Community Mental Health Partnership of Southeast Michigan PIHP	*Policy* **Women's Specialty Treatment Services**
Department: Substance Use Disorders	**Regional Operations Committee Review Date 08/02/2021**
Implementation Date 10/29/2021	**Oversight Policy Board Approval Date 10/28/2021**

I. PURPOSE

The purpose of this policy is to describe the philosophy and requirements for women's treatment services (designated as both women's programs and gender competent programs) and to describe the contracting of specialized services for women and their children. Women's specific funding is restricted to assuring access for chemically dependent pregnant women, post-partum women and single men who are in treatment while raising their children. Services offered include the provision of transportation, childcare and medical care assistance, as well as needed treatment service and coordination.

II. REVISION HISTORY

DATE	REV. NO.	MODIFICATION
1/2016	1	Revised language
9/2016	2	Language updates
11/2019	3	Language updates and addition of Enhanced Women's Services criteria
3/2021	4	Language and source document updates; addition of MDOC priority population
10/28/2021	5	Change "client" to "individual"

III. APPLICATION

This policy applies to all staff, students, volunteers, and contracted organizations receiving any funding directly or sub-contractually, within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM), who would either provide designated women's specialty treatment services *or* refer individuals who meet criteria for Women's Specialty Treatment services.

IV. DEFINITIONS

Care Management/Care Coordination: an administrative function performed at the PIHP or through the access system, via the core provider

Case Management: a Substance Use Disorder (SUD) program that coordinates, plans, provides, evaluates and monitors services or recovery from a variety of resources on behalf of and in collaboration with an individual who has a Substance Use Disorder. A SUD Women's case management program offers these services through designated staff working in collaboration with the SUD treatment team and as guided by the individualized treatment planning process.

Community Mental Health Partnership of Southeast Michigan (CMHPSM): The Regional

Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and Substance Use Disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Community Based: the provision of services outside of an office setting. Typically these services are provided in an individual's home or in other venues, including while providing transportation to and from other appointments.

Core Components - those elements of an evidence-based program that are integral and essential to assure fidelity to a project, and that must be provided.

Eligible: Pregnant women and women with dependent children, including women who are attempting to regain custody of their children. Men with dependent children are also eligible for this program's ancillary services; see VI. Standards below.

Fetal Alcohol Spectrum Disorder (FASD): an umbrella term describing the range of effects that can occur in an individual whose mother drank during pregnancy. These effects may include physical, mental, behavioral and/or learning disabilities with possible lifelong implications. The term FASD is not intended for use as a clinical diagnosis. It refers to conditions such as fetal alcohol syndrome (FAS), fetal alcohol effects (FAE), alcohol-related neurodevelopment disorder (ARND) and alcohol related birth defects (ARBD).

Gender Competent: capacity to identify differences on the basis of gender is significant, and to provide services that appropriately address gender differences and enhance positive outcomes for the population.

Gender Responsiveness (Designated Women's Program): creating an environment through site selection, staff selection, program development, content and material that reflects an understanding of the realities of the lives of women and girls, and that addresses and responds to their strengths and challenges. (Bloom and Covington, 2000)

Individual Assessment: a face-to-face service for the purpose of identifying functional and treatment needs, and to formulate the basis for the Individualized Treatment Plan to be implemented by the provider.

Individual Treatment Planning: direct and active individual involvement in establishing the goals and expectations for treatment to ensure the appropriateness of the current level of care, to ensure true and realistic needs are being addressed and to increase the individual's motivation to participate in treatment. Treatment planning requires an understanding that each individual is unique and each treatment plan must be developed based on the individual needs, goals, desires and strengths of each individual and be specific to the diagnostic impression and assessment.

OROSC – Office of Recovery Oriented Systems of Care, within the Behavioral Health and Developmental Disabilities Administration (BHDDA), Michigan Department of Health and Human Services (MDHHS)

Recovery: a highly individualized journey of healing and transformation where the person gains control over his/her life. It involves the development of new meaning and purpose, growing beyond the impact of addiction or a diagnosis. This journey may include the pursuit of spiritual, emotional, mental and physical well-being.

Recovery Planning: a process that highlights and organizes a person's goals, strengths and capacities to determine the barriers to be removed or problems to be resolved in order to help people achieve their goals. This should include an asset and strength-based assessment of the individual.

Substance Use Disorder (SUD): a term inclusive of substance abuse and dependence, which also encompasses problematic use of substances.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

V. POLICY

This policy establishes that all services are to be gender and culturally competent, understanding the individual and their environment and embrace the values of a recovery oriented system of care with a full continuum of services. It is the expectation that all *eligible* individuals are evaluated for referral to specialty services where indicated

VI. STANDARDS

The CMHPSM is dedicated to the following fundamental principles as the foundation for integrating women-specific Substance Use Disorder treatment services and non-gender specific services, while focusing on effective and comprehensive treatment of women and their families.

Background:
The Substance Abuse Prevention and Treatment (SAPT) Block Grant requires states to spend a set minimum amount each year for treatment and ancillary services for eligible women. Eligible women have been defined as, "pregnant women and women with dependent children, including women who are attempting to regain custody of their children." (42 U.S.c. 96.124 [e]). Pregnant women are identified as a priority population under the SAPT Block Grant regulations. The ancillary services in this program can also be provided to men who are primary caregivers. Substance Use Disorder

Michigan law extends priority population status to men whose children have been removed from the home or are at danger of being removed under the child protection laws. To support their entrance into and success in treatment, men who are shown to be the primary caregivers for their children are also eligible to access ancillary services such as child care, transportation, case management, therapeutic interventions for children, and primary medical and pediatric care, as defined by 45 CFR Part 96.

To be able to offer services that are gender and culturally competent, it is important to understand the individual and their environment, and embrace values that promote the best services possible to the population. Successful recovery for women requires that the service delivery system integrates Substance Use Disorder treatment, mental health services, recovery supports and, frequently, treatment for past traumatic events. When it is left to the woman seeking treatment to integrate these services, an unnecessary burden is placed on her and her potential for recovery.

To meet the specific needs of women, successful programs begin with an understanding of the emotional growth of women. Current thinking describes a woman's development in terms of the range of relationships in which a woman can engage. This is very different from the theories of emotional growth, which have been the basis of Substance Use Disorder treatment, and which apply to the psychological growth of men. The relationship theories for women suggest that the best context for stimulating emotional growth comes from an immersion in empathic, mutual relationships.

The strongest impetus for women seeking treatment is problems in their relationships, especially with their children. A woman's self-esteem is often based on her ability to nurture relationships. Her motivation and willingness to continue treatment is likely to be fueled by her desire to become a better mother, partner, daughter, etc. Programs that meet the needs of women acknowledge this desire to preserve relationships as strength to be built upon, rather than as resistance to treatment. When a program operates from this theoretical point of view, the characteristics of the clinical treatment program, and its objectives and measures of success are defined very differently from those of traditional treatment programs.

The MDHHS Vision is to implement a change in the practice of women's Substance Use Disorder treatment providers and system transformation in Michigan. This will be accomplished by having a strength-based coordinated system of care, driven by a shared set of core values that is reflected and measured in the way we interact with, and deliver supports and services for families who require substance abuse, mental health, and child welfare services.

Core Values

- Family-Centered: A family centered approach means that the focus is on the family, as defined by the individual themselves. Families are responsible for their children and are respected and listened to as we support them in working toward meeting their needs, reducing system barriers, and promoting changes that can be sustained over time. The goal of a family-centered team and system is to move away from the focus of a single individual represented in a system, to a focus on the functioning, safety and well-being of the family as a whole.
- Family Involvement: The family's involvement in the process is empowering and increases the likelihood of cooperation, ownership and success. Families are viewed as full and meaningful partners in all aspects of the decision-making process affecting their lives, including decisions made about their service plans. It is important to recognize that a woman defines her own family and that this definition may not be traditional.
- Build on Natural and Community Supports: Recognize and utilize all resources in our communities creatively and flexibly, including formal and informal supports and service systems. Every attempt should be made to include the family's relatives, neighbors, friends, faith community, co-workers or anyone the family would like to include in the team process. Ultimately families will be empowered and have developed a network of informal, natural, and community supports so that formal system involvement is reduced or not needed at all.
- Strength-Based: Strength-based planning builds on the family's unique qualities and identified strengths that can then be used to support strategies to meet the family's

needs. Strengths should also be found in the family's environment through their informal support networks, as well as in attitudes, values, skills, abilities, preferences and aspirations. Strengths are expected to emerge, be clarified and change over time as the family's initial needs are met and new needs emerge, with strategies discussed and implemented.

- Unconditional Care: Means that we care for the family, not that we will care "if." It means that it is the responsibility of the service team to adapt to the needs of the family - not of the family to adapt to the needs of a program. If difficulties arise, the individualized services and supports change to meet the family's needs.
- Collaboration Across Systems: An interactive process in which people with diverse expertise, along with families, generate solutions to mutually defined needs and goals building on identified strengths. All systems working with the family have an understanding of each other's programs and a commitment and willingness to work together to assist the family in obtaining their goals. The Substance Use Disorder, mental health, child welfare and other identified systems collaborate and coordinate a single system of care for families involved within their services.
- Team Approach Across Agencies: Planning, decision-making and strategies rely on the strengths, skills, mutual respect, and creative and flexible resources of a diversified, committed team. Team member strengths, skills, experience and resources are utilized to select strategies that will support the family in meeting their needs. Team members may include representatives from the multiple agencies a family is involved in, as well as any who offer support and resources to families. All family, formal and informal team members share responsibility, accountability, and authority; while understanding and respecting each other's strengths, roles and limitations.
- Ensuring Safety: When Children's Protective Services, foster care agencies, or domestic violence shelters are involved, the team will maintain a focus on family and child safety. Consideration will be given to whether the identified threats to safety are still in effect, whether the child is being kept safe by the least intrusive means possible and whether the safety services in place are effectively controlling those threats. In situations involving domestic violence, the team will need to work with the family to develop and maintain a viable safety plan.
- Gender, Age, Culturally Responsive Treatment: Services reflect an understanding of the issues specific to gender, age, disability, race, ethnicity and sexual orientation, and also reflect support, acceptance, and understanding of cultural and lifestyle diversity.
- Self-sufficiency: Families will be supported, resources shared and team members held responsible for achieving self-sufficiency in essential life domains (including, but not limited to safety, housing, employment, financial, educational, psychological, emotional and spiritual).
- Education and Work Focus: Dedication to positive, immediate and consistent education, employment and or employment-related activities that result in resiliency and self-sufficiency, improved quality of Life: for self, family and the community.
- Belief in Growth, Learning and Recovery: Family improvement begins by integrating formal and informal supports that instill hope and are dedicated to interacting with individuals with compassion, dignity and respect. Team members operate from a belief that every family desires change and can take steps toward attaining a productive and self-sufficient life.
- Outcome Oriented: From the onset of family team meetings, levels of personal formal and informal supports, are discussed, agreed upon and maintained. Identified outcomes are understood and shared by all team members. Legal, education,

employment, child-safety and other applicable mandates are considered in developing outcomes. Progress is monitored and each team member participates in defining success. Selected outcomes are standardized, measurable and based on the life of the family and its individual members.

MDHHS is dedicated to the following fundamental principles as the foundation for integrating women-specific Substance Use Disorder treatment services and non-gender specific services, while focusing on effective and comprehensive treatment of women and their families.

Developing a Philosophy of Working with Women with Substance Use Disorders:

Program Structure:

1. Treatment revolves around the role women have in society, therefore treatment services must be gender specific.
   - Gender-responsive programs are not simply "female only" programs that were designed for males.
   - A woman's sense of self develops differently in women-specific groups as opposed to co-ed groups.
   - Because women place so much value on their role in society and relationships, to not take this into consideration in the recovery process is to miss a large component of a woman's identity.
   - Equity does not mean sameness; in other words, equity of service delivery is not simply about allowing women access to services traditionally reserved for men. Equity must be defined in terms of providing opportunities that are relevant to each gender so that treatment services may appear very different depending on to whom the service is being delivered.
   - The unique needs and issues (e.g., physical/sexual/emotional victimization, trauma, pregnancy and parenting) of women should be addressed in a safe, trusting and supportive environment.
   - Treatment and services should build on women's strengths/competencies and promote independence and self-reliance.

2. A relational model, based on the psychological growth of women shall be the foundation for recovery (e.g., the Self-in-Relation model). The recognition that, for women, the primary experience of self is relational; that is, the self is organized and developed in the context of important relationships. (Surrey, 1985)
   - A model that emphasizes the importance of relationships in a woman's life, and attempts to address the strengths as well as the problems arising for women from a relational orientation.

3. A collaborative philosophy, driven by the woman and her family, shall be used.
   - Utilizing cross-systems collaboration and the involvement of informal supports to promote a woman's recovery.
   - An individual-centered, goal-oriented approach to accessing and coordinating services across multiple systems by:
      i. assessing needs, resources and priorities,
      ii. planning for how the needs can be met

iii. establishing linkages to enhance a woman's access to services to meet those identified needs

- Coordinating and monitoring service provision through active cross-system communication and coordinated treatment plans and services.
- Removing barriers to treatment and advocating for services.
- A woman's needs determine the connections with agencies and systems that impact her life or her family's life, despite the number of agencies or systems involved.
- Ideally, each woman will have a single, collaborative treatment plan or service plan used across systems. When this is not possible, coordination of as many systems as possible will lessen the confusion and stress this creates in a woman's life.
- Care coordination and case management are the key to a woman's progress in recovery.

4. A model of empowerment is utilized in treatment and recovery planning.
   - The individual is shown and taught how to access services, advocate for herself and her family, and request services that are of benefit to her and her family.
   - This process is woven into recovery, and could be taught by a recovery coach or women's case manager
   - The ultimate goal for the service system is to weave the woman so well into the informal support systems that the role of formal services is very small or not needed.
5. Employment is recommended as an important component in recovery and serves as an important therapeutic tool.
   - The structure of work is a benefit to recovery, and treatment providers need to be aware of the work requirements of Temporary Assistance for Needy Families/Work First. Historically, treatment providers have been reluctant to encourage individuals to return to work or engage in work related activities during the early stages of recovery. However, waiting to address employment concerns may create further challenges for the individual facing Work First requirements.

6. A multi-system approach that is culturally aware shall be employed in the recovery process.
   - Gender specificity and cultural competence go hand-in-hand. There are a number of gender and cultural competencies that allow people to assist others more effectively. This requires a willingness and ability to draw on community-based values, traditions and customs, and to work with knowledgeable people of and from the community.

Education/Training of Staff:

In addition to current credentialing standards, individuals working and providing direct service within a designated women's program (gender responsive) must have completed a minimum of 12 semester hours, or the equivalent, of gender specific Substance Use Disorder training or 2080 hours of supervised gender specific Substance Use Disorder training/work experience within a designated women's program. Those not meeting the requirements must be supervised by another individual working within the program, and be working towards meeting the requirements. Documentation is required to be kept in personnel files.

Those working and providing direct service within a gender competent program must have completed a minimum of 8 semester hours, or the equivalent, of gender specific Substance Use Disorder training or 1040 hours of supervised gender specific Substance Use Disorder training. Those not meeting the requirements must be supervised by another individual working within the program and be working towards meeting the requirements. Documentation is required to be kept in personnel files. Other arrangements can be approved by the Office of Recovery Oriented Systems of Care (OROSC) Women's Treatment Coordinator.

Appropriate topics for gender specific Substance Use Disorder training include, but are not limited to:

Women's studies
Trauma
Grief
Relationships
Parenting
Child Development
Self-esteem/empowerment
Relational treatment model
Women in the criminal justice system
Women and addiction

Admissions:
Treatment providers must follow the priority population guidelines identified in the State contract with the PIHP, listed below, for admitting women to treatment:

Population	Admission Requirement	Interim Service Requirement
Pregnant Injecting Drug User	1) Screened and referred within 24 hours. 2) Detoxification, methadone or residential- offer admission within24 business hours. 3) Other Levels of Care- offer admission within 48 business hours.	Begin within 48 hours: 1. Counseling and education on: a. HIV and TB. b. Risks of needle sharing. c. Risks of transmission to sexual partners and infants. d. Effects of alcohol and drug use on the fetus. 2. Referral for pre-natal care. 3. Early Intervention Clinical Services.
Pregnant with Substance Use Disorder	1) Screened and referred within 24 hours. 2) Detoxification, methadone or residential- offer admission within 24 business hours. Other Levels of Care – offer admission within 48 business hours.	Begin within 48 hours: 1. Counseling and education on: a. HIV and TB. b. Risks of transmission to sexual partners and infants. c. Effects of alcohol and drug use on the fetus. 2. Referral for pre-natal care. 3. Early Intervention Clinical Services.

Injecting Drug User	Screened and referred within 24 hours. Offer admission within 14 days.	Begin within 48 hours – maximum waiting time 120 days: 1. Counseling and education on: a. HIV and TB. b. Risks of needle sharing. c. Risks of transmission to sexual partners and infants. 2. Early Intervention Clinical Services.
Parent at Risk of Losing Children	Screened and referred within 24 hours. Offer admission within 14 days.	Begin within 48 business hours: Early Intervention Clinical Services.
Individual Under Supervision of MDOC and Referred by MDOC or Individual Being Released Directly from an MDOC Without Supervision and Referred by MDOC	Screened & referred w/in 24 hours. Offer admission w/in 14 days.	Begin w/in 48 business hours: Early Intervention Clinical Services Recovery Coach Services
All Others	Screened and referred within seven calendar days. Capacity to offer admission within 14 days.	Not Required.

* The full table can be found in the MDHHS contract with CMHPSM.

The admission standards listed in the table should be considered minimum standards. Those programs interested in providing the best possible treatment to families should be meeting a higher standard for admission and interim service provision.

Treatment:

Programs that are designed to meet women's needs tend to be more successful in retaining women individuals. For a provider to be able to offer women-specific treatment, its programs shall include the following criteria:

1. Accessibility
   Women's case managers and providers must demonstrate a process to reduce barriers to treatment by ensuring that priority population requirements are met, as well as providing ancillary services or ensuring that appropriate referrals to other community agencies are made.
   - There are many barriers that may critically inhibit attendance and follow-through for women with children. They may include child care, transportation, hours of operation and mental health concerns.

2. Assessment
   Assessment shall be a continuous process that evaluates the individual's psychosocial needs and strengths within the family context, and through which progress is measured in terms of increased stabilization/functionality of the individual/family. In addition, all assessments shall be strength-based.
   - Women with children need to be assessed and treated as a unit. Women often both enter and leave treatment because of their children's needs. By assessing the family and addressing areas that need strengthening, providers give women a better chance at becoming stable in their recovery.

3. Psychological Development
   Providers shall demonstrate an understanding of the specific stages of psychological development and modify therapeutic techniques according to individual needs, especially to promote autonomy.
   - Many of the traditional therapeutic techniques reinforce women's guilt, powerlessness and "learned helplessness," particularly as they operate in relationships with their children and significant others.

4. Abuse/Violence/Trauma
   Providers must develop a process to identify and address abuse/violence/trauma issues. Services will be delivered in a trauma-informed setting and provide safety from abuse, stalking by partners, family, other participants, visitors and staff.
   - A history of abuse, violence and trauma often contributes to the behavior of substance abusing and dependent women. A provider who does not take this history into consideration when treating the woman is not fully addressing the addiction or resulting behaviors.
   - Incorporating Adverse Childhood Events (ACEs) into such work is an essential consideration; see Resources for a helpful tool from the CDC.

5. Family Orientation
   Providers must identify and address the needs of family members through direct service, referral or other processes. Families are a family of choice defined by the individuals themselves. Agencies will include informal supports in the treatment process when it is in the best interest of the individual.
   - Many women present in a family context with major family ties and responsibilities that will continue to define their sense of self. Drug and alcohol use in a family puts children at risk for physical and emotional growth and

developmental problems. Early identification and intervention for the children's problems is essential.

6. Mental Health Issues

Providers must demonstrate the ability to identify concurrent mental health disorders and develop a process to have the treatment for these disorders take place, in an integrated fashion, with Substance Use Disorder treatment and other health care. It is important to note that treatment for both mental health issues and Substance Use Disorders may lead to the use of medication as an adjunct to treatment.

- Women with substance use problems often present with concurrent mood disorders and other mental health problems.

7. Physical Health Issues

Providers shall:

- inquire about health care needs of the individual and her children, including completing the Fetal Alcohol Syndrome Disorder (MDHHS: FASD POLICY #11, 2009) screening as appropriate
- make appropriate referrals, and document individual and family health needs, referrals, and outcomes.
    - Women with a Substance Use Disorder and their children are at high risk for significant health problems. They are at a greater risk for communicable diseases such as HIV, TB, hepatitis and sexually transmitted infections. Prenatal care for women using/abusing substances is especially important, as their babies are at risk for serious physical, neurological and behavioral problems. Early identification and intervention for children's physical and emotional growth and development, and for other health issues in a family is essential.

8. Legal Issues

Providers shall document each individual's compliance and facilitate required communication to appropriate authorities within the guidelines of federal confidentiality laws. Additionally, programs will individualize treatment in such a way as to help a individual manage compliance with legal authorities.

- Women entering treatment may be experiencing legal problems including custody issues, civil actions, criminal charges, probation and parole. This adds another facet to the treatment and recovery planning process and reinforces the need for case management associated with women's services. By helping a woman identify her legal issues, steps that need to be taken, and how to incorporate this information into goals for her individualized treatment plan, a provider can greatly reduce stress on the individual and make this type of challenge seem more manageable.

9. Sexuality/Intimacy/Exploitation

Providers shall:

- conduct an assessment that is sensitive to sexual abuse issues,
- demonstrate competence to address these issues,
- make appropriate referrals,

- acknowledge and incorporate these issues in the recovery plan, and
- assure that the individual will not be exposed to exploitive situations that continue abuse patterns within the treatment process (co-ed groups are not recommended early in treatment, physical separation of sexes is recommended in residential treatment settings).
  - A high rate of treatment non-compliance among females with Substance Use Disorders, with a history of sexual abuse, has been documented. The frequent incidence of sexual abuse among women with Substance Use Disorders necessitates the inclusion of questions specifically related to the topic during the initial evaluation (assessment) process. Lack of recognition of a sexual abuse history or improper management of disclosure can contribute to a high rate of non-compliance in this population.

10. Survival Skills

Providers must identify and address the individual's needs in the following areas, including but not limited to:

- Education and literacy.
- Job readiness and job search.
- Parenting skills.
- Family planning.
- Housing.
- Language and cultural concerns.
- Basic living skills/self-care.

The provider shall refer the individual to appropriate services and document both the referrals and the outcomes.

- Women's treatment is often complicated by a variety of problems that must be addressed and integrated into the therapeutic process. Many of these problems may be addressed in the community, utilizing community resources, which will in turn help the individual build a supportive relationship with the community.

11. Continuing Care/Recovery Support

Providers shall:

- Develop a recovery/continuing care plan with the individual to address and plan for the individual's continuing care needs.
- Make and document appropriate referrals as part of the continuing care/recovery plan and remain available to the individual as a resource for support and encouragement for at least one year following discharge.
  - In order for a woman to maintain recovery after treatment, she needs to be able to retain a connection to treatment staff or women's case managers and receive support from appropriate services in the community.

Enhanced Women's Services:

Agencies with the Women's Specialty Services Designation may apply to the PIHP and

MDHHS to provide enhanced programming. Consultation with the CMHPSM is required to obtain approval for seeking this designation. Standards and program description are fully defined in Exhibit 1, “Enhanced Women’s Services Treatment Technical Advisory, #08”. Men with dependent children are also eligible for this program’s ancillary services; see VI. Standards above.

Purpose:
The purpose of this policy is to incorporate long-term case management and advocacy programming for pregnant, and up to twelve months post-partum, women with dependent children who retain parental rights to their children.

Traditional case management services offered through designated women’s programs tend to be for the duration of the woman’s treatment episode and only office-based interventions. These interventions are frequently performed by the assigned clinician and involve linking and referring the individual to the next level of care or other supportive services that are needed. Enhanced Women’s Services are designed to encourage providers to take case management to the next level for designated women’s providers. This is a long-term case management and advocacy program, and outcomes such as increased retention, decreased use, increased family planning, and a decrease in unplanned pregnancies have shown that the extended support time and commitment to keeping women involved serves this population well.

The Enhanced Women’s Services Treatment model shares the same theoretical basis, relational theory, as women’s specialty services. Relational theory emphasizes the importance of positive interpersonal relationships in women’s growth, development and definition of self, and in their addiction, treatment and recovery. It is the relationship between the woman and the advocate that is the most important aspect of Enhanced Women’s Services Treatment. The Enhanced Women’s Services Treatment model uses both the Stages of Change model and motivational interviewing when working with individuals. The stage of change that the woman is at for each of the identified problem areas of her life is taken into consideration when developing the plan of service. The case manager/advocate uses motivational interviewing techniques to help the woman move along the path toward meeting her goals.

As part of this work, a set of guiding principles has been developed to describe the values and elements that Michigan wants this new system to have. The Enhanced Women’s Services Treatment model, with its peer focus and strategies that include treatment, prevention, and recovery services delivered in a community-based setting, demonstrates the critical components of a ROSC. The long-term support gives individuals a stable basis for a future healthy lifestyle without the need to use or abuse alcohol and drugs. Enhanced Women’s Services Treatment also fits into identified practices in the ROSC transformation process, including peer-based recovery support services, strengthening the relationship with community, promoting health and wellness, expanding focus of services and support, using appropriate dose/duration of services, and increasing post-treatment checkups and support.

As part of sustaining evidence-based practices and core components of the Enhanced Women’s Services Treatment model, a technical advisory has been developed to provide guidance on implementing enhanced women’s services in the state. This technical advisory identifies core components needed for implementation of enhanced women’s services and should be considered as a supplement to the OROSC Women’s Treatment Policy (OROSC Treatment Policy #12). In addition, implementation of these services can also serve as evidence of ROSC transformation.

Components Required for Enhanced Women's Services Programming

1. Any Designated Women's Program is eligible to offer Enhanced Women's Services to the target population. Programs choosing to develop an Enhanced Women's Services program will be required to follow the guidelines of the Women's Treatment Policy (OROSC Treatment Policy #12), as well as those outlined here.

2. The Enhanced Women's Services model will use a three-pronged approach to target the areas where women have problems that directly impact the likelihood of future alcohol or drug exposed births:

- The first is to eliminate or reduce the use of alcohol or drugs. Individuals who are involved with Enhanced Women's Services are connected with the full continuum of Substance Use Disorder services to help the woman and her children with substance use and abuse.
- The second is to promote the effective use of contraceptive methods. If a woman is in control of when she becomes pregnant, there is a higher likelihood that the birth will be alcohol and drug-free. Referrals for family planning, connecting with a primary care physician, and appropriate use of family planning methods are all considered interventions for this aspect of programming.
- The third is to teach the woman how to effectively use community-based service providers, including accessing primary and behavioral health care. The peer advocate teaches women how to look for resources and get through the formalities of agencies in order to access needed services, and how to effectively use the services.

3. Peer advocates in Enhanced Women's Services must be peers, to the extent that they are also mothers and may have experienced similar circumstances as their potential individuals. They do not need to have a Substance Use Disorder (SUD), or be in recovery from a SUD. Agencies should also follow their cultural competency plan for hiring peer advocates. The peer advocate must meet current state training or certification requirements applicable to their position. An additional list of training requirements is provided later in this document.

4. One of the core components of Enhanced Women's Services is transportation. The program requires that peer advocates be community-based and provide reasonable transportation services for their enrolled individuals to relevant appointments and services. Beyond the transportation assistance that this provides to the woman, this has proven to be an excellent time to exchange information.

5. Another core component is the persistence with which the peer advocates stay in touch with their individuals. A woman is not discharged from Enhanced Women's Services because she has not been in contact with her peer advocate for a month or more. It is expected that the peer advocate will actively look for individuals when they have unexpectedly moved and will utilize emergency contacts provided by the individual to re-engage her in services.

Enrollment Criteria

Any woman who is pregnant, or up to twelve months post-partum with dependent children, is eligible for participation in Enhanced Women's Services. This includes women who are involved with child welfare services and are attempting to regain custody of their children. If a woman enrolled in Enhanced Women's Services permanently loses custody of her children, and is not currently pregnant, she must be transferred to other support services, as she is no longer eligible for women's specialty services.

As identified in the Individualized Treatment Policy (OROSC Treatment Policy #06), treatment must be individualized based on a biopsychosocial assessment, diagnostic impression and individual characteristics that include, but are not limited to age, gender, culture, and development. As a individual's needs change, the frequency, and/or duration of services may be increased or decreased as medically necessary. Individual participation in referral and continuing care planning must occur prior to a move to another level of care for continued treatment.

Service Requirements
In addition to the services provided through Women's Specialty Services, the following are requirements of Enhanced Women's Services:

1. Maintain engaged and consistent contact for at least 18 to 24 months in a home visitation/community based services model, expandable up to three years.
2. Provide supervision twice monthly.
3. Require maximum case load of 15 per peer advocate.
4. Continue services despite relapse or setbacks, with consideration to increasing services during this time.
5. Initiate active efforts to engage individuals who are "lost" or drop out of the program, and efforts made to re-engage the individual in services.
6. Coordinate service plan with extended family and other providers in the individual's life.
7. Coordinate primary and behavioral health.
8. Utilize motivational interviewing and stages of change model tools and techniques to help individuals define and evaluate personal goals every three months.
9. Provide services from a strength-based, relational theory perspective.
10. Link and refer individuals to appropriate community services for individuals and dependent children as needed, including schools.
11. Continue to offer services to a woman and her children no matter the custody situation, as long as mother is attempting to regain custody.
12. Provide community-based services; these are services that do not take place in an office setting.
13. Provide transportation assistance through peer advocates, including empowering individuals to access local transportation and finding permanent solutions to transportation challenges.
14. Peer advocates' billable time for transporting individuals to and from relevant appointments is allowable and encouraged.
15. Develop referral agreement with community agency to provide family planning options and instruction.
16. Screen children of appropriate age using the Fetal Alcohol Syndrome (FAS) Pre-screen form attached to the Fetal Alcohol Spectrum Disorders Policy (OROSC Treatment Policy #11).
17. Identify individuals in Enhanced Women's Services programming with the "HD" modifier.

Education/Training of Staff, including Peer Advocates:
Individuals working and providing direct services for Enhanced Women's Services must complete training on the following topics within three months of hire:

- Fundamentals of Addiction and Recovery*
- Ethics (6 hours)
- Motivational Interviewing (6 hours)
- Individualized Treatment and Recovery Planning (6 hours)
- Personal Safety, including home visitor training (4 hours)
- Client Safety, including domestic violence (2 hours)

- Advocacy, including working effectively with the legal system (2 hours)
- Maintaining Appropriate Relationships (2 hours)
- Confidentiality (2 hours)
- Recipient Rights (2 hours, available online)
  *Could be accomplished by successful completion of the MAFE if no other opportunity is available.

In addition, the following training must also be completed within the first year of employment:

- Relational Treatment Model (6 hours)
- Cultural Competence (2 hours)
- Women and Addiction (3 hours)
- FASD (including adult FASD) (6 hours)
- Trauma and Trauma Informed Services (6 hours)
- Gender Specific Services (3 hours)
- Child Development (3 hours)
- Parenting (3 hours)
- Communicable Disease (2 hours, available online)

Peer advocates must complete the above trainings as indicated. Any training provided by domestic violence agencies, the Michigan Department of Health & Human Services, or child abuse prevention agencies would be appropriate. If these trainings are not completed within the one-year time frame, the peer advocate would not be eligible to continue in the position until the requirements are met. Until training is completed, peer advocates must be supervised by another individual who meets the training requirements and is working within the program. Documentation is required and must be kept in personnel files. Other arrangements can be approved by the OROSC Women's Treatment Coordinator.

VII. EXHIBITS

None.

VIII. REFERENCES

Reference:	**Check if applies:**	**Standard Numbers:**
42 CFR Parts 400 et al. (Balanced Budget Act)	X	
45 CFR Parts 160 & 164 (HIPAA)	X	
42 CFR Part 2 (Substance Abuse)	X	
Fetal Alcohol Spectrum Disorders Screening and Referral Policy	x	
Michigan Mental Health Code Act 258 of 1974	X	
The Joint Commission - Behavioral Health Standards		
Michigan Department of Health and Human	X	

Services (MDHHS) Medicaid Contract		
MDHHS Substance Abuse Contract	X	
Michigan Medicaid Provider Manual	X	
HITECH Act of 2009	X	

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