit structures and limits.

Global Strategic Thinking

Out of this complicated web of issues, several states, like California, Illinois and North Carolina, have tried to take an integrated approach to treatment services. Obviously California is in the midst of this process through Prop 36, and Illinois has its statewide TASC system. North Carolina is slightly different – they’ve built upon a decade of collaboration between treatment and community corrections to develop a statewide infrastructure of independent TASC programs, with standards and protocols generated by the state and overseen by a regional management structure. Each of these strategies possesses its share of opportunities and challenges.

One such challenge is local control. California and Illinois are similar in respect to our county structure. We both have a great disparity between large, fairly advanced urban counties and sparsely populated, less advanced rural counties. We both also have county systems that protect their sovereignty, particularly when it comes to spending money. This poses some unique challenges with programs such as Proposition 36, where money for a specific program goes to counties, who spend the money as they see fit. This is not to suggest that counties should not be allowed to tailor programs to meet local needs, but the distance between federal policy and local implementation is a reality of funding policy that must be considered.

Another challenge to global thinking is ensuring adequate service delivery, specifically as concerns service staff and standards for clinical care. You’ve seen a proliferation of treatment programs here in California with the advent of Prop 36, and you need to make sure that the infrastructure is in place to certify the quality of these programs and their staff.

Program quality also presents a challenge in terms of accessibility of adequate services. Certainly a county like Los Angeles County will have a wide array of services available at any given time. But right next door you’ve got San Bernardino County, which is five times as big, with one-fifth the population. The challenges for accessing services for publicly-served populations become exponentially greater when availability of treatment and accessibility of treatment are an issue.

What I’d suggest to the Commission is the need for an independent specialty care management system for linking the highest need, highest risk clients of public systems with treatment in their communities. This is the model we have in Illinois via TASC, the model being developed in North Carolina, and a model you’ll have the foundation for in California via Prop 36. I’d like to highlight some of the components and benefits of this approach, based on our experience in Illinois:

- **Science Based Client Management.** A specialty care management system brings the latest evidence-based practices to bear in clinical decision-making. As new “best practices” emerge, a specialty care entity is able to encourage their implementation on a systemic level, not just a program-by-program level.

- **Responsiveness to Fiscal Constraints.** A broad systemic perspective allows for the optimal application of limited resources for treatment, and provides a mechanism for accessing those resources that may be otherwise unavailable to a specific program or locality.
- **Clinical Case Management.** Cost effectiveness is achieved through matching specific client needs with specific treatment resources. This can only be accomplished with a comprehensive assessment of the needs of each client. From this assessment the appropriate level of care can be identified. And case management must be treated as flexible and responsive process. As the client's needs change, the intensity of treatment and supervision can be adjusted. Continuously matching needs with the appropriate level of treatment ensures that the minimum amount of resources are being committed to a client to achieve the maximum long-term results. Ultimately this frees up resources for additional clients.
- **Access to Continuum of Care.** A systemic case management system has access to a full continuum of care options, and the case manager can move clients along that continuum as clinical needs dictate. One of the greatest challenges for public system clients is their ability to navigate the complicated processes of identifying and accessing treatment and other services, particularly when they may be involved in multiple public systems with unique requirements. Clinical case management facilitates this process. Local categorically funded programs may be limited in the providers they have access to. Clients are referred to a program whether the appropriate level of care is available or not. Ultimately this strategy is costly – either clients will not receive an intense enough level of treatment and be prone to relapse, or they will receive a level of treatment that is too intense, wasting resources. An independent infrastructure can help those remote clients in San Bernardino county gain access to the best available local treatment, and can engage additional resources, such as transportation, if necessary.
- **Client Support and Accountability.** A clinical case management system is uniquely aware of the full range of needs for each individual client, including the conditions of their placement in treatment, their treatment needs, and their need for other social services, even beyond their involvement in the public system and through the recovery process. The case manager can also leverage the sanctions of the public system to encourage treatment participation, be they increased levels of supervision, loss of custodial rights, and even incarceration.
- **Organizational Independence.** An independent entity managing public client care has the ability to objectively balance the clinical needs of the client with requirements of the public system.
- **System Accountability.** Ultimately, the specialty care system is answerable to local and state authorities and the public entities they support. This accountability is translated to the providers to which clients are referred.
- **Statewide Standards, Local Flexibility.** At the highest level, specialty care systems promulgate statewide standards for treatment delivery and outcome measurement. But at the local level, such an entity is able to adapt services to meet the nuances of local systems, practices and other social and political considerations. In Illinois, all TASC services are provided under a common operating procedure, but how that procedure is manifested in downstate Murphysboro is much different than how it is manifested in Chicago.

- **Quality Control.** A centralized specialty system of care is more able to implement and enforce quality control measures with systemic impact. Quality control functions may range from application of best practices, to the use of client service and outcome data to improve treatment delivery, to managing certification and licensure for staff and treatment programs.
- **Information Management.** Many publicly-served clients will become involved in a wide range of public systems over the course of their lives. Unless these systems interact and share information, work will be duplicated, and in some cases treatment will be duplicated unnecessarily. Centralized client management means centralized information management, which informs clinical decision-making and expedites any future publicly-mandated treatment involvement.

Obviously, an independent case management entity is not the solution to every problem associated with drug treatment. But when treatment resources are finite and limited, as they often are, independent case management is a viable option for more effectively managing high-risk, high-need clients and the resources associated with treating them.

I thank the Commission for inviting me to testify, and I'd be happy to answer any questions.