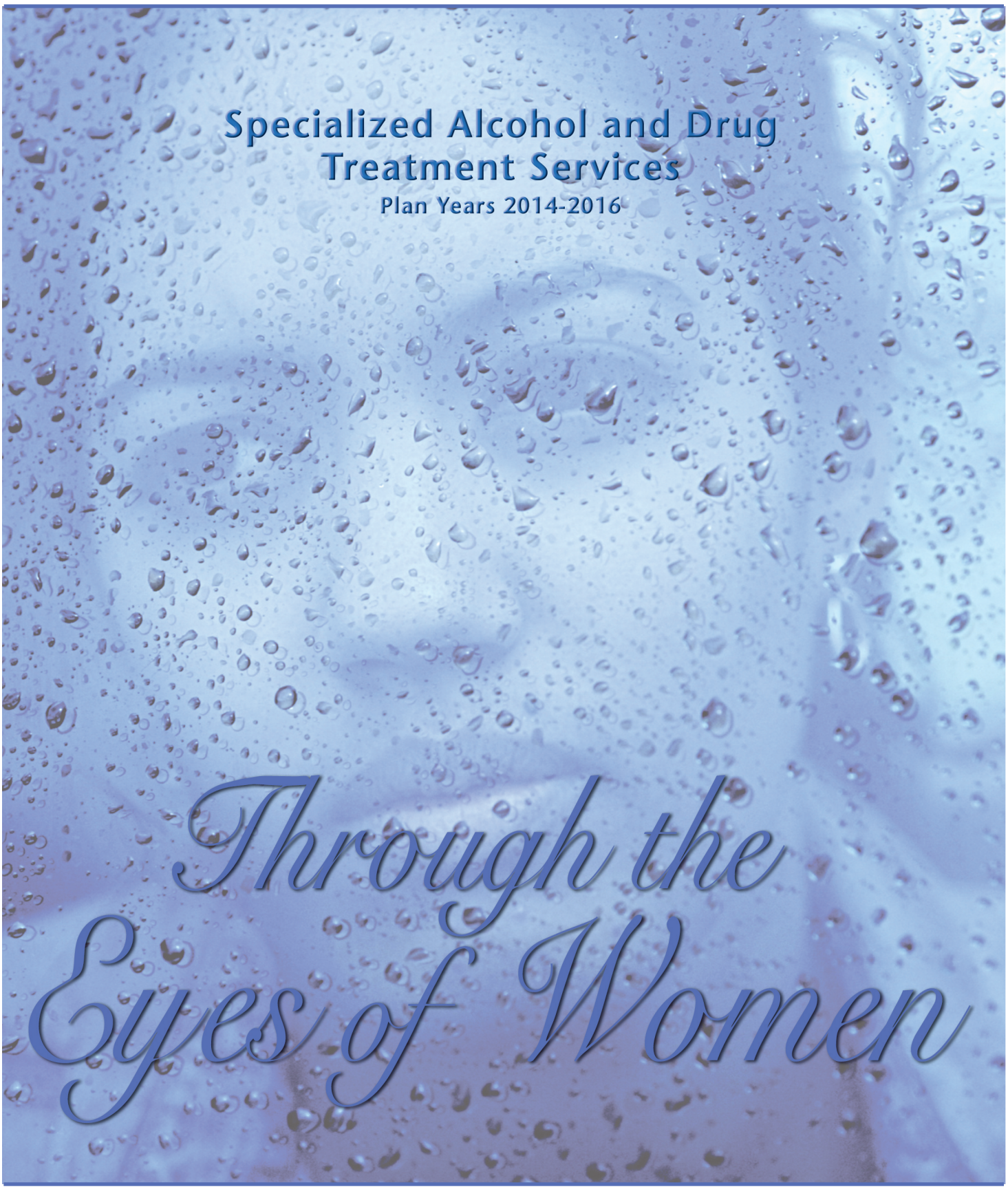
State of Illinois
Department of Human Services

Specialized Alcohol and Drug Treatment Services

Plan Years 2014-2016



15 Years
Partnering with Communities
IDHS
Illinois Department of Human Services

Lived Experience Story

Growing up as a small child, I felt unloved and didn't fit in. I was shy and isolated. I started using alcohol at the age of 15. The alcohol gave me the ability to be part of the group and to be more outgoing. By the age of 16, I continued drinking and eventually became addicted to alcohol, marijuana and cocaine.

At 17, I dropped out of high school as education was not a priority, partying was. I was hanging around with the wrong crowd and become pregnant at 17. Once I became pregnant, I quit using and went back to get my GED. After the birth of my daughter, I returned to the drugs. I continued to use and my first treatment experience was when my daughter was 2. By this time, my cocaine addiction was so out of hand I would leave my daughter with my mother for days at a time. After my first 30 day treatment program, I knew "I had this" and went to the closest employer to me – a bar. This decision started the insanity all over again, which lead to another pregnancy.

Not understanding addiction, I thought will power could help me "manage" my drug use. Due to my lack of understanding of addiction, my usage followed a pattern of periods of sobriety followed by relapses and return to my old way of life. The insanity of my use lead me to legal involvement – both criminal and DCFS – in and out of jail, institutions and my children were taken from me. In my active addiction my children suffered. They did not get to enjoy childhood like other children do. They had to raise one another, since I was incapable of doing so. I robbed their childhood. They grew up without love and security in their home. They went to bed scared and fearful every night not knowing who would come in and out of the bedrooms while they cried themselves to sleep. There were no rules or discipline for them to learn. Children crave discipline to feel loved. There were no consequences reinforced or praise given. My children were put in life and death consequences. Between my lying and all my broken promises, my children developed major trust issues. No matter what, they never stopped loving me.

At age 30, I was accepted into a drug court program. I graduated from the program, stayed clean for over a year but then returned to my old ways. I did not do what was suggested to remain clean – I did it my way. I violated my intense probation, sat in county jail for three months. During this time, I realized I was wasting my life, regretting who I had become. My probation officer stated he would give me one more chance – I knew it was up to me. I dropped to my knees and prayed to my Higher Power to help me as I did not trust myself.

At age 32, I committed myself to a 12-step program which brought recovery into my life. I was returned custody of my daughter (who was now 15) but not my son, which was hard to accept.

My daughter continued the cycle of drug use. She had a child at age 17 (same age I was when she was born). Due to relationship issues, my grandson was removed from her care and I have been raising him since he was 4 months old. My daughter become involved in the criminal justice system and was ordered into treatment. She now has eight months of sobriety.

I am in recovery and my life is completely different today. I have a good relationship with my children. They are proud of me today and that is so very important to me. My daughter is a recovering heroin addict and is sober today. My son graduated from high school and I got to be part

of that. I am employed at the facility where I received treatment. I am giving back what has been given to me – HOPE! Being a good example is a gift to me today. Life is good.
Debbie[1]

[1] The author's name has been changed to protect her identity.

15 Years
Partnering with Communities

Pat Quinn, *Governor*

Illinois Department of Human Services

Michelle R.B. Saddler, *Secretary*

100 South Grand Avenue, East • Springfield, Illinois 62762
401 South Clinton Street • Chicago, IL 60607

December 20, 2012

Dear Colleague:

It is my pleasure, along with DASA Director Theodora Binion, to introduce the 8th Edition of the 2014-2016 Women's Plan: *"Through the Eyes of Women - Specialized Alcohol and Drug Treatment Services 2014-2016."*

Starting in 2014, 15 million uninsured Americans, including 7 million women will be newly eligible for Medicaid coverage. Medicaid is, and will continue to be, a crucial source of healthcare for women in Illinois, and it has direct impact on addiction services for women. This issue of the Women's Plan will examine treatment through the eyes of women who have been impacted by treatment and recovery. Valuable research articles and information have been gathered to educate and inform our legislative leaders as the state moves forward in this new healthcare environment.

The Illinois Department of Human Services recognizes that the Affordable Care Act (ACA) provides vitally important advances for the health of women and their families. As the law is implemented on the State and Federal levels, and as more Americans gain access to health insurance, the Women's Committee of the Advisory Council continues to ensure that the new health care law benefits women in the struggle against addiction and as part of the effort to improve women's overall health.

Sincerely,

Michelle R.B. Saddler
Secretary

15 YEARS
PARTNERING WITH COMMUNITIES

Illinois Department of Human Services

Pat Quinn, *Governor*

Michelle R.B. Saddler, *Secretary*

Division of Alcoholism and Substance Abuse
100 West Randolph, Suite 5-600
Chicago, IL 60601-3224

December 20, 2012

Dear Colleague:

"The Voice and Eyes of Women with Lived Experiences" is being presented as the 8th legislatively mandated Women's Plan for 2014-2016.

The Women's Committee's of the Illinois Alcoholism and Other Drug Abuse Advisory Council is charged to advise and submit recommendations to DASA concerning substance abuse treatment and recovery for women and their families.

The Committee has been in the forefront in identifying gaps and helping DASA understand and address disparities in services and outcomes. The alignment in vision and planning between the Committee and DASA have resulted in advancing access to treatment for women and the development of gender specific treatment approaches.

As we enter the era of Medicaid Reform in Illinois and Health Care Reform nationwide it is even more imperative that informed stakeholders continue to provide input and initiate relevant discussions concerning women's health care. I am looking forward to continuing this important alliance in the service of providing women with the best substance abuse treatment available anywhere.

Meanwhile, let us all look forward to a successful and productive time in the field of gender specific substance abuse treatment and recovery.

Sincerely,

Theodora Binion, Director
Illinois Department of Human Services
Division of Alcoholism and Substance Abuse

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Executive Summary of Recommendations

Family-Centered Services Workgroup

- **Recommendation 1:** Leverage multi-state systems and maximize funding and resources for family-centered services in the community.
- **Recommendation 2:** Develop and promote best practice guidelines for family-centered services based on research findings and survey data collected from community-based providers.

Women Veterans

- **Recommendation 1:** Transform community service providers to furnish gender responsive services to all women veterans, including those who have experienced military sexual trauma.
- **Recommendation 2:** Help community service providers understand the veterans and military language and associated cultural barriers of a male-dominated system.

Essential Health Benefits & Women's Services

- **Recommendation 1:** Ensure that the essential health benefits (EHB) package adopted in Illinois includes comprehensive treatment for women suffering from mental health disorders, substance use disorders, and other behavioral health issues.

Criminal Justice

- **Recommendation 1:** Advocate for statutory protections that prevent misusage of health information exchanges ("HIEs") by law enforcement and other agencies for prosecution of prescription drug abuse and instead focus on treatment.
- **Recommendation 2:** Add dedicated treatment facility for women within correctional facilities.
- **Recommendation 3:** Establish a collaborative partnership with the criminal justice system/adult and juvenile drug courts to ensure a continuum of services including treatment alternatives to incarceration throughout the state.
- **Recommendation 4:** Cultivate dialogue on re-entry of women from criminal justice system and how they can have more effective access to substance abuse services.

Technology Transfer

- **Recommendation 1:** Ensure funding for implementation of evidence-based practices.
- **Recommendation 2:** Encourage coordinated ongoing substance abuse training with providers and child welfare and purchase of service ("POS") providers.

Electronic Health Records

- **Recommendation 1:** Encourage providers and state agencies to focus on using electronic health records to improve coordination of care and to ensure that Medicaid benchmarks are achieved.
- **Recommendation 2:** Promote discussion amongst providers and state agencies about the importance of understanding confidentiality provisions as they relate to use of electronic health records.

- **Recommendation 3:** Advocate for the appropriate balance of acquiring adequate patient information and respecting the privacy of patients so as to avoid unnecessary invasions of privacy and prevent increased stigma and discrimination.
- **Recommendation 4:** Recommend that suitable funding be afforded to behavioral health care providers attempting to adopt electronic health records and associated health information technology.

Substance Exposed Infants

- **Recommendation 1:** Inform and educate mothers, collateral influences, and the general community about the risk of substance use pre and post-pregnancy.
- **Recommendation 2:** Work collaboratively with the Illinois Department of Human Services Division of Alcoholism and Substance Abuse to include fetal alcohol spectrum disorder ("FASD") screening services for pregnant women.
- **Recommendation 3:** Increase statewide training opportunities for professionals in the substance use disorder field.

Medication Assisted Treatment

- **Recommendation 1:** Educate prescribers about reducing overprescribing for women through a multi-system approach.
- **Recommendation 2:** Increase funding for medication-assisted treatment due to rising use of opiates by women aged 20-26 in Illinois border counties.
- **Recommendation 3:** Recognize limitations of medication-assisted treatment for pregnant women (e.g., suboxone is not indicated for pregnancy).

Overview

In 2012, alcohol and substance abuse disorders continue to affect Illinois women and their families. Therefore, the Illinois Advisory Council on Alcoholism and Other Drug Abuse's Committee on Women's Alcohol and Substance Abuse Treatment ("Women's Committee") remains committed to accurately understanding, reflecting, and supporting the diverse lived experiences of women with alcohol and substance abuse disorders.

The Women's Committee and its workgroups continue to devote time and resources to the successful establishment and implementation of gender-specific strategies aimed at improving the quality of care for women with alcohol and substance abuse disorders.

The Illinois Department of Human Services/Division of Alcoholism and Substance Abuse ("DASA") and the Women's Committee continually strive to accomplish DASA's mission that a comprehensive and coordinated strategy be developed through the leadership of a state agency and implemented through the facilities of federal and local government and community based organizations to empower individuals and communities through local prevention efforts and to provide intervention, treatment, rehabilitation and other services to those who misuse alcohol or other drugs (and, when appropriate, the families of those persons) to lead healthy and drug-free lives and become productive citizens in the community.

The 2014-2016 Women's Plan seeks to accurately and clearly reflect the lived experiences of women with mental health and substance abuse disorders. The goal of women's treatment services is to empower women and their families to seek appropriate treatment for addiction and mental illness and to support women in continuing healthy lifestyles through adequate aftercare following inpatient or similar treatment. Effective treatment spans the continuum of care and sensitively reflects the varied health needs of women.

This plan was written collaboratively by women of diverse disciplines, but who together remain committed to the mission of the Women's Committee and to the authentic reflection of women's mental health and substance use disorder needs in the treatment services made available to them. We eagerly look forward to the increased understanding of the female experience by treatment providers across the nation.

Renée Popovits, Interim Chair
Women's Committee

Women's Lived Experiences Introduction: The Relevance of Consumer Input in Substance Use Disorders

Barbara J. Brooks, "BJ", Administrator

The Women's Committee has found that many providers in the arena of alcohol and substance use disorder ("SUD") services are overlooking the potential benefits that can be learned and the benefit gained from direct consumers' lived experiences woven into the fabric of service delivery design. The potential for program innovation can provide in-depth answers to effective person-centered outcomes for women when lived experiences of these women are considered and included in developing effective services for women in treatment and recovery.

First, it has been clearly recognized that successful treatment best meets consumers' needs when the information digs deeply into a consumer's desires. Discovering what those needs are is not always identifiable through traditional screening, assessment or even American Society for Addiction Medicine ("ASAM") diagnostic placement criteria. "*Lived Experience"* input offers the opportunity to *listen* to consumer comments on a real-time continual basis and use this information as a "locus" of programming for gender-based services.

The Women's Committee in this planning period will diligently seek to and utilize the rich, insightful input of women who have gone through treatment, are in recovery and have gained a wealth of "Lived Experiences" that will richly inform the field regarding the policies and practices that have been recommended.

One of the primary goals of this endeavor is to insure that members of the Committee are actively listening to and open to capturing the voice of women's history in substance involvement, mental health concerns, trauma and other life situations that may have created challenges and barriers to continuity of care as well as obtaining and/or continuing in their post-treatment and recovery.

Focus groups and satisfaction surveys to women in treatment and recovery will be one primary method of obtaining this valuable information. Asking will offer valuable authentic knowledge concerning women and their unique experiences both in an anonymous and voluntary manner.

As part of the Committee's ongoing effort to meet the needs of a culturally diverse audience of women for their "Lived Experiences" care will be taken to honor their personal particular worldview, and confidentiality.

The focus groups and satisfaction surveys that will be administered will focus on communication spanning all or most of the aspects listed in the Women's Plan. The committee acknowledges that women's "Lived Experience" will strengthen the overall content of recommendations made in the Women's Plan.

Obtaining direct information from women consumers will offer the incredible ability to generalize findings to clinical substance abuse programming, a straightforward and honest nature for engagement of women in treatment, on-going consistent retention and genuine continuity of care that will assure positive outcomes. Proper non-threatening screening questions and effective instrument validation through lived experience feedback in a gender-specific substance abuse treatment population will be reality based when developed through the lens of these women and their shared experiences regardless

of race, ethnicity or culture. The Women' Committee recognizes that the "Lived Experience" of women consumers is fundamental to the implementation of best possible practices specific for women in substance abuse treatment.

There continues to be a strong need to improve treatment programs and gender competencies for women in all modalities of treatment services. This "Lived Experience" is intended to be integrated into addiction education, credentialing and ongoing training of staff working with women and girls. Implementing this knowledge and training staff to really be gender-responsive is necessary to assure women's positive health outcomes.

A report to Congress issued in 2000_1 indicated that the National Institute of Health (NIH) has made progress in the inclusion of women. The National Institute of Mental Health (NIMH), The National Institute on Drug Abuse ("NIDA"), and the National Institute of Alcohol and Alcoholism ("NIAAA") currently support research focused on specific risk factors, resiliency factors, prevalence, symptomatology, interventions, adverse effects of medication, and ongoing recovery needs of women and girls. Now, the Women's Committee will listen, hear and learn from the "Lived Experiences" of women.

Client Profile

Females by Modality in SFY2011				
	Served in SFY11		Opened in SFY11	
	Services	Individuals	Services	Individuals
Assessments	168	168	166	166
Level I (outpatient)	16,602	13,832	12,371	10,535
Level II (intensive outpatient)	6,245	5,313	4,893	4,213
Level III (residential rehabilitation)	8,294	5,173	7,303	4,609
Detoxification	6,781	4,225	6,611	4,137
Halfway House	413	357	333	286
Recovery Home	546	518	409	388
Intervention	1,693	1,624	1,576	1,510
Case Coordination(TASC)	2,132	2,109	1,363	1,358
Missing -prior to setting code screen	3,109	2,868	0	0
Missing	2,030	1,853	1,991	1,816
Total	48,013	38,040	37,016	29,018

Tables for Race, Race/Ethnicity, Females
Ethnicity

	Served in SFY11		Opened in SFY11	
Race	Services	Individuals	Services	Individuals
American Indian	218	158	171	114
Alaska Native	19	17	14	12
Asian	115	91	94	72
Nat. Hawaiian/Pacific Islander	57	37	36	25
Black/African American	17,630	9,358	13,529	6,919
White	27,328	15,114	21,054	11,523
Other Single Race	2,646	1,633	2,118	1,288
	48,013	26,408	37,016	19,953

	Served in SFY11		Opened in SFY11	
Race/Ethnicity	Services	Individuals	Services	Individuals
American Indian	200	144	158	104
Alaska Native	17	16	12	11

	Served in SFY11		Opened in SFY11	
Race/Ethnicity	**Services**	**Individuals**	**Services**	**Individuals**
Asian	112	89	91	70
Nat. Hawaiian/Pacific Islander	43	28	27	19
Black/African American	17,229	9,176	13,220	6,786
White	25,334	13,894	19,544	10,565
Other Single Race	761	488	597	370
Hispanics	4,317	2,773	3,367	2,140
	48,013	26,608	37,016	20,065

	Served in SFY11		Opened in SFY11	
Ethnicity	**Services**	**Individuals**	**Services**	**Individuals**
Puerto Rican	845	542	637	408
Mexican	1746	1142	1363	876
Cuban	73	59	61	48
Other Specific Hispanics	1083	714	849	547
Not of Hispanic Origin	43696	23516	33649	17788
Hispanic Origin not Specified	570	449	457	359
Total	48,013	26,422	37,016	20,026

Females				Pregnant			
Served in SFY11		Opened in SFY11		Served in SFY11		Opened in SFY11	
Services	Individuals	Services	Individuals	Services	Individuals	Services	Individuals
4,707	2,456	3,620	1,907	57	41	41	30
8,239	4,769	6,480	3,723	626	395	477	289
24,515	13,111	18,786	9,709	1,070	661	670	388
10,403	5,847	8,012	4,291	21	15	16	11
149	111	118	86	2	1	2	1
48,013	**26,294**	**37,016**	**19,716**	**1,776**	**1,113**	**1,206**	**719**

Females by Discharge Reason in SFY2011

	Served in SFY11		Opened in SFY11	
Transfer/ Discharge Reason	**Services**	**Individuals**	**Services**	**Individuals**
Assessment - No Diagnosis	948	928	944	924
Completion of Services	14,382	9,402	11,240	7,119
Left Against Staff Advice	9,605	6,458	7,859	5,197
Terminated by Facility	3,808	2,939	2,763	2,080
Incarcerated	437	329	271	201
Deceased	33	30	10	8
External Transfer - Non-Completion	1,345	1,068	1,034	809
External Transfer - Completion	4,922	3,950	4,768	3,830
Internal Transfer - Completion	326	174	217	104
Internal Transfer - Non-Completion	49	43	36	31
DASA - Administrative Closing	12,158	8,931	7,874	5,464
Total	**48,013**	**34,252**	**37,016**	**25,767**

Females - Chicago Community Area

	Served in SFY11		Opened in SFY11	
Client Community Area	Services	Individuals	Services	Individuals
Rogers Park	262	196	201	142
West Ridge	109	92	85	69
Uptown	323	256	192	136
Lincoln Square	73	49	46	33
North Center	55	44	32	24
Lake View	78	59	51	34
Lincoln Park	45	31	35	23
Near North Side	200	136	147	93
Edison Park	14	12	12	10
Norwood Park	34	27	21	15
Jefferson Park	91	63	69	43
Forest Glen	23	18	19	14
North Park	18	15	14	11
Albany Park	156	119	108	78
Portage Park	184	98	159	82
Irving Park	156	104	115	76
Dunning	70	47	51	31
Montclare	41	30	31	21
Belmont Cragin	224	159	178	122
Hermosa	131	80	107	62
Avondale	112	75	84	53
Logan Square	262	175	203	125
Humboldt Park	1,095	674	779	430
West Town	223	153	165	105
Austin	1,767	1,065	1,390	785
West Garfield Park	480	290	357	200
East Garfield Park	448	287	328	200
Near West Side	1,581	919	1,349	745
North Lawndale	600	356	437	240
South Lawndale	206	143	153	100
Lower West Side	115	72	88	49
Loop	28	22	22	16
Near South Side	82	74	49	43
Armour Square	44	32	35	26
Douglas	90	76	54	44
Oakland	47	33	36	23
Fuller Park	50	31	36	21
Grand Boulevard	227	148	159	94

	Served in SFY11		Opened in SFY11	
Client Community Area	Services	Individuals	Services	Individuals
Kenwood	80	56	57	35
Washington Park	167	112	117	66
Hyde Park	53	36	42	27
Woodlawn	264	198	207	150
South Shore	349	234	260	164
Chatham	287	176	233	135
Avalon Park	192	164	154	130
South Chicago	171	114	129	79
Burnside	43	40	19	16
Calumet Heights	44	32	35	26
Roseland	354	235	257	167
Pullman	60	31	47	24
South Deering	69	53	50	35
East Side	42	20	30	13
West Pullman	187	122	145	93
Riverdale	46	34	31	25
Hegewisch	16	9	10	6
Garfield Ridge	52	39	36	25
Archer Heights	14	10	10	8
Brighton Park	79	50	57	34
McKinley Park	35	26	30	21
Bridgeport	29	25	22	19
New City	262	156	209	116
West Elsdon	11	10	10	9
Gage Park	41	31	30	21
Clearing	38	21	31	16
West Lawn	42	26	36	22
Chicago Lawn	278	155	239	125
West Englewood	466	291	383	231
Englewood	395	262	310	195
Greater Grand Crossing	297	184	247	149
Ashburn	89	60	67	38
Auburn Gresham	301	203	233	152
Beverly	43	26	36	20
Washington Heights	84	66	57	45
Mount Greenwood	23	14	20	12
Morgan Park	49	36	40	28

	Served in SFY11		Opened in SFY11	
Client Community Area	Services	Individuals	Services	Individuals
O'Hare	11	8	6	3
Edgewater	371	235	308	194
Unknown	1,360	967	1,241	859
Total	**16,538**	**10,827**	**12,878**	**7,951**

Females - Suburbs

	Served in SFY11		Opened in SFY11	
	Services	Individuals	Services	Individuals
Barrington	24	23	21	20
Berwyn	116	85	93	68
Bloom	235	149	202	120
Bremen	297	167	267	147
Calumet	55	42	41	29
Cicero	224	131	161	87
Elk Grove	99	69	83	54
Evanston	97	76	69	49
Hanover	132	93	99	71
Lemont	21	13	21	13
Leyden	188	129	131	88
Lyons	202	133	147	101
Maine	153	110	112	75
New Trier	13	12	8	7
Niles	149	121	115	92
Northfield	50	35	35	29
Norwood Park	47	35	40	29
Oak Park	80	47	64	34
Orland	80	33	69	28
Palatine	74	59	57	46
Palos	97	67	76	49
Proviso	504	315	367	219
Rich	106	68	83	49
River Forest	51	46	38	33
Riverside	32	22	25	15
Schaumburg	119	87	96	67
Stickney	69	56	57	46
Thornton	550	334	450	257
Wheeling	270	217	184	141
Worth	239	154	195	117
Unknown	243	219	194	175
Total	**4,616**	**3,147**	**3,600**	**2,355**

Females by Client County in SFY2011

	Served in SFY11		Opened in SFY11	
Client County	Services	Individuals	Services	Individuals
Adams	414	229	277	143
Alexander	59	44	41	28
Bond	72	58	42	34
Boone	136	79	114	67
Brown	18	16	13	13
Bureau	96	59	81	51
Calhoun	12	7	11	7
Carroll	76	48	56	35
Cass	60	41	49	35
Champaign	630	369	479	279
Christian	114	69	94	53
Clark	63	43	47	34
Clay	64	50	41	35
Clinton	74	63	58	49
Coles	523	245	361	183
Cook (Sub)	4,616	2,936	3,600	2,187
Crawford	93	74	72	57
Cumberland	29	22	21	15
DeKalb	291	229	217	167
DeWitt	46	38	32	27
Douglass	21	17	14	11
Du Page	810	481	644	380
Edgar	90	53	62	38
Edwards	28	16	21	11
Effingham	128	81	107	64
Fayette	89	64	62	42
Ford	61	42	46	28
Franklin	282	170	236	141
Fulton	142	84	118	71
Gallatin	33	23	26	16
Greene	44	30	29	20
Grundy	179	105	146	88
Hamilton	30	20	18	13
Hancock	48	39	33	30
Hardin	21	14	10	6
Henderson	23	15	20	13
Henry	177	121	137	94

	Served in SFY11		Opened in SFY11	
Client County	Services	Individuals	Services	Individuals
Iroquois	149	73	128	59
Jackson	268	138	235	115
Jasper	63	46	46	31
Jefferson	235	139	199	122
Jersey	95	68	77	53
Jo Davies	46	35	35	26
Johnson	54	34	44	27
Kane	1,149	754	876	565
Kankakee	453	274	328	189
Kendall	135	98	106	74
Knox	268	168	204	131
Lake	1,753	1,129	1,475	943
LaSalle	495	297	446	268
Lawrence	104	76	79	58
Lee	209	128	165	101
Livingston	226	119	188	98
Logan	140	77	98	61
Macon	725	439	522	317
Macoupin	108	85	73	58
Madison	1,821	764	1,013	535
Marion	252	182	195	139
Marshall	40	19	31	16
Mason	89	52	67	33
Massac	107	69	82	47
McDonough	60	50	48	39
McHenry	706	415	553	313
McLean	976	403	783	316
Menard	19	10	19	10
Mercer	34	27	29	24
Monroe	55	42	47	35
Montgomery	95	78	68	58
Morgan	165	114	105	79
Moultrie	75	29	68	23
Ogle	187	133	140	102
Peoria	1,118	543	880	419
Perry	95	64	65	41
Piatt	105	83	86	68
Pike	69	51	61	44
Pope	16	12	13	9

	Served in SFY11		Opened in SFY11	
Client County	Services	Individuals	Services	Individuals
Pulaski	34	28	28	23
Putnam	17	9	13	7
Randolph	128	75	103	60
Richland	131	89	106	71
Rock Island	716	391	570	310
Saline	172	111	154	96
Sangamon	859	499	644	363
Schuyler	27	21	19	14
Scott	13	10	13	10
Shelby	86	58	69	47
Stark	14	12	12	10
St. Clair	988	480	734	377
Stephenson	278	197	172	122
Tazewell	717	372	575	294
Union	74	56	62	48
Vermilion	490	296	383	236
Wabash	90	76	67	56
Warren	59	37	49	32
Washington	41	17	37	13
Wayne	108	62	86	49
White	88	45	65	32
Whiteside	282	183	207	136
Will	1,286	672	1,079	548
Williamson	451	273	354	209
Winnebago	1,596	857	1,195	654
Woodford	72	44	57	33
Out of State	133	111	110	94
Unknown	74	51	63	41
Chicago	16,538	8,543	12,878	6,288
Total	**48,013**	**27,086**	**37,016**	**20,484**

Changes in Illinois Women's Substance Abuse Patterns from 2000-2010

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According to the data from the Treatment Episode Data Set ("TEDS") for admissions to substance abuse treatment from 2000 to 2010, the following trends were identified for women in the State of Illinois:

- The largest age bracket for women receiving services continues to be age 25 and up. However, during the past 10 years there has been a 39% increase in the number of females in the 18-24 age bracket receiving treatment -- with a 5-6% decrease in other age brackets.
- In 2000, African American women accounted for 51% of women receiving treatment services. However in 2010, Caucasian women represented 56% of women in treatment.
- Between 2000 and 2010, there has been a:
    - 52% increase in the number of Hispanic women receiving treatment services
    - 37% increase in the number of Caucasian women receiving treatment services
    - 25% decrease in the number of African American women receiving treatment services
- The primary drugs used by women were:

2000	2010
1. Alcohol	1. Alcohol
2. Cocaine	2. Opiates
3. Marijuana	3. Marijuana
4. Opiates	4. Cocaine
5. Other Stimulants	5. Methamphetamine/Psychotropic (tied)

- In 2010, there was an increase in use of the following drugs among women:
    1. Marijuana (20%)
    2. Opioids (50%)
    3. Methamphetamine (300%)
    4. Psychotropic (252%)
- In 2010, there was a decrease in the use of the following drugs among women:
    1. Alcohol (9%)
    2. Cocaine (26%)
    3. Stimulants other than methamphetamine (36%)
- In 2000, women represented 33.2% of substance abuse treatment; whereas, in 2010, they represented 35.1%.
- The number of pregnant women entering treatment has dropped from 5% to 3%.
- Between 2000 and 2010, the number of prior treatment episodes has increased. In 2000, 53% of women stated they had not received any prior treatment. In 2010, only 36% of women reported no prior treatment. The percentage of women reporting 5+ prior treatment episodes increased from 3% to 7%.[1]

According to an article published in the Scientific American in October 2012, the following national trends were identified regarding drug overdose:

[1] TEDS Data, 2000-2010.

- According to the most recent analysis of overdose deaths in the U.S., more than 40% involved prescription narcotics.
- According to the Centers for Disease Control ("CDC"), sale of painkillers, including oxycodone, hydrocodone and methadone, have increased by 300% between 1998 and 2008.
- A 2008 study profiling West Virginia, published in the Journal of the American Medical Association, yielded the following results:
    - 56% of 275 people who overdosed on prescription narcotics had not been prescribed the medication that killed them
    - 21% of those 275 people had received prescriptions for narcotics from 5 or more doctors in the year before they died
    - Nearly 80% of those who died were on a medley of drugs that usually included benzodiazepines and had sometimes consumed alcohol as well
- Legal narcotics now kill more people every year than heroin and cocaine combined.
- Poisoning is the leading cause of death from injuries in the U.S., surpassing car crashes
    - Nearly 9 out of 10 fatal poisonings are caused by medicinal or recreational drugs.[2]

[2] Deborah Franklin, SCIENTIFIC AMERICAN, *Drug Detectives: Physicians struggle to curb the growing number of lethal overdoses* (Oct. 2012).

Today's Climate

The most recent National Survey on Drug Use and Health indicates that in today's climate, an estimated 58.1 percent of young adult females ages 18 to 25 reported current drinking in 2011. Among pregnant women ages 15 to 44, an estimated 9.4 percent reported current alcohol use, 2.6 percent reported binge drinking, and 0.4 percent reported heavy drinking in 2011. The rate of current illicit drug use among women ages 12 or older was 6.5 percent in 2011, while the rate of current illicit drug use among women ages 12 to 17 was 9.3 percent. The rate of substance dependence or abuse for females ages 12 or order was 5.7 percent in 2011, which did not differ from the rate in 2010. Among female youths ages 12 to 17, the rate of substance dependence or abuse was 6.9 percent in 2011.[3]

The national economy experienced one of the longest economic downturns since the Great Depression beginning in December 2007. While the National Bureau of Economic Research scored the recession as ending in June 2009, the effects of the recession continue to be felt five years later. In response to the recession, lawmakers enacted the American Recovery and Reinvestment Act ("ARRA") in 2009. While the Congressional Budget Office ("CBO") and the staff of the Joint Committee on Taxation estimated the ARRA would increase budget deficits by $787 billion between fiscal years 2009 and 2019, CBO now estimates that the total impact over the ten year period will amount to about $831 billion.[4] A report released in June 2012 indicated that Illinois' budget deficit was the worst in the nation. Illinois Auditor General William Holland reports that the state's budget deficit has more than doubled over the last five years and currently stands at $43.8 billion as of 2011.[5]

Consequently, the addiction treatment field has and will continue to experience significant reductions in state funding for both treatment generally and treatment for women. The Fiscal Year ("FY") 2013 proposed budget represents a modest $2.0M general revenue fund decrease from FY 12 Agency estimated expenditures. However, many valuable programs are being reduced in the Governor's proposed budget, including the Child Card budget, Temporary Assistance for Needy Families ("TANF") benefits, general revenue for community youth services, addiction prevention, and general revenue funds.[6]

Moreover, under the proposed budget for FY 2013, DASA is charged with implementing utilization management and quality review measures for Medicaid services to assure the most efficient and clinically effective use of scarce resources. Such efforts are expected to yield savings of $5 million. Additionally, the state funded portion of the Addiction Prevention services were eliminated in the FY 2013 budget which will result in approximately 33,500 school aged youth and adults losing access to evidence-based substance abuse prevention services. Reductions are also noted in Healthy Families

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[3] SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION OFFICE OF APPLIED STUDIES, *Results from the 2011 National Survey on Drug Use and Health: National Findings,* HHS Publication No. SMA 09-4434 (2012).

[4] CONGRESSIONAL BUDGET OFFICE, *Estimated Impact of the American Recovery and Reinvestment Act on Employment and Economic Output from January 2012 through March 2012* (May 2012), *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/05-25-Impact_of_ARRA.pdf.

[5] BLOOMBERG BUSINESSWEEK, *Auditor: Total Illinois deficient nears $44 billion* (June 21, 2012), http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=12&ved=0CCUQFjABOAo&url=http%3A%2F%2Fwww.businessweek.com%2Fap%2F2012-06-21%2Fauditor-total-illinois-deficit-nears-44-billion&ei=No6FUJ88j4TxBLaUgYAK&usg=AFQjCNG3tz6lMGpmrdUBJNlZqWLDctusyQ&sig2=qPJaZppyROnCoU3Mjx1hPA.

[6] ILLINOIS DEPARTMENT OF HUMAN SERVICES, *Budget Request FY2013 Agency Budget Briefing* (Feb. 22, 2012).

grants, Youth Programs (Teen Reach), Domestic Violence Shelters and Community Services, many of which provide necessary services to women with addiction and their families.[7]

Key Trends

The addiction treatment system has experienced considerable hurdles over the past few years, however it has persevered despite these hardships and continues to evolve in order to better meet the needs of the women it serves. It is our hope that in the years to come, legislation, regulation and policy will come to better understand and recognize the experiences and therefore, the needs, of women with addiction.

Below is a summary of the legal and policy trends impacting women in treatment. At least in the near future, it is our thought that these trends will continue to remain on our radar and in the public spotlight for some time. In light of the state of the economy, rising unemployment, increasing budget cuts and changes to health care under the Affordable Care Act ("ACA"), these areas of law and policy will change as treatment providers, state agencies and other professional associations continue to advocate on behalf of all women.

State of Healthcare in the United States

On March 23, 2010, President Obama signed the Affordable Care Act ("ACA") into law, putting in place comprehensive reforms that seek to improve access to affordable health coverage and protect consumers from abusive insurance company practices. Provisions included in the ACA are intended to expand access to insurance, increase consumer protections, emphasize prevention and wellness, improve quality and system performance, expand the healthcare workforce, and curb rising healthcare costs.[8]

Specifically, the ACA aims to extend health insurance coverage to about 32 million uninsured Americans by expanding both private and public insurance. For example, the Act requires employers to cover their workers or face a penalty and also includes a mandate that individuals have insurance. Additionally, the Act expands Medicaid to cover individuals with incomes below 133% of the federal poverty level.[9]

The ACA also enacted a variety of insurance reforms that do the following: prohibit lifetime monetary caps on insurance coverage and limit the use of annual caps; prohibit insurance plans from excluding coverage for children with preexisting conditions; prohibit insurance plans from cancelling or rescinding coverage, except in cases of fraud; and establish state-based rate reviews for "unreasonable" insurance premium increases.[10]

While many of the provisions of the ACA have the potential to improve health care delivery and access to care, it remains unclear what visible effects the ACA will have on the industry both in the immediate future and long-term.

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[7] *Id.*
[8] National Conference of State Legislatures, *States Implement Health Reform* (March 2011), *available at* http://www.ncsl.org/portals/1/documents/health/hraca.pdf.
[9] THE COMMONWEALTH FUND, *Realizing Health Reform's Potential*, at 2 (Jan. 2011).
[10] National Conference of State Legislatures, *State Roles in Health Reform Provisions Related to Insurance* (Oct. 2011), http://www.ncsl.org/issues-research/health/state-roles-in-health-reform-provisions-related-to.aspx.

Essential Health Benefits

Section 1302(b) of the ACA requires the Secretary of Health and Human Services to define what are called essential health benefits ("EHBs"). Non-grandfathered plans in the individual and small group markets both inside and outside of the Health Benefit Exchanges, Medicaid benchmark and benchmark-equivalent plans, and Basic Health Programs must cover EHBs beginning in 2014. The ACA requires that EHBs includes items and services within the following 10 benefit categories: 1) ambulatory patient services, 2) emergency services, 3) hospitalization, 4) maternity and newborn care, 5) mental health and substance use disorder services, including behavioral health treatment, 6) prescription drugs, 7) rehabilitative and habilitative services and devices, 8) laboratory services, 9) preventive and wellness services and chronic disease management, and 10) pediatric services, including oral and vision care. Included in these benefit categories is maternity and newborn care, as well as mental health and substances use disorders. The inclusion of both categories of care represents an important recognition on the part of the U.S. Department of Health and Human Services ("HHS") of the critical health needs of women with addiction and their families.

A bulletin issued by the Center for Consumer Information and Insurance Oversight ("CCIIO") on December 16, 2011 outlined its intent to allow states to select a benchmark plan as among specified existing health plans as the standard for plans required to offer EHBs in the state. The EHB-benchmark plan must offer coverage in each of the 10 statutory benefit categories.

On September 28, 2012, Illinois officials approved the Blue Cross and Blue Shield of Illinois BlueAdvantage Plan ("Plan") as the benchmark plan for EHBs in the state of Illinois. The Plan covers the following mental illness treatment and substance abuse rehabilitation treatment: 30 inpatient hospital days per calendar year and 30 outpatient visits per calendar year combined annual maximum and 100 outpatient visits per lifetime maximum. The Plan also requires that the policyholder notify the Blue Cross and Blue Shield Mental Health Unit for all care related to mental health and substance abuse. The Plan has been submitted to HHS and HHS is expected to take public comment on the Plan recommendation. It is therefore imperative that we fervently advocate for the proper inclusion of items and services within the EHB package that adequately address the needs of women in treatment.

Outcome Measures and Performance Based Contracting

The Center for Substance Abuse Treatment continues to work with state agencies and substance abuse treatment providers to improve the use of outcome measures and performance based contracting in an effort to ensure patients are receiving high quality, cost-effective substance abuse treatment.

DASA is in its fourth year of performance based contracting ("PBC") implementation. In implementing PBC, DASA has adopted the National Outcome Measures framework, which dictates how the Department identifies and measures performance and outcomes. The Department also uses its Automated Reporting and Tracking System ("DARTS"), a legacy service billings database, to manage both performance and payments.[11]

[11] ILLINOIS DEPARTMENT OF HUMAN SERVICES, *Performance-Based Contracting Implementation Plan* (2011), *available at* http://www2.illinois.gov/gov/budget/Documents/Budgeting%20for%20Results/Related%20Documents/IDHS%20Performance%20Based%20Contracting%20Implementation%20Plan.pdf.

The Division of Mental Health ("DMH") has similarly taken steps to implement performance based contracting and outcome measures. DMH, together with the Substance Abuse and Mental Health Services Administration ("SAMHSA") Center for Mental Health Services ("CMHS") and other states, has worked to define and report National Outcome Measures. Specifically, DMH employs an enterprise level web-based system which it uses to capture demographic, clinical, and claims information which serves as the basis for monitoring service delivery and will hopefully aid in adoption of performance based contracting, as that initiative moves forward.[12]

Implementing an outcome and performance measurement system also remains a top policy priority of the National Association of State Alcohol and Drug Abuse Directors ("NASADAD"). NASADAD supports the implementation of national outcome measures to improve substance abuse treatment services and is committed to working with SAMHSA to ensure that states effectively capture and utilize data to improve outcomes.

Finally, the Illinois Department of Human Services appreciates the importance of measurement and performance based contracting. With the advent of the "Budgeting for Results" Commission, Illinois has been focused on the use of measurement and performance based contracting to ensure transparency and accountability in public services. In September 2011, IDHS prepared a Performance Based Contracting Implementation Plan in furtherance of the "Budgeting for Results" process. The Plan outlines the future of performance based contracting in Illinois, with the goal of requiring the incorporation of performance measures in every state contract by fiscal year 2013.[13]

These efforts play a fundamental role in ensuring that the treatment women receive for mental health and substance use disorders is continually assessed for appropriateness and effectiveness, leading to improved treatment outcomes for these women.

Continuity of Care

Continuity of care refers to coordination of care as clients move across different service systems. Since both mental health and substance use disorders are typically chronic disorders affecting patients in the long-term, continuity of care is critical.

For this reason, treatment for substance use disorders should not stop following intensive, inpatient, or residential care. Particularly for women with families and dependent children, it is important that treatment for substance use disorders involves aftercare or continuing care following discharge from formal treatment. Adequate support services can help to ensure that women do not have to re-enter treatment and that they can remain on the recovery track. Given the likelihood of relapse, it is imperative that substance use disorder treatment promotes continuing care.

Ideally, transitions between levels of care for treatment of mental health and substance use disorders should be based on clear criteria such as those contained in ASAM's PPC-2R. Satisfactory level of care transitions can be achieved only through an integrated, client-driven, community-based system of care. Such a system necessitates a thorough understanding of the female client.

[12] *Id.*
[13] *Id.*

Standards for Women's Treatment

As a component of the National Association of State Alcohol and Drug Abuse Directors ("NASADAD") and the National Treatment Network ("NTN"), the Women's Services Network functions in collaboration with the National Prevention Network (NPN), focusing on women's treatment and prevention issues while remaining dedicated to the NTN's overall goal of effective, socially responsive treatment delivery for all populations. In 2008, NASADAD together with Women's Services Network ("WSN") and support from SAMHSA's Center for Substance Abuse Treatment ("CSAT") released "Guidance to States: Treatment Standards for Women," which recommended that treatment providers furnish a range of clinical treatment and support services to women and children, as well as community support services to families that cut across the continuum of care. The treatment standards also addressed more general administrative issues such as staffing, outcomes and monitoring and recommended primary treatment services such as screening and assessment.

These standards specifically describe what is meant by gender-specific treatment, encouraging the practice of defining this category of services. However, it is important that these standards are regularly evaluated and updated. Providing states with tangible guidelines with respect to the treatment of women with addiction is crucial to ensuring that women everywhere in the U.S. are afforded the gender-specific treatment they require.

Mental Health

Mental health treatment has evolved considerably over the years. The provision and coordination of mental health services is becoming more commonplace in the assessment of women presenting for addiction treatment. According to a report published by the Journal of the American Medical Association, 37% of alcohol abusers and 53% of drug abusers also have at least one serious mental illness. Of all people diagnosed as mentally ill, 29% abuse either alcohol or drugs. [14]

The integrated dual diagnosis approach recognizes the co-occurrence of substance use and mental health disorders and attempts to provide treatment to individuals that addresses these related health needs. The dual diagnosis approach includes the following:

- Individualized treatment, based on a person's current stage of recovery
- Education about the illness
- Case management
- Help with housing
- Money management
- Relationships and social support
- Counseling designed especially for people with co-occurring disorders, which encompasses individual, group and/or family treatment counseling.

[14] NATIONAL ALLIANCE ON MENTAL ILLNESS, *Dual Diagnosis and Integrated Treatment of Mental Illness and Substance Abuse Disorder* (Sept. 2003), *available at* http://www.nami.org/Template.cfm?Section=By_Illness&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=54&ContentID=23049.

Thanks to the dedicated work of various mental health agencies and organizations, states are adopting dual diagnosis services that ensure women's co-occurring mental health and substance use disorder needs are met in a logically integrated way.

Trauma/Violence

It is essential that providers of substance abuse treatment for women understand the intersection of violence, trauma, mental health and substance abuse. Studies show that women with histories of trauma are at a much higher risk for co-occurring disorders.[15]

SAMHSA's National Center for Trauma-Informed Care works to build awareness of trauma-informed care and promotes the implementation of trauma-informed practices in mental health and substance abuse programs and services.

The U.S. Department of Health and Human Services ("HHS") in partnership with provider organizations across the country, such as Witness Justice, recently unveiled recommendations for treating women with histories of trauma and co-occurring mental health and substance use disorders. HHS alleges that survivors of violence have complex and varied health needs and often encounter roadblocks to the comprehensive medical treatment they require or are provided treatment that only partially addresses their needs. HHS's recommendations are outlined in the Women, Co-occurring Disorders and Violence Study, which suggests that women with a history of trauma and co-occurring disorders would benefit significantly from more holistic, integrated counseling.

Given the alarming rate at which American women fall victim to violence, such violence must be appropriately addressed in treatment for often related mental health and substance abuse disorders.

Parity

One of the biggest barriers to treatment in behavioral health is access. Access is in large part a function of insurance coverage. For years, many insurance companies failed to provide coverage for mental health and substance use disorder services under the same terms and conditions as they provided medical and surgical benefits. Due to recent changes in both federal and state law, parity is now required with respect to mental health and substance use disorder treatment.

Parity generally refers to the concept that insurers must offer the same coverage for mental health and substance use disorder treatment as they do for general medical and surgical treatment. The most significant federal Parity law is The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) and its interpretive regulations. Under MHPAEA, as of July 2012, plans sponsored by employers with 51 or more employees that cover both mental health/substance use disorder treatment and medical/surgical treatment, must not impose financial requirements (e.g., deductibles, copays, coinsurance, or out-of-pocket maximums) or treatment limitations (e.g., day or visit limits or medical management standards) on mental health/substance use disorder benefits that are more restrictive than financial requirements or treatment limitations imposed on medical/surgical benefits.

[15] WITNESS JUSTICE, *Women, Trauma, Mental Health and Substance Abuse* (Nov. 15, 2011), http://www.witnessjustice.org/health/women.cfm.

At the state level, the Illinois Parity Law goes one step further than MHPAEA. Under the law, effective August 18, 2011, plans sponsored by employers with 51 or more employees are required to provide the following coverage for treatment of substance use disorders: 45 days of inpatient treatment per calendar year, and 60 visits for outpatient treatment per calendar year (which includes both group and individual treatment). Moreover, the law defined inpatient treatment for substance use disorders to include treatment in a licensed residential treatment center. Finally, the law required that plans make medical necessity determinations in accordance with ASAM patient placement criteria.

Electronic Health Records

Electronic health records ("EHRs") are now mandated under the ACA. Beginning in 2012, hospitals and doctors will be subject to financial penalties if they are not using EHRs.

Summarily, the ACA institutes a series of changes to standardize billing and requires health plans to begin adopting and implementing rules for the secure, confidential, electronic exchange of health information. The hope is that using EHRs will reduce paperwork and administrative burdens, cut costs, reduce medical errors and most importantly, improve the quality of care.

In July 2010, the HHS issued rules that reward doctors and hospitals for the meaningful use of EHRs. Doctors will have to meet 15 specific requirements, plus 5 chosen from a list of 10 objectives. Hospitals will have to meet 14 requirements, plus 5 chosen from a menu of 10 goals. Doctors, for example, will have to use electronic systems to record patients' demographic data (sex, race, date of birth); their height, weight and blood pressure; their medications; and their smoking behavior. To meet the new standards, doctors will also have to transmit 40 percent of prescriptions electronically.[16]

These requirements under the ACA, however, pose cause for concern with regard to the security and privacy of protected health information transmitted within EHRs. Although the Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") governs access and sharing of standard health information, it does not sufficiently protect behavioral health information. The records of all individuals receiving substance abuse treatment through federally funded programs, however, are governed by additional regulations at 42 C.F.R. Part 2. These regulations do not allow the exchange of information under most circumstances without an individual's consent. However, EHRs present unique challenges for behavioral healthcare providers that both HIPAA and 42 C.F.R. Part 2 do not contemplate, therefore it is especially important that attention be paid to ensuring the safety and security of sensitive behavioral health information as EHRs become more commonplace.

Medicaid

In 2008, Medicaid provided over 21 million low-income women with basic health and long-term care coverage. This number will increase considerably in 2014 given the expansion of Medicaid will serve as the main vehicle for extending health care coverage to low-income, uninsured persons under the ACA. Moreover, the ACA makes additional changes to Medicaid that will particularly impact women's care.

Before the ACA, a woman qualified for Medicaid only if she met categorical and income criteria.

[16] NY TIMES, *New Rules on Electronic Health Records* (July 14, 2010), http://query.nytimes.com/gst/fullpage.html?res=9500E1DA113AF937A25754C0A9669D8B63.

For example, a woman had to be pregnant, a mother of a dependent child, or have a disability. Each category also has different income eligibility criteria. Since women are more likely to fall into one of these categories and are more likely than men to be poor, more women than men qualify for Medicaid. In fact, women comprise over two-thirds of Medicaid enrollees.

Compared to uninsured women, women on Medicaid experience fewer barriers to care and have utilization rates comparable to women with private insurance on several measures. Although women on Medicaid are less likely than uninsured women to face cost barriers, affordability remains a problem for women on Medicaid since many states impose limits on the number of visits or number of prescriptions that Medicaid will cover.

The ACA will bring significant change to Medicaid coverage for women. For example, the ACA will remove categorical requirements for eligibility, such that women without children or women that are not pregnant will be eligible for coverage if their income is below 138% of the federal poverty level. Data estimates as many as 10 million currently uninsured women could qualify for Medicaid by 2014 based on their current income levels.[17]

However, even with the ACA, many fiscal constraints the Medicaid program is currently experiencing will persist, both at the federal and state level. Moreover, because women comprise the majority of Medicaid beneficiaries, cuts to provider payments and limits on benefits and scope of coverage will be especially detrimental to the female population.

Federally Qualified Health Centers ("FQHCs")

Federally Qualified Health Centers ("FQHCs"), established in the 1960's as part of the federal government's "War on Poverty" are becoming a foundation for the provision of medical care to the medically underserved across the nation. HHS funds FQHCs through the Health Resources and Services Administration ("HRSA"). FQHCs have become a national network of more than 1,100 community, migrant, homeless and public housing health center grantees. These organizations provide health care at more than 7,500 clinical sites, ranging from large medical facilities to mobile vans. Funding for FQHCs has been continuously allocated by Congress since their inception in the 1960's.

The passage of the Affordable Care Act ("ACA") in March 2010 resulted in increased federal funding to FQHCs to help them meet the anticipated health care demand of millions of Americans who will gain health care coverage as a result of the health reform law. The ACA set aside $11 billion for community health centers over a period of five years to meet this goal. Additionally, the ACA created an initiative titled the "FQHC Advanced Primary Care Practice Demonstration," designed to evaluate the impact of the advanced primary care practice ("APCP") model, also known as the patient-centered medical home ("PCMH"), on improving health, improving quality of care, and lowering the cost of care provided to Medicare beneficiaries served by FQHCs. The Demonstration will pay an estimated $42 million over three years to 500 FQHCs to coordinate care for almost 200,000 Medicare beneficiaries. The ACA also establishes a Medicare prospective payment system ("PPS") for FQHCs starting October 1, 2014. In the first year of the PPS, aggregate payments under the PPS must equal the estimated payments that would have occurred under the

[17] Henry J. Kaiser Family Foundation, Women's Issue Brief, Medicaid's Role for Women Across the Lifespan: Current Issues and the Impact of the Affordable Care Act (2012), *available at* http://www.kff.org/womenshealth/upload/7213-03.pdf.

current reasonable cost payment system without regard to the productivity target or the per visit upper payment limit. The result will likely be higher total payments on average. The Secretary of HHS is afforded considerable flexibility in designing the Medicare FQHC PPS, including the ability to create a system with differentiation of payment rates by service and intensity.[18]

Federally Qualified Behavioral Health Centers ("FQBHCs")

Although in July 2009, the House Energy and Commerce Committee voted to include an amendment containing the definition of a Federally Qualified Behavioral Health Center ("FQBHC") in the Affordable Health Choices Act, that bill was unsuccessful as the Senate approved instead the Patient Protection and Affordable Care Act ("ACA"). Unfortunately, the ACA does not specifically contemplate FQBHCs.

However, defining FQBHCs remains an important first step toward strengthening the safety net that struggles to meet the significant and growing unmet need for comprehensive healthcare services for persons with mental illness and addiction disorders. Creation of FQBHCs would put mental health and addictions treatment providers on equal footing with the rest of healthcare, paving the way for our nation to make good on its commitment to persons with serious mental illness and addiction disorders, to provide the right care, at the right time, within communities.

Medical Home

There exist several provisions under the ACA directed at the establishment and promotion of the patient-centered medical home ("PCMH"). The PCMH is a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes. Patients treated in a PCMH are provided preventive services, as well as the treatment of acute and chronic illness. Included in the ACA provisions on the subject of PCMH are the following: use of the medical home model for treatment or services under private health plans; requirement of health plans to provide incentives to promote and report on medical home services provided; and establishment of community health teams and a primary care extension program to educate and support primary care practices in the delivery of medical home services.[19]

Medical homes of this kind have great potential to serve women with mental health or substance abuse problems, who frequently go unrecognized and untreated. Women's medical problems are often complicated by other factors, such as substance abuse, psychiatric disorders, or poor social support systems. By implementing a multidisciplinary medical home model for some "high-risk" clients, we can reduce these clients' utilization of hospital resources while most importantly, improving the overall health and recovery outcomes for women and their children. Together, these types of efforts are leading to three fundamental system improvements –healthcare will become better coordinated; prevention, early intervention and disease management services will grow with a

[18] CENTERS FOR MEDICARE & MEDICAID SERVICES,
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice (APCP) Demonstration Frequently Asked Questions (FAQs), *available at* http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/FQHC_APCP_Demo_FAQsOct2011.pdf.
[19] AMERICAN COLLEGE OF PHYSICIANS, *Patient Centered Medical Home (PCMH).*

corresponding decline in secondary and tertiary care; and errors and overuse will be dis-incentivized by replacing fee for service payments with risk and reward financial arrangements.[20]

Peer Based Recovery Services

Peer-based recovery services, or peer recovery support services, are services designed and delivered by people who have experienced both substance abuse disorders and recovery. The SAMHSA Center for Substance Abuse Treatment ("CSAT"), through the Recovery Community Services Program ("RCSP"), funds grant projects to develop and deliver this type of service.

Research demonstrates that social support provided through peer recovery support services facilitates recovery. One of the many benefits of peer recovery support services is its adaptability. Peer leaders are able to provide support services to individuals throughout the continuum of care. Moreover, support services can take various forms and can be provided in a wide range of settings.

Peer recovery support services importantly emphasize individuals' strengths and resiliencies, helping women to focus on their abilities, interests, knowledge, resources, and aspirations. For these reasons alone, peer recovery support services play a critical role in the treatment of substance abuse disorders. Furthermore, recovery support services enable individuals to identify their goals, skills and talents, promoting long-term recovery and helping women to assimilate to their home environments following treatment.[21]

Technology and Treatment

As technology evolves, so does the treatment of addiction. Technology-based treatment, such as web-based support groups and telephonic counseling, provide women with busy schedules and many responsibilities an alternative avenue for seeking treatment. Moreover, technology-assisted treatment increases the ability of substance abuse treatment providers to serve clients who have historically been underserved due to lack of access to treatment in their communities, which can be the result of lack of transportation or an inadequate amount of treatment providers. However, there exists concern within the treatment community that the spirit of treatment may be disturbed if there exists too much reliance on e-counseling. For the purposes of treatment, it is important that technology does not destroy the quality of human interaction, since human interaction is such an integral element of successful behavioral health treatment.

Over the last few years, there has also been rapid development of "e-health." E-health refers to practically any healthcare practice that is supported by electronic process and communication. For example, the practice of telemedicine represents a kind of e-health practice. Telemedicine is defined as the use of medical information exchanged from one site to another via electronic communications to improve patients' health status, which commonly takes the form of real-time video conferencing.[22] Such conferencing has the potential to redesign the delivery of counseling and holds the promise of increased access and more patient-centered treatment.

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[20] NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE, *Healthcare Payment Reform and the Behavioral Health Safety Net: What's on the Horizon for the Community Behavioral Health System* (April 2009), *available at* http://www.thenationalcouncil.org/galleries/policy-file/Healthcare%20Payment%20Reform%20Full%20Report.pdf.

[21] RECOVERY COMMUNITY SERVICES PROGRAM, *What are Peer Recovery Support Services?*, http://store.samhsa.gov/shin/content/SMA09-4454/SMA09-4454.pdf.

[22] AMERICAN TELEMEDICINE ASSOCIATION, *Telemedicine Defined*, http://www.americantelemed.org/i4a/pages/index.cfm?pageid=3333.

Still, behavioral health providers continue to express concern about striking an appropriate balance between reliance on technology to deliver treatment for substance use and mental health disorders and the usefulness of in-person communication and assessment. Providers of substance abuse treatment rely on human interaction to provide respectful, productive treatment to clients. Furthermore, human interaction in addiction treatment is particularly important for women, given that women place greater emphasis on interpersonal interaction and things like team-building, than do men.

Pharmaceutical Intervention/Medication Issues

The use of medications to treat substance abuse has been popular for quite a while. Pharmaceutical intervention, or medication-assisted treatment, refers to the process in which medication is substituted for the substance to which the patient is addicted. For example, methadone treatment is commonly used to combat heroin addiction.

In recent year, advances in pharmaceuticals that diminish withdrawal symptoms, but also block the pleasure producing symptoms associated with certain drugs have aided in the treatment of alcohol, cocaine and opioid abuse. However, there continues to exist controversy regarding the practice of replacing one drug for another.

Regardless, studies show that pharmacological treatment can play a vital role in the treatment of addiction. For example, medications can be used to detoxify a person/prevent withdrawal, reduce the frequency and intensity of cravings, block the experience of feeling "high" or intoxicated, guard against impulsive use of drugs, and treat or control symptoms of a medical or mental disorder, that if left untreated could lead to relapse.[23]

Methadone treatment for opioid addiction presents a good example of the benefits of medication-assisted treatment. Research indicates that methadone keeps patients in treatment longer and decreases opioid use as compared to treatments that do not include medication. A meta-analysis of six studies found that patients receiving methadone maintenance were three times as likely to remain in treatment and one third as likely to have used heroin.[24] Research also indicates that methadone is safe in that it does not impair reasoning or performance of everyday tasks, nor does it produce harmful physical effects, even with chronic use. Maintenance on methadone treatment is also shown to substantially reduce criminal activity and improve psychosocial functioning.

Additionally, alcohol abuse can also be treated with medications. Approved medications for the treatment of alcohol abuse include acamprosate, disulfiram, and naltrexone.[25]

Research clearly indicates that medication-assisted treatment and pharmaceutical interventions can play an important role in the safe and effective treatment of substance abuse. As usage of medications in treating substance abuse becomes more widely accepted, it becomes more and more critical that physicians, psychiatrists, clinical staff, nurses, and treatment program directors,

[23] NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE, INC., NCADD's Consumer Guide to Medication-Assisted Recovery, *available at* http://www.ncadd.org/images/stories/PDF/Consumer-Guide-Medication-Assisted-Recovery.pdf.
[24] Mattrick et al., *Methadone Maintenance Therapy Versus No Opioid Replacement Therapy for Opioid Dependence*, Cochrane Database of Systematic Reviews 8, CD002209 (2009).
[25] *Id.*

providers, and staff understand the safety concerns associated with this treatment methodology and ensure that such medication-assisted treatment is carefully catered to the patient. Moreover, it is essential that medication-assisted treatment be provided in conjunction with necessary supportive services such as psychosocial counseling, treatment for co-occurring disorders, and vocational rehabilitation.

Finally, it is essential that prescribers be properly and thoroughly educated about the dangers of overprescribing medications to women with addiction. In recent years, the healthcare industry has seen an incredible growth in overdiagnosis and overprescribing, and the field of mental health and substance use disorder treatment is no exception. Therefore, a multi-system approach is necessary in this regard to ensure that those involved in the prescribing of medications to women with addiction are made aware of the very serious potential harms posed to these women by such overprescribing.

Mergers

Due to the co-occurrence of mental illness and substance use disorders, combining mental health therapy with substance abuse treatment makes perfect sense. In fact, the National Alliance on Mental Illness ("NAMI") focused on exactly that during Mental Illness Awareness Week, October 7 through 13 of 2012.

According to SAMHSA, only 7.4% of individuals receive treatment for both mental illness and substance abuse, while about 8.9% of adults in the United States have both a mental illness and substance use disorder. Even still, there remains a conflict between the two care systems, as some treatment centers still oppose biochemical intervention.[26]

It is therefore necessary that more is done to merge and integrate mental health and substance abuse treatment. For example, the use of depression screening in substance abuse programs works to integrate the two treatment systems and ultimately, better help patients.

However, it is imperative that integration of mental health and substance abuse treatment does not result in less-individualized care for women.

Ethical Issues

The field of substance abuse treatment presents a variety of ethical issues. Unfortunately, biases and misperceptions have affected the care provided to those with mental health and substance use disorders. Due to this fact, it is essential that providers possess the tools necessary to evaluate ethical dilemmas and proceed with the delivery of care based on scientific fact, as opposed to emotion. It is also important that unethical behavior in this regard is appropriately dealt with. Hopefully, as accountability grows in the nonprofit sector, this type of behavior will be effectively extinguished. We, as the Women's Committee, encourage all involved in this important field to keep cognizant and respectful of the sensitivities and vulnerabilities of the women we serve.

[26] Celia Vimont, *Better Integration Needed for Treatment of Substance Abuse and Mental Illness*, Join Together, the Partnership at DRUGFREE.ORG (Oct. 12, 2012).

Voices from Leaders in the Field

Veterans Affairs: Trends and Issues of Women Veterans

By Dr. Mary Henderson, Ed.D., LCPC
Deputy Director
Nicasa

Returning women veterans are faced with a myriad of behavioral and mental health issues. Women veterans are experiencing difficulties related to drug or alcohol use, mental health challenges – including Post Traumatic Stress Disorder ("PTSD"), and disrupted family relationships. Along with these are the questions of "What is a female veteran? What does she look like? What does she bring to the table? How can we as providers help her?"

As of September 30, 2011, the population of women veterans numbered 1,853,690 in comparison to the total veteran population in the United States and Puerto Rico of approximately 22.2 million (DVA, November, 2011). According to the Department of Veteran Affairs, Illinois has 57,479 women veterans and women are now the fasting growing subgroup of US veterans (DVA, July, 2011).

Women veterans have spent years in a male-dominated culture that subjugated their needs and ignored their multiple life roles. As they return to their homes, it is critical that providers in the state of Illinois understand the culture from which they've come and the barriers this culture presented.

Women face a unique set of challenges associated with their military service that can lead to substance abuse. Studies indicate they are twice as likely as men to develop posttraumatic stress disorder, twice as likely to have a serious psychosocial distress, and twice as likely to experience a past-year major depressive episode. One out of every five woman veteran reports a military sexual trauma as opposed to one in every 100 male veterans. Female veterans have a suicide rate that is more than twice the rate of women in the general population (SAMHSA, 2012).

In considering the implications of the voices and experiences of women veterans there is a cultural disconnect in the state of Illinois. We must listen to these voices and appreciate these experiences:

> *In the VA system, most services are directed toward the male vet. I can't talk really talk of my trauma issues for fear of appearing weak or complaining.*
> *I wish there was somewhere I could go that understands a woman veteran's experience.*
> *My family doesn't understand why I can't sleep at night or why I wake up screaming.*

Treatment providers are best served by addressing the multiple challenges of women veterans holistically while providing assistance for substance-related difficulties. The approach must be trauma-informed and family-centered. These women have faithfully served their country. We must all insure that we their voices are heard.

Essential Health Benefits and Women's Services

By Renée Popovits, J.D. and Laura Ashpole, J.D.
Popovits & Robinson

The inclusion of mental health and substance use disorder services, including behavioral health treatment within the 10 categories of essential health benefits ("EHBs") required to be covered by qualified health plans offered in the individual and small group markets represents an important understanding on the part of the Federal Government that ensuring access to mental health and substance use disorder treatment services is crucial to improving Americans' overall health and thereby achieving cost savings in healthcare delivery. This important incorporation of mental health and substance use disorder services within the 10 categories of EHBs will be especially beneficial to the many women we serve who are suffering from addiction. Furthermore, categorization of mental health and substance use disorder services as among what are deemed *essential* health benefits elevates the importance of such services for the public in general, promoting acceptance of those suffering from addiction and reducing the stigma and discrimination associated with such treatment services. Finally, inclusion of *both* mental health and substance use disorder services among the EHBs is critical considering the high rate of co-occurring mental health and substance use disorders.

Although most states have already proposed EHB benchmark plans that once approved by the HHS will dictate what specific items and services will be covered within the 10 categories of EHBs, a proposed rule issued by HHS on November 20, 2012 permits states to change their previous selection by the end of the proposed rule's comment period. It is therefore important that Illinois constituents closely examine the Blue Cross and Blue Shield of Illinois BlueAdvantage Plan to ensure that the mental health and substance use disorder services it covers will meet the needs of women with addiction. If the plan does not include coverage for these important women's services, it is imperative that Illinois constituents make their voices heard so as to promote the coverage of necessary treatment services for women with mental health and/or substance use disorders.

Specifically, the following principles should be reflected in the package of mental health and substance use disorder services benefits: comprehensiveness of mental health and substance use disorder treatment services that span the entire continuum of care; prevention of sex discrimination with regard to treatment of mental health and substance use disorders; recognition of the co-occurrence of mental health and substance use disorders among women, including the occurrence of eating disorders alongside mental health and substance use disorders; and routine evaluation and revision of the mental health and substance use disorder package to ensure that the changing needs of women with addiction are adequately addressed.

Moreover, the following specific items and services should be included in the package of mental health and substance use disorder services benefits: preventive care related to substance use disorder treatment, which includes services that discourage risky behaviors, such as substance abuse; adequate screening for abuse of tobacco, alcohol, and illicit drugs; education, counseling and referral services that enhance health and prevent substance abuse; counseling and training in connection with family, sexual, marital, and occupational issues; coverage for co-occurring mental health and substance abuse disorders, including eating disorders and post-partum depression; and services appropriate for pregnant women and women with children.

Criminal Justice Services and Women

By Barbara Brooks, M.S., Ed., MSW, LSW
Administrator, Women, Youth and Criminal Justice Services
Illinois Department of Human Services
Division of Alcoholism and Substance Abuse

In spite of the decline of incarcerated women in Illinois, there continues to be a need for substance abuse treatment and the overwhelming provision of recovery support services as they enter back into their communities. Budget cuts over the past years have reduced services tremendously therefore, the leveraging of multi systematic services and resources between agencies will certainly be an intrinsic strategy for the effective enhancement used to recommend to DASA, policies and protocols for women in the criminal justice system over the next three year Women's Plan.

Of the 13,317 treatment facilities that responded to SAMHSA's 2005 National Survey of Substance Abuse Treatment Services ("N-SSATS"), 13% did not accept women as clients. Those substance abuse treatment facilities that did were more likely to be larger facilities. Of the 11,578 substance abuse treatment facilities that accepted women as clients, 41% provided special programs or groups for women: 24% for adult women only, 3% for pregnant or postpartum women only, and 14% for adult women and/or pregnant or postpartum women.

Facilities offering special programs or groups for women were more likely to provide a variety of additional treatment services than facilities that did not offer women programs or groups. Such additional services included relapse prevention groups (91% vs. 74%), aftercare counseling (84% vs. 78%), and family counseling (81% vs. 74%).

Facilities providing special programs or groups for women were also more likely to offer programs for other types of clients than facilities that did not provide women programs or services. Special programs or groups were offered for men (63% vs. 3%), adolescents (78% vs. 48%), persons with co-occurring disorders (56% vs. 31%), persons with HIV/AIDS (23% vs. 4%), and senior citizens (16% vs. 3%).[1] *SAMHSA's 2005 National Survey of Substance Abuse Treatment Services ("N-SSATS")*

Numerous probation departments have created gender-responsive programming for women (see Ritchie, 2006). These programs provide clients with Mental Health (MH), trauma related and substance abuse (SA) treatment as well as coordination with other agencies that provide ancillary services to address the unique needs and problems of women. (Bloom, Owens & Covington, 2005). In keeping with this nationwide trend the Women's Committee aim is to recommend that women in the criminal justice system receive specialized services, higher quality supervision upon reentry, are offered trauma specific clinical care, primary and mental health care, familial and intimate relationship support and self-sufficiency treatment and/or services.

The Illinois Department of Corrections ("IDOC") data for State fiscal year 2011, states, there "were 2876 (5.9%) incarcerated women within IDOC and 2406 (9.74%) out on parole." As referenced in the former Women's Plan, "there is a critical need to develop and implement societal support systems that will provide adequate assistance and program services for women both within the IDOC institutions as well as support as they transition back into the societal mainstream."

The Affordable Care Act ("ACA") that is to be enacted January 14, 2014 will expand Medicaid coverage to women in the criminal justice system. This will offer a significant opportunity to enhance services to women within the criminal justice sector. That said; the Women's Criminal Justice Committee's mission is dedicated to the total improvement and empowerment of clinical and social support practices in multiple systems that will provide comprehensive addiction services. These include and are not limited to; pre/post qualification for Medicaid, prescriptions for addiction medication, enrollment in community services, access and referral to recovery support services, trauma specific services and primary health care. Recommendations to address these policies and practices for women are included as planning agenda recommendations for 2014-2016.

Finally, while the rate of recidivism for female inmates released from IDOC is lower than that of males, regardless of how it is measured, and in part reflects higher levels of access to rehabilitative services such as substance abuse treatment and opportunities for diversion from being returned to prison, the overall recidivism rate it is still considerably high. It is the Women's Committee intent to improve the quality and accessibility of available gender based treatment for women and stronger recovery planning during the next three years.

Substance Abuse Through the Eyes of the 21st Century Adolescent Female[27]

By Kellie Gage
Program Manager
Illinois Department of Human Services
Division of Alcoholism and Substance Abuse

Most any adult who has survived adolescence would probably attest to what an exciting, yet scary, and turbulent time it can be. Adolescence in America has traditionally involved breaking away from parents, experimenting with the trappings of adult life, and searching for autonomy and independence. However, many adolescents today face serious pressures at an earlier age than that at which adolescents in the past did. These pressures can include, the pressure to fit in; pressure to be the perfect body size; pressure to be sexually active; the pressure to bully others, and the pressure to be successful, which are just a few of the many societal pressures/stressors adolescents face today.

Most teenagers respond to stressful events in their lives by doing something relaxing and positive, or by seeking friendships and support from others, enabling them to move beyond the stress. But some teens are not able to cope with any kind of stressful event and become overburdened with emotional stress over a period of time. This may result in serious health problems such as anxiety, withdrawal symptoms, aggression, suicidal tendencies, physical illness, or even drug and/or alcohol abuse. These young people self-medicate themselves with drugs and alcohol in an attempt to make them feel better.

Today, teen girls are more likely than teen boys to identify potential benefits from drugs and alcohol, says a study released by the Partnership for a Drug-Free America. (PFDA, 2010) Research trends indicate that girls are catching up with, and even surpassing, boys with regard to illicit drug and alcohol use. (NSDUH, 2009) The latest findings on drug use in the United States from the National

[27] Partnership for a Drug-Free America, *Teenage Girls: Increasingly vulnerable to alcohol and drug use* (July 2010); Results from the 2009 National Survey on Drug Use and Health 2009; Department of Health and Human Services, Substance Abuse and Mental Health Services Administration; *Status of Girls in Illinois*, www.womenandgirlscan.org (2009); Call, K. and J.T. Mortimer, *Arenas of Comfort in Adolescence: A Study of Adjustment in Context*, Mahwah, NJ: Lawrence Erlbaum Associates, 2001.

Survey on Drug Use and Health (NSDUH, 2009) show that marijuana is the most widely used illicit drug by girls.

More teenage girls use marijuana than cocaine, heroin, ecstasy and all other illicit drugs combined. However, girls are closing the gap with boys in terms of usage of marijuana, alcohol and cigarettes. Teen girls have also surpassed boys in their misuse of prescription drugs. (NSDUH, 2009)

More specific to Illinois, according to the 2007 National Survey of Children's Health, girls in Illinois are using alcohol, cigarettes and illegal drugs at an alarming rate. In many cases, use of these substances began before girls reached their teenage years. (Status of Girls in Illinois, 2009)

- Drinking was listed as most common among Illinois high school girls; with 46.6% reporting current alcohol use.
- Nearly a third of Illinois high school girls (31.4%) reported engaging in binge drinking.
- Over 1 in 5 female high school students in Chicago had their first experience with alcohol before age 13
- Chicago high school girls (13.7%) were much less likely to be current smokers than their counterparts across the state of Illinois (21.8%) and the nation (18.7%)
- Nearly 1 in 5 (19.3%) Chicago high school girls were current marijuana users. More young women in Chicago also reported ever having used marijuana than their peers in Illinois and across the nation as a whole.
- Over 1 in 10 (10.9%) Chicago high school girls first used marijuana before they turned 13. This was more than double the national average (5.2%)

Alcohol/drug use can place girls in danger of physical, mental and sometimes social consequences, during a very critical time in their lives, when their bodies and brains are still developing. Some of these consequences might include; disrupted growth and puberty associated with consuming even moderate amounts of alcohol; early engagement in sexual activity, leading to pregnancy, juvenile justice involvement, homelessness, and a host of other life altering consequences.

In conclusion, it has often been said, that when you help a girl, you save a village. Helping adolescent girls make healthy life choices must be a collaborative effort of those involved in her development to womanhood. This collaboration begins with:

- Parental involvement is the most important influence in their daughter's decisions about drug use. Parental disapproval of drug use plays a strong role in turning back drug use. Youth who felt their parents did not strongly disapprove of marijuana use were about six times as likely to use marijuana as youth who felt their parents would disapprove. (2009 NSDU)
- Girls appear to be more sensitive to conflict and related issues in the family. When parenting quality declines, or when an adolescent girl is exposed to high levels of negative emotion from parents or other family members, her developing capacities for coping and self-regulation may be overwhelmed by life stressors or challenges. (Call & Mortimer, 2001)
- Schools providing school based prevention programs, based on a model of identifying social influences for young girls.
- Families, schools and communities helping girls find healthy ways to manage stress through healthy extra curricula activities.
- Community organizations enlisting adolescent girls to become peer mentors and educators around substance abuse prevention education to which can impact the lives of their peers.

Recovery and Reunification: Substance Affected Women Involved with the Department of Children and Family Services

By Sam Gillespie
DCFS Clinical Services Division

Alcohol and other drug disorders contribute to child abuse and neglect and represent a significant barrier to reunification for many women and their children. The child welfare and substance abuse treatment systems, through collaborative efforts have found promising approaches and have developed evidence based practices to address the substance abuse needs of women and their families in the child welfare system.

Two mothers served through the DCFS recovery coach program share below their lived experiences and journeys to recovery and reunification. The recovery coach program provides engagement and support to families as they move through the substance abuse and child welfare systems. Recovery coaches work with families, treatment programs, caseworkers, and the courts to keep all parties informed and on the same page and working together toward common goals.

One of the mother served through DCFS shares below her lived experience:

"My recovery coach was awesome. Whenever I was going through something and needed someone to talk to, she was there."
- Kimberly, former TASC Recovery Coach Program client, 5 years sobriety

"5-4-3-2-1," counts Kimberly, 37. "Marshall, when Mommy says come here, you come here."

"I want to play," giggles four-year-old Marshall, a plastic baseball in hand. Kim, a single mother of four, is learning to parent for the first time. She lost custody of her eldest son and daughter, now 15 and 13 years old respectively, and gave guardianship of her 10-year-old son to a close friend. At the time, Kim was addicted to alcohol and crack cocaine.

"I have four children but Marshall is the only one that I have the opportunity to raise and parent.

"Addiction ran throughout my whole family: my grandmother, grandfather, mother, aunt, and uncle," explains Kim. "It was everywhere on my mother's side. That was all that I ever knew. That was all that I'd ever seen. So that's what turned out to be my own coping method. I was selfish, and I put myself in the position to have to live without my children."

Kim dreams of becoming a substance abuse counselor and establishing a recovery home to help other women struggling with drug dependence. She credits the TASC Recovery Coach Program and her faith for her newfound determination and hope.

"My recovery coach was awesome," says Kim. "Whenever I was going through something and needed someone to talk to, she was there. She called me weekly to check on me to see how I was doing. That let me know that somebody cared and that I had someone of positive influence in my life that cared about me. She stuck by me.

"I now keep my focus on my son and doing the right thing." Kim, a full-time student at Harold Washington College in Chicago, is expecting to graduate with an associate's degree in Applied Science and a concentration in substance abuse counseling. She also works part-time in the human resources department at a local community college.

"I don't get frustrated or discouraged," Kim says regarding how she manages to juggle parenting, work, and school. "I want my family to be comfortable, happy, and healthy. So, I just do it."

Women's Treatment Issues – Yesterday and Today[28]

By Pamela P. Irwin, Ph.D.
Executive Director
Central East Alcoholism and Drug Council

In consideration of the differences and similarities between how women present for substance abuse treatment currently as opposed to those of ten to fifteen years ago, a walk down "memory lane" may provide a window of insight. In the late 1970's, the substance abuse field in Illinois was in early stages of development with dedicated professionals and members of self-help fellowships at local and State levels wrestling with extremely limited resources, meager budgets, inconsistent research foundations, societal problems, and in spite of the difficulties - committed visions toward development of a comprehensive array of services to facilitate remediation of substance abuse and chemical dependency. Community resources that had been available frequently included only local jail cells, hospital emergency rooms, nursing homes, church basements, and kind-hearted recovering individuals who would willingly assist "newcomers." Substance abuse treatment was in its infancy with most treatment centers across the State having been in existence for less than 10 years. Stigma about alcoholism and chemical dependency was rampant across society and within those that attempted to hide from their own reality – burying their shame and guilt – and thereby exacerbating their pain and dysfunction.

With the wisdom that comes from hindsight, we can now see that those days created the perfect-storm environment for substance abuse to expand to epidemic proportions in the decades to come. Alcoholism and drug abuse were among the family secrets that were never to be mentioned. Prevention had not yet even been invented. Treatment was just beginning. Individuals, families, and communities were suffering. Untreated addiction was costing society billions of dollars and ravaging the lives of addicts and their families.

Treatment began as a response to the pain that existed in the bodies, minds, and souls of individuals, families, and society. Treatment methods, facilities, and services were most geared toward the needs of men in those early years making the struggles for women entering treatment all the more difficult. But because the substance abuse field had been born from a foundation of fellowship and responsiveness, dedication to improvement of skills and services continued. An entire nation-wide system of treatment and prevention has been developed, has been tested over time and in rigorous

[28] Blume, S. B., *Women and alcohol: A review*, JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 256, 1467-1470 (1986); Irwin, P. P., *Internal evaluation in a women's chemical dependency treatment program*, Ann Arbor, MI, UMI Dissertation Services (1997); Irwin, P. P., S*ubstance abuse treatment for women with children: A story of complexity*, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, Contract No. 270-95-0015, Rockville, MD (1998).

research, has been proven to be effective and efficient, and has facilitated millions of recovery stories being lived and shared across our country.

In her seminal research on female addiction treatment, Blume (1986) summarized particular treatment issues as: a) rapid development ("telescoping") of the course of the illness in women; b) inappropriate male/female relationships concomitant with the chemical dependency; c) onset of pathology preceded by a particular stressor; d) histories of suicide attempts and concomitant psychiatric treatment; e) health and family problems as motivators for treatment; f) reduced self-esteem; g) feelings of guilt relating to presumed parenting failures; h) sensitivity to societal stigma; i) higher rates of other substance abuse in addition to alcohol, particularly including tranquilizers, sedatives and amphetamines; and, j) the need for understanding of the pertinent treatment issues surrounding female socialization in our society into stereotypical roles.

Evaluation research in a women's treatment center in central Illinois in the late 90's (Irwin, 1997) combined both quantitative and qualitative analyses of data to shed light on women's issues. According to the author, "Quantitative analysis of the clinical issues may anesthetize the reader to the magnitude of the problems evident in the women's lives prior to their admission to treatment." Qualitative analysis, on the other hand, revealed the following within the clinical histories:

- Disclosure of incest victimization history
- Dealing with the death of her infant child due to her cocaine use during pregnancy
- Growing up watching alcoholic father physically abuse her mother
- Abusive current adult relationships and being the victim of childhood abuse
- Childhood sexual abuse by mother's boyfriends
- Being treated for various mental health issues such as depression, anxiety disorders, panic attacks, etc., without examination of substance abuse patterns
- No prior suicide attempts yet being treated for depression for 5-6 years – became prescription drug addict
- $40 - $400 per day cocaine habits with no "legal" source of income
- Substances of abuse including alcohol, dilaudids, white cross, heroine, speed, LSD, benzodiazepines, marijuana, hashish cocaine, crack, and crystal meth

So now we jump to the current day and plan for the future of women's services.

What do we find to be different or similar in today's women's issues? Anecdotal data from women's treatment professionals reveals that Blume's analysis of issues pertinent to women of the 80's is equally relevant today. The qualitative data discussed above is reflective of the same multi-faceted complexity in women's issues and needs for innovative, responsive, gender-competent provision of care as what has been foundational in our field. We have seen younger women entering services (average age of treatment entry dropping from around 37 to 29); however, Blume's concept of telescoping of the illness continues to describe the corresponding increases in dysfunction that plague today's younger entrants to treatment. We have also now seen an entirely new epidemic of substances of abuse readily available in rural locales that had previously been assumed to be isolated and separated from the "urban" drug cultures -- that include methamphetamine, bath salts, K-2 and derivatives, etc. Simultaneous to the increasing combinations of substances being abused by women is the concomitant increases in physiological and psychological dysfunction that is produced. Women's needs for top-quality treatment have only increased over the years as has the complexity of their illness.

Additionally, we must also remember that the issues facing women are both complex and dynamic. Though disease progression may be rapid, psychological and sociological manifestations may vary over time. In a paper presented at the 14th Annual National Rural Institute on Alcohol and Drug Abuse, Irwin (1998) reported research comparing women's past and present issues rated for level of severity as documented in their treatment admission records across the following variables: chemical dependency problems, family problems, social problems, environmental problems, vocational problems, legal problems, physical problems, emotional problems, educational problems, and financial problems. The most frequently noted problem area in the severe rating category in the client record was current chemical dependency problems (93%), followed by past chemical dependency (83%). The second most frequently noted problem areas at the severe rating level were past family problems (60%) and present family problems (47%). Interestingly, although past emotional problems were evidenced as severe at a fairly high frequency (37%), current emotional problems were noted far less frequently as severe impairments (7%). Thus, even as women present for treatment, their perception of severity of issues affecting their lives contains variability over time and is reflective of the dynamic nature of illness progression and their needs in treatment.

Perhaps the most noteworthy difference in today's issues affecting women's needs for treatment has been the epidemic of methamphetamine abuse and addiction. By the mid-2000's in our rural area treatment center, methamphetamine was reported at admission as among the primary substances of abuse in approximately one third of our admissions. Use of this substance by women produced the following: extremely rapid progression to full-blown addiction; physiological problems; malnutrition; neurological deficits with slow remediation; dental issues; extreme impulsivity; promiscuity; legal issues; cognitive impairments; psychological devastation; and needs for long-term intensive treatment that is often interrupted by the woman's difficulty in coping with abstinence from the substance. Additionally, because of the methods of producing and consumption of methamphetamine within a local "sociological" network, we see increasing cases needing simultaneous intensive treatment admission for multiple members of the same family – mother, father, and adolescent children – all having progressed to addiction at the same time. Again, the complexity of issues to be addressed within the context of treatment becomes all the more intertwined when women are faced with their own needs for treatment while simultaneously wrestling with the issues inherent in family members of addicts.

Thus, the substance abuse field has grown immensely over the past 40+ years in our abilities to treat the ever-complex and dynamic needs of women – yet we find ourselves in many ways at much the same place where we began. We still wrestle with extremely limited resources; we see increasing needs for our services; and, we see increasing problems in society from untreated addiction as the demand for our services continues to exceed the resources that are available. We have our history as a foundation for our future efforts and we have our vision, hope, and strength to enlighten our planning efforts. We have our knowledge of thousands of "recovering" women – their voices of recovery, their stories, their hopes, their dreams. What we do not and should not have is the option to give up – we must plan for the continuation, expansion, and continuous improvement of our field to meet the needs of those we serve.

Opiate Maintenance Treatment Services in Illinois

By Richard Weisskopf
State Opiate Treatment Authority, State of Illinois

The Illinois Department of Human Services ("IDHS") Division of Alcoholism and Substance Abuse ("DASA") licenses 62 opiate treatment programs utilizing Methadone in Illinois serving approximately 12,000 patients. Methadone is the standard for medication-assisted opiate treatment. In addition to Chicago, Cook County, and the surrounding counties, licensed opiate treatment programs are located in Alton, Champaign, Decatur, East St. Louis, Galena, Kankakee, Peoria, Rockford, Rock Island, and Springfield.

In DASA's opiate treatment programs, pregnant women are a priority, receiving special consideration for admission to programs without regard to the size of a treatment program's active patient population or waiting list. DASA and the treatment programs encourage pre-natal care for pregnant patients and post-partum healthcare and support.

DASA has solicited and supported specific Department of Children and Family Services ("DCFS") funding for opiate treatment for addicted women with children. DASA works closely with DCFS to ensure the continuity of opiate treatment for women with children and periodically provides information to the courts in conjunction with Treatment Alternatives for Safer Communities ("TASC") to support opiate treatment for addicted women.

The State Methadone Authority, DASA's point contact for issues involving opiate treatment, is a permanent staff member to the Illinois Advisory Council on Alcoholism and Other Drug Abuse's Committee on Women's Alcohol and Substance Abuse Treatment, and provides information, and other support on initiatives and policies specific to opiate treatment.

Substance abuse treatment for women has always been a priority in the Illinois opiate treatment system. During the 1970's and 1980's, the Division of Alcoholism and Substance Abuse ("DASA") supported an outpatient program, the Special Treatment Unit, for pregnant opiate treatment patients.

In 1990, DASA recognized the acute shortage of residential drug treatment programming for pregnant women and mothers and purchased Mary Thompson Hospital through the Drug Free Illinois initiative in support of The Women's Treatment Center. The Women's Treatment Center is a nationally recognized community-based rehabilitation and support program for women recovering from addiction in residential and outpatient settings. Today, with DASA support, the Women's Treatment Center serves 1200 women and 400 children per year, helping support a sober lifestyle, rebuilding lives, and mending family bonds.

In addition to the Methadone programs, Illinois has more than 300 physicians who are approved by Center for Substance Abuse Treatment ("CSAT") and Drug Enforcement Administration ("DEA") to prescribe Suboxone (buprenorhine) from their private practices. Patient medication is obtained by prescription and filled at a local pharmacy. Initially these physicians are limited to thirty patients but after one year they may apply to increase the patient limit to one hundred patients. Once a patient is stabilized, this modality has the advantage of reducing the number of required visits making treatment more advantageous for women with children or who are caregivers to others, and who might otherwise have to travel long distances to Methadone programs.

Drug overdose and deaths are a growing problem in Illinois as it is all over the country. As of 2010, the use of opiates by women was second only to alcohol. Illicit opiate use is rising and as the federal government has cracked down on the availability and illicit distribution of Methadone, Oxycontin, and other opiates, the number of people turning to heroin for the first time is increasing. As a direct result, overdoses with heroin are increasing.

Having identified this trend and increased treatment capacity within the existing budget, DASA has initiated a Drug Overdose Prevention Program, under Illinois Public Act 096-0361 (20 ILCS 301/5-23), for agencies which provide outreach, information, training, and distribute Narcan for drug overdose reversals. These programs voluntarily register and periodically report information including the identification of prescribing physicians, the number of people trained for overdose prevention, and the number of drug overdose reversals in which they have participated, benefiting all genders.

Looking to the future, DASA is currently reviewing the efficacy of Telemedicine which allows a reduction in required travel to programs, especially useful for rural patients. DASA is also reviewing the use of the drug Vivitrol, a successful treatment for alcoholism, for use in opiate treatment. DASA will continue to seek out new or alternative treatments and medications in support of treatment for pregnant women and women with children.

The Women's Committee's focus with this new plan is to outline for the substance abuse field, legislators and concerned parties the key trends affecting women in need of substance abuse treatment services. The Committee recognizes that in order to make an impact on the field in the current atmosphere of budget issues, loss of staff and elimination of programs designed for specific populations that a list of recommendations that span larger than the focus of the previous plan was needed. This in no way diminishes the importance of the committees work groups that had been the focus of the goals and objectives outlined in previous plans. The Women's Committee will continue to utilize current work groups and create ad hoc groups as needed that will allow the committee to continue to monitor, integrate and capture opportunities to emerge aspects of other trends into treatment services for women.

Recommendations

Family-Centered Services Recommendations[29]

The Family-Centered Services workgroup created and administered a statewide survey for two primary purposes: 1) obtain baseline information on how family-centered services is defined and delivered in the state, particularly information not tracked (i.e., family services, evidence-based practices, community partnerships/collaborations, agency demographics, and sustainability of programs), and 2) create a directory for treatment providers of adjunct services (mental health, prevention etc.) to make referrals.

The survey included the following domains: Demographics, assessment, community involvement/collaborations, models/EBP's/curriculum, trainings, and family involvement. The

[29] Covington, S., Gender Responsive Program Assessment (2007); Women and Addiction: A Gender Responsive Approach; Institute for Health Recovery's Integrated, Trauma Informed Self-Assessment for Providers Adapted from a previous version developed by the WELL Project State Leadership Council (Schillings, 2010); Family Centered Treatment for Women with Substance Use Disorders: History, Key Elements and Challenge (SAMHSA, 2007).

survey was administered to 160 providers through survey monkey. About a third of the providers completed the survey. The Family-Centered Services workgroup analyzed the baseline data by highlighting themes presented by the providers. As a result of the findings recommendations will be presented to the Women's Committee.

Themes that Emerged from the Survey-Analysis
Dr. Bakahia Madison

Family-Centered Services. Most of the providers (61%) who completed the survey identified as a family-based treatment program. About, 89% reported servicing families, which included: mother, father, significant other, extended family members, friend, and children. Several providers stated that pastors and sponsors were involved in family-based treatment.

Providers rated the delivery of services for family-based treatment as well as the effectiveness of those services. The primary menu of services included: Family counseling, parenting skills, family social activities/education, mental health services, transportation, case coordination, and spirituality. These services were consistently ranked high and seemed to be the theme among providers.

In contrast, indicators that were significantly low included: Children's Early Intervention Services, nursery pre-school, pediatric care, prenatal care, after school recreation, housing, medical care, and legal services. Although, providers rated these services substantially low research data suggests these indicators are the basic menus of family-based treatment services.
Several themes were identified as barriers to sustaining family-centered services: 1) Lack of funding, resources, and fee scales for families, 2) Engagement and motivation (e.g. mandated clients not interested in family-centered services) and 3) Lack of family involvement in services.
In conclusion, 100% of the providers who did not offer family-centered services stated they have an interest in offering family-centered services.

Procedure, Protocols, Screening and Assessments of Families. The majority of the provider respondents had challenges describing their procedure and protocols for screening families. Only, 57% of the providers stated that they implement protocols for screening family members and significant others for possible substance abuse disorders. The assessment tool implemented was the biopsychosocial assessment. Other examples, included DASA standards, youth integrated assessments, and brief screening tools.

On the other hand, 43% noted that protocols are not implemented for several reasons. The following themes were noted: 1) limited staff, 2) lack of resource, 3) family involvement, and 4) financial burden.

Partnerships and Collaborations. According to the data most of the providers have initiated and/or participated in the coordination care-planning process. Only, 67% reported partnerships with medical health clinics and out of the 67% three agencies identified being involved with FQBHC's. Establishing linkage agreements with medical clinics is noted as the primary source of partnership with medical providers.

Notably, providers consistently partnered with community-based agencies that are available for clients and their families outside their agency. The primary referrals made to outside agencies included: Substance Abuse Services, Mental Health Services, and Public Assistance. These indicators noted were ranked with the highest frequency of services utilized by providers. In addition,

Educational (G.E.D), Health/ Nutrition Services (e.g. food pantries, HIV.AIDS services) had considerably high responses. Importantly, family advocacy center services, vocational training housing services, and faith-based services were sometimes utilized.

Gender Responsive Approaches and Trauma-Informed Practices. About, 72% of the providers stated that trauma-informed approaches have been implemented in their agencies. Many of the providers completing the survey stated that standardized gender- specific assessment instruments are not integrated. Gender-responsive approaches and trauma-informed practices were evaluated and the following themes were identified: 62% offered female only groups, however, 64% stated they do not offer services based on gender-responsive principles, nor are the curriculums and materials gender-responsive. But, 89% stated that treatment is based on a holistic model attending to the physiological, social, emotional, spiritual, an environmental factors. Finally, over 50% stated that the programs do not prepare women/girls to become economically self-sufficient.

Conversely, trauma-informed practices seemed to have more positive ratings of the services offered to adults and children. For example, data indicated staff knowledge about symptoms of trauma, risk for retraumatization of victims of violence by staff and peers, knowledge about secondary trauma and self-care were rated consistently or often by over 50% of the provider respondents.

Consistently, providers stated that they implement crisis prevention plans, collaborate between participants and staff, and develop guidelines for maintaining confidentiality in order to maintain safety, have procedures in place to protect staff and clients being served if there is a known perpetrator. In addition, providers consistently noted that individuals are given choices of, which services they can access, policies and procedures are in place for collecting information from diverse group of people, and programs have flexibility with program rules in order to meet the needs of individuals and children. In conclusion trauma-informed approaches and gender-responsive assessments were rated consistently or often when evaluating parenting education at appropriate levels of care, and services are provided for the family support system and safety of the participants.

Evidence-Based Practices, Quality Assurance, and Trainings. Seeking Safety is the primary evidence-based curriculum implemented among provider Respondents. The second most utilized EBP is Motivational Interviewing and third is Cognitive Behavioral therapy. Other EBP's were noted as practices often implemented such as DBT, EMDR, and the Matrix Model. Several providers noted the following reasons for the selection of the curriculums: 1) cost-effective, 2) trauma-informed curriculum, 3) effective and good outcomes, and 4) meet the needs of the clients receiving services (e.g. women and children). Some of the training-related practices for EBP's included: 1) continue education (workshops and webinars) required and encouraged, 2) in-service trainings, and 3) consultation and supervision.

Providers rated fidelity checks and evaluations as the quality assurance measure for evidence-based practices. About, 64% stated that consultation has been another practice to monitor the fidelity of the practices. In contrast, providers were unable to elaborate on the fidelity checks or evaluation process. When asked to describe the quality assurance measure, clinical supervision, chart audit, and audio-recorded sessions were written as the measures.

Providers described barriers or challenges encountered with employing the EBP's. The following barriers were noted: 1) staff concerns (e.g. staff turnover, staff competencies to implement model and resistance, 2) lack of funding, and 3) client's engagement and participation.

Importantly, most of the EBP's have been utilized for 3- 10 years, with a majority over 5 years. Finally, 76% providers support staff obtaining Gender Competency Endorsement for professionals in Illinois. Only 34% offer in-service trainings to partners, 26% offer no trainings to partners, and 31% did not respond.

Summary and Recommendations

Overall, the findings provide ***baseline*** information regarding family-centered services in the field. The data suggests that the family-based treatment providers offer comprehensive services to their clients and families. Most of the providers practice from a family-centered service model and have sustained the model by participating in consultation and trainings. However, the lack of funding, technical assistance and staffing seemed to be the result in difficult implementation of family-centered services.

The data attempted to track key trends and evidence-based practices specific to Family-Centered Services. There were gaps and inconsistencies in defining Family-Centered Services. For example, Children's Early Intervention Services, nursery pre-school, pediatric care, prenatal care, after school recreation, housing, medical care, and legal services Data indicator provider response percentages were low. Research suggests these indicators are the basic (domains and/or aspects) of family-based treatment. Provider respondents consistently noted that screening families for family-centered services seemed to be one the major challenges as well as developing protocols, and inserting fees for services. Although providers seemed to integrate gender-responsive approaches and trauma-informed practices, some of the elements to support approaches were rated significantly low for gender-specific treatment. In conclusion, evidence-based practices were implemented with most of the agencies. Overall, clients were noted as having positive outcomes from the EBP's. However, providers appear to need parameters to measure the practices and technical assistance to support the on-going implementation of evidence-based practices.

The Women's Committee has the following recommendations concerning Family-Centered Services:

- **Recommendation 1:** Leverage multi-state systems and maximize funding and resources for family-centered services in the community.
- **Recommendation 2:** Develop and promote best practice guidelines for family-centered services based on research findings and survey data collected from community-based providers.

Women Veterans Recommendations[30]

The Women's Committee has the following recommendations concerning Women Veterans:

- **Recommendation 1:** Transform community service providers to furnish gender responsive services to all women veterans, including those who have experienced military sexual trauma.

[30] Department of Veterans Affairs, Health Awareness Campaign: Substance Abuse Treatment (July, 2011); Department of Veterans Affairs, *Women Veterans Population Fact Sheet* (Nov. 2011); SAMHSA In Brief, *Behavioral Health Issues Among Afghanistan and Iraq U.S. War Veterans* (Summer 2012).

- **Recommendation 2:** Help community service providers understand the veterans and military language and associated cultural barriers of a male-dominated system.

Essential Health Benefits & Women's Services Recommendations

The inclusion of women's services for mental health and substance use disorders in the Essential Health Benefits ("EHB") package under the ACA is imperative in order to ensure that women are afforded access to needed mental health and substance use disorder services.

The Women's Committee has the following recommendation concerning Essential Health Benefits and Women's Services:

- **Recommendation 1:** Ensure that the essential health benefits ("EHB") package adopted in Illinois includes comprehensive treatment for women suffering from mental health disorders, substance use disorders, and other behavioral health issues.

Criminal Justice Recommendations

These recommendations have been developed to insure that women who have been incarcerated in the criminal justice system have the opportunity to have effective treatment and/or recovery support services. It is anticipated that the recommendations for the 2014-2016 *Women's Plan* will ultimately increase resources and gender competent care that will improve women's overall well-being and treatment outcomes. By appealing to legislators and key stakeholders in Illinois, these recommendations offer opportunities to incorporate best possible practices, policy implementation for service delivery system changes, innovation, and new policy standards under healthcare reform.

Moreover, due to the increasing digitalization of medicine, it is essential that associated electronic tools are used for treatment purposes and in an effort to improve coordination of care. In this regard, it is important to note that the use of Health Information Exchanges ("HIE") to track patients' use of prescription medication for law enforcement purposes has a chilling effect on treatment. The Women's Committee strongly supports any and every effort to help women receive necessary treatment for addiction. Therefore, usage of HIEs for law enforcement purposes must be appropriately limited. The Women's Committee maintains the importance of focusing on treatment of drug abuse as the medical disorder that it is. The first priority should always be treatment, and not criminalization of such behaviors.

The Women's Committee has the following recommendations concerning Criminal Justice:

- **Recommendation 1:** Advocate for statutory protections that prevent misusage of health information exchanges ("HIEs") by law enforcement and other agencies for prosecution of prescription drug abuse and instead focus on treatment.
- **Recommendation 2:** Add dedicated treatment facility for women within correctional facilities.
- **Recommendation 3:** Establish a collaborative partnership with the criminal justice system/adult and juvenile drug courts to ensure a continuum of services including treatment alternatives to incarceration throughout the state.

- **Recommendation 4:** Cultivate dialogue on re-entry of women from criminal justice system and how they can have more effective access to substance abuse services.

Technology Transfer Recommendations

The Women's Committee has the following recommendations concerning Technology Transfer:

- **Recommendation 1:** Ensure funding for implementation of evidence-based practices.
- **Recommendation 2:** Encourage coordinated ongoing substance abuse training with providers and child welfare and purchase of service ("POS") providers.

Electronic Health Records Recommendations

The recognition of the sensitivity of patient information regarding mental health and substance use disorder treatment is particularly important for women who are often balancing family and work responsibilities in addition to their treatment. With the advent of electronic health record adoption by virtually all providers due to the mandate under the ACA, it is essential that the voice of women with addiction is heard.

The Women's Committee has the following recommendations concerning Electronic Health Records:

- **Recommendation 1:** Encourage providers and state agencies to focus on using electronic health records to improve coordination of care.
- **Recommendation 2:** Promote discussion amongst providers and state agencies about the importance of understanding confidentiality provisions as they relate to use of electronic health records.
- **Recommendation 3:** Advocate for the appropriate balance of acquiring adequate patient information and respecting the privacy of patients so as to avoid unnecessary invasions of privacy and prevent increased stigma and discrimination.
- **Recommendation 4:** Recommend that suitable funding be afforded to behavioral health care providers attempting to adopt electronic health records and associated health information technology.

Substance Exposed Infants Recommendations

The Women's Committee has the following recommendations concerning Substance Exposed Infants:

- **Recommendation 1:** Inform and educate mothers, collateral influences, and the general community about the risk of substance use pre and post-pregnancy.
- **Recommendation 2:** Work collaboratively with the Illinois Department of Human Services Division of Alcoholism and Substance Abuse to include fetal alcohol spectrum disorder ("FASD") screening services for pregnant women.
- **Recommendation 3:** Increase statewide training opportunities for professionals in the substance use disorder field.

Medication Issues-Assisted Treatment ("MAT") for Women Recommendations

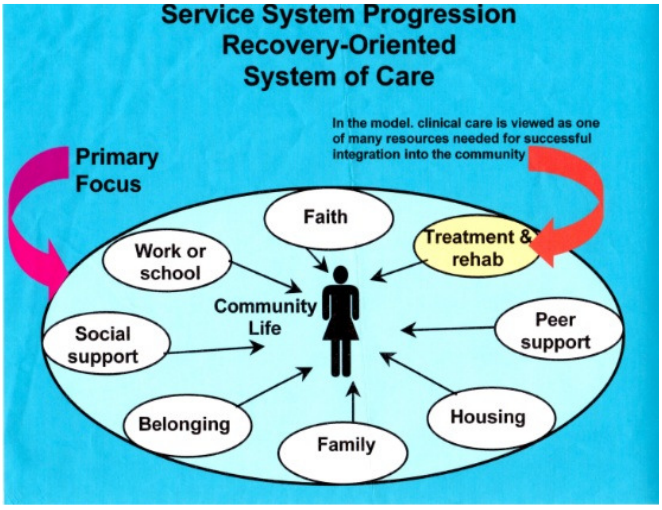
The Women's Committee has the following recommendations concerning Medication-Assisted Treatment:

- **Recommendation 1:** Educate prescribers about reducing overprescribing for women through a multi-system approach.
- **Recommendation 2:** Increase funding for medication-assisted treatment due to rising use of opiates by women aged 20-26 in Illinois border counties.
- **Recommendation 3:** Recognize limitations of medication-assisted treatment for pregnant women (e.g., suboxone is not indicated for pregnancy).

Recovery Oriented Systems ("ROS")

It is the hope, and strong expectation, that women receive person-centered, evidence-based services that are supported in and by their community. A recovery oriented systems of care ("ROSC") creates a unique infrastructure whereby substance use providers partner with other disciplines (e.g., mental health, primary care, local business, community organizations) (Partners for Recovery, 2010) with the end result being a menu of individualized, strength-based services from which women may design their personal pathway to recovery. In essence, women are provided more options with which to make informed decisions regarding their care.

The partnerships consist of the substance use field positioned to effectively address the full range of substance use problems, including early intervention, treatment, and prevention while simultaneously recognizing the role of collaboration, client self-management, and peer supports.
Various recovery support services are integrated into and valued by the community, enhancing the availability and support capabilities of families, social networks, community-based organizations and others in recovery. The services are not marginalized or on the fringe of the community; on the contrary, recovery support services have a facilitative role in creating recovery-oriented resources that are accessible, welcoming, and easy to navigate.[31]



[31] Northwest Frontier Addiction Technology Transfer Center, 2007.

Appendix

- Legislative Mandate
- Executive Committee Member List
- Contributors to the Plan
- Acronyms

Legislative Mandate
20 ILCS 301: Alcoholism and Other Drug Dependency Act

Section 10-20. Committee on Women's Alcohol and Substance Abuse Treatment established. There is established a Committee on Women's Alcohol and Substance Abuse Treatment of the Illinois Advisory Council on Alcoholism and Other Drug Dependency. Members shall serve without compensation but shall be reimbursed for any ordinary and necessary expenses incurred in the performance of their duties. The chairperson of the Council shall annually appoint a chairperson for the Committee on Women's Alcohol and Substance Abuse Treatment from among the membership of the Council. The Committee shall meet no less often than quarterly and at other times at the call of its chair or a majority of its members.

Section 10-25. Powers and duties of the Committee. The Committee shall have the following powers and duties:

(a) advise the Council and the Secretary in the development of intervention, prevention and treatment objectives and standards, educational and outreach programs, and support services specific to the needs of women.

(b) advise the Council and the Secretary in the formulation, preparation and implementation of a State plan for intervention, prevention and treatment of alcoholism and other drug abuse and dependency targeted to women.

(c) advise the Council and the Secretary regarding strategies to enhance service delivery to women.

(d) advise the Council and the Secretary in the development and implementation of a State plan, in conjunction with the Department of Children and Family Services, to provide child care services, at no or low cost, to addicted mothers with children who are receiving substance abuse treatment services.

(e) by December 1, 1994, and by December 1 of every third year thereafter, prepare and submit to the Council for approval a planning document specific to Illinois' female population. The document shall contain, but need not be limited to, interagency information concerning the types of services funded, the client population served, the support services available and provided during the preceding 3 year period, and the goals, objectives, proposed methods of achievement, client projections and cost estimate for the upcoming 3 year period. The document may include, if deemed necessary and appropriate, recommendations regarding the reorganization of the Department to enhance and increase prevention, treatment and support services available to women.

(f) perform other duties as requested by the Council or the Secretary.

Section 10-30. Membership.

(a) The Committee shall be composed of 15 individuals appointed by the chairperson of the Council, with the advice and consent of the Secretary, from among the medical and substance abuse prevention and treatment communities who have expertise and experience in women-specific programming and representatives of appropriate public agencies. Members may be, but need not be, members of the Council.

(b) Members shall serve 3-year terms and until their successors are appointed and qualified, except that of the initial appointments, 5 members shall be appointed for one year, 5 members shall be appointed for 2 years, and 5 members shall be appointed for 3 years until their successors are appointed and qualified. Appointments to fill vacancies shall be made in the same manner as the original appointments, for the unexpired portion of the vacated term. Initial terms shall begin on January 1, 1994. The chairperson of the Council shall annually appoint a chairperson from among the membership of the Committee.

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Acronyms

42CFR Part 2	42 Code of Federal Regulations, Part 2 of the Confidentiality of Alcohol and Drug Abuse Patient Records
ACA	Affordable Care Act
APCP	Advanced Primary Care Practice
ARRA	American Recovery and Reinvestment Act of 2009
ASAM	American Society of Addiction Medicine
CBO	Congressional Budget Office
CCIIO	Center for Consumer Information and Insurance Oversight
CDC	Centers for Disease Control and Prevention
CMHS	Center for Mental Health Services
CSAT	Center for Substance Abuse Treatment
DMH	Division of Mental Health
DARTS	Department Automated Reporting and Tracking System
DASA	Division of Alcoholism and Substance Abuse
DCFS	Department of Children and Family Services
DBT	Dialectical Behavioral Therapy
DEA	Drug Enforcement Administration
DVA	Department of Veterans Affairs
EBP	Evidence Based Practice
EHB	Essential Health Benefits
EHR	Electronic Health Records
EMDR	Eye Movement and Desensitization and Reprocessing
FQHC	Federally Qualified Health Centers
FQBHC	Federally Qualified Behavioral Health Centers
FASD	Fetal Alcohol Spectrum Disorder
FY	Fiscal Year
G.E.D.	General Education Development
HHS	Department of Health and Human Services
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HRSA	Health Resources and Services Administration
IDHS	Illinois Department of Human Services
IDOC	Illinois Department of Corrections
MAT	Medicated Assisted Treatment
MH	Mental Health

MHPAEA	The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act
NAMI	National Alliance on Mental Illness
NASADAD	National Association of State Alcohol and Drug Abuse Directors
NBER	National Bureau of Economic Research
NCTIC	National Center for Trauma Informed Care
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
NOMS	National Outcomes Measurements System
N-SSATS	National Survey of Substance Abuse Treatment Services
NSDUH	National Survey on Drug Use and Health
NTN	National Treatment Network
OMT	Opioid Maintenance Treatment
PCB	Performance Based Contracting
PCMH	Patient-Centered Medical Home
PFDA	Partnership for a Drug-Free America
POS	Purchase of Service
PPC-2R	ASAM's Patient Placement Criteria Second Revised Edition
PPS	Medicare Prospective Payment System
PTSD	Post Traumatic Stress Disorder
RCSP	Recovery Community Services Program
ROSC	Recovery Oriented Systems of Care
SA	Substance Abuse
SAMHSA	Substance Abuse Mental Health Services Administration
SUD	Substance Use Disorder
TASC	Treatment Alternatives for Safer Communities
TEDS	Treatment Episode Data Set
WSN	Women's Service Network

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