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JUSWR

A JOURNAL OF UNDERGRADUATE SOCIAL WORK RESEARCH, POLICY REVIEWS, & OTHER CREATIVE WORKS

BREAKING BARRIERS · HUMANITY FIRST · TRANSFORMING · PERSON-CENTERED

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School of Social Work
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JUSWR

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About the Journal

Acknowledgements

We would like to express our gratitude to Dean Steven Anderson for supporting our efforts to continue publishing undergraduate student's original work in *JUSWR*: A Journal of Undergraduate Social Work Research, Policy Reviews and Other Creative Works. We also thank the School of Social Work faculty for the encouragement they extended to the authors of our 6th issue. We further wish to acknowledge and extend a very special thanks to the faculty and PhD student advisors for their extraordinary mentoring, guidance, and support on behalf of the student authors.

Dr. Rachel Garthe is our Undergraduate Research Program Coordinator. She brings her enthusiasm and her extensive knowledge of research to our advisory board. We are grateful for her expertise, guidance, and steady support.

Last, but far from least, the Advisory Board and Senior Editor wish to express our pride in and gratitude for our undergraduate peer editors. These stellar students understood they were making a commitment: to participate in mandatory training, to review materials, and to offer viable, supportive recommendations to the student authors. We especially are grateful for their flexibility and dedication. Well done! You'll notice among our Senior Editors, there are five newly minted BSWs. These five editors gave us their support and expertise over the years, and we truly appreciate their dedication. Liz began as a peer editor her freshman year and her positive critiques will be missed. Reed and Maddie became editors during the COVID shutdown and demonstrated their flexibility during those chaotic times. Sarah and Alexis both have contributed to the journal as authors and peer editors. We want to thank these five exceptional students for everything they have done for our journal. Best of luck in your futures!

Staff

Dear Reader:

Welcome to the sixth volume (second issue) of JUSWR: A Journal of Undergraduate Social Work Research, Policy Reviews and Other Creative Works. This journal is a result of a highly collaborative effort between students, faculty, and staff. Undergraduate peer editors were instrumental in the selecting, editing, and submitting recommendations for research pieces to be accepted for publication. These undergraduate peer editors worked closely with the Senior Editor, Rebecca Dohleman Hawley, who did an outstanding job providing feedback, guidance, and prowess throughout the entire publication process. In addition to the work of the undergraduate peer editors and senior editor, we had the help of a doctoral student to help with training, editing, and advising. Faculty members also generously mentored their students in the writing and publication processes, of which we are grateful for their time and energy. Fellow Advisory Board Member, Dr. Jan Carter-Black, provided the team with exceptional guidance and feedback. As the Undergraduate Research Program Coordinator for the School of Social Work and Advisory Board Member of the JUSWR, I approached my role with commitment and enthusiasm, assisting with the peer editor training and editing process. Together, this collaborative team proudly brings you the sixth volume of JUSWR.

The journal was published for the first time in the spring of 2017. This year, Volume 6 is split into two issues to accommodate the number of excellent pieces submitted. Topics range from policy reviews (e.g., SNAP policy, Medicaid, Controlled Substances Act, and policies determining gender affirming care), a research piece on Adverse Childhood Experiences, and a creative piece on invisible labor.

As the Undergraduate Research Program Coordinator for the School of Social Work, I am honored to join such a remarkable editorial team and direct undergraduate research efforts. The journal originated with the aim of supporting undergraduate research and scholarly work, becoming a platform for students to disseminate their findings and work. Some of the ways students can become involved in research at the School of Social Work include: 1) participating as a Research Assistant to a faculty-directed research project, or 2) leading their own area of research with an Independent Study or Project. Students can find more information about these opportunities in the Course Catalog (SOCW 310, 418, and 480). It is from these projects that many students submit posters and papers to this journal or present at the University of Illinois Undergraduate Research Symposium. Other research opportunities include authoring or co-authoring research papers and presentations for peer- reviewed journals and academic conferences, serving as a peer editor for the journal, or pursuing the Undergraduate Research Certificate Program offered by the Office of Undergraduate Research.

The title of this journal was updated to be more reflective of the array of pieces submitted to the journal. For example, the journal includes research pieces, as well as policy briefs and analyses, class papers, and opinion pieces. This journal also accepts original creative pieces for publication. These creative pieces may reflect aspects of students' cultural backgrounds, experiences, or perspectives. As you flip through the current and previous issues of this journal, you will see a glimpse into the knowledge, creativity, critical thinking, and thoughtfulness of the authors across these diverse platforms. Students make contributions that advance social and economic justice, further enhancing their own and their readers' appreciation toward our diverse and constantly evolving social world.

I am pleased to announce the sixth volume (second issue) of JUSWR. This publication provides clear and compelling evidence of the high quality of undergraduate social work research and creative works that contribute to knowledge permeating the School of Social Work and the University of Illinois at Urbana-Champaign.

Sincerely,

Rachel Garthe, PhD
Assistant Professor & Undergraduate Research Program Coordinator
School of Social Work

JUSWR

Creative Expressions

Critical Thinking Forum
Creative Expressions

From the editor:

Critical Thinking Forums give students the opportunity to consider and process rather dense course content through creative expression. Family trees, collages, analysis of existing or creating original song lyrics, poetry, videos, and various other art forms are welcomed. The one caveat is the creative piece must reflect some aspect of the student's lived experience as a member of a particular or combination of their multiple intersecting identities. Students are also required to submit a written description or reflection that addresses the relationship between their chosen creative piece and topics covered in a specific course. Some descriptions discuss the evolution of a student's thought processes, factors that have influenced their core beliefs, and values about how the world should be and what they should expect from said world, as well as issues they are still striving to reconcile that are related to the specific issues conveyed in their creative work.

Note to the reader:

Expletives associated with a particular identity group are included. However, such words must have an expressive and substantive purpose. The inclusion of potentially offensive words for entertainment or mere shock value is forbidden.

Invisible Labor

Michelle Morrison

University of Illinois at Urbana-Champaign

Reflections from the author

I chose to make a book about motherhood, specifically some of my experiences with childbirth, postpartum, and breastfeeding. In my intersectionality paper for diversity class, I wrote about being a mother as my experiential identity, saying the experiences of motherhood have shaped my identity in many ways. As intersectionality demonstrates, we can't separate out our identities, and I can see how this is true here. Motherhood for me is an impactful experiential identity, but it is also an outer and inner identity. For instance, I get carded at the grocery store less often when I have my kids with me because of how I am perceived.

In this piece, I wanted to explore the inner part of this identity, some of the parts of motherhood that aren't seen and aren't known to the world. I suppose I mean some of the parts of myself that aren't seen or known to the world; the parts that aren't easy or pretty or often talked about; the parts that don't make my Instagram feed or the family Christmas card…the parts that only I know.

The most intense moments of motherhood, the moments that became turning points in my life, haven't happened at the park, or the grocery store, or on vacation. They happened in our home, in a hospital, or at a medical appointment, or in the middle of the night. Moments and struggles that very few people really know about or were present for. These moments taught me who I am and who I could be. These moments scared me, empowered me, and most definitely transformed me.

When I look at these images, I feel the feelings that past versions of me felt. I remember what it was like to be her. To struggle, and cry, and work, and love, and care, and grow, and suffer, and succeed. For me these are the iconic images of my motherhood, all turning points in my life, the moments that were pregnant with my developing identity.

Keywords: birth, postpartum, labor and delivery, pregnancy

About the Author: *Michelle Morrison is a senior Social Work. Next fall, she will start the Master of Social Work program in the Leadership and Social Change concentration. Her interests are in policy and macro work within social work.*

INVISIBLE LABOR

The birth of a child is, usually, a distinct turning point in the life course of a parent. Although this event effects every aspect of a parent's life it can, specifically and deeply, impact the inner identity and self-knowledge of the birth giving parent. The experiences of pregnancy, childbirth, and postpartum can be intense and overwhelming, and are so privately and internally experienced.

I have been pregnant five times and have carried to term and delivered four of those times. These experiences for me were so intensely physical, emotional, medical, and mental. Looking back I can see how they were turning points in my life. They happened in my body and to my body. They changed my body’s chemistry and rewired my brain, they injured me, and empowered me, and educated me, and changed me. These moments shaped who I knew myself to be.

It is hard to explain how all encompassing these experiences were. The way my heart still races when I think of my fourth baby being stuck in my pelvis for a few minutes and the risk that put him in, or the mental blur of the years when I had three children under the age of 5... and then had one more. It is hard to sum up the feeding struggles, the torn tissue, the sleep deprivation, the smiles, giggles, love, and struggles. It all happened to me, in moments that no one saw.

I started this project in an attempt to make these invisible experiences, and turning points, visible, to demonstrate how a birth giving parent is also reborn as a new person each time they have a child. The experience can be uncomfortable and scary, but also beautiful and always transformative.

Content warning:
This project deals with my experiences in labor, childbirth, postpartum, and breastfeeding and includes pictures of labor, delivery, and breastfeeding.
Please take care of yourself accordingly.

2009

24years old

About 3:30am

As I was in transition and nearing the pushing stage, I remember thinking :"I can't believe this feels like this!"

Nothing can really prepare you for how intense the experience of childbirth is.

I had been awake for close to
24 hours at this point

I had a Certified Nurse Midwife/Nurse Practitioner as my medical provider.

"A midwife is a trained health professional who helps healthy women during labor, delivery, and after the birth of their babies. Midwives may deliver babies at birthing centers or at home, but most can also deliver babies at a hospital."

(What Is a Midwife?, 2012)

Coming home

How do I reenter my life?

I am not the same person I was when we left here 4 days ago.

I don't know what I'm doing.

I haven't slept in days.

Everything hurts.

I'll hold my baby.

We are in this together.

Nipple Shield

"A nipple shield is a flexible silicone nipple that is worn over the mom's nipple during a feeding. Nipple shields should in general be considered a short-term solution and should be used under the guidance of a lactation consultant".

(Nipple Shields, 2018)

Feeding isn't always easy

1 Baby

Miscarriage

""the natural expulsion of an embryo or fetus from the womb before it is sufficiently developed to survive"

"failure to carry out what was intended"

(Collins English Dictionary. Copyright © HarperCollins Publishers, n.d.)

About 10 to 20 percent of known pregnancies end in miscarriage."

(Miscarriage - Symptoms and Causes, 2021)

I was pregnant for the second time. I only made it to 8 weeks.
The pregnancy wasn't viable, but I wasn't bleeding.
I had a D&C, Dilation and curettage, abortion procedure.

I bled, I recovered, we tried again.

For me, having a miscarriage wasn't devastating. It was sad, and a little strange, it felt like a lot for my body to go through but it was ok to.
I was glad it happened early in the pregnancy.

I was surprised how many women, told me that they had a miscarriage when they found out that I had one.

Miscarriage happens often, we tend not to talk about it.

2011

- Water Birth -

"is the process of giving birth in a tub of warm water."

(Water Births, 2021)

While I was pushing I remember thinking that it felt like there was a bowling ball between my hips. it was, of course, that baby's head.

26 years old

Newborns
smell
like
magic.

2 Babies

All of the things that seemed hard with the first baby felt more natural this time.
I knew what I was doing with a baby now.
But now there were two little ones needing my attention. I once cried while nursing this second baby because I had to tell my first that I couldn't play cars with him.

We eventually all adjusted to this new situation and found our footing again.

Labor

"Regular contractions of the uterus that result in dilation and effacement of the cervix." (Labor and Birth Terms to Know, 2022)

starting transitional labor

2013

28 Years Old

I was an old pro at labor by this time.
This baby came so fast at the end that the midwife almost didn't make it into the room before I delivered.

I remember waiting to get into the tub of soothing warm water and thinking "It feels like there is a freight train running through my body"
As soon as I hit the water, baby started crowning.

My
Easiest
feeding
experience

"...parents lose an average of 133 nights' worth of sleep before their babies turn one."

(Survey Shows Parents Lose a Total of 133 Nights of Sleep in Baby's First Year, 2021)

I had 3 babies in 4 years

3 Babies

Home Birth

"The act of giving birth to a child in one's own home."

(Homebirth, n.d.)

31 years old

2016


La Bassine

Shoulder Dystocia

"Shoulder Dystocia occurs when the shoulders of the fetus become lodged behind the maternal pubic symphysis, impeding descent and expulsion."

(Gesner et al., 2022)

He was stuck...my baby's shoulder was stuck on my pelvic bone. the most uncomfortable part of labor was stretching on for minute after agonizing minute.

Would he be injured?
Would he come out?

We are at home, not in a hospital.

In this picture my husband still looks happy and relaxed because he didn't yet realize that there was a problem.

The next 2-5 minutes were harrowing.

These are still hard for me to look at

McRoberts Maneuver

"Performing the McRobert's technique requires two personnel positioned at each leg of the patient. The assistants grab and push the maternal feet cephalad — this action results in hyperflexion of the maternal hips and knees onto along with slight hip abduction resulting in the superior displacement of the pubic symphysis by 1-2 cm."

(Gesner et al., 2022)

They got my knees up and he came out...he finally came out!

Relief and concern. worry and gratitude.

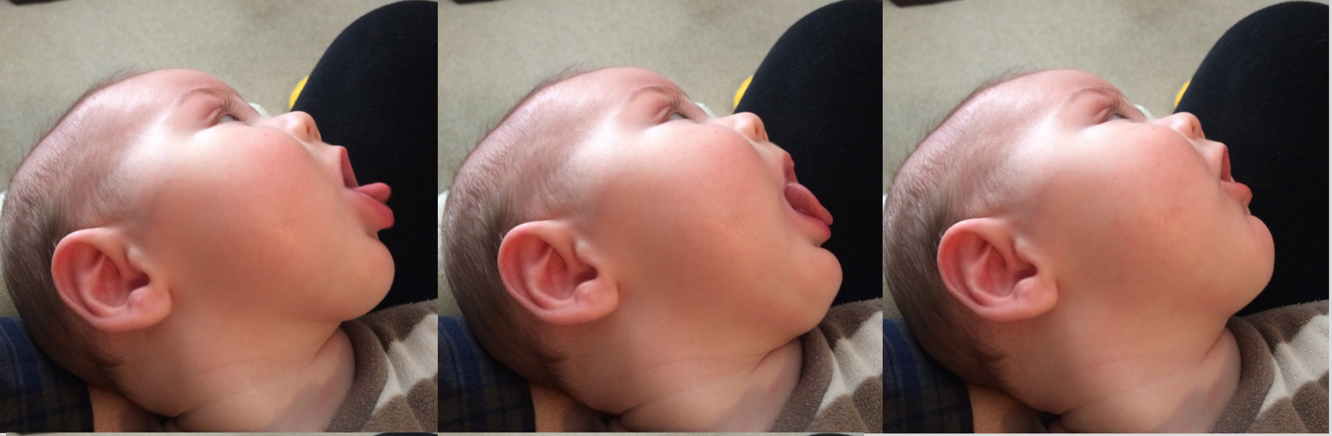
This is the moment the storm past.

We had all been scared.

Postpartum

"The Period after childbirth."
(Labor and Birth Terms to Know, 2022)

One day postpartum;
soaking my stitched-up
perineum in a warm bath.
continuing to bleed from
childbirth and just starting to
leak milk from my sore nipples.



Moving his tongue in new
ways
now that it was released.

Tongue Tie

"A congenital condition that can affect infants and children due to having a short lingual frenulum that restricts tongue movement and impacts the function of the tongue.

Infants...experience feeding difficulties because of the condition." (Issues Feeding With Tongue & Lip Tie | Early Intervention, 2022)

Treatment: laser surgery done by a pediatric dentist

My most difficult feeding experince

He was so hungry but would lose the seal and gulp in air. He worked so hard that he would tire sooner and not get the fatty milk he needed, then be hungry sooner.
He was tenacious and never had a weight problem but we struggled.

He had laser surgery at 3 months.
I wish I had done it sooner.

We did stretches after every feeding for a month. Babies usually feed every 2-3 hours, sometimes longer stretches at night.

Everything started to change; feeding felt normal, easy, good.

2017

Diastasis Recti

"During pregnancy, the growing uterus stretches the muscles in the abdomen. This can cause the two large parallel bands of muscles that meet in the middle of the abdomen (rectus muscles) to become separated by an abnormal distance — a condition called diastasis recti or diastasis recti abdominis." (Diastasis Recti: How Does Pregnancy Affect Stomach Muscles?, 2020)

Besides my separated abdominals I was struggling with a bulging disk in my back, extra weight and a worn down body. I felt broken. I had to rebuild myself, I had to rebuild my body . It took a few years, some specialized physical therapy programs, and consistency, but I did it.

2019

4 Babies

1 Family

Parents go through intense life changing experiences quietly, privately, invisibly. These can be private moments but are also often seen as taboo. No one wants to hear about bleeding, or tearing, or sore nipples...it isn't polite. We birthing parents then often feel alone and as a society we lose connection to the work and labor of childbearing. The risk, and reward, and turmoil.

Take Aways

If this project leaves you with questions; good!
Go read about the history of gynecological care, America's maternal and fetal death rate, and how much we spend as a country on OB care.
Go ask your grandmothers, sisters, aunts, and friends about their experiences. Go find out what people have been through.

With this project I hope to salute all the birth giving parents, and their support people.
Especially those who had complicated pregnancies, deliveries, or postpartum. Those who suffered loses, had surgeries, and Neonatal intensive Care stays.

You brought life into this world.
And you became a new person at the same time.

References

Collins English Dictionary. Copyright © HarperCollins Publishers. (n.d.). Miscarriage definition. Collins Dictionary. Retrieved August 29, 2022, from https://www.collinsdictionary.com/us/dictionary/english/miscarriage

Diastasis recti: How does pregnancy affect stomach muscles? (2020, August 18). Mayo Clinic. https://www.mayoclinic.org/healthy-lifestyle/pregnancy-week-by-week/expert-answers/diastasis-recti/faq-20057825?reDate=30082022

Gesner, T., Toncar, A., & Griggs Jr., R. (2022, July 19). NCBI - WWW Error Blocked Diagnostic. McRobert's Maneuver. https://www.ncbi.nlm.nih.gov/books/NBK537280/

homebirth. (n.d.). TheFreeDictionary.com. https://www.thefreedictionary.com/homebirth

Issues Feeding with Tongue & Lip Tie | Early Intervention. (2022, January 20). Pathways.org. https://pathways.org/feeding-difficulties-infants-tongue-tie-lip-tie/

Labor and Birth Terms to Know. (2022, February 14). American Pregnancy Association. https://americanpregnancy.org/healthy-pregnancy/labor-and-birth/labor-and-birth-terms-to-know/

Miscarriage - Symptoms and causes. (2021, October 16). Mayo Clinic. Retrieved September 12, 2022, from https://www.mayoclinic.org/diseases-conditions/pregnancy-loss-miscarriage/symptoms-causes/syc-20354298

Nipple shields. (2018, January 13). KellyMom.com. https://kellymom.com/ages/newborn/nb-challenges/wean-shield/

Survey Shows Parents Lose a Total of 133 Nights of Sleep in Baby's First 2021, April 1). Parents. https://www.parents.com/news/survey-shows-parents-lose-a-total-of-133-nights-of-sleep-in-babys-first-year/

Water Births. (2021, December 9). American Pregnancy Association. https://americanpregnancy.org/healthy-pregnancy/labor-and-birth/water-births/

What Is a Midwife? (2012, June 8). WebMD. Retrieved September 14, 2022, from https://www.webmd.com/baby/what-is-a-midwife-twins

Policy Analyses

SNAP Policy: A Policy to Grapple with Food Insecurity in the United States

Liz Guenther

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Abstract

Every month, 35 million Americans struggle with food insecurity and receive Supplemental Nutrition Assistance (SNAP) benefits (Coleman-Jensen et al., 2019). SNAP has a vibrant history and has made a tremendous impact on the lives of Americans. Not only does the policy help address hunger in the United States, it also impacts the American economy. For every billion dollars invested, the gross domestic product of the United States increases by 1.5 billion dollars (Nestle, 2019). SNAP has many strengths in its eligibility and benefits as it offers a clear-cut approach to food insecurity with its specific poverty classifications. It also offers flexibility with the usage of the Link Card to buy and purchase groceries (Gunderson, 2019). Additionally, the Families First Coronavirus Response Act offers alterations to the policy to address COVID-19 concerns (Poole et al., 2021). While the policy has made a significant impact on hunger in the United States, there are several ways that SNAP could be improved to expand its impact on Americans and represent a more equitable policy.

Keywords: SNAP, Supplemental Nutrition Assistance Program, food insecurity, food equity, COVID-19 food insecurity

About the Author: *Liz Guenther graduated with her BSW in 2022 and is pursuing an MSW at the University of Illinois at Urbana-Champaign. She is interested in community wellness, health equity, healthcare, and wellness interventions to improve communities across the United States.*

Introduction to Social Issue

A shocking 35 million Americans battle food insecurity and receive SNAP benefits monthly (Coleman-Jensen et al., 2019). While food insecurity has been improving since the 2008 recession, it has been projected that the impacts of the COVID-19 pandemic will show increases in hunger across the United States (Coleman-Jensen et al., 2019). It was reported that 15 percent of households were impacted by food insecurity during the early stages of the COVID-19 pandemic, increasing from 11 percent pre-pandemic (Harrison, 2021). Food insecurity is connected to many significant negative health effects, and children are particularly victimized by the harms associated with hunger and food insecurity. Many research studies have echoed children in households that struggle with food insecurity are more likely to have cognitive issues, anxiety, developmental issues, and behavioral problems (Gundersen & Ziliak, 2015). A shocking 44% of SNAP participants were found to be children (USDA, 2021). These findings also connect to the demographics of people who struggle with hunger. Households that were at the greatest risk for food insecurity were single-parent households (USDA, 2021). Additionally, Latinx and African American households were much more likely to be food insecure than White families (USDA, 2021). In Kornbluh's research, they argue hunger has always been a civil rights problem because it has disproportionately impacted People of Color (POC) individuals in the southern United States (Kornbluh, 2015). Kornbluh traces how the movement to establish the Food Stamp Act of 1964 nationwide was greatly connected to African American activists in the South during the 1960s (Kornbluh, 2015). Latinx households also have had a very complex history of fighting to improve food access. Language barrier issues, racial discrimination, and immigration issues all represent significant barriers when obtaining nutritious and healthy food options (Vasquez-Huot & Dudley, 2021).

Even though research is still being conducted about the implications of COVID-19 on food insecurity and hunger in the United States, preliminary studies of the impacts of COVID-19 have found insights about the rise of hunger in the United States. More than one out of four families did not have dependable sources of food during the recent events of COVID-19 (Poole et al., 2021). COVID-19's impact on schools have affected food security tremendously, and families with children have had to rely on food programs to buoy their households (Poole et al., 2021). When the pandemic first began, around 30 million children were not able to receive food that they would typically receive at school due to the pandemic (Poole et al., 2021). Heads of households had lost jobs, and many schools closed during the height of the pandemic (Poole et al., 2021).

Current Policy Provisions and Funding

When policies are put into place to address food insecurity and hunger, there are many benefits for the country at large. The Supplemental Nutrition Assistance Program (SNAP) is the largest federally funded program to address hunger in the United States, and it is an aspect of the Food Stamp Act of 1964 (Nestle, 2019). Although its name has been changed to SNAP, the benefits associated with SNAP were an important aspect of the Food Stamp Act of 1964 (Nestle, 2019). The Food Stamp Act of 1964 was passed in response to John F. Kennedy finding out that the views of American prosperity were not the case for all Americans (Kornbluh, 2015). The Food Stamp Act of 1964 was passed in order to address hunger that was fueled by the rampant poverty issues in the United States, particularly in the South and Appalachia America (Kornbluh, 2015). This act included the Women, Infants, and Children program, food programs for children, and food stamps (Kornbluh, 2015). One distinguishing characteristic of SNAP is its protection under the Farm Bill, which does not allow for SNAP to ever be fully eliminated from American policy (Nestle, 2019). This was partially passed because there has been a long-term uproar by politicians to eliminate SNAP participants who abuse the welfare system (Nestle, 2019). There are many reasons why investing in SNAP represents value for American society. When money is invested into SNAP, there are many beneficial effects to the economy. One billion dollars of funding has established around 8,900 to 17,000 jobs (Feeding America, 2021). Additionally, when 1 billion dollars is invested into SNAP, the United States' gross domestic product increases by 1.5 billion dollars (Nestle, 2019). Currently, 68 billion dollars are spent on SNAP (Center on Budget and Policy Priorities, 2019). The United States Department of Agriculture (USDA) funds all of the benefits, but 50% of the administrative costs are up to the specific states and counties to cover (Barusch, 2018). Even though it is funded federally, states have their own offices that individuals attempting to receive SNAP benefits must go to in order to complete the SNAP application process (Center on Budget and Policy Priorities, 2019).

Eligibility

Any person can apply to receive SNAP benefits if they have qualifying incomes because SNAP is a means-tested program (Nestle, 2019). Federally, incomes at or below 130 percent of the federal poverty line qualify for SNAP (USDA, 2021). The program targets families with children, and there are rules surrounding households without any children (USDA, 2021). If you do not have children and are able to work, you can only get benefits for three months during a three-year timeframe, then you are required to work a minimum of 20 hours a week in a job or participate in a job training program for an equivalent timeframe (USDA, 2021). Additionally, most participants are United States citizens. There are certain immigrant groups that qualify for

SNAP, but other groups, like undocumented immigrants, do not qualify (Keith-Jennings et al., 2019). In Illinois, income, household expenses, and the number of people in a household are considered in the determination of SNAP benefits (Illinois Department of Human Services, 2019). It is necessary to consult one's state-specific office to determine the benefits (Illinois Department of Human Services, 2019).

Benefits and Delivery of SNAP

Individuals who receive SNAP benefits will be given these resources through the Illinois Link Card, and this card functions similarly to a debit card (Illinois Department of Human Services, 2020). However, individuals cannot spend their SNAP money on all items available for purchase. They can buy most food items, drinks, and food plants, but there are some exceptions relating to what SNAP participants are able to purchase (Nestle, 2019). They cannot buy tobacco, pet food, foods that are hot, supplements, or alcohol (Nestle, 2019). The USDA, which helps facilitate the SNAP program, regulates some official stores to have SNAP-approved food available for those in the program (Nestle, 2019). For this reason, most SNAP benefits are spent at grocery stores and gas stations/convenience stores, but New York has recently tested how SNAP could be used online food markets, like Amazon and Walmart (Nestle, 2019).

Strengths and Weaknesses of SNAP

With SNAP being a significant program to address hunger issues in the United States, it is important to consider how well it targets the policy's concerns. One major strength of the program is its ability to focus on the vulnerable populations in the United States (Gundersen, 2019). In some ways, SNAP adequately addresses hunger for those who are below the 130 percent index, and the very specific eligibility requirements successfully targets those with the greatest likelihood of struggling with hunger (Gundersen, 2019). Even though poverty alleviation is not necessarily the prime reason for SNAP's development, those who are struggling are targeted through the income requirements (Gundersen, 2019). An additional strength of SNAP is its options which allow those who receive benefits more flexibility, such as how many stores allow shoppers to use their SNAP Cards to purchase food items (Gundersen, 2019). This allows recipients the opportunity to choose how they spend their SNAP benefits, and it does not limit them into specific locations to use their benefits (Gundersen, 2019). Another strength of the SNAP program is that the current concerns associated with hunger and the COVID-19 pandemic have been incorporated into the policy. For instance, programs that target the malnutrition of children often took place in schools, such as the National School Lunch Program (Poole et al., 2021). In the Families First Coronavirus Response Act, SNAP benefits were allowed to increase to the maximum amount for a family of four people (Poole et al., 2021). Even though the attempts to adapt the SNAP program to fit the new needs of the pandemic are admirable, it also is important to consider that the increase in the SNAP benefits did not impact the families collecting the maximum amount of SNAP benefits (Poole et al., 2021).

Though SNAP has greatly impacted hunger and food insecurity in the United States, it is important to note that there are significant weaknesses in the current policy. Even though it could be argued that SNAP's current iteration adequately provides benefits, one weakness of SNAP is that the eligibility requirements can be very rigid and favor individuals with children. For this reason, some people may be left out and unable to receive food resources. Those who are unemployed, able-bodied, and do not have any children are held to very rigid standards with limited timeframes of program involvement (Gundersen, 2019). College students often fit into these descriptions, and even though they have limited income, they typically are not able to qualify for SNAP (Keith-Jennings et al., 2019). Additionally, these strict requirements are punitive to individuals who are viewed as able-bodied. The specific work requirements of SNAP can ignore a very vulnerable population of individuals with disabilities (Ku et al., 2020). Another problematic component of SNAP is its limitations on the types of items purchased (Gundersen, 2019). The USDA affirms these rules and regulations are important in order to make sure that the recipients are using their SNAP benefits for the most important items to prevent malnutrition (Gundersen, 2019). These limitations are important to consider because they limit the self-determination of SNAP recipients and also intensify the stigmas associated with individuals who partake in SNAP (Gundersen, 2019). By making SNAP more regulated and making some purchases taboo, these regulations alienate and isolate SNAP recipients further from their communities. Some of the taboo items are pet foods, hot foods, and vitamins (USDA, 2021). There can be additional restrictions if an individual has a felony, and this can greatly impact marginalized communities who have been targets of mass incarceration (Gundersen, 2019). In Ku et al.'s work, they examined how the work requirements can impact the equity of SNAP and put the supposed equality of the program into question. Their research found that the work requirements of SNAP made Black and Latinx Americans less likely to participate in SNAP than their White counterparts (Ku et al., 2020). Another weakness is that the program might not provide adequate resources in order for families to purchase enough food. SNAP recipients often purchase the bulk of their goods at the beginning of the month, having little money left over. As a result, families often decrease their caloric intake by 38% in the later part of any given month (Keith-Jennings et al, 2019). This is an important point to consider because families may not be able to purchase nutrient-dense foods with such a limited budget. As a result of this low amount of money per meal, the SNAP benefits provided often causes many families to seek out unhealthier food options to make SNAP stretch. Obesity has become a significant issue after the passage of SNAP in the Food Stamp Act of 1964 (Baum, 2011).

The SNAP program also can be evaluated through the lens of adequacy, equality, and equity. This program is very much adequacy-based because there is a standard which if not met is considered inadequate. That standard is at or below 130% poverty line (USDA, 2021). The government has deemed that those below this poverty line would be living in inadequate conditions, primarily food insecurity. The SNAP program does not seem to be concerned with numeric or proportional equality. If it were, these benefits would be going equally to everyone in the United States or to only those who earn more and thus pay more taxes. On the other hand, SNAP can be seen as equitable depending on one's perspective. If one believes that families are providing the state with an important service, that service being raising children to be productive citizens, then the assistance they receive would be equitable. However, if one believes that children and less advantaged families are a drain on society, providing little benefit compared to families with higher earning jobs, then SNAP would not be seen as equitable. SNAP is equitable, because it is providing crucial resources for families to nurture the next generation.

Policy Recommendations

Even though SNAP has provided significant resources for individuals struggling with hunger in the United States, it is important that the policy continually improves to fit the needs of American society. One aspect of the SNAP program that should be reconsidered to improve its adequacy, equity, and equality is the work requirements necessary to receive these benefits. For instance, if the United States changed the work requirements, SNAP would cover more Americans and as such would better represent numeric equality. College students are an extremely vulnerable population, and it would be worthwhile to reconsider work requirements in their case (Keith-Jennings et al., 2019). Relaxing student work requirements would make the policy more equitable, as students would be receiving compensation for the future value the state will receive in tax revenue after these individuals become educated. Additionally, the work requirements would also help to address the equality issues of SNAP. The policy associated with SNAP is unintentionally not providing equality to African American and Latinx individuals in the United States (Ku et al., 2020).

Another component of SNAP that should be examined and altered is its stipulations on the products that individuals can buy with SNAP. In American history, there has been a maligning of welfare policies, leading to the limiting of these types of purchases (Nestle, 2019). These effects have predominantly been present in African American and Latinx individuals and families, realized in lowered participation in the program (Nestle, 2019). By relaxing these regulations, the policy better represents equality through the increased participation of qualifying families and individuals.

SNAP has been a revolutionary policy to address food insecurity in the United States. It has made tremendous strides to improve food access for all Americans and has had a significant impact on the lives of future generations in the United States. Its impact shouldn't be understated, but there are several avenues to improve its effectiveness and efficiency. With these alterations, SNAP can continue to amplify its legacy and reach more Americans to create a more abundant, equitable, and flourishing country.

References

Barusch, A. S. (2017). *Foundations of Social Policy: Social Justice in Human Perspective, Sixth Edition*. Belmont, CA: Brooks/Cole.

Baum, C. L. (2011). *The Effects of Food Stamps on Obesity*. Southern Economic Journal, 77(3), 623–651. https://doi-org.proxy2.library.illinois.edu/10.4284/sej.2011.77.3.623

Center on Budget and Policy Priorities. (2021). *Policy Basics: The Supplemental Nutrition Assistance Program (SNAP)*. Retrieved April 9, 2021, from https://www.cbpp.org/research/food-assistance/the-supplemental-nutrition-assistance program-snap

Coleman-Jensen, A., Rabbitt, M., Gregory, C., Singh, A. (2020). *Household Food Insecurity in the United States in 2019.* Economic Research Report. Retrieved from: https://www.ers.usda.gov/webdocs/publications/99282/err 275.pdf?v=9606.7

Feeding America. (2021). *Understanding SNAP, the Supplemental Nutrition Assistance Program.* Retrieved April 11, 2021, from https://www.feedingamerica.org/take action/advocate/federal-hunger-relief-programs/snap

Gundersen, C. (2019*). The Right to Food in the United States: The Role of the Supplemental Nutrition Assistance Program (SNAP).* American Journal of Agricultural Economics, 101(5), 1328–1336. https://doiorg.proxy2.library.illinois.edu/https://academic.oup.com/ajae/issue

Gundersen, C. & Ziliak, J. (2015). *Food Insecurity and Health Outcomes: Health Affairs Journal.* Retrieved April 11, 2021, from https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.0645

Illinois Department of Human Services (2020). *Supplemental Nutrition Assistance Program - SNAP* (10/01/2020). Retrieved April 11, 2021, from https://www.dhs.state.il.us/page.aspx?item=30357

Harrison, R. (2021, September 22). *Covid-19 pandemic exacerbated food insecurity, especially in families with children*. NYU. Retrieved August 15, 2022, from https://www.nyu.edu/about/news-publications/news/2021/september/pandemic-food insecurity.html

Keith-Jennings, B., Llobrera, J., & Dean, S. (2019). *Links of the Supplemental Nutrition Assistance Program With Food Insecurity, Poverty, and Health: Evidence and Potential*. American Journal of Public Health, 109(12), 1636–1640. https://doi-org.proxy2.library.illinois.edu/10.2105/AJPH.2019.305325

Kornbluh, F. (2015). *Food as a Civil Right: Hunger, Work, and Welfare in the South after the Civil Rights Act. Labor: Studies in Working Class History of the Americas*, 12(1/2), 135 158. https://doi-org.proxy2.library.illinois.edu/10.1215/15476715-2837640

Ku, L. (2020). *Association of Work Requirements With Supplemental Nutrition Assistance Program Participation by Race/Ethnicity and Disability Status, 2013-2017.* JAMA Network Open., 3(6), e205824. https://doi.org/10.1001/jamanetworkopen.2020.5824

Nestle, M. (2019). *The Supplemental Nutrition Assistance Program (SNAP): History, Politics, and Public Health Implications.* American Journal of Public Health, 109(12), 1631–1635. https://doi-org.proxy2.library.illinois.edu/10.2105/AJPH.2019.305361

Poole, M. K., Fleischhacker, S. E., & Bleich, S. N. (2021). *Addressing Child Hunger When School Is Closed - Considerations during the Pandemic and Beyond*. The New England Journal of Medicine, 384(10), e35.

Vasquez-Huot, L. M. (1), & Dudley, J. R. (2). (2021). The Voices of Latinx People: Overcoming Problems of Food Insecurity. Journal of Hunger and Environmental Nutrition, 16(1), 64–81. https://doi org.proxy2.library.illinois.edu/10.1080/19320248.2020.1717713

USDA. (2021). *Food security and Nutrition Assistance.* Retrieved April 11, 2021, from https://www.ers.usda.gov/data-products/ag-and-food-statistics-charting-the essentials/food-security-and-nutrition-assistance/

Policy Analysis: The Expansion of Medicaid

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Abstract

This paper analyzes the expansion of Medicaid through the Affordable Care Act. The impact that this expansion has had is reviewed, further examining its effect on varying populations, strengths, and weaknesses. It also assesses how well the policy addresses equality and equity by looking at its level of coverage among varying populations. This assessment explores a flaw in the policy's implementation: the coverage gap, which leaves many Americans without access to affordable health insurance. Furthermore, alternative solutions that address any weaknesses are considered and further reviewed such as universal healthcare and premium tax credits. These solutions take into account where the current policy may be lacking, and recommendations are put forth.

Keywords: Medicaid, Medicaid expansion, Affordable Care Act, healthcare, affordable health insurance

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The Social Problem

Visiting a doctor when one is ill should be an instinctive response, yet in the United States, this is often when the thoughts and fears of unwavering debt occur. One trip to the doctor can become a life-altering decision for many due to resulting financial hardship. A lack of health insurance (or affordable health insurance) is a dilemma that millions face, about 32.8 million under 65 years old to be exact (Centers for Disease Control and Prevention, 2019). In Addition, it is known that racial disparities are extremely prevalent in the United States, and they do not stop at health insurance. The largest uninsured demographics are Hispanic adults at 30.2%, followed by 14.3% of those that are non-Hispanic Black adults. Non-Hispanic white adults have the lowest rates of being uninsured, at 10.2% (Centers for Disease Control and Prevention, 2019). Without health insurance, one is much more likely to face adverse health effects. Henry J. Kaiser Family Foundation (KFF), a credible, non-profit research organization, found evidence of these consequences through their research. An incredibly important aspect of healthcare is preventative care, where one goes for regular checkups and screenings. Those who are uninsured are much more likely to postpone or disregard this type of healthcare, which can leave preventable or chronic conditions to persist without awareness. Reportedly, 42.5% of those uninsured have not seen a healthcare professional in the last 12 months (Tolbert & Orgera, 2020). One crucial reason that preventative care is so important is its ability to avert chronic disease. The United States has some of the highest rates of chronic disease, which can be prevented through access to this type of care. (Levine et al., 2019). Sixty percent of American adults have one chronic disease, and 42% have more than one, with the three most common being heart disease, cancer, and diabetes. These substantial numbers indicate that something in the U.S. healthcare system is not working (Centers for Disease Control and Prevention, 2021).

Compared to 10 other high-income countries, the United States spends the most on healthcare (proportionately to all economic expenses) and has the lowest life expectancy and highest suicide rates. Chronic disease rates also exceed these other countries (The Commonwealth Fund, 2020). Being the top reason for death and disability in the United States, these diseases are often preventable. Without affordable access to healthcare, many have no choice but to forgo their annual visit or screening.

With the many consequences associated with avoiding preventative care, including one's own life, it may seem obvious that the solution is to obtain insurance coverage. The disappointing truth is that this phenomenon is not attainable for many groups in the United States. Of the uninsured, 73.7% of non-elderly adults do not obtain coverage because it is not affordable and 25.3% are not eligible (Tolbert & Orgera, 2020). Low-income families often do not have a choice, even with a worker in the family. Furthermore, 73.2% of those uninsured (non-elderly) have one or more workers in the family (Tolbert & Orgera, 2020), which contradicts the common idea that getting a job will fix one's financial problems. Healthcare policies in the United States are certainly not comprehensive. These policies leave many with the terrifying choice of allowing an illness to take over their lives or falling into debt.

Policy Provisions

One policy that has impacted this issue by decreasing the number of those uninsured is the Patient Protection and Affordable Care Act (ACA). The number of those uninsured in America is now 13.7 million lower than it was in 2010, prior to this policy implementation (KFF, 2019). The ACA has had many implementations, but one specifically is the expansion of Medicaid. Medicaid is the national public insurance plan available to low-income individuals, children, and those with disabilities. It is an entitlement program, meaning all who meet its criteria are eligible (Center on Budget and Policy Priorities, 2018). Before the expansion of Medicaid, states were required to cover the following populations to receive some governmental funding through Medicaid: children in families below 138% of the federal poverty line (FPL), pregnant women below 138% of the FPL, certain parents/caregivers with extremely low incomes, and some seniors and those with disabilities who received Supplemental Security Income (Center on Budget and Policy Priorities, 2018). Although these vulnerable groups were covered, many others were left without any sort of governmental insurance help, including adults under 138% of the FPL. To put things into financial perspective, 138% of the federal poverty line is $29,974 for a family of three, as of 2020. (Center on Budget and Policy Priorities, 2018). With the implementation of the ACA, Medicaid has been expanded in (now) 39 states, increasing eligibility to all adults who are below 138% of the FPL, not just certain vulnerable populations.

Originally, this expansion was going to be required in all states, but with a supreme court ruling, states can now decide whether they want to expand among themselves. Despite states being able to decide this, all of their Medicaid services remain the same, they just impact different groups of people in states that did expand versus those that did not. Several healthcare services are required to be covered, including physician visits, laboratory services, hospital visits, home health care, and nursing care services (Center on Budget and Policy Priorities, 2018). Although not required, all states' Medicaid services also cover prescriptions, and many cover dental and vision services. As long as one meets the qualifications enlisted by the states they reside in, they will qualify for Medicaid. The delivery of Medicaid is through one of two options (or both), these being: fee-for-service or managed care plans. States receive a majority of funding through the federal government to cover these costs. Looking at these payment models from a simple perspective, the fee-for-service plan requires states to pay the providers directly for each service received by a Medicaid beneficiary. Used more frequently, the managed care plans work by enrolling Medicaid beneficiaries in a plan, paying a fee to the company running the plan, and then the managed care plan pays the providers for the client's services (MACPAC, n.d.). A majority of those enrolled in Medicaid are in managed care plans, but this type of plan is more limited for higher cost populations, such as older adults and those with disabilities. Because these populations cost more, they are more likely to be enrolled in a fee-for service plan. This is why spending for both plans are fairly similar, even though one plan has the majority of beneficiaries. (MACPAC, n.d.).

Policy Strengths

It is no secret the creation of policies through our legislative system come with many controversies. There will be differing opinions and both pros and cons to any implemented policy. With the expansion of Medicaid through the ACA, the greatest strength was a decrease in the uninsured. Medicaid expansion did not begin until January 1, 2014, with the most specific goal of impacting those who were non-elderly adults. With this, looking at the rates of those uninsured in this population, there is an obvious correlation between the expansion of coverage and a decrease in the uninsured population. Although not all states opted in for the expansion, from the year 2008 to 2013 the approximate percentage of those uninsured was about 17% nationally. In 2014 this went down to 13.5% and has stayed around 10.5% from 2015 to 2019 (Tolbert & Orgera, 2020). Looking a bit more in-depth, one meta-analysis reviewed 77 peer-reviewed studies to identify the effects of Medicaid expansion related to the original goals of the ACA. Of the 90% of studies that analyzed access to care, three-fourths reported an expansion of insurance coverage due to the ACA (Mazurenko et al., 2018).

Another strength that this analysis found relates to the earlier discussed consequence of not being insured: lack of access to primary care. There was an association between an increase in primary, mental health, and preventative care with the expansion of Medicaid (Mazurenko et al., 2018). With continuous findings that those who are uninsured are less likely to obtain preventative care for chronic conditions, finding an increase in these services identifies another key strength that the expansion of Medicaid has brought forth (Tolbert & Orgera, 2020) Studies have even found a decrease in mortality rates overall, and specifically for some chronic conditions (Guth et al., 2020).

Looking at the equity of this policy, another KFF meta-analysis (2020), found that states with expansion saw significant increases in coverage among low-income populations and vulnerable populations (Guth et al., 2020). This analysis by the KFF reviewed and summarized findings from 404 published studies through government, policy, and research organizations from 2014 to 2020. Besides just an increase in coverage, many other strengths of Medicaid's expansion were identified. Continuing to look at the policy regarding equality, a majority of findings identified an improvement in the utilization and affordability of healthcare services, as well as an increase in financial security within low-income populations (Guth et al., 2020). More recent research that the KFF looked at also saw an association between Medicaid expansion and a decrease in poverty, home evictions, and rates of food insecurity (Guth et al., 2020). Due to the high costs of healthcare, it makes sense that those with increased coverage would do better financially. Without coverage, illnesses, both serious and acute can have a substantial effect on one's economic status.

Policy Weaknesses

Although we see these positive outcomes for low-income populations, the weaknesses of this policy must be assessed. Medicaid is a social welfare program; it is providing extra resources for populations in need. Yet, the questions that arise through this policy are: are all in-need populations being covered, and how adequate is this coverage? Looking at the research discussed, it is obvious that the expansion of Medicaid has created a positive impact on the healthcare system, but as also mentioned, every policy has its weaknesses. The strengths previously discussed were based on both national data and data from states that did expand Medicaid. In the states that did not opt-in for Medicaid expansion, there is a very large gap of people who remain uninsured. As of 2019, the average of those uninsured in non-expansion states was 15.5% versus 8.3% in those that did expand (Tolbert & Orgera, 2020). States who did not expand Medicaid can also decide on their eligibility income limits, with the median income limit in these 12 states being only 41% of the poverty line. This is the equivalent of $8,905 annually for a family of three, which is $742.08 a month. This incredibly low monthly income does not even take needed necessities into account, such as rent, groceries, and potential doctor's visits. (Tolbert & Orgera, 2020)

In addition, one's geographic location (their state) is a determinant of whether they will be with or without insurance. Universally, this is not a policy of equality. The policy also fails to consider the differing livable incomes that are dependent on geographic locations. Every state bases its eligibility on the federal poverty line, yet the same annual income in two states could look completely different based on living costs. In the 12 states that have not expanded Medicaid, 2.2 million people are stuck in what is known as the "coverage gap" (Lukens & Sharer, 2021). Before giving states the right to decide if they wanted to expand Medicaid or not, the policy was supposed to be implemented to all adults up to 138% of the FPL federally. Another federal extension through the ACA was subsidized marketplace coverage, or tax credits for insurance, to those with higher annual earnings. These tax credits reduce monthly insurance expenses for those between 100% and 400% of the FPL (Garfield & Orgera, 2021). These tax credits were applied federally, and the Medicaid expansion was applied by state. Many states cut off Medicaid coverage to incomes of much less than 100% of the FPL, with a median cutoff to those making 41% of the FPL and less. Those making more than their state's FPL cutoff and less than 100% of the FPL are offered no form of Medicaid or discounted insurance rates (Garfield & Orgera, 2021). This is the coverage gap.

To put this into perspective, in some unexpanded states, one childless adult making $12,760 - $51,040 (100% to 400% of the FPL for an individual) annually would be able to get subsidized marketplace to converge. Those making anything less than this are eligible for nothing. This is because they only provide Medicaid for adults younger than 64 years old who have children. (Tolbert & Orega, 2020). An adult with a child would also receive nothing if they annually make more than their state's Medicaid eligibility limit (median of 41% of the FPL for a family of three), but less than 100% of the FPL for a family. Put simply, there is a gap of millions who are not able to afford insurance. They make too much to qualify for Medicaid and too little to qualify for subsidized marketplace coverage in the 12 states that have not expanded (Wisconsin does have an exception because their Medicaid eligibility is for those making up to 100% of the FPL (Lukens & Sharer, 2021).

Although the policy itself is a way to provide more equitable healthcare coverage, its implementation diminishes this. The coverage gap is harming marginalized communities at greater rates than any other group. Within the non-elderly population in non-expansion states, Black people make up 19% of the population yet 28% of people in the coverage gap. Similarly, Latinx people make up 17% of the population and 28% of the coverage gap (Lukens & Sharer, 2021). Besides this, the ACA did not include undocumented immigrants in either Medicaid or marketplace subsidies. Likely due to this, foreign-born Latinx make up 25% of the uninsured population as of 2018 (Gunja & Collins, 2019). Those who are undocumented must obtain individual marketplace plans, which can be very expensive without any supplemental help. Certain groups being harmed at greater rates by a policy exhibits the inequality it holds, even if only in certain states. As also mentioned, the policy is supposed to provide equitable coverage to reach populations in need due to socioeconomic status. Yet, many still dealing with a lack of any coverage demonstrate its inadequacy.

Policy Recommendations

One policy implementation through President Biden's Build Back Better bill would close the Medicaid gap, reducing these disparities greatly. The bill was passed through the House of Representatives as of November 20, 2021. It would provide people with premium tax credits in states where one makes too much to qualify for Medicaid, but too little to qualify for tax credits federally. Similar to Medicaid, the plan would have no deductibles or copays (Solomon, 2021). This would be the first phase of the plan, beginning in 2022. In the second phase, beginning in 2025, those under the subsidized tax credit plans would transition into an even more Medicaid-like plan. (Solomon, 2021). Additional Medicaid benefits would become applicable in this phase, such as benefits for chronic conditions, both physical and mental, as well as long-term services. This bill would permanently close the coverage gap, which disproportionately affects Black and Latinx populations. Closing this gap would increase the equity and adequacy of this policy (Solomon, 2021). Although not leading to all being insured, this bill would have a positive health outcome for these populations, especially marginalized groups who already face disparities in the healthcare system.

Another policy, which would equitably cover nearly all people in the United States, would be Medicare for All through Massachusetts Senator Elizabeth Warren's model. This plan displays how reaching full coverage for all in the United States would take a slower implementation process but would eventually transition into a universal healthcare system. When running for president, she discussed this transition as giving everybody the option to stay with their private insurance but offering Medicare freely to children and families making below 200% of the FPL. Additionally, those over 50 years old will be given in improved version of Medicare and those aged 18 to 49 would first be given modest costs for Medicare, which would eventually be free. (Warren, n.d.). The plan would transition into actual Medicare for All, giving every single person health insurance (including dental, vision, long-term care, and more) by taxing large corporations and our top 1%. With this, middle-income taxes would not increase. On her website, Warren provides three expert articles and studies that explain how Medicare for All would provide better quality coverage and cost less for middle-income families. The policy would also cost the country itself just slightly less than what we pay now (Warren, n.d.).

Providing all with insurance would ensure coverage on a basis of equality. Research provides evidence that low socioeconomic status, often associated with marginalized communities, results in worse health outcomes and life expectancies. A universal healthcare policy would not create barriers based on socioeconomic status, provide more accessible care, and mitigate our chronic disease epidemic (Zieff et al., 2020). One peer-reviewed journal article explains that the road to universal coverage may be complicated, but necessary, ensuring better health outcomes, lower chronic disease rates, and increased economic outcomes in the United

States (Zieff et al., 2020). A healthcare policy for all would combat all weaknesses associated with our current expansion of Medicaid, as we wouldn't have millions of Americans unable to access care. This access to care would save Americans from both health and financial hardships. One should not have to choose between a life of debt or a life at all. Through the Patient Protection and Affordable Care Act we have come a long way, but there are still many gaps that must be addressed in order to provide healthcare services to all Americans in an accessible and equitable way.

References

Centers for Disease Control and Prevention. (2021, April 28). *About chronic diseases.* US Dept. of Health and Human Services. Retrieved November 16, 2021, from https://www.cdc.gov/chronicdisease/about/index.htm.

Centers for Disease Control and Prevention. (2020, September 30). *Reasons for Being Uninsured Among Adults Aged 18–64 in the United States, 2019.* US Dept. of Health and Human Services. Retrieved November 16, 2021, from https://www.cdc.gov/nchs/products/databriefs/db382.htm#section_1.

Guth, M., Garfield, R., & Rudowitz, R. (2021, May 6). *The effects of Medicaid expansion under the ACA: Studies from January 2014 to January 2020.* KFF. Retrieved November 21, 2021, from https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-up dated-findings-from-a-literature-review/.

Garfield, R., Orgera, A., Damico, A. (2021, January 21). *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid.* KFF. Retrieved August 10, 2022, from https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/

Levine, S., Briss, P., Lekishvili, A., & Malone, E. (2019, March 14). *Health Care Industry Insights: Why the Use of Preventive Services Is Still Low.* Centers for Disease Control and Prevention. Retrieved November 16, 2021, from https://www.cdc.gov/pcd/issues/2019/18_0625.htm#interview findings.

Lukens, G., & Sharer, B. (2021, June 14). *Closing the Medicaid coverage gap would help diverse groups and narrow racial disparities.* Center on Budget and Policy Priorities. Retrieved

November 21, 2021, from https://www.cbpp.org/research/health/closing-medicaid-coverage-gap-would-help-diverse -group-and-narrow-racial.

Gunja, M. Z., & Collins, S. S. (2019, August 28). *Who are the remaining uninsured, and why do they lack coverage?* Commonwealth Fund. Retrieved November 21, 2021, from https://www.commonwealthfund.org/publications/issue-briefs/2019/aug/who-are-remaining-uninsured-and-why-do-they-lack-coverage.

Policy basics: Introduction to Medicaid. Center on Budget and Policy Priorities. (2020, April 14). Retrieved November 21, 2021, from https://www.cbpp.org/research/health/introduction-to-medicaid.

Provider payment and Delivery Systems. MACPAC. (2020, December 29). Retrieved November 21, 2021, from https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/.

Solomon, J. (n.d.). *Building back better legislation would close the Medicaid Coverage Gap.* Center on Budget and Policy Priorities. Retrieved November 21, 2021, from https://www.cbpp.org/research/health/build-back-better-legislation-would-close-the-medicaid-coverage-gap.

Tolbert, J., & Orgera, K. (2020, November 6). *Key facts about the uninsured population.* KFF. Retrieved November 16, 2021, from https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.

U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes? (2020, January 20). The Commonwealth Fund. Retrieved August 10, 2022, from https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019

Warren. (n.d.). Retrieved November 21, 2021, from https://elizabethwarren.com/plans/paying-for-m4a.

Zieff, G., Kerr, Z. Y., Moore, J. B., & Stoner, L. (2020). *Universal Healthcare in the United States of America: A Healthy Debate.* Medicine, 56(11), 580. MDPI AG. Retrieved from http://dx.doi.org/10.3390/medicina56110580

An Evaluative Analysis of the Controlled Substances Act

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Abstract

The Controlled Substances Act (CSA) has defined U.S. drug policy for more than 50 years, determining what substances are outlawed, restricted, and egregiously punished with sentences up to life in prison. Yet, the recent motions by Congress proposing federally decriminalize the use of marijuana, a Schedule 1 substance, has brought a crucial question to light: what is the true purpose and effectual impact of drug legislation? How do the intentions of our legislators to safeguard the nation from drug-related crime and chaos correlate with the environmental changes and inequitable outcomes that are not always reflected in law? According to the present data provided federally and independently by journals alike, the ripple that the CSA and its branching drug policies have caused in spheres of civil justice and healthcare is proven to be expansive (Lampe, 2021). The reputational stain placed against substances associated with high health risks (I.e., Schedule 1 and 2 drugs) is arguably reversible but has also been an immediate barrier to access in cases where the substance's physiological and mental benefits could be useful for stabilizing one's wellbeing instead of endangering it (Strohman, 2020). The disproportionate enforcement of drug arrests in communities of color and low-income areas threatens both racial and class equity within the United States, due to the unjust targeting for criminalization without solutions or resources for the vulnerable (Taifa, 2021). Nonetheless, the benefits contribute to upholding an acceptable level of public safety, producing responsible standards for medicinal classification, and involving the interests of large pharmaceutical companies and their accompanying research (Lampe, 2021). As spotlighted in the following explorations of congressional efforts and scholastic studies, the complexities of life under recent drug policy cannot be understated, which opens many considerable avenues for necessary revisions.

Keywords: drug, policy, distributive justice, opioid, criminalization, United States

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An Evaluative Analysis of the Controlled Substances Act

Consistent in many approaches to substance use is the need to define, regulate, or limit certain substance use as a means for social control and perceived harm prevention. Historians trace the most significant substance use legislation back to the criminalization and anti-Asian racialization of opium use, prompting the passing of 1914 Harrison Narcotics Act. At the turn of the 20th century, products laced with addictive narcotics remained unregulated, producing a misunderstood phenomenon of addiction that began to rear its head globally and alarm congressional leaders. Prior to the act's proposal, the cultural habits of Chinese immigrants in the United States were regularly associated with opium smoking due to their preferred use of opium smoking dens and how widely publicized the Opium Wars between China and the United Kingdom were in the mid-19th century (Mccaffrey, 2019). These practices differed from American users, who mostly accessed opium through over-the-counter products available for pain relief, making immigrants a vulnerable anomaly and perceived threat to the cohesion of American culture (Mccaffrey, 2019). Coincidentally, Chinese migration to the West and opium addiction in the United States proliferated alongside each other, further painting immigrants as convenient targets to blame for the onset, despite other factors such opium's role on common pharmaceuticals or its usage as a wartime casualty treatment during the U.S. Civil War (Mccaffrey, 2019). Still, anti-Chinese prejudice was common for this period as Chinese laborers were already the target for racial animus due to their portrayals as competing laborers presenting an employment risk for the California labor force during the 1850s Gold Rush (Mccaffrey, 2019).

These tensions combined brewed negative commentary and even violence towards Chinese immigrants throughout the country and by the federal government, which culminated in the persistent efforts to suppress the influence of Chinese immigrants. Limitations on recreational use were passed as a measure of social control that disproportionately criminalized Chinese Americans, as ordinances placed restrictions solely against opium smoking and smoking dens in western U.S. cities during the

1870s (Mccaffrey, 2019). Other measures were more explicit, such as Chinese Exclusion Act of 1882 and the federal ban of opium smoking (but not opium use) in the Opium Exclusion Act of 1909 (Mccaffrey, 2019). Resultantly, legislators followed a similar political trend of treating Chinese involvement as causation, framing the emergence, and spread of the opium crisis as a "Far East" issue related to China's role in opium trade (Lesser, 2014). This opened the door for the United States to advocate for harsher international and domestic regulation of opium and assert moral authority over Chinese political and cultural influences. Simultaneously, the U.S. representatives supported invoking the involvement of police enforcement to sever and punish the relationship between medical providers and substance users (Mccaffrey, 2019). The passage of the Harrison Narcotics Act of 1914 would then signify the end of a short-lived support system for opium and other narcotic addicts in healthcare and a new beginning in criminalizing drug addicts through assertions of moral superiority, fearmongering in the U.S. media and public sphere, and substance use politicizations that maintain a federal and cultural agenda.

Racialization tactics and criminalizing rhetoric expanded to include other substances during Nixon's "War on Drugs" campaign in the early 1970s, which succeeded in vilifying substance use and users by labeling use as indication of illegal, countercultural behavior rather than a societal failure or environmental outcome (Taifa et al., 2021). The moralization and essentialist attitude implying "individual pathologies" in drug users often justified stigmas and no-tolerance punitive approaches found in even the softer campaigns (i.e., D.A.R.E or "Just Say No" by Nancy Reagan), rejecting as little as harm reduction methadone treatments (Roberts, 2021). Still, it is true that holistic dangers of drug use are supported by reputable scientific consensus and the Drug Enforcement Administration (Drug Enforcement Administration, n.d.). About 165 million American adults, or 60% of the adult population, have used substances at least once over a month-long period, indicating a high prevalence of use. Around a fifth of adults in the United States have used illicit drugs within the last year, a fraction much greater than those using alcohol in the same period (NCDAS, 2022).

Additionally, a quarter of illicit drug users have a drug disorder. For context, according to Merikangas & McClair (2012), illicit drug disorders present a 2-3% prevalence rate compared to the rate of alcohol use disorder at 17.8%. Opioid disorders comprise a quarter of these drug disorder cases (NCDAS, 2022).

Throughout the nation's history, the United States has shown legitimate efforts to confront the reality of substance use and their accompanying detriments, a reality that ripples into the welfare and quality of American life. To maximize the effectiveness of the substance use policies, key legislation like Controlled Substances Act, Anti-Drug Abuse Act of 1986, and other relevant provisions deserve to be evaluated for their effect on the treatment of substance users and the punitive consequences for use, possession, and distribution.

Current Policy Provisions

Current drug policy regarding public use and individual crimes of possession and distribution is meant to address substance use through decreasing the footprint of harmful substances and the presence of drug offenders domestically, often through imprisonment, penalties, and rehabilitative efforts. Since the topic of this analysis is through a criminal justice lens, this paper will not analyze drug policy related to rehabilitation since it is rooted in the lens of public health, which prioritizes concerns for physical and mental health over legality. Apart from this fresher perspective, there are two main policy perspectives to be found in U.S. contemporary drug policy: the first policy by the U.S. government that drug users and offenders should be criminalized based on their interactions with certain substances as participants in prohibited activity, adapting our laws and enforcements to match this belief; the second policy is to disincentivize substance abuse through loss of civil privileges.

The first policy perspective operates primarily on the idea that the classification of substances determines their legalities and purposes, and, in the case of illicit drugs, can result in criminal consequences for offenders according to their use, possession, distribution, manufacturing, and trade.

This U.S. federal policy is heavily driven by the guidance of the Controlled Substances Act of 1970, also known as Title II under the Comprehensive Drug Abuse Prevention and Control Act of 1970 enacted by President Nixon. The Controlled Substances Act (CSA) is responsible for the classification, or scheduling, of certain controlled substances and relevant chemicals identified administratively by Congress for their deemed risk for abuse, dependence, or bodily harm (Lampe, 2021). With these schedules, lawmakers consider the severity of drugs and respond accordingly to the specific violations of controls and protections against the given substances (Drug Enforcement Administration, 2020). For example, violations involving substances with a high scheduling, such as heroin or marijuana in Schedule 1, will be treated with heavier fines or more severe risks of imprisonment in comparison to a lower-scheduled substance, such as prescribed medications or common cough medicines in Schedules 4 and 5. The intended recipients of these consequences would be any entities interacting with higher scheduled substances.

Additionally, the registration and trafficking provisions set by Drug Enforcement Administration (DEA) enforce the schedules under the CSA, utilizing the administration's temporary control powers in the case of rapid-changing contexts or substances needing immediate attention (Lampe, 2021). The agency also regulates, authorizes, and keeps record of distribution and usage operations in pharmaceutical companies who are necessary mediums between drug policy and medical application of substances, which further necessitates special provisions addressing illegal operations that can result in fines or prison sentences (Lampe, 2021). In the judicial sphere, the Anti-Drug Abuse Act of 1986 has since reinforced the significance of drug scheduling in determining consequence severity and established the CSA's precedent for penalties that are staggered according to scheduling through mandatory minimum sentences (Taifa, 2021). The bill also expands upon the procedures provided by the CSA by adding drug analogues into scheduling and increasing resources for the Department of Justice to enforce these changes ("Subtitle J" of the bill). Altogether, the 1986 act widens their scope of power for distinguishing between substance types and applying nuanced penalties (Anti-Drug Abuse Act, 1986).

As demonstrated through the contributions of each governmental branch to the CSA's procedures, the first drug policy perspective requires extensive faith in Congress, its government agencies, the judiciary, and pharmaceutical companies to properly handle and assess substances for distribution and use. However, this relationship alone provides little avenue to prevent political and business interests from translating into legislation, affording all the power in constructing reputations and narratives of each substance to political players and leading pharmaceutical companies. Moreover, while pharmaceutical companies are subject to the same judgments for scheduled drugs, few would doubt that the negotiating power of these distributors is similar to the negotiating power of citizens or their advocates over the same drugs. An argument can be made that this inherently breeds inequity between the stakeholders in drug policy since the interests and experiences of public citizens, specifically struggling addicts or the chronically ill, may be neglected when deciding the criminality of drug activities. The neglect of these interests could contribute to dividing society between the stakeholders with the privilege to impact drug policy and the stakeholders subject to it without representation.

The second drug policy perspective is that drug use needs to be disincentivized in the civil sphere to dispel drug use. This can be achieved through the guise of a moral agenda to persuade others into supporting massive funding for anti-drug initiatives and harsher penalties, such as the implications made by the elimination of parole and special provisions for drugs addicts in Comprehensive Crime Control and Safe Streets Act of 1984 (Taifa, 2021). One of the most severe instances regarding drug sentencing guidelines was found in the Violent Crime Control and Safe Streets Act of 1994, which expanded the death penalty to include narcotic offenses, targeted gangs and gang-affiliated communities with increased police presence to scope out drug crimes and introduced a "three strikes" rule for offenders in addition to other revocations of privileges (Taifa, 2021). Although the attitude behind the bill has now been walked back, the $12.5 billion dollars in funding that was originally allotted for the bill is still responsible for expanding prison capacities and constructing more correctional facilities to speed up incarceration, leading to a 43% increase in the number of total prisons (Eisen, 2019). According to journalist Lauren-Brooke Eisen with the Brennan Center for Justice (2019), grant programs that were authorized by the 1994 act, such as the Violent Offender Incarceration and Truth-in-Sentencing Incentive Grants Program, served to encourage states to cut parole provisions and implement harsher sentencing laws, increasing their incarceration capacity and adding an incentive for increasing arrest. As mass incarceration continues to trouble the 21st century, it is difficult to separate this phenomenon from the lasting penalties, stigmas, and loss of freedoms introduced against drug users as result of these notable acts.

In addition to the introduction of lengthy sentences under this policy approach, the introduction of penalties for smaller violations also functions tactically to discourage the public from harboring any associations with the target substances due to the fear of criminal violation. According to the DEA, sections of the Anti-Drug Abuse Act of 1986 titled “User Accountability” and “Personal Use” reflect their goal for making drug use civilly disadvantageous. The sections include multiple provisions for holding users accountable for their activities, including invoking anti-drug statements in the courts and in public as well as adding civil penalties for “personal use” possession charges (Drug Enforcement Administration, 2020). For communities, the sections encourage instruction in grade levels as low as kindergarten about drug abuse to shift general opinion and allow the eviction of residents whose units are used for drug activity without any restoration of federal benefit privileges (Drug Enforcement Administration, 2020); businesses also became liable for drug-free workplaces. Moreover, penal codes, such as U.S. Code 862, legalize a loss of benefits such as contracts, licenses, and scholarships for up to a year because of a federal drug conviction, a decision that was also present in the Violent Crime bill of 1994 with the loss of Pell grant access (Boston University, n.d.). Due to the association created between substance use behavior and criminality, the regulations give the public good reason to feel paranoid about substance use and harbor strong negative feelings about users that they may not have considered so strongly before these civil penalties. The propagation of fear related to substance use also acts as a barrier to recognizing the complex risks and benefits of certain drugs. As the moral standards associated with these regulations are rooted in their enforcement, efforts to host a national conversation about drugs is bound to evoke resistance as it draws criticism to this moralistic agenda that is strongly internalized by the American public and intertwined with anti-drug culture.

When exploring the implicit content in both policy perspectives, the implied benefits and beneficiaries must also be examined, as they provide insight into the intentional and unintentional costs and outcomes that these policies may be creating. A helpful framework for identifying these conditions has been best outlined by Neil Gilbert and Paul Terrell, two social policy experts and authors from University of California in Berkeley; they theorized there are four main aspects through which to examine the impact of benefits, including who the beneficiaries, what benefits they receive, how they receive the benefits, and how benefits are funded (Gilbert & Terrell, 2010). Beginning with who the beneficiaries are in both policy perspectives, each branch of the federal government benefits directly from the regulatory processes within these policies. The fines and processing fees paid by offenders go toward governmental revenue with varying percentages for where it ends up (the judicial budget, law construction, schools, community projects, debts, etc.) (Menendez & Eisen, 2019). According to the Brennan Center for Justice, these inputs are insufficient sources of revenue on the state and local level anyways even after circling through the system (Menendez & Eisen, 2019). Federally, solely the U.S. Treasury received funds from legal proceedings, according to NBC News (Chmura, 2017). Exceptions to this would be cases in cases with invested victims or plaintiffs looking for settlement. In a different light, each level of government benefits politically from the federal government being the primary source of power over drug policy. Legislators determine government responsibility and involvement in public crises; enforcers manipulate who they enforce the law on; the judicial system can dole out arbitrarily merciful sentences when allowed outside of sentencing minimums. Once an individual is sent to prison, for-profit prisons benefit from housing inmates, receiving money from the government through grants to do so while prioritizing the lowest possible cost choices to maximize profit overall (Wagner & Rabuy, 2017). Yet, a loss of funding for these facilities does not significantly favor anyone since the money saved is also indirectly spent back on housing inmates.

Considering how these drug policies are funded, the decision to invest a sizable chunk of the nation's budget into drug law enforcement must be made valuable through the arrests and seizures that are made, which is then paid back as revenue through penalties, fees, and any seizures of assets that can be made through incarceration tactics. Nonetheless, as stated before, this cycle is not the most beneficial since estimated trillions of dollars were invested in the War on Drugs over the past four decades and yet the problem persists. Instead, a new burden has been created as there is larger need to finance the housing for the growing incarcerated population, a burden that could have been predicted by past legislations which produced mass incarceration. The funds left are then divided up into an amount of revenue on state and local levels. Regardless of any commentary on the current system's state, the short answer is that enforcement is funded by federal, state, and local budgets. depending on the issue at hand and the context.

However, not all entities considered in drug policy directly benefit from the current structure of drug policy. There is also the assumed, indirect benefit to the public that results from removing certain drugs and drug traffickers from the street. The primary purpose of scheduling under the CSA has been establish a straightforward key for controlling drugs at substantial risk for abuse, dependence, and harm. Therefore, it is logical to deduce that, with harsher registration provisions for trafficking and distributing the potent substances of Schedule 1 and 2, it is thus harder for these substances to get in the hands of vulnerable populations like children or individuals without knowledge of a drug's potential. The resulting benefit would be the reduction or elimination of the prospective harm that these substances' exposure would have caused to the community. Furthermore, the funding dedicated to enforcement of regulation and trafficking provisions would correspond to how much prospective harm may be reduced. Still, it is difficult to attribute this benefit directly to the work of CSA when other confounding variables may have an equal or greater role in protecting vulnerable groups, such as contributions of community welfare projects in drug education and safety. The effects of negative experiences with drug enforcement and excessive policing may also counteract the benefit through the creation of a distrustful or chaotic environment. However, it is certain that the procedures of the CSA help to contain substances in correct medical circles, authorizing deliveries of drugs through hospitals and pharmacies. In this way, citizens who receive quality medical care with the permitted use of highly scheduled substances benefit through the supply of necessary medications and pain relief, giving substances an opportunity to sedate or promote healing in safe settings.

Strengths of Policy Approach

One of the primary strengths of these policies and their supporting legislation is that there are constant opportunities for laws to be updated to reflect the values of the public, new drug information, and cultural impacts on classifications. A great context to demonstrate this would be recent changes related to marijuana as research recognizes the potential medical benefits of marijuana against chronic pain relief without any indication of extreme withdrawal or adverse effects (Hill, 2015). Furthermore, states in the United States are beginning to see the recreational and medicinal benefits and have begun the process of legalizing marijuana. As of August 2022, 19 states have legalized marijuana with an additional 19 states legalizing only medical marijuana (Zhang, 2022). While legalization eliminates the criminality of the substance and allows its regulation and taxation as a product, decriminalization only reduces the penalties and the level of enforcement over the possession of marijuana under a specific quantity. For example, in states like Ohio, Louisiana, and North Carolina where marijuana is still illegal, possession under half an ounce does not constitute jail time but does require offenders to pay a fine (The NORML Foundation, 2022). According to data posted by the NORML Foundation (2022), possession amounts close to this limit also constitute fines and reduced potential jail times, but there is opportunity for probation or a conditional discharge in these areas.

Furthermore, there is demonstrated interest by U.S. lawmakers to introduce legislation to decriminalize marijuana. Some bills proposed in the past few years include the Ending Federal Marijuana Prohibition Act of 2017, the Marijuana Justice Act of 2017, Cannabis Administration and Opportunity Act of 2022, and Marijuana Opportunity Reinvestment and Expungement (MORE) Act of 2022; both the Marijuana Justice Act and MORE Act include a pathway for legalization, while the MORE Act goes a step further to propose expunging records of offenders with previous marijuana convictions and dedicating funding to social equity programs for communities disrupted by the War on Drugs. In the public sphere, polling statistics show a trend of increased support toward legalization, according to research by Vera writer Kristi DiLallo in their recent article about marijuana “wins” (DiLallo, 2016). Regardless of which legislative avenue the public prefers, the increase in proposals by both the House and Senate points to a potential removal of marijuana from its high scheduling, a decision that could also lift the limitations on researchers who wish to conduct public studies on the health benefits and risks of marijuana.

Another strength of the current drug policies is that they have increased attention to the struggles of drug addicts, despite the original stigmas presented. With the national discourse around drugs developing over the past few decades, addiction has been more readily recognized in the United States as a physical and psychological condition instead of a personal failure. This is reflected in the Comprehensive Addiction and Recovery Act of 2016, which allocated funds to increase naloxone availability and opioid overdose treatment, to expand rehabilitation, treatment, and education programs, and to allocate more grant support for residential rehabilitation services (Comprehensive Addiction and Recovery Act, 2016). There is also credit to be given to the

Affordable Care Act, which provides coverage for the uninsured, including covered access to substance use disorder and opioid treatments (Abraham et al., 2017). As reflected in this contrast from drug policy 30 years ago, our nation is amid a change from a criminal justice policy approach to a public health policy approach to substance use, but this would have never been possible without initial efforts to address substance use at all.

Weaknesses of Policy Approach

When classifying substances with multiple uses and harms, there comes a risk of placing the substance in an undeserving box or a category that underestimates its potential benefits. Unfortunately, this rationale can be applied to the Controlled Substances Act's scheduling, especially to the more restrictive categories of Schedule 1 and 2. In the opinion of data analyst Andrew Strohman from the American Action Forum, Schedule 1 classification, such as the current scheduling of synthetic opiate analogues, makes it difficult to conduct clinical research to develop productive alternatives based off the substance's power, such as new avenues for pain relief treatment (Strohman, 2020). Strohman furthers references the existence of a substance called Epidiolex, a drug including a cannabidiol analogue, that presents curing effects for epilepsy, but is still limited by its scheduling. The drawbacks of cutting corners with quick bans and scheduling may not be evident initially, but, to Strohman's point, it begs the questions of what the Controlled Substance Act and legislators may ignore in its scheduling, which introduces doubt about their comprehensiveness in evaluating drugs of interest and developing appropriate legal frameworks to address drug users and their environments.

Strohman's insights about the limitation of substance generalizations parallel the critiques presented by addiction advocates about generalizations of drug users or traffickers. Using self-reported questionnaires to field White and Black demographics, drug issue research determined that there were significant differences between socioeconomic status and employment background for each racial group, and that Black participants were more likely than White participants to be charged with drug possession (27% vs. 4%) and sales violations (20% vs. 16%) (Rosenberg et al., 2017). This highlights the relevance of contexts on the development of drug interactions, including the likelihood that, in communities with varying socioeconomic and health struggles, reasons for drug involvement may not hold the same intentions or moral weights as other communities. Because of the quick and general nature of both policies, underrepresented communities are immediately susceptible to neglect by our justice system, which decreases the efficacy of these policies to address the root of drug prevalence and offenses in diverse areas.

Finally, considering the severity of the current opioid crisis post-War-on-Drugs, the public must wonder if either policy perspective had the proper effect on the topic of substance use when one of the well-known addictive drug classification, narcotics, still plagues American communities. Today, about 1.6 million American suffer from opiate addiction (NCDAS, 2022), all while incidence of exposure and overdose deaths from prescription opioids, heroin, and synthetic opiates like fentanyl both significantly rise each year by 93% (NCDAS, 2022) and 5% respectively (Centers for Disease Control and Prevention, 2022). This demonstrates the urgent need for an effective and efficient substance use response. While the first policy addresses the punitive calls against traffickers providing these dependence-prone substances, it fully ignores the other key aspect of substance use, which is the humanistic impact. According to research by Vera, only 11% of incarcerated people in need of addiction treatment receive it, despite making up 65% of the prison population (Cloud et al., 2018) Both policies lack attention to aspects of life satisfaction and mental health on drug use, which will reduce its overall generalizability.

Elements of Distributive Justice

The primary aim of this analysis has been to assess the CSA and the drug policies that build on it on whether their framing of drug use concerns translates to just guidance for handling drug interactions and crimes. The previously outlined policy perspectives, strengths, and weaknesses present reasons to both criticize and credit the scheduling, regulatory processes, and enforcements of the CSA for its effect on drug use and acceptance in the United States. Still, there is a concept that may further aid this exploration in the sphere of criminal justice, which would be assessing these policies against the elements of distributive justice. According to the Markkula Center for Applied Ethics, distributive justice can be defined as the degree to which societal institutions ensure an equitable and fair distribution of benefits and harms among societal players (Velasquez et al., 2014). In relation to drug policy, distributive justice would mean that institutions such as the federal government and their governmental agencies try to check the impacts of their drug policies and policy-related enforcements using measures of equity and fairness. To develop our understanding of the distributive justice of the CSA, this exploration will be broken down using conditions developed by social policy experts Neil Gilbert and Paul Terrell, conditions based on three core values: adequacy, equality, and equity (Gilbert & Terrell, 2010).

Regarding the adequacy of the CSA in contributing to distributive justice, it is best to view these policy perspectives according to their separate goals and the outcomes of those goals. Regarding the first policy, the goal was to adapt the laws and enforcement to match the known scientific data presented about drugs as well as the unknown, differentiating between substances with complex purposes and criminalizing interactions with illicit substances. This was achieved through the general guidelines and restrictions placed on specific substances through scheduling. Through the implementation of the Controlled Substances Act of 1970, this policy goal has been successful in creating a uniform space for medically useful drugs to be administered via prescription or medical personnel, while also monitoring for potential misuse or abuse. Scheduling under the CSA also allows us to make relative comparisons between substances within the same class, which can aid in cost-benefit analyses regarding substance potency when determining drug interventions or public health policies. In this aspect, this policy utilizes accepted knowledge about some controlled substances and has adapted their registration provisions to reflect that.

Contrarily, for substances that are criminalized within the first policy and by the second policy, limitations on exposure with these substances come with benefits and costs, especially those in Schedule 1. While this may be intentional to avoid exposing volatile substances and risking future abuse for the public, this does severely limit the ability to further research new substances and understand their benefits, instead discarding them for initial detriments. In this way, criminalization of substances and affairs related to their use opens the door for misguidance due to overlooking and overgeneralizing the characteristics of a drug. The process of criminalization also acts so absolutely that it is difficult to adapt upon emergent drug research and revelations if its presence is already heavily stigmatized in the public. In this way, scheduling drugs for this policy is counterproductive, and, with the given impacts of incarceration, the cons may outweigh the pros depending on one's point-of-view.

Assessments of equality, according to the explicit parameters of these policies, can be misleading, which is why this assessment will be paired closely with the assessment of equity. Technically, scheduling of drugs is standardized for all jurisdictions under the federal government, meaning the identity of the drugs should determine minimum sentencing and penalties. This implies that, without any provisions differentiating perpetrators of these offenses, it can be assumed that this policy will be implemented equally against all individuals and groups under the law. Since the second policy is dependent on the moral agenda being pushed, there is more potential for discriminatory tactics to result from biased attitudes and dog whistling, such as with the Harrison Narcotics Act of 1914 that semi-explicitly targeted Chinese immigrants; as a result, I would not consider this policy to be inherently equal since many could argue the rhetoric around the War on Drugs used dog whistles against communities of color through references to urban settings and gangs in addition to the use of Black and Brown individuals for propaganda against crime.

However, both polices produce issues in equity. Referring to the Anti-Drug Abuse Act of 1986, a notable provision included a large disparity in minimum sentencing for crack in comparison to powder cocaine, a decision that is widely seen as racially driven and discriminatory against lower classes due to severe penalties placed on low quantities of cheaper crack cocaine in combination with increased police presence during to the Violent Crime Bill of 1994 (Taifa, 2021). Considering how crack cocaine circled predominantly in communities of color while powder cocaine circled in predominantly White communities, this subtle distinction perpetuated inequitable outcomes, such as lengthier sentences, for communities of color over the possession and distribution of the same substances found in White communities. In the second policy, the inequitable outcomes are rooted in the implicit biases that affect the writing of legislation and who it is enforced against based on the enforcer's idea of the law's intentions. Overall, the variation in drug use and the context surrounding community exposure and dependence on certain substances leads inevitably to inequitable outcomes when intersections of culture, race, socioeconomics, and other identities are not considered, which is the case for both policy perspectives.

Policy Recommendations

My first policy recommendation is that Congress consider carefully reassessing all data and research available about Schedule 1 and 2 substances while also considering changing the level of limitations placed on these substances within the realm of research. As stated earlier, these classifications halt the tracks of clinical research to discover new ways to heal and help our ever-developing nation. The future depends on current advancement, so providing an exception for researchers to work with Schedule 1 drugs using ethical methods would be something to consider.

My second policy recommendation would be that the Controlled Substances Act includes exception policies or reduced penalties for offenders demonstrating symptoms of substance use disorders or having significant survivalist or environmental justifications for their involvement. Examples of environmental justifications would be the need for employment in areas with significantly low opportunities or when one has had significant and undue exposure to drugs and violence in their upbringing and environment. The policy approach in this act is meant to penalize criminal behavior, but addiction behaviors, efforts to reduce chronic or severe pain, and cases where environmental determinants present severe disadvantages should be provided leniency as a matter of public health, in the same way we adapt our treatment towards other disabling and debilitating conditions.

References

Abraham, A. J., Andrews, C. M., Grogan, C. M., D'Aunno, T., Humphreys, K. N., Pollack, H. A., & Friedmann, P. D. (2017). The Affordable Care Act transformation of substance use disorder treatment. *American Journal of Public Health*, *107*(1), 31–32. https://doi.org/10.2105/ajph.2016.303558

Anti-Drug Abuse Act of 1986, H.R.5484 - 99th Congress (1985-1986). (1986). http://www.congress.gov/

Boston University. (n.d.). *State and federal laws and sanctions concerning drugs and alcohol*. Safety on Campus RSS. Retrieved September 30, 2022, from https://www.bu.edu/safety/alcohol-drugs/laws/

Centers for Disease Control and Prevention. (2021, March 17). *Understanding the epidemic: Drug overdose*. Centers for Disease Control and Prevention. Retrieved April 22, 2022, from https://www.cdc.gov/drugoverdose/epidemic/index.html

Chmura, C., Roher, C., & Rojas, J. (2017, February 7). *Where do those huge federal fines go?* NBC Bay Area. Retrieved April 22, 2022, from https://www.nbcbayarea.com/news/local/where-do-those-huge-federal-fines-go/36953/

Cloud, D., Haskel-Hoehl, M., & Pope, L. (2018). *The state of opioids and substance use.* Vera Institute of Justice. Retrieved April 22, 2022, from https://www.vera.org/state-of-justice-reform/2018/the-state-of-opioids-and-substance-use

Comprehensive Crime Control Act of 1984, S.1762 - 98th Congress (1983-1984). (1984). http://www.congress.gov/

Comprehensive Addiction and Recovery Act of 2016, S.524 - 114th Congress (2015-2016). (2016). http://www.congress.gov/

DiLallo, K. (2016, December 12). *Recent wins on marijuana signal a change in drug policy nationally*. Vera Institute of Justice. Retrieved April 22, 2022, from https://www.vera.org/news/recent-wins-on-marijuana-signal-a-change-in-drug-policy-nationally

Drug Enforcement Administration. (n.d.). *Drug and chemical information*. Diversion Control Division. Retrieved April 22, 2022, from https://www.deadiversion.usdoj.gov/drug_chem_info/index.html

Drug Enforcement Administration (2020). *Drugs of abuse, a DEA resource guide (2020 edition)*. https://gsaddev.dea.gov/sites/default/files/publications/Drugs%20of%20Abuse%202020-Web%20Version-508%20compliant-4-24-20.pdf

Eisen, L.-B. (2019, September 9). *The 1994 crime bill and beyond: How federal funding shapes the criminal justice system.* Brennan Center for Justice. Retrieved April 22, 2022, from https://www.brennancenter.org/our-work/analysis-opinion/1994-crime-bill-and-beyond-how-federal-funding-shapes-criminal-justice

Gilbert, N., & Terrell, P. (2010). A framework for social welfare policy analysis. In N. Gilbert & P. Terrell (Eds.), *Dimensions of social welfare policy* (7th ed., pp. 70–71). Allyn & Bacon, Inc.

Hill K. P. (2015). Medical marijuana for treatment of chronic pain and other medical and psychiatric problems: A clinical review. *JAMA*, *313*(24), 2474–2483. https://doi.org/10.1001/jama.2015.6199

Lampe, J. R. (2021). *The Controlled Substances Act (CSA): A legal overview for the 117th Congress.* Congressional Research Service. https://sgp.fas.org/crs/misc/R45948.pdf

Lesser, J. (2014, December 16). *Today is the 100th anniversary of the Harrison Narcotics Tax Act.* Drug Policy Alliance. Retrieved April 22, 2022, from https://drugpolicy.org/blog/today-100th-anniversary-harrison-narcotics-tax-act

Mccaffrey, Patrick. (2019). *Drug war origins: How American opium politics led to the establishment of international narcotics prohibition*. [Master's thesis, Harvard Extension School.] Digital Access to Scholarship at Harvard.

Menendez, M., & Eisen, L.-B. (2019, November 21). *The steep costs of criminal justice fees and fines.* Brennan Center for Justice. Retrieved April 22, 2022, from https://www.brennancenter.org/our-work/research-reports/steep-costs-criminal-justice-fees-and-fines

Merikangas, K. R., & McClair, V. L. (2012). Epidemiology of substance use disorders. *Human Genetics*, *131*(6), 779–789. https://doi.org/10.1007/s00439-012-1168-0

National Center for Drug Abuse Statistics. (2022, April 6). *Drug abuse statistics.* NCDAS. Retrieved April 22, 2022, from https://drugabusestatistics.org/

Roberts, S. K. (2021). *The politics of stigma and racialization in the early years of methadone maintenance regulation.* National Academies of Sciences, Engineering, and Medicine. Retrieved April 22, 2022, from https://www.nationalacademies.org/documents/embed/link/LF2255DA3DD1C41C0A42D3BEF0989ACAECE3053A6A9B/file/DB9DE4A29281EB740DB6D3CAC55B1EFCB9FDB94AF835

Rosenberg, A., Groves, A. K., & Blankenship, K. M. (2017). Comparing Black and White drug offenders: Implications for racial disparities in criminal justice and reentry policy and programming. *Journal of Drug Issues*, *47*(1), 132–142. https://doi.org/10.1177/0022042616678614

Strohman, A. (2020, February 14). *The drawbacks of the drug-scheduling regime.* American Action Forum. Retrieved April 22, 2022, from https://www.americanactionforum.org/weekly-checkup/the-drawbacks-of-the-drug-scheduling-regime/

Taifa, N., Cohen, A., Taylor-Thompson, K., & Thomas, R. N. Y. (2021, May 10). *Race, mass incarceration, and the disastrous War on Drugs.* Brennan Center for Justice. Retrieved April 22, 2022, from https://www.brennancenter.org/our-work/analysis-opinion/race-mass-incarceration-and-disastrous-war-drugs

The NORML Foundation. (2022, March 4). *Decriminalization*. NORML. Retrieved October 2, 2022, from https://norml.org/laws/decriminalization/

Velasquez, M., Andre, C., Shanks, T., S.J., & Meyer, M. J. (2014). Justice and fairness. *Issues in Ethics*, *3*(2). https://doi.org/https://www.scu.edu/ethics/ethics-resources/ethical-decision-making/justice-and-fairness/

Wagner, P., & Rabuy, B. (2017, January 25). *Following the money of mass incarceration.* Prison Policy Initiative. Retrieved April 22, 2022, from https://www.prisonpolicy.org/reports/money.html

Policies Determining Access to Gender Affirming Care for Illinois Residents

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Abstract

Access to gender-affirming care in Illinois and other states is facilitated by a combination of federal and state policies. The Biden Administration repealed the Trump Administration's Final Rule discontinuing non-discrimination protections related to gender identity in Health and Human Services programming. However, federal policy regarding gender-affirming care is only tenuously established through features of other policies, such as the Affordable Care Act and the Civil Rights Act. The Illinois Human Rights Act establishes firmer protections for gender identity in state statutes, resulting in better access to gender-affirming care in Illinois that includes Medicaid coverage of gender-affirming procedures. Although this is a step in the right direction, we recommend further policy actions to improve access to gender-affirming care. A federal mandate, private insurance regulation, and professional training for health care providers are necessary to ensure more equitable access to gender-affirming care nationwide.

Keywords: transgender health, transgender policy, gender-affirming care, health care policy

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Introduction

Despite living in one of the world's richest countries, many Americans face significant barriers to accessing appropriate health care. Even after the passage and implementation of the Patient Protection and Affordable Care Act, lack of health insurance remains a significant barrier to care, with an estimated 28 million Americans still uninsured (Keisler-Starkey & Bunch, 2021). Other common barriers to accessing health care include cost concerns, lack of health care providers in rural locations, and not having an established point of contact to begin accessing care (Centers for Disease Control and Prevention, 2022; Wishner, Solleveld, Rudowitz, Paradise, & Antonisse, 2016).

While many Americans struggle with access to health care, transgender individuals face additional barriers to accessing appropriate health care because of specialized needs related to their transitions, as well as routine health care that may require additional training for physicians (WPATH, n.d). Transgender people, especially those who were assigned female at birth, experience disproportionately elevated rates of neglect within health care settings, which may include vilification, negation of health care resources, and physical aggression by medical practitioners (Shires & Jaffee, 2015; Wingo et al., 2018). Private health insurance often fails to cover necessary procedures, thus resulting in negative financial outcomes when care was sought, and negative health care outcomes when it was not (Bakko & Kattari, 2020; Bakko & Kattari, 2021). In part because of the difficulty and limited availability of high-quality gender-affirming health care, transgender individuals in the country face significant health disparities in comparison to their cisgender counterparts. For example, in a report published by the Center for American Progress (Medina et al., 2021), transgender respondents were twice as likely to report being diagnosed with a depressive disorder, and 2 in 3 of transgender respondents reported they held concerns that their health evaluations were in some way impacted by their sexual orientation or gender identity. These circumstances are not without ramifications. Because transgender individuals feel as though the medical system does not serve them adequately, many may choose to limit their interaction with medical personnel or restrict and remove themselves from the medical environment altogether (Kattari et al., 2020). This can have dire consequences, as not only does it reinforce aforementioned health disparities, but it prevents transgender individuals from seeking the necessary, affirming care they need to create happy, functional livelihoods (Kattari et al., 2020). The avoidance of medical professionals and systems on the basis of fear over discrimination can prevent transgender individuals from receiving gender affirming services, such as hormone replacement therapy or surgery (Grant et al., 2011).

Given the challenges that transgender Americans face in seeking appropriate health care, what policies and protections exist to facilitate transgender individuals' access to care? Like many aspects of health care in the United States, trans individuals' access to care is typically governed by a patchwork of federal and state policies, meaning that it can vary substantially from state to state. In Illinois, three federal and state policies play a major role in governing access to gender affirming health care for trans: The Patient Protection and Affordable Health Care Act (specifically, its requirements for health insurance plans sold on the federal or state marketplaces); the Illinois Human Rights Act (IHRA); and Medicaid, which operates as a federal/state partnership to provide health care coverage to low-income individuals and families in Illinois. This paper highlights the aspects of these three policies that determine access to appropriate health care for trans individuals, as well as offers suggestions for how these policies might be altered to achieve better access to quality health care for trans Americans.

The Patient Protection and Affordable Care Act

The ability for individuals and families to purchase insurance at more affordable rates outside of employer groups on state and federal online marketplaces is the bedrock of the Patient Protection and Affordable Care Act (ACA). Not only do these insurance marketplaces increase access to insurance for many Americans, but they also provide a key mechanism for the federal government to establish requirements for policies sold on the marketplaces. One of these requirements with particular significance to trans individuals is that any insurance plans offered through the marketplaces must cover preventive care procedures at no cost to the consumer and cannot deny payment for any procedure based on criteria protected by previous civil rights and legal nondiscrimination protections (ACA, 2010). Put simply, insurance plans offered through the Marketplace are not allowed to deny claims even in cases where the procedure code does not match with the person's self-identified gender. For example, a transgender man who has not yet undergone a hysterectomy and needs a pap smear for cervical cancer screening cannot be denied this procedure even if his insurance records and identity documents state he is male. Because the ACA is federal law, this coverage is mandated at the national level and is thus consistently applied no matter where in the United States a transgender individual may live, including Illinois.

While the ACA did expand access to care for many Americans, including many transgender individuals, it did not solve every problem. Although routine screenings and annual physicals were now required to be covered by policies sold on the marketplaces, other procedures not defined under the law as preventive care were not, thus still leaving insurance companies with the option to decline covering a procedure or test, such as for gender-affirming care not deemed "medically necessary" (Health care.gov, n.d.). Procedures related to transition rather than preventive care are not mandated to be covered nationwide because transition-related procedures, including hormone replacement therapy and gender affirmation surgeries, may be classed as "elective" surgery by insurance companies. Although some states will cover transition procedures, no federal statutes have established what care is medically necessary for transgender people beyond that what is also considered necessary for cisgender individuals.

Additionally, while subsidies assist with the cost of insurance premiums, many of the more affordable policies carry high deductibles, which can still make medically necessary procedures prohibitively expensive for an individual or family. The fact that insurance companies can opt-in to providing coverage in an area or decide not to do so if there are an insufficient number of applicants, can also still lead to poor health coverage in rural areas, thus still making insurance coverage less accessible in some areas (Rivlin, 2016). Coupled with this, Medicaid expansion to cover a broader range of citizens is a state-by-state decision, which still produces a gap in coverage where those who cannot afford health insurance on the marketplace even with subsidies still lack coverage elsewhere (Matthew, 2018). How do these gaps impact transgender people specifically? Though the Supreme Court decision in Bostock v. Clayton County stated that Title VII protections regarding sex discrimination extended to LGBTQ+ individuals, transgender individuals have historically had a lower rate of employment than cisgender individuals in the United States (Ciprikis et al., 2020), and higher poverty rates as a result (Badgett et al., 2019). Thus, the benefits of the ACA do a poor job of supporting trans individuals. Language changes and recommendations surrounding gender-affirming care have not been updated, and laws that might have provided more comprehensive coverage have stalled in committee or not been passed (Stroumsa, 2014). The policy as it exists is simply not enough.

The Illinois Human Rights Act

In 2020, the Trump administration issued a final ruling on section 1557 of the Affordable Care Act (Musumeci et al., 2020). This section, which prohibited discrimination on the basis of race, color, national origin, sex, age and disability in federal health care programs and activities, was drastically narrowed. The revised section allowed for certain types of discrimination in health care settings, including removal of protections that guarded transgender individuals from gender-identity or sex stereotyping, and protections within health care insurance (Musumeci et al., 2020). In eliminating these valuable protections, the 1.4 million transgender individuals in the United States, of whom nearly 50,000 reside in the state of Illinois, were exposed to discriminatory practices from medical providers, including insurance companies, primary care, and other health care officials (Flores et al. 2016; U.S. Transgender Survey, 2017). While the Biden administration has overturned this ruling since May of 2021, transgender individuals within Illinois continue to have additional protections established by the Illinois Human Rights Act (IHRA). Passed in 1979, the bill ensures individuals are broadly protected from discrimination in a variety of domains, which includes employment, financial credit, public accommodation, housing, and sexual harassment. In the case of discrimination within health care, Article 5, which prohibits discrimination within public accommodations, includes specifically health care, medical providers, and insurers (Illinois Human Rights Act, 1979).

Under the IHRA (1979), individuals covered include anyone who is included under a protected category in Illinois statute, which does include sex and gender identity and thus protects gender minority individuals. Other protected statuses include the following: age (individuals 40 and over), citizenship status, disability, national origin, race, those with unfavorable military discharge, ancestry, color, familial and marital status, religion, military status, pregnancy, and sexual orientation.

The benefits within the IHRA are largely intangible, as they deal with guarding and maintaining the rights of individuals, specifically with protecting individuals from discrimination based on one of the protected classes. More specifically though, the IHRA makes it illegal for health care professionals to refuse to treat or provide unequal care to an individual on the basis of their gender identity and prohibits discrimination on the basis of actual or perceived gender identity. This includes, but is not limited to, refusing to admit or treat an individual based on their gender identity, refusing to provide counseling, referrals, or other supportive services on the basis of one's gender identity, and attempting to coerce, harass or interfere in any way with an individual's health care due to their gender identity (Illinois Department of Human Rights, 2020).

Additionally, these protections extend to both individual and group insurance coverage. Under the IHRA, health insurance companies are prohibited from discrimination in offering and maintaining health care coverage based on one's gender identity, and no health insurer may refuse or decline to renew a health insurance contract on the same basis, nor may a company establish different conditions, benefits, or policy limits based on gender identity. These protections also extend to the state's Medicaid program, and under the IHRA individuals who receive Medicaid are provided reimbursement for gender-affirming services given prior authorization (Illinois Department of Human Rights, 2020). The coverage of gender-affirming care and limitations under Illinois Medicaid specifically will be covered in greater detail later in this paper.

The Illinois Department of Human Rights (IDHR) and the Illinois Human Rights Commission oversee enforcement of the act, and thus are involved in scenarios in which individuals' rights have been violated under the act. Individuals who feel as though they have been discriminated against on the basis of one of the protected identity categories may file an IDHR Complaint Information Sheet and deliver it to the IDHR via email, mail, or fax within 300 days of the incident (Illinois Department of Human Rights, n.d.). Additionally, as mentioned prior, individuals who receive Medicaid care and seek gender-affirming services can be reimbursed for said services, which is overseen and done by the Illinois Department of Health care and Family Services (Illinois Department of Human Rights, 2020).

Under the IHRA, the nearly 50,000 gender minority individuals in Illinois are given clearly outlined protections that give them legal grounds to guard against discrimination on the basis of their protected identity, joining the ranks of many other protected classes. With regards to equality, the IHRA ensures that all individuals covered under the act are not only given the same protections, but they are all able to report acts of discrimination and seek the same compensation. With regards to adequacy, under the IHRA, health professionals such as doctors, nurses, etc., cannot discriminate against an individual on the basis of their gender identity, protecting them from direct discrimination and ensuring that they are not only able to access the same level of care as any other Illinois citizen, but that they are met with a baseline level of decency and respect in their interactions with health care professionals.

However, while the IHRA does have strong points, it also lacks sufficiency in the same areas of adequacy, equality, and equity. Currently, one of the primary issues encountered is in the case of insurance, because while Medicaid users are ensured proper reimbursement for gender-affirming services, only 14.4 % of Illinois residents are on Medicaid (Kaiser Family

Foundation, 2019). Although the ACA mandates that all insurance policies, whether through employers or sold on the marketplaces, cover certain essential benefits, many employer-based plans are not subject to all the requirements of policies sold directly through the marketplaces. The majority of Illinois residents, 54%, receive their insurance through their employer. For up to 68% of Illinois residents, this type of insurance is typically either fully or partially self-funded, and is not covered under the IHRA (Schencker, 2019). As noted earlier, insurance companies can deny their transgender patient's coverage for important transition related care, such as hormones, gender affirming surgeries, and counseling by deeming them as "elective" procedures. Thus, while the more frequent interactions with medical providers may not pose a threat, the bureaucracy and overarching systems that manage a transgender person's medical care can work against them. By preventing them from accessing important transition related care vital for their overall wellbeing, many trans people may be left bogged down by the expensive costs of gender transition services rather than being assisted through their insurance.

Another part of the IHRA that lacks equality and adequacy is more structural in nature, but inherently it creates wide disparities in health services, and that is medical education itself. Under the IHRA, it is illegal to provide unequal treatment to a gender minority person compared to their cisgender counterpart, and while health care professionals may intend the best for patients and seek the same standard for care, ultimately the education system that built their knowledge and practice may inadvertently lead to an unequal standard of care due to lack of knowledge on transgender specific issues. In a study done by Nowaskie & Sowinski (2018), researchers surveyed a sample of 127 medical professionals and found that while a majority were comfortable treating sexual and gender minority patients, they felt uninformed on what specific treatments, clinical management, and referrals these patients may need. Furthermore, clinicians who had negative biases were less likely to know about specific LGBT+ health needs and more likely to deliver substandard care to this population. Thus, while the IHRA may prohibit unequal treatment, the structural issues that lie underneath are able to maneuver their way around this safeguard, and even clinicians with the best of intentions may be unintentionally discriminating against their gender minority patients due to a lack of knowledge that renders them unable to provide equivocal care.

Medicaid

Despite the U.S. Department of Health and Human Services' retracted protections against discrimination on the basis of sexual orientation and gender-identity, referred to as the 2020 Final Rule, the Illinois Department of Health care and Family Services declared that within the state of Illinois, Medicaid would now cover gender-affirming services to fulfill its obligations under the IHRA (Illinois Department of Human Rights, 2020).

For transgender individuals in Illinois to access gender-affirming care under Illinois Medicaid, they must first meet the general requirements of the Illinois Medicaid program. Adults aged 19 to 64 with an income under 133% of the federal poverty line; individuals who are blind, have other disabilities, or are over the age of 65, and who have an income of 100% of the federal poverty level; and individuals who are pregnant and meet income limits are eligible to enroll in Illinois' Medicaid program (Illinois Legal Aid Online, n.d.). In addition, low-income families and individuals must also be U.S. citizens or must be either a refugee or an individual lawfully present in the United States for more than five years (Illinois Legal Aid Online, n.d.).

Illinois Medicaid, per the Illinois Human Rights Act, will cover gender-affirming surgeries, services, and procedures for eligible individuals. Various qualified gender-affirming surgeries, services, and procedures can be covered, including breast or chest surgeries (i.e., breast augmentation or masculine chest reconstruction) and genital surgeries (e.g., hysterectomies, oophorectomies, orchiectomies, and vaginoplasties) (American Psychiatric Association, n.d.; Ill. Admin. Code tit. 89, § 140.413, 2020). Additionally, related therapies, such as counseling and hormone therapy, are covered by Medicaid (American Psychiatric Association, n.d.; Ill. Admin. Code tit. 89, § 140.413, 2020). Medicaid recipients are eligible to receive gender-affirming services so long as they meet the distinct requirements for such services. Individuals seeking gender-affirming procedures or services must be 21 years old or older (Ill. Admin. Code tit. 89, § 140.413, 2020). A prior approval process is required for both genital and non-genital surgeries in order to be covered by Illinois' Medicaid.

Prior approvals for non-genital surgeries must be obtained through the submission of one letter from either the individual's primary care provider or the practitioner overseeing the individual's gender-related health care, underscoring that the individual has been assessed and is being referred for gender-affirming services, not including genital gender-affirming surgery (Ill. Admin. Code tit. 89, § 140.413, 2020). In essence, the letters must clearly indicate that the individual has a formal diagnosis of gender dysphoria (Ill. Admin. Code tit. 89, § 140.413, 2020), which can be best conceptualized as the psychological distress one endures induced by an incompatibility between one's sex assigned to them at birth and one's gender identification (American Psychiatric Association, n.d.). The individual must have also acquired the adequate and appropriate hormonal therapy and treatment needed to achieve the individual's preferred gender goals for a minimum of 12 months if keen on pursuing genital surgery, unless the hormonal therapy or treatment is considered inadvisable given that it is detrimental to the individual's health or if the individual is unable to undergo gender-affirming hormone treatment (Ill. Admin. Code tit. 89, § 140.413, 2020).

Prior approvals for genital surgeries must be acquired through the submission of letters from two qualified medical providers (Ill. Admin. Code tit. 89, § 140.413, 2020). One letter must be retrieved from the individual's primary care provider or from the practitioner presiding over the individual's gender-related health care, disclosing that the individual has been assessed and is being referred for gender-affirming services, which would include surgery (Ill. Admin. Code tit. 89, § 140.413, 2020). The other letter must be obtained from a Licensed Practitioner of the Healing Arts (LPHA), indicating that the individual has been assessed and is being referred for gender-affirming services, which would include surgery (Ill. Admin. Code tit. 89, § 140.413, 2020). Furthermore, individuals striving to undergo genital surgery must also have lived unceasingly for a minimum of 12 months in the gender role corresponding to the individual's gender identity (Ill. Admin. Code tit. 89, § 140.413, 2020). The letter must also confirm that the individual completed an adequate assessment by an LPHA and have received sufficient counseling and education on the diverse procedures and treatment options, implications, and, if recommended, psychotherapy (Ill. Admin. Code tit. 89, § 140.413, 2020). If a notable medical or mental health condition exists that would preclude the gender-affirming surgery, service, or procedure from being performed, it is critical that it be prudently managed (Ill. Admin. Code tit. 89, § 140.413, 2020). The individual must also have the capacity to make fully informed, knowledgeable decisions and assent to treatment (Ill. Admin. Code tit. 89, § 140.413, 2020). It is also imperative that the medical practitioner has collaboratively deliberated and communicated the prospective surgery, service, or procedure, and that they provide clear and convincing evidence regarding the medical necessity of the surgery, service, or procedure the individual is seeking (Ill. Admin. Code tit. 89, § 140.413, 2020). Finally, the letter must include post-operative care instructions (Ill. Admin. Code tit. 89, § 140.413, 2020). If an individual pursuing gender-affirming surgeries, services, and procedures does not meet the minimum age requirement but medical necessity is evidenced and prior authorization is granted, then payment will be provided (Ill. Admin. Code tit. 89, § 140.413, 2020).

The expansion of Medicaid coverage for gender-affirming care in Illinois provides Medicaid recipients who may not have the resources to afford gender-affirming care on their own (Zaliznyak et al., 2021). Prior to January 1, 2020, gender affirming surgery was included in the physician list of services excluded from coverage and payment (Illinois Department of Health Care and Family Services, 2020). Nevertheless, on January 1, 2020, it was enforced that gender-affirming procedures will be reimbursed by the Department of HFS if medical need and prior authorization are established (Illinois Department of Health Care and Family Services, 2020). Given these provisions, providers may be more willing to accept Medicaid for individuals seeking gender-affirming care, especially providers working in larger health care facilities. However, it does not ensure that all providers will accept Medicaid.

There are a few identifiable weaknesses associated with the current provisions. For instance, Medicaid covers only a portion of the fees required for health care surgeries, services, and procedures. A second weakness is that although the Department of HFS will reimburse providers who provide gender-affirming services, providers at smaller health care facilities will be taking a financial risk as Medicaid provides lower reimbursement rates compared to the standard market cost for such services (Checkpoint EHR, 2021). Because of this, facilities that have a large Medicaid patient base are at risk of reduced revenue (Checkpoint EHR, 2021).

Another significant weakness is that the age requirement does not take into consideration that there are individuals prior to the age of 21 who can make informed and knowledgeable decisions regarding gender-affirming surgeries or procedures. The age requirement could be more flexible to take this into account and to not hinder one’s ability to seek the procedure(s) that will positively impact their life and overall psychological welfare (Almazan & Keuroghlian, 2021). They no longer have to feel trapped in a body that they are not comfortable with and to have to prove that gender-affirming is medically necessary. Finally, the process to qualify for gender-affirming services is a daunting one. It does not account for the fact that many individuals face barriers navigating the health care system and may still combat implicit prejudicial bias from their practitioners (Zaliznyak et al., 2021).

Discussion and Policy Recommendations

Access to health care in the United States is governed by a patchwork of federal, state, and local policies, as well as by the private health care industry. Access to specialized health care for transgender people is no exception. Little federal policy directly addresses the health needs of trans people, resulting in a reliance on state and local policies to determine if, how, and to what extent gender-affirming health care will be made accessible to transgender residents. Because of this, national policy regarding specialized care for trans individuals is especially fragmented and varies widely across state lines. All trans Americans are protected by the nondiscrimination clauses of the Patient Protection and Affordable Care Act following repeal of the 2020 “Final Rule,” and this paper has described additional protections available to transgender individuals living in Illinois. While transgender residents of Illinois may have more opportunities to access gender-affirming care with insurance coverage, there are still significant limitations to those opportunities as noted throughout this paper. We as authors now offer a range of policy recommendations to revise, build on, and expand the rights of transgender individuals to access appropriate health care in Illinois and nationwide.

Federal Policy Recommendations

Perhaps the most critical action to establish a national threshold for access to gender-affirming care is to issue a federal mandate that insurance policies must cover transition-related care as needed for each individual, and as defined by the World Professional Association of Transgender Health (WPATH) Standards of Care. A similar policy has already been proposed in Congress and died in committee (Stroumsa, 2014), but could easily be reintroduced, perhaps with modifications. WPATH is currently in the process of updating their Standards of Care, and with this document already lined out, it would not be difficult to encode these standards into existing laws regarding what care is medically necessary.

Updates to both federal and state Medicaid policies could also play a significant role in improving transgender individuals' access to appropriate health care. If the federal government were to find a legal way to mandate the expansion of Medicaid according to the option provided within in the ACA, requiring states to do so would narrow an important disparity in access for transgender people. Because so many transgender individuals do fall into the lower end of the socioeconomic range, this would increase their access to health insurance coverage and their ability to obtain appropriate, gender affirming care. Even if private insurance companies could not be required to cover transition-related health care in all states, Medicaid could be required to do so nationwide, which would make access to care more equitable for this population. By extension, having access to this care and allowing them to physically transition as well as socially, we could reduce the stigma and systemic barriers they face in day-to-day life. This would likely increase access to employment, thus also helping to raise tax revenues paying into the program and lifting more trans people out of poverty.

Developing a more detailed and inclusive comprehensive list of the gender-affirming surgeries, services, and procedures that can be covered by Medicaid would better facilitate access to appropriate care for trans individuals. Doing so allows for providers and individuals seeking gender-affirming care to be knowledgeable on the multitude of genital and non-genital surgeries, services, and procedures that are covered by Medicaid. Providers should be well-informed about the gender-affirming services they are providing to best assist patients or refer them to another competent provider. Furthermore, producing and disseminating a more comprehensive and detailed list of gender-affirming surgeries, services, and procedures that Medicaid may cover can help make the process to confirm coverage less time-consuming and frustrating for patients (Zaliznyak et al., 2021).

Requiring better medical education on gender-affirming health care and practice with transgender people is another way to improve access to appropriate care across federal and state levels. A lack of appropriately educated providers is an identified weakness within all three policies covered in this paper. Stroumsa (2014) has written extensively about the need for medical professionals to be trained on, if not WPATH’s Standards of Care exactly, then at least related care for transgender individuals that includes understanding what bodily systems are impacted by hormones and surgical intervention, and which systems are not, as well as respectful and affirming communication skills. It is imperative to consider the lack of proper training and cultural humility within health care (Sabin et al., 2015). Therefore, we recommend that professional education for health care practitioners and providers providing services to gender non-conforming, non- binary, and transgender patients should include the essential tools and knowledge necessary to adequately care and support the distinct desires and needs of gender non-conforming, non-binary, and transgender patients in a culturally competent holistic and equitable manner (Shires & Jaffee, 2015). For health care providers who have already completed their professional training, continuing medical education (CME) requirements for medical license renewal should require education on current standards and practices for high-quality, gender-affirming care that are rooted in cultural competence and equity. By providing education on the unique needs of transgender patients during both professional training and as a condition of continued licensure, more providers will have the skills and cultural competence necessary to offer high-quality, gender-affirming care to transgender people.

Recommendations for Illinois Policy

Within Illinois, an important recommendation to make regarding the IHRA is to expand its language to explicitly include self-funded insurance policies as well as establishing gender affirming care as a medically necessary right that transgender patients should be entitled to under any type of health insurance coverage. According to Drydakis (2020), transgender individuals who are able to transition experience a considerable increase in self-esteem, life-positivity, body image, social relations, and more compared to their pre-transition selves. Thus, much like procedures that can improve quality of life, well-being, and safety, such as preventative double-mastectomies for individuals at high risk for breast cancer, gender affirming procedures should be considered as something vital to the health and wellbeing of gender minority individuals. This in fact may be on the path to change, as the Illinois Department of Insurance is seeking to expand protections and add gender identity as a protected category to employer insurance plans (Illinois Department of Human Rights, 2020). This could then expand adequacy and equity by allowing transition related services to be considered a vital part to one's personal health and allow for gender minority individuals to pursue procedures that are able to suit and improve their lives.

In Illinois, partial funding from the IHRA could be used to fund professional education programs like those described earlier. Funds from IHRA could be used to enrich medical education curricula and continuing education credits regarding the unique needs of gender minority patients. By addressing the structural issues creating such gaps in the first place, the unintended discrimination that lies underneath can be significantly diminished or even removed. This would improve equality by allowing gender minority individuals to be treated akin to cisgender patients as doctors would have the knowledge to treat this population, and adequacy by giving gender minority patients the minimum standard of care and decency.

Conclusion

The patchwork of federal and state policies that regulate access to gender affirming care for trans individuals results in significant inequities between states. At the federal level, many of the policies that protect access to gender affirming care do so implicitly, making such protections tenuous and subject to interpretation. Explicitly stating protections for trans Americans and their rights to appropriate health care would significantly strengthen the power of existing policies and reduce inequities across state lines. Although Illinois has already taken important steps to protect trans people's access to appropriate health care through antidiscrimination policies in the Illinois Human Rights Act and expanding Medicaid to include coverage for gender-affirming care, there is still room to do more. By expanding the types of health insurance subject to antidiscrimination rules and providing professional education on gender-affirming care, Illinois can continue to lead in facilitating access to high-quality gender-affirming care for trans individuals.

References

2015 U.S. Transgender Survey: Illinois State Report. (2017). Washington, DC: National Center for Transgender Equality.

Almazan, A. N., & Keuroghlian, A. S. (2021). Association between gender-affirming surgeries and mental health outcomes. *JAMA surgery 156*(7): 611–618. doi: 10.1001/jamasurg.2021.0952

American Psychiatric Association. (n.d.). *What is gender dysphoria?* Retrieved November 3, 2021, from https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria

Badgett, M. L., Choi, S. K., & Wilson, B. D. (2019). LGBT poverty in the United States. Los Angeles, CA: *The Williams Institute and American Foundation for Suicide.* https://escholarship.org/content/qt37b617z8/qt37b617z8_noSplash_4b0b58d8b1dc638982abf3279abda10e.pdf

Bakko, M., & Kattari, S. K. (2020). Transgender-related insurance denials as barriers to transgender health care: Differences in experience by insurance type. Journal of General Internal Medicine, 35(6), 1693–1700. doi: 10.1007/s11606-020-05724-2

Bakko, M., & Kattari, S. K. (2021). Differential access to transgender inclusive insurance and health care in the United States: Challenges to health across the life course. *Journal of Aging and Social Policy*, *33*(1), 67–81.

Centers for Disease Control and Prevention (2022). FastStats: Health Insurance Coverage. Retrieved from https://www.cdc.gov/nchs/fastats/health-insurance.htm

Checkpoint EHR. (2021, July 19). *The pros and cons of accepting Medicaid*. Retrieved December 5, 2021, from https://checkpointehr.com/blog/pros-and-cons-of-accepting-medicaid/

Ciprikis, K., Cassells, D., & Berrill, J. (2020). Transgender labour market outcomes: Evidence from the United States. *Gender, Work & Organization, 27*(6), 1378-1401. doi: 10.1111/gwao.12501

Drydakis, N. (2020). Trans people, transitioning, mental health, life, and job satisfaction. *Handbook of Labor, Human Resources and Population Economics* (pp. 1–22). Springer International Publishing. doi: 10.1007/978-3-319-57365-6_33-1

Flores, A.R., Herman, J.L., Gates, G.J., & Brown, T.N.T. (2016). *How many adults identify as transgender in the United States?* Los Angeles, CA: The Williams Institute.

Grant, J. M., Mottet, L. A., Tanis, J., Harrison, J., Herman, J. L., and Keisling, M. (2011). *Injustice at every turn: a report of the national transgender discrimination survey*. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force.

Health care.gov (n.d.) Transgender health care. https://www.health care.gov/transgender-health-care/ ‘

Illinois Administrative Code tit. 89, § 140.413 (2020).

Illinois Department of Health care and Family Services (HFS)[a]. (2020, 29). Provider Notice Issued 01/09/2020. Retrieved November 3, 2021, from https://www2.illinois.gov/hfs/MedicalProviders/notices/Pages/prn200109a.aspx.https://www2.illinois.gov/dhr/Documents/Joint%20Nondiscrimination%20Guidance.pdf

Illinois Department of Human Rights. (n.d.) Retrieved from https://www2.illinois.gov/dhr/Pages/default.aspx

Illinois Department of Human Rights. (2020, June 26). Guidance relating to nondiscrimination in health care services in Illinois. The Illinois Department of Human Rights (IDHR). (2020, June 26). Guidance Relating to Nondiscrimination in Health care Services in Illinois. Retrieved November 2, 2021, from https://www2.illinois.gov/dhr/Documents/Joint%20Nondiscrimination%20Guidance.pdf

Illinois Legal Aid Online. (n.d.). *Am I eligible for Medicaid?* Retrieved December 5, 2021, from https://www.illinoislegalaid.org/legal-information/am-i-eligible-medicaid

Illinois Human Rights Act, 775 ILCS 5 (1979). https://www.ilga.gov/legislation/ilcs/ilcs5.asp?ActID=2266&ChapterID=64

Kaiser Family Foundation. (2019). Health insurance coverage of the total population, multiple sources of coverage. Retrieved from https://www.kff.org/other/state-indicator/health-insurance-coverage-of-the-total-population-multiple-sources-of-coverage/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Kattari, S. K., Bakko, M., Langenderfer-Magruder, L., & Holloway, B. T. (2020). Transgender and nonbinary experiences of victimization in health care. *Journal of Interpersonal Violence*, https://doi.org/10.1177/0886260520905091

Keisler-Starkey, K., & Bunch, L. (2021). *Health insurance coverage in the United States: 2020*. Kaiser Family Foundation. Retrieved from https://www.census.gov/library/publications/2021/demo/p60-274.html

Matthew, D. B. (2018). Next steps in health reform: Hospitals, Medicaid expansion, and racial equity. *The Journal of Law, Medicine & Ethics, 46*(4), 906–912. doi: 10.1177/1073110518821988

Medina, C., Santos, T., Mahowald, L., & Gruberg, S. (2021). *Protecting and advancing health care for transgender adult communities*. Center for American Progress. Retrieved from https://www.americanprogress.org/article/protecting-advancing-health-care-transgender-adult-communities/

Musumeci, M. B., Kates, J., Dawson, L., Salganicoff, A., Sobel, L., & Artiga, S. (2020). *The Trump administration's Final Rule on Section 1557 non-discrimination regulations under the ACA and current status.* Kaiser Family Foundation. Retrieved from https://www.kff.org/racial-equity-and-health-policy/issue-brief/the-trump-administrations-final-rule-on-section-1557-non-discrimination-regulations-under-the-aca-and-current-status/

Nowaskie, D. Z., & Sowinski, J. S. (2018). Primary care providers' attitudes, practices, and knowledge in treating LGBTQ communities. *Journal of Homosexuality, 66*(13), 1927-1947. doi:10.1080/00918369.2018.1519304

Rivlin, A. M. (2016, December 6). *How to create TrumpCare and make it great*. The Brookings Institution. https://www.brookings.edu/opinions/how-to-create-trumpcare-and-make-it-great/

Sabin, J. A., Riskind, R. G., & Nosek, B. A. (2015). Health care providers' implicit and explicit attitudes toward lesbian women and gay men. *American Journal of Public Health, 105*(9), 1831-1841. doi: 10.2105/AJPH.2015.302631

Schencker, L. (2019, October 7). ‘I’m a human, right?’ Transgender patients fear health care discrimination under Trump administration proposal. *Chicago Tribune.* Retrieved from https://www.chicagotribune.com/business/ct-biz-transgender-discrimination-trump-administration-regulation-20191004-kziuhdc6lbgavksx2bzdn6owf4-story.html

Shires, D. A., & Jaffee, K. (2015). Factors associated with health care discrimination experiences among a national sample of female-to-male transgender individuals. *Health & Social Work*, *40*(2), 134-141. doi: 10.1093/hsw/hlv025

Stroumsa, D. (2014). The state of transgender health care: Policy, law, and medical frameworks. *American Journal of Public Health, 104*(3), e31–e38. doi: 10.2105/AJPH.2013.301789

Wingo, E., Ingraham, N., & Roberts, S. C. (2018). Reproductive health care priorities and barriers to effective care for LGBTQ people assigned female at birth: A qualitative study. Women's Health Issues, 28(4), 350-357. https://doi.org/10.1016/j.whi.2018.03.002

Wishner, J., Solleveld, P., Rudowitz, R., Paradise, J., & Antonisse, L. (2016). *A look at rural hospital closures and implications for access to care.* Kaiser Family Foundation. Retrieved from https://www.kff.org/medicaid/issue-brief/a-look-at-rural-hospital-closures-and-implications-for-access-to-care/

World Professional Association for Transgender Health. (n. d.) https://www.wpath.org

Zaliznyak, M., Jung, E. E., Bresee, C., & Garcia, M. M. (2021). Which U.S. states’ Medicaid programs provide coverage for gender-affirming hormone therapy and gender-affirming genital surgery for transgender patients?: A state-by-state review, and a study detailing the patient experience to confirm coverage of services. *The Journal of Sexual Medicine, 18*(2), 410-422.

Research Based Poster Presentation

An Analysis of the Inequality of Adverse Childhood Experiences Facing African Americans in Illinois and the Impact of State Economic Policy

Chance Flemming and Michelle Morrison

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Abstract

In the words of a past president of the American Academy of Pediatrics, Dr. Robert Block; "Adverse Childhood Experiences are the single greatest unaddressed public health threat facing our nation today". Adverse Childhood Experiences or "ACEs" are potentially traumatic events that occur before a child turns 18. With that in mind, we want to look at the connections between economic policy, both current and historic, and their effect on ACEs, specifically within the Black community in Illinois. Although ACEs are not solely confined to the Black community, through data reports of ACEs across all racial populations in our state, it is found that Black people experience ACEs more often than any other racial population. We know that ACEs increases risk factors in various medical diseases and mental health issues, which makes researching solutions to reduce elevated ACEs rates in Black individuals that much more vital. By looking at recent data on ACEs from Illinois as well as economic policies, we hope to discover what impact state policy can play in reducing the elevated ACEs score in Black individuals, with hope to reduce this elevated number, leading to less harmful effects on Black people because of a high ACEs score.

Keywords: Adverse Childhood Experiences, Illinois Black community, Illinois economic policy

About the Authors: *Chance Flemming is a senior in the BSW program. His research interests are violence prevention and racial equity research with an emphasis on economic factors and solutions.*

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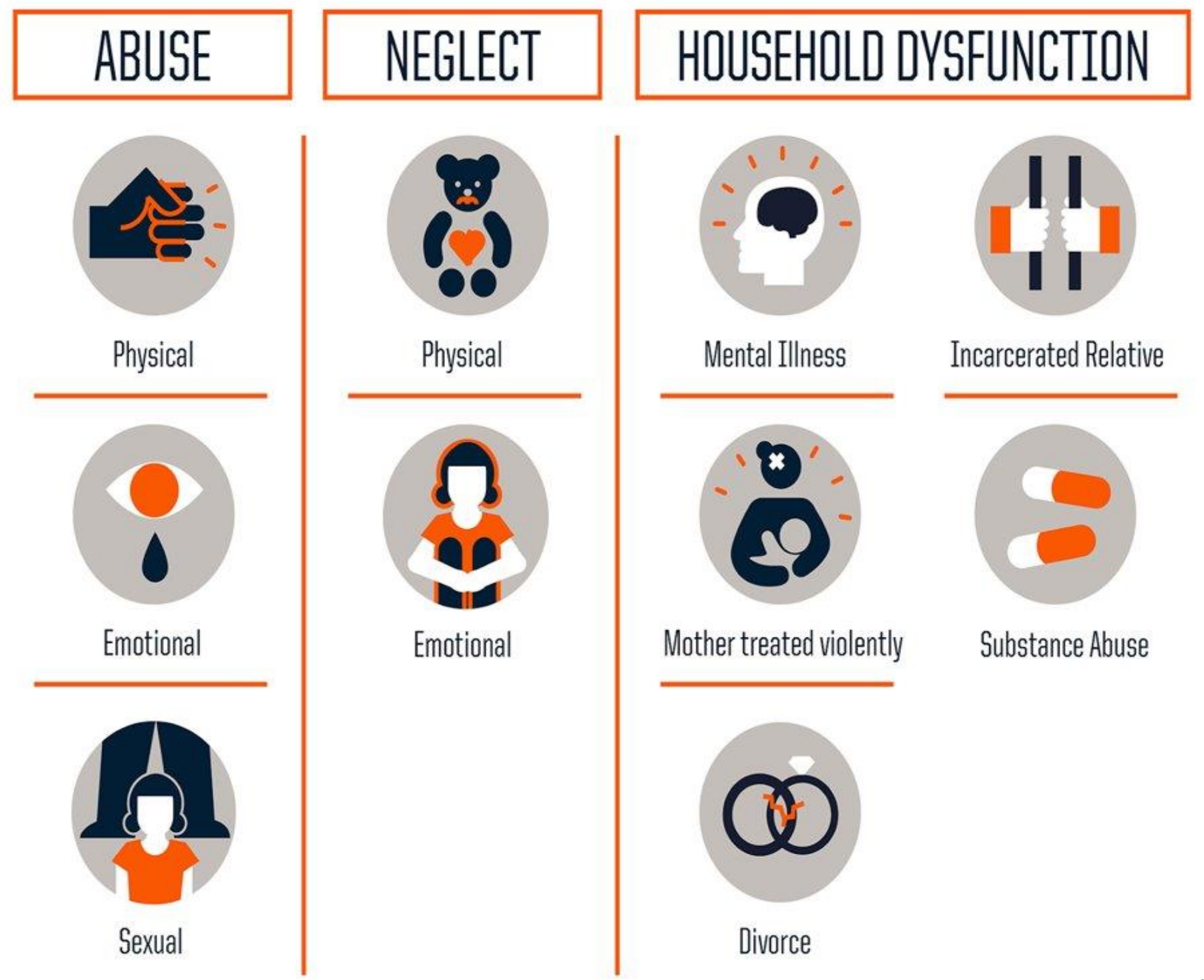
An Analysis of the Inequality of Adverse Childhood Experiences Facing African-Americans in Illinois and the Impact of State Economic Policy

Chance Flemming and Michelle Morrison - Violence Prevention Research Lab, Dr. Garthe
School of Social Work, University of Illinois Urbana-Champaign

INTRODUCTION

- "Adverse Childhood Experiences are the single greatest unaddressed public health threat facing our nation today". - Dr. Robert Block (1)
- Adverse Childhood Experiences (ACEs) are experiences that occur in childhood and produce toxic levels stress that negatively alters brain development. (2).
- ACEs are linked to higher amounts of chronic health problems, mental illness, and substance abuse in adulthood. (3).
- We expect to find a connection between the ACEs scores, economic factors, and race in Illinois.



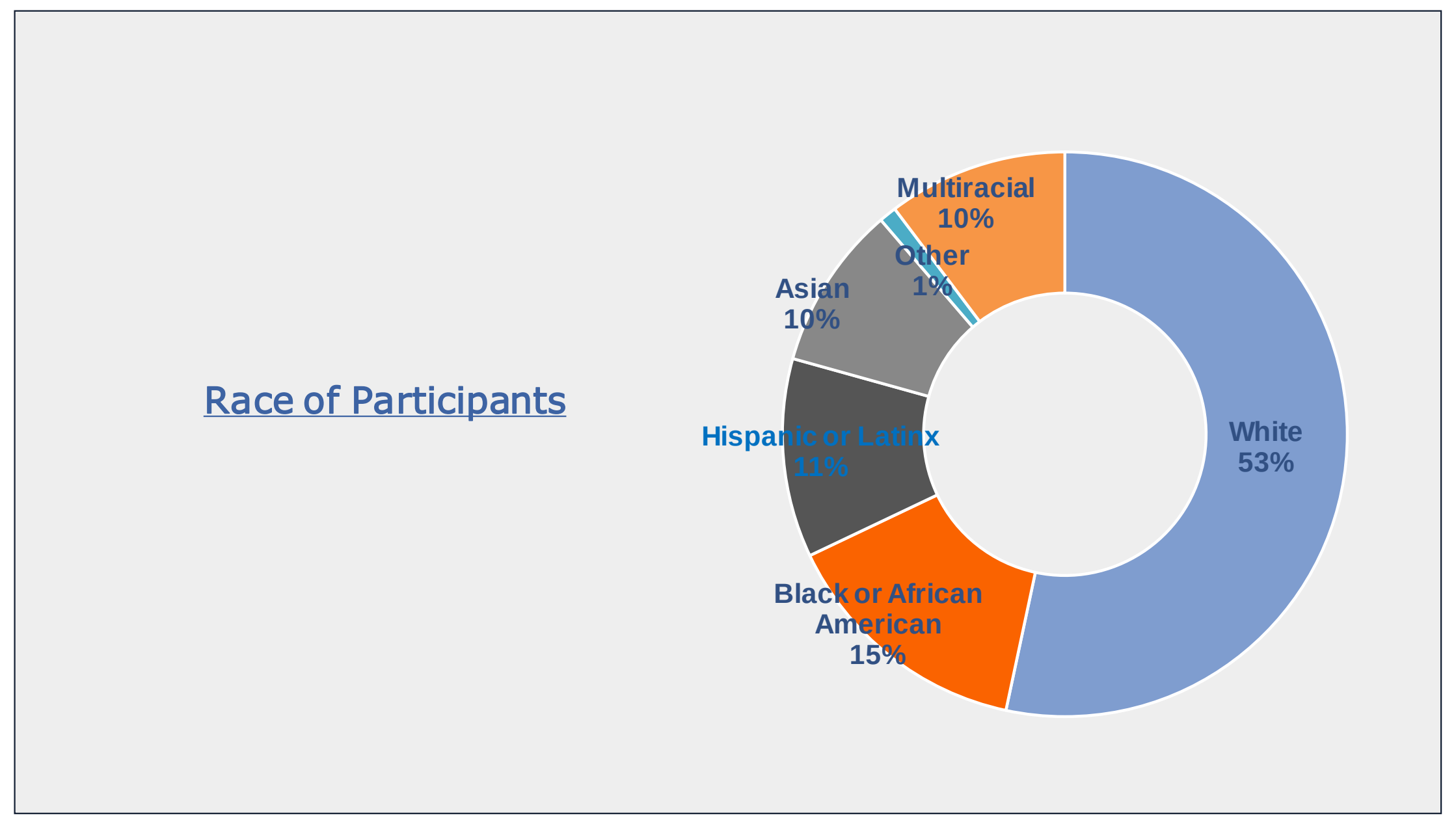
1. Harris, 2014
2. CDC, 2019
3. CDC, 2019

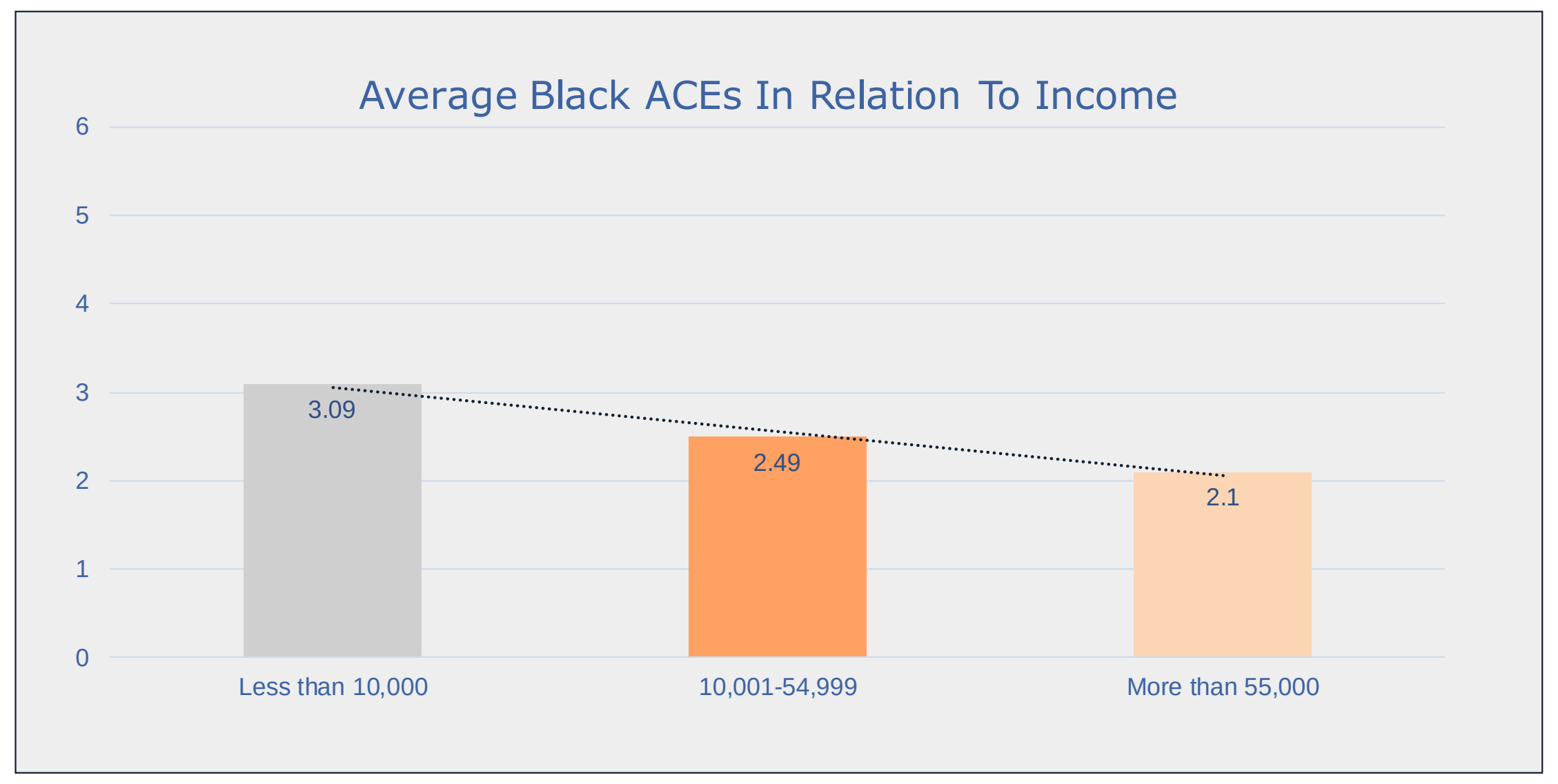
CURRENT STUDY

- We focused our research on the interaction of economic factors and ACEs in the Black community of Illinois. We looked at income, but after reviewing the literature we now wonder if economics is too singular a lens through which to understand the elevated ACEs scores that we see in the Black population not only in Illinois but across the nation.

METHODS

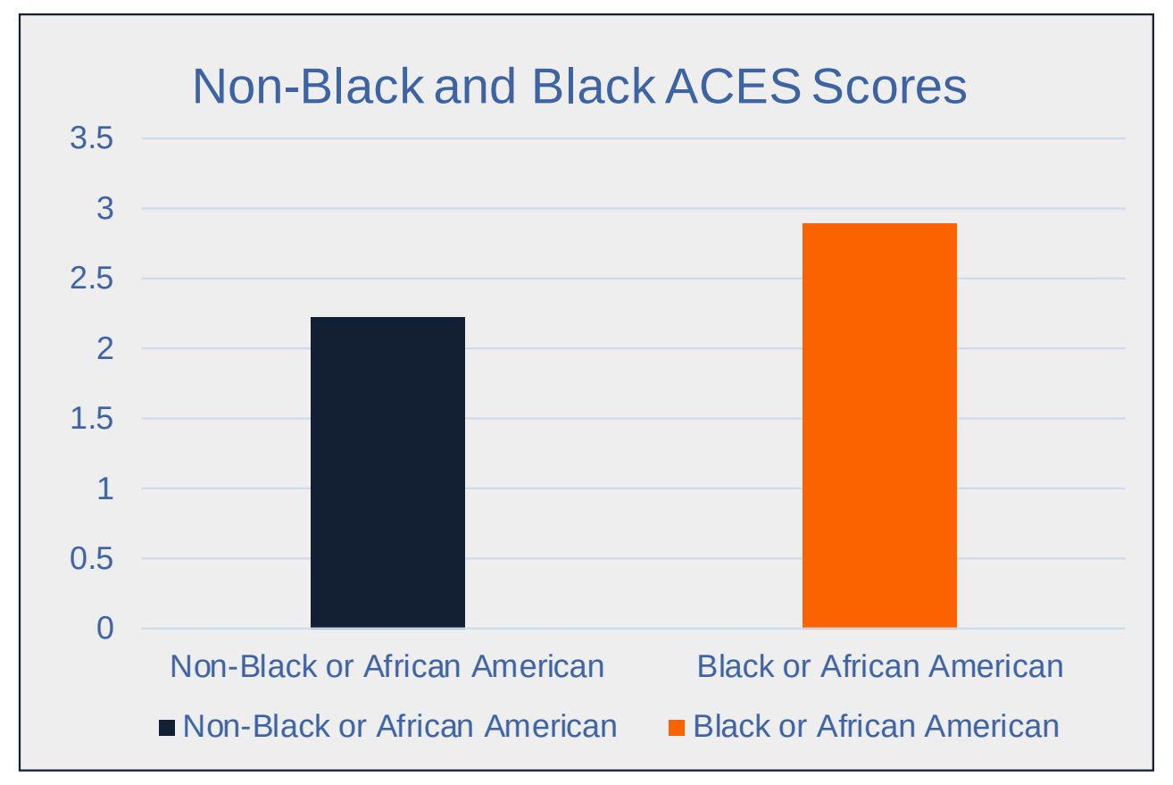
- The survey was administered utilizing Qualtrics survey software.
- Sample Size: <u>712</u> Adults.
- The mean age of participants was **<u>40.1</u>** years old.
- The **participants** in the survey are **exclusively** living in **Illinois.**





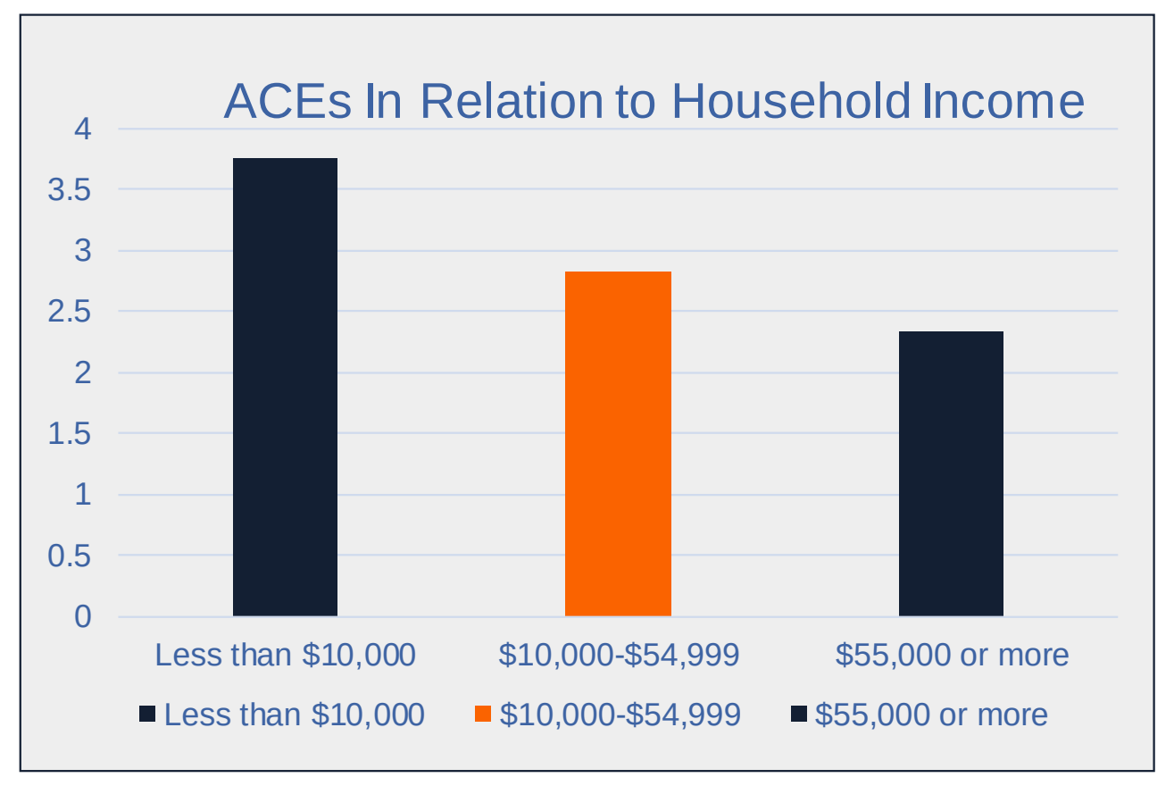
- Black participants reported, on average, higher ACEs scores than any other population by race.
- Black participants were also more likely to be in lower income brackets.
- As Income goes down ACEs scores go up.

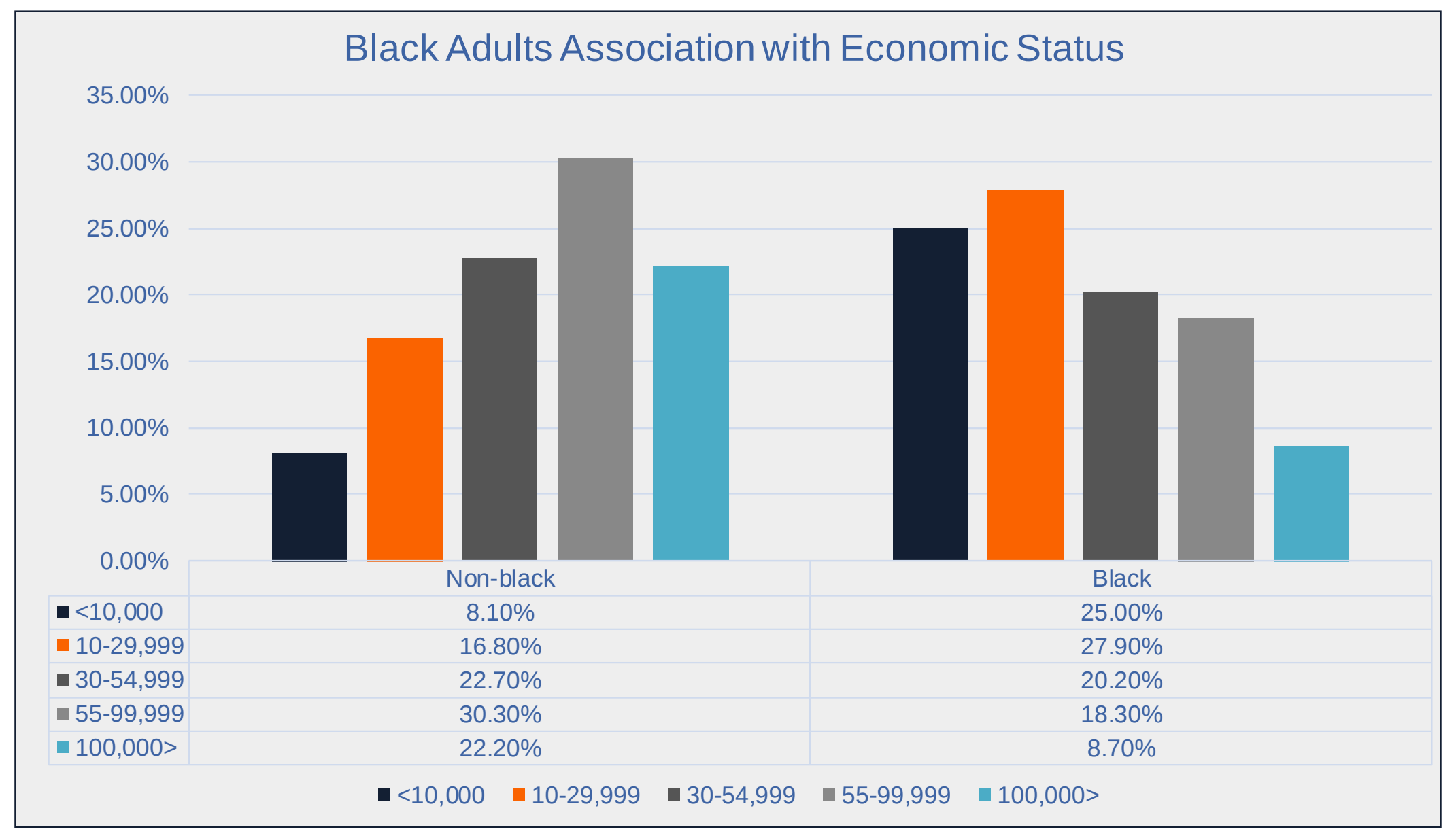
RESULTS



- An independent-samples t-test was conducted to compare ACEs between non-Black adults and Black adults.
- There was a significant difference in ACEs between non-Black adults (M = 2.22) and Black adults (M = 2.89), t (700) = -2.43, p < .05

- A one-way ANOVA was conducted to compare levels of ACEs by three economic categories. The three conditions were 1) less than $10,000, 2) $10,000-$54,999, and 3) $55,000 or more.
- There was a significant effect of economic categories on ACEs, F (2, 699) = 5.03, p < .05.





	Non-black	Black
■ <10,000	8.10%	25.00%
■ 10-29,999	16.80%	27.90%
■ 30-54,999	22.70%	20.20%
■ 55-99,999	30.30%	18.30%
■ 100,000>	22.20%	8.70%

- There was a significant association between race and ACEs, B = .572, p < .05.
- There was a significant association between economic level and ACEs, B = -.41, p < .05.
- The interaction between race and economic level was not statistically significant, B = -.43, p = .48.

DISCUSSION

- Our sample shows a clear inequality for Black people in experiencing increased levels of ACEs.
- Our research found that within the Black population of Illinois, a lower annual household income is associated with elevated ACEs scores, showing an economic role in ACEs for Black individuals.
- With that in mind, it is a necessity for future studies to acknowledge and research the effects of various racist economic policies that are furthering Income & ACEs inequalities in the Black population.
- Looking at the relationship between the Black population and economic factors in Illinois, we found that there is research in both areas but no concrete link between them.
- Socioeconomic status and poverty play an important role in rates of ACEs, neighborhoods of concentrated poverty heightens the risk of elevated ACEs scores for their residence. (1)
- There is little data looking at the relationship between the higher ACEs scores found in Black individuals and contributing economic factors.
- Socioeconomic factors, as they relate to ACEs and race have a complex interplay. (2)

1. (Maguire-Jack, K et a..l 2021).
2. (Slack.S et al. 2017)

LIMITATIONS

- With our strictly statewide sample our study is not generalizable beyond areas with similar regional demographics to Illinois. Future studies should include state diversity and a larger sample size.
- It's clear that income plays a role in higher ACEs scores for the Black population of Illinois but there are clearly other factors that influence ACE scores as well. Economic factors beyond income should be looked at.
- Our research emphasizes the need to include additional expansive ACEs. These expansive ACEs should include items purely revolving around racism and the effects of racist violence/abuse. (Bernard et al., 2020:Karatekin & Hill, 2018)

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References

Bernard, D. L., Calhoun, C. D., Banks, D. E., Halliday, C. A., Hughes-Halbert, C., & Danielson, C. K. (2020). Making the "C-ACE" for a Culturally-Informed Adverse Childhood Experiences Framework to Understand the Pervasive Mental Health Impact of Racism on Black Youth. *Journal of Child & Adolescent Trauma*, *14*(2), 233–247. https://doi.org/10.1007/s40653-020-00319-9

Harris, N. B. (2015, February 17). *How childhood trauma affects health across a lifetime*. TED Talks. Retrieved April 4, 2022, from https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime?language=en

Karatekin, C., & Hill, M. (2018). Expanding the Original Definition of Adverse Childhood Experiences (ACEs). *Journal of Child & Adolescent Trauma*, *12*(3), 289–306. https://doi.org/10.1007/s40653-018-0237-5

Maguire-Jack, K., Font, S., Dillard, R., Dvalishvili, D., & Barnhart, S. (2021). Neighborhood Poverty and Adverse Childhood Experiences over the First 15 Years of Life. *International Journal on Child Maltreatment: Research, Policy and Practice*, *4*(1), 93–114. https://doi.org/10.1007/s42448-021-00072-y

Preventing Adverse Childhood Experiences. (2021, August 23). Centers for Disease Control and Prevention. Retrieved April 11, 2022, from https://www.cdc.gov/vitalsigns/aces/index.html

Resource Library | Health & Medicine Policy Research Group. (2013). Adverse Childhood Experiences Understanding Health Risks Across Generations in Illinois and Chicago.

Retrieved April 11, 2022, from https://hmprg.org/resource-library/search?q=adverse%20childhood%20experiences

Slack, K. S., Font, S. A., & Jones, J. (2016). The Complex Interplay of Adverse Childhood Experiences, Race, and Income. *Health & Social Work*, *42*(1), e24–e31. https://doi.org/10.1093/hsw/hlw059