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Strategies for Rural Communities for Addressing Substance Misuse among Families Involved with the Child Welfare System

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KEY FINDINGS

- This brief describes nine programs and highlights ways they have addressed challenges to serving child welfare-involved parents with substance use issues, with a particular focus on their applicability to rural communities. These programs offered various types of services, including parent mentoring, case management, home visiting, treatment for opioid use disorders, or an array of substance use disorder treatment and family services.
- These programs implemented strategies that could address challenges in rural and non-rural communities. The strategies included improving timely access to substance use disorder treatment, better coordinating services and sharing information among key entities, providing transportation to reduce barriers to treatment, providing other services necessary for reunification, and delivering intensive treatment and support services in a transitional housing setting.
- The need for family services beyond substance use disorder treatment required organizations to identify multiple funding streams to provide child care, transportation, and housing.
- Program leaders offered several considerations for expanding or replicating programs in rural communities. Their suggestions included factoring in the local context, considering differences in policies or practices, having existing treatment infrastructure, securing flexible funding from diverse sources to support programs, and monitoring program implementation.

I. Introduction

Parental substance use is a risk factor for involvement with the child welfare system (Belanger et al. 2007; Radel et al. 2018). In 2018, parental drug use was a factor in 36 percent of the cases that led to a child's removal from the home, and parental alcohol use was a factor in 5 percent of such cases (Children's Bureau 2019). Illicit substance use is associated with child maltreatment, and child welfare cases involving substance use tend to be complex. Generally, the maltreatment is more severe and foster care placements are more likely in cases that involve substance use than in those that do not (Radel et al. 2018).¹

Rural communities have been particularly hard hit by substance use. Their per capita opioid overdose rate is 45 percent higher than the rate in urban areas (Weintraub et al. 2018). But opioids are not rural communities' only substance use concern. Although some rural communities have high rates of opioid use, others have high rates of methamphetamine use (Admon et al. 2019; Dombrowski et al. 2016; MacMaster 2013). Polysubstance use—using more than one illicit substance or using a substance in combination with alcohol—is also common, complicating the treatment of substance use everywhere but particularly in rural communities in which treatment capacity is more limited than in non-rural communities (Andrilla et al. 2019; Jarlenski et al. 2017; Jones 2018; Radel et al. 2018).

Substance use issues in rural areas, and their association with child welfare involvement, have become a federal priority. The U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE) contracted with Mathematica to identify practices for serving child welfare-involved parents with substance use issues in rural communities. In an [earlier brief](#) for ASPE, Clary et al. (2020) described the challenges of and barriers to serving these families.

This brief describes nine programs and highlights ways they have addressed challenges that rural communities face in serving child welfare-involved parents with substance use issues. In this brief, we do not assess which programs are most effective. Rather, we summarize the context in which these programs operate, their target populations, and how the programs blend funding and collaborate with service systems to help parents with recovery and to help families reunify.

How we conducted the study

The goal of this study was to identify current programs with potential for helping rural communities address the needs of parents with substance use disorders who are involved with the child welfare system. We gathered information about selected programs through site visits or key informant interviews. In this section, we describe briefly (1) the process we used to identify and select programs for site visits or key informant interviews, (2) how we collected data, and (3) how we analyzed the qualitative data.

We used a four-step process to identify and select programs with potentially promising practices. First, we conducted a targeted literature review to find models, programs, curricula, or practices that address substance misuse among parents with child welfare involvement and were delivered in rural communities or could have implications for rural communities. Appendix A includes more detail on the literature review methodology.

We categorized these programs based on whether they used an integrated child welfare and treatment approach to serve families that involved an array of services and programs. We then categorized programs that implemented a specific approach, such as family drug treatment

¹ Throughout this brief, substance use or misuse refers exclusively to illicit substances, including non-medical use of prescription medications such as opioids or stimulants.

court, home visiting, or parent or peer mentoring. Finally, some programs focused on a specific therapeutic intervention, such as Seeking Safety or trauma-focused cognitive behavioral therapy.

Then we prioritized and, in close collaboration with ASPE, selected programs based on three criteria:²

1. Programs that targeted rural populations of parents with substance use issues and child welfare involvement.
2. Programs that offered an array of intervention types or a specific program model, which could include several types of interventions or services within the program model.
3. Programs we could confirm were currently in operation, as the next step in our study involved gathering more information from program staff.

We selected a total of nine programs to include in this study (Table 1). For five of those programs, we conducted key informant interviews with one or more program leaders or someone knowledgeable about implementation. We conducted site visits to the remaining four programs between July and October 2019, during which we interviewed program administrators, managers, and staff who worked directly with clients.³ Whenever possible during site visits, we also interviewed key program partner organizations. After each interview and site visit, we reviewed our notes for completeness and consistency. After completing all interviews and site visits, we organized our notes by topic for analysis using a structured template. Within each topic, we created and analyzed subtopics to identify recurrent themes.

To identify promising practices, we asked program staff to describe the program components or strategies they used that could address challenges in rural areas and be adopted in rural communities. We aimed to gather information about both strategies that have been tested for their effectiveness and those that might have only anecdotal support. However, limited evaluation findings were available for the programs we selected; as a result, we were not able to use evaluation findings to identify promising practices.

This study had several limitations. First, we did not use a single, specific definition of rural to select programs; rather, we relied on the program's definition of its target population or catchment area, which could have resulted in programs with greater variation in the population served than we intended. Second, we interviewed local and state-level staff who were familiar with the programs, the clients they serve, community resources to which they refer their clients, and policy and service delivery context in which the program operates. However, we did not interview program participants or a large number of staff who deliver programming, which could have resulted in a more comprehensive understanding of the program. Also, we did not independently verify information obtained through interviews, such as the incidence or prevalence of substances, the existence or availability of specific types of services, or outcomes respondents described.

² We excluded individual therapeutic interventions. We also gathered information about the following characteristics (but did not ultimately use these characteristics to select programs): the level of evidence supporting the program's effectiveness; the type of organization implementing the program, such as substance use disorder treatment organizations, child welfare agencies, the courts, or multidisciplinary collaboratives; contextual factors such as the main substances used in the community; and types of funding that supported the programs.

³ We selected programs to visit based on how closely the program addressed the core goals of the study and how closely aligned the programs fit the selection criteria. For example, after consultation with ASPE, we decided to interview by telephone (rather than visit) a program that serves parents with substance use disorders but does not explicitly focus on parents with child welfare involvement or families in rural areas. In addition, we considered the program's location and our ability to visit more than one site in one trip, to maximize project resources.

Table 1: OVERVIEW OF THE PROGRAMS IN THIS STUDY

Program name and description	Type of program	Location and year program began
Key informant interviews		
<p>Children and Recovering Mothers (CHARM) Care Collaborative is a partnership among treatment, child welfare, and social service agencies enabling them to jointly serve pregnant and postpartum women with opioid use disorders and their infants to improve the health and safety of babies. Participants are asked to sign a release of information so that partner agencies can share information about their cases. The collaborative coordinates care primarily through monthly case review meetings in which partner agencies share information to provide a comprehensive view of the client's needs. CHARM does not have a role in direct service delivery; its role is to facilitate information sharing among the partner agencies that deliver services for clients.</p>	Cross-system collaborative	Burlington, Vermont 2002
<p>The Iowa Department of Human Services Parent Partner mentoring program is a voluntary peer mentoring model pairing child welfare-involved parents with Parent Partners who have been through the child welfare system and successfully reunified with their children. Many of the participating parents, and their Parent Partners, struggle or have struggled with substance use issues. Parent Partners advocate for participating parents, helping them navigate recovery and reunification by interacting with child welfare, courts, and other related systems. Parent Partners attend ongoing meetings with parents and provide transportation and support related to their recovery and reunification. In addition, Parent Partners help parents access community resources and build positive support networks.</p>	Parent mentoring model	Iowa 2006
<p>Kentucky Sobriety Treatment and Recovery Teams (START) is a model intended for child welfare agencies to implement. The program aims to help families with parental substance use who have substance-exposed newborns and/or children up to age 5. START focuses helping parents access a substance use assessment within 48 hours of the referral from child welfare. The program pairs and co-locates a family mentor with a child welfare worker; each team has a caseload of 12 to 15 families and conducts weekly home visits. The family mentor (a peer in recovery who often has had previous child welfare involvement) coaches parents on life skills, reinforces child safety plans, helps parents navigate social service systems, and accompanies parents to court hearings and substance use disorder treatment.</p>	Cross-collaboration model through team-based case management	Boyd, Daviess, Fayette, Jefferson, and Kenton, Counties, Kentucky 2007
<p>Vermont Hub and Spoke model, also known as the Care Alliance for Opioid Addiction, is Vermont's opioid use disorder treatment system. The statewide system includes nine regional Hubs and more than 75 Spokes. Hubs are opioid treatment programs, providing intensive treatment services. Spokes are office-based opioid treatment settings (often primary care or family practice providers) in which addiction treatment is integrated in the patient's overall care. The system is intended to create linkages so patients can move between the Hub and Spoke depending on changes in their treatment needs.</p>	Hub and spoke system of medication-assisted treatment for opioid use disorders	Vermont 2013

Program name and description	Type of program	Location and year program began
<p>Women in Recovery (WIR), an intensive outpatient program, is an alternative for women facing prison sentences for nonviolent drug-related offenses. This dual-generation program provides addiction and trauma treatment and recovery support services for mothers, housing, reunification services, mental health services, parent education, job training and placement, therapy for children who experienced trauma, and school support. Women participate for 14 to 24 months (18 months on average), and graduates have lifelong access to recovery support through WIR's aftercare program.</p>	Court-based (prison diversion) program	Tulsa, Oklahoma 2009
Site visits		
<p>The Arizona Families in Recovery Succeeding Together (F.I.R.S.T.) program, known as AFF, was established by Arizona state law (Senate Bill 1280). AFF is a partnership between the Arizona Department of Child Safety (DCS) and the state's Medicaid agency, the Arizona Health Care Cost Containment System. AFF aims to reduce barriers related to substance use disorder treatment among parents involved in the child welfare system to preserve or reunify families. The program receives referrals from the local child welfare agency and conducts outreach to engage women in care. AFF case managers connect parents to substance use disorder treatment providers and provide service coordination and wraparound services, such as transportation and relapse management.</p>	Intensive case management model for parents with substance misuse and child welfare involvement	Arizona 2000
<p>The Helen Ross McNabb Center (HRMC) Family Treatment Services Division provides substance use disorder treatment services along a continuum of care for pregnant and parenting women. Great Starts, the main program in this division, is a transitional living facility for mothers and their children, with an embedded intensive outpatient program (IOP). Great Starts also provides psychotherapy for children and a co-ed IOP that fathers can participate in. The division also offers an outpatient program for fathers, called Amazing Dads, and partners with a family drug court program called Safe Babies Court, though not all mothers in the Family Treatment Services Division are involved in Safe Babies Court.</p>	Integrated child welfare and substance use disorder treatment model	Knoxville (serves East Tennessee region) 1990 (Great Starts)
<p>HRMC's Outpatient Substance Use and Specialty Services Division has three programs: Motivating Our Mothers to Succeed provides substance use disorder treatment services for pregnant and parenting women with assessments for treatment, case management, counseling, links to other services, and skills and recovery supports and classes (for example, parenting classes and family and relationship support). Silver Linings IOP provides group IOP for postpartum mothers with infants in the Neonatal Intensive Care Unit for neonatal abstinence syndrome. Rise to Recovery (added in summer 2019) serves mothers involved in the criminal justice system through a partnership with a criminal justice liaison. Funded by the SAMHSA Residential Treatment for Pregnant and Postpartum Women grant, Rise to Recovery provides assessments, referrals for treatment, some transportation services, a peer component, and progress reports to the court.</p>	Substance use disorder treatment program for pregnant and parenting women	Knoxville (serves East Tennessee region) 2014 (Motivating Our Mothers to Succeed)
<p>The Parent-Child Assistance Program (PCAP) is a three-year home visitation and case management model for women who are pregnant or postpartum and have substance use issues. The main goals of PCAP are to help mothers achieve and maintain sobriety, build healthy family lives, and prevent the birth of future substance-exposed infants, with an emphasis on providing education about family planning.</p>	Intensive case management model for parents with substance misuse and child welfare involvement	15 sites serve 18 counties in Washington State 1991

Sources: Mathematica interviews and site visits; California Evidence-Based Clearinghouse for Child Welfare 2017; Family & Children's Services, n.d.; Helen Ross McNabb Center, n.d.; LeCroy & Milligan Associates 2019; SAMHSA 2016; University of Washington 2019; Vermont Blueprint for Health n.d.a.

II. The Context and Characteristics of Programs in This Study

Through a targeted literature review of program studies and evaluations, we identified a range of programs. These included but are not limited to, peer or parent mentoring programs, court-based interventions (including family drug treatment courts and other court-based programs), and home visiting programs. Some programs focused on supporting the treatment and recovery for pregnant and parenting women. We also found intensive case management programs that focused on addressing parental substance misuse among families involved in the child welfare system.

The programs use different processes and structures to improve collaboration or integration of services. For example, some programs integrate child welfare and substance use disorder treatment programs into a package of interventions and wraparound services tailored to the needs of individual families. Others co-locate substance use disorder treatment clinicians in child welfare settings to improve access to and quality of substance use assessments. Some developed multi-agency collaboratives to improve coordination across systems.

We looked at available evaluation findings from the literature, but we did not conduct an evidence review of the programs given the scope of the study. Most studies identified through our targeted literature review were qualitative, descriptive studies or used quasi-experimental designs. We identified only a few studies with an experimental design (randomized controlled trials) that could demonstrate effectiveness. We also identified a few meta-analyses that summarized findings across several studies. At the time of our literature review and data collection, the programs selected for this study were not among program models being reviewed by the Title IV-E Prevention Services Clearinghouse.⁴

Although there were studies of programs that were implemented in rural communities and included features to improve access to treatment, none of the programs were specifically designed to overcome known challenges in rural communities, according to the information we found.⁵ Studies providing evidence of program effectiveness were implemented across a range of communities and did not provide evidence specific to rural areas.

Some challenges that affect efforts to improve child welfare outcomes due to parental substance use can occur regardless of location. However, other challenges are unique to, or exacerbated by, rural locations. These challenges include, for example, long distances to services, low density and low diversity of service providers, lack of qualified workforce, and less privacy in small communities. We summarize from the interviews and site visits the approaches and practices across all areas the programs served, but we note aspects specific to rural communities where possible. All the following findings are from the interviews or site visits unless otherwise noted.

A. Community characteristics



The nine selected programs in seven states serve families from rural and urban areas. The programs, located in Arizona, Iowa, Kentucky, Oklahoma,

⁴ The Administration for Children and Families within the U.S. Department of Health & Human Services established the Title IV-E Prevention Services Clearinghouse to conduct an objective review of research on programs and services intended to support children and families and prevent foster care placements (U.S. Department of Health & Human Services n.d.). The Clearinghouse, developed in accordance with the Family First Prevention Services Act (FFPSA), reviews and rates mental health, substance abuse, in-home parent skill-based, and kinship navigator programs and services.

⁵ We found one training program designed to improve child welfare practice in rural communities, called the Resources to Address the Unique Needs of Rural Communities for Availability/Accessibility of Local Services Project. However, we were unable to verify whether it was still offered or active or had any evaluations.

Tennessee, Vermont, and Washington, vary in the size of their catchment areas (see Table 1) and the extent to which the areas they serve are rural.

Three programs (AFF, Iowa Parent Partner, and the Vermont Hub and Spoke system) are implemented statewide and two programs (KY START and PCAP) serve multiple regions across the state. The Arizona Partnership for Children operates the AFF program we visited in Mohave County, Arizona, which is predominantly rural and shares borders with California, Nevada, and Utah. PCAP serves 18 of the 49 counties in Washington State; many of the counties PCAP serves are rural. We visited the Cowlitz County PCAP, in the southwestern part of the state. KY START serves five counties in Kentucky, including urban, rural, and mixed counties, according to respondents.

Four programs (both HRMC programs, CHARM, and WIR) are in urban areas but also serve people from rural areas. We visited two HRMC programs in Knoxville, Knox County, Tennessee. Knox County includes urban, suburban, and rural areas, and HRMC serves people from rural counties adjacent to Knox County. Other HRMC sites are located across eastern Tennessee. The CHARM Collaborative convenes in Burlington, Chittenden County, Vermont, which is considered the state's only urban area. When CHARM began in 2002, clients from rural areas across the state traveled to Burlington to receive substance use disorder treatment services. The availability of treatment services has since expanded across the state, largely because of the Vermont Hub and Spoke model, and women can access services closer to their homes, outside the Burlington area. WIR operates in Tulsa, Oklahoma, which is not rural but serves women from neighboring rural areas who have a non-violent felony charge issued in Tulsa County.

Persistent, high rates of poverty and unemployment depressed the local economies in many communities, exacerbating the challenges families had to overcome to achieve reunification. These findings are consistent with findings from our [earlier literature review](#), which identified challenges to serving child welfare-involved families with substance misuse issues in rural communities. Respondents said that job opportunities were often limited to minimum- or low-wage jobs. For example, respondents from Mohave County, Arizona (AFF), said that many of the jobs available were minimum-wage jobs in casinos or hotels across the border in Nevada. Cowlitz County, Washington (PCAP) once had a manufacturing economy with jobs in logging and lumber mills, which are no longer as prevalent. Respondents from KY START stated that many of the communities the program served were economically depressed, and respondents from HRMC described high levels of poverty and unemployment in the communities they served in Tennessee.

High prevalence of drug trafficking was a commonly mentioned problem in the communities in this study. Respondents from Cowlitz County, Washington (PCAP), Knox County, Tennessee (HRMC), and Mohave County, Arizona (AFF), described drug trafficking as problems in their communities. Both Cowlitz County, Washington, and Mohave County, Arizona, are in areas used as thoroughfares for drug trafficking, since they are close to interstate corridors and near state or national borders. In Mohave County and Knox County, manufacturing of methamphetamines is also a problem. Respondents from Mohave County, Arizona, reported that the rural setting makes it easier to manufacture methamphetamines without detection. In Knox County, Tennessee, respondents said that although law enforcement shut down many methamphetamine labs in rural Tennessee, drug cartels bring methamphetamines into communities.

Methamphetamine, opioid, and polysubstance misuse were cited as common. The types of substances commonly used in communities varied, but respondents across the programs said methamphetamines and opioids are the most common substances misused. In addition, respondents from all programs said that polysubstance use and opportunistic substance use (whereby people use whatever they can afford or find) are very common. The exception is the Iowa Parent Partner program, where respondents stated methamphetamine use is the most common and opioid misuse is less common. PCAP and the HRMC programs said that a culture

of drug use and intergenerational drug use were common in their service areas. PCAP, AFF, and WIR staff also said that alcohol misuse was common.

Recent changes to state policies have expanded access to substance use disorder treatment in some states. Six programs are in states that expanded Medicaid eligibility under the Affordable Care Act (Arizona, Iowa, Kentucky, Vermont, and Washington). Multiple respondents said expanding Medicaid helped more people qualify for Medicaid benefits, which enabled more people to access treatment that they otherwise could not afford. In at least one case, it also resulted in an increase in the types of services covered through Medicaid. For example, after Kentucky expanded Medicaid in 2014, funds available for substance use disorder treatment increased by \$17 million, and the state Medicaid program started covering peer recovery support services (Children’s Bureau n.d.).

Some communities benefitted from state investments that increased the availability of substance use disorder treatment. In Vermont, policy changes over the past two decades have changed the landscape of medication-assisted treatment prescribing for opioid use disorders. Historically, providers had to obtain one-time waivers for each patient from the state’s Opioid Treatment Authority to prescribe methadone (SAMHSA 2016). In 2004, the state began to allow providers to obtain waivers under the Drug Addiction Treatment Act of 2000 in order to prescribe buprenorphine (SAMHSA 2016). This change allowed for an immediate increase in the availability of medication-assisted treatment.

The use and acceptance of medication to treat opioid use disorder varied by community. In one rural community, the availability of both buprenorphine and methadone treatment increased in recent years. Parents with opioid use disorder, many of whom have co-occurring mental health issues and recovery support needs, might benefit from the combination of medication and behavioral therapy (National Academies of Sciences 2019). However, evidence supports that medication without behavioral therapy is effective for some individuals (National Academies of Sciences 2019). A few respondents expressed concern, however, that some clients receiving buprenorphine treatment do not receive behavioral therapy beyond a 15-minute appointment to get a prescription each week, and thus the underlying issues contributing to their substance use remain unaddressed. In addition, these respondents felt clients use medication to achieve intoxication or continue to use other substances during methadone treatment. In another community in our study, respondents described a community-wide mistrust of buprenorphine and methadone, including among their clients and local judges. Some respondents said their clients questioned the effectiveness of buprenorphine as a treatment option, because they previously abused illicitly obtained buprenorphine.

Despite improvements in treatment access in some locations, respondents across programs said that people in rural communities still faced greater challenges accessing treatment compared with their urban counterparts. Respondents from KY START and AFF in Mohave County said it was difficult to find people in their areas with the education, training, or experience to provide the services that families require, such as substance use counselors and child welfare workers. Even in areas in which treatment has expanded, rural communities still have fewer options for substance use disorder treatment. In addition, rural communities are often geographically spread out and have little or no public transportation. For example, in Washington, staff said that the bus system does not operate in the evenings or on weekends, and even when buses are running, they stop infrequently. As a result, staff reported that it could take clients four to five hours to get to an appointment.

B. Client characteristics



Most of the programs we selected focus on serving parents. Seven programs focus on serving parents. Of these, five serve both mothers and fathers or partners, but mothers make up the majority of the programs’ clients. The programs within one division at HRMC serve only pregnant and parenting women. PCAP is also specifically for pregnant and parenting women, but if mothers disenroll or disengage

from the program, PCAP caseworkers will continue to serve the family by working with fathers if they are willing. However, PCAP does not otherwise serve fathers.

WIR and the Vermont Hub and Spoke model do not focus on serving parents specifically. About 75 percent of participants in WIR are mothers and about 15 percent have children in state custody. The Vermont Hub and Spoke model is a statewide treatment system that serves people with opioid use disorder, whether or not they are parents. Although the Iowa Parent Partner program does not limit enrollment to parents with substance use issues, staff estimated that 80 percent of parents in the program are involved in the child welfare system because of substance use issues. Several programs aimed to improve reunification for parents with child welfare involvement and thus required child welfare involvement as a criterion for program eligibility.

Programs in this study serve clients with many social and economic challenges, including housing challenges, high rates of poverty, and criminal justice involvement. Respondents from nearly all programs said the lack of safe, affordable housing was the number one challenge for their clients, especially as families try to meet child welfare requirements for reunification. For example, one respondent attributed PCAP clients' struggle to find affordable housing to the high cost of living in the state of Washington. Respondents from HRMC's transitional living program, Great Starts, said that it is difficult for their clients to find safe and affordable housing when they leave the program. Respondents from WIR noted that finding housing for women coming out of the prison system is difficult in both urban and rural settings.

Clients also faced economic challenges. For example, the median gross monthly income of parents in AFF is \$300 (LeCroy & Milligan Associates, Inc, 2019).⁶ In PCAP, respondents said that wages are not high enough for their clients to afford the cost of living in the state of Washington, even with the state's recent minimum wage increases. In fact, for some, the increase in the minimum wage resulted in their income exceeding the limit to be eligible for Medicaid.

For some people served by these programs, economic hardship, substance use, or other factors might influence them to engage in criminal activity. Respondents from HRMC said that, in their experience, adults facing severe poverty and a lack of job opportunities sometimes turned to illegal activities to make ends meet. Many of the parents served by the HRMC programs have criminal justice involvement. Rise to Recovery, a program in HRMC's Outpatient Substance Use and Specialty Services Division, specifically serves mothers with substance use issues who have criminal justice involvement.

Involvement in the criminal justice system can also create financial hardship for parents because of jail and parole fees and the difficulty finding employment with a criminal conviction. Some jails in Oklahoma, where WIR operates, charge a daily fee to people who cannot afford bail and remain in custody while awaiting a court date (Law 2018). In addition, because of the state's mandatory minimum sentences, according to program staff, many women stay in prison longer than they might in other states.⁷ When women finish their prison sentence, they have accumulated debt from the daily jail fees. In Mohave County, where AFF operates, respondents said that people with a felony conviction are usually disqualified from the most commonly available jobs in the area, which are in casinos and hotels just across the border in Nevada.

Respondents reported that many of their clients have co-occurring mental health issues and trauma-related symptoms. Respondents from multiple programs described high rates of co-occurring mental health issues. In the Vermont Hub and Spoke system, data available for Medicaid enrollees showed that over half have a mental health issue, such as depression (Vermont Blueprint for Health, n.d.b). Respondents from AFF, WIR, and across programs at

⁶ As reported during the initial assessment for clients served by AFF in the state's 2018 fiscal year. The mean gross monthly income was \$823, and 30 percent of clients reported no income.

⁷ The goal of WIR is to help address the state's high female incarceration rate, where 64 percent of female incarceration is for nonviolent drug-related offenses (Family & Children's Services n.d.).

HRMC said that most women in their programs have a history of trauma and many have experienced domestic violence. Forty-seven percent of women in AFF have a history of domestic violence (LeCroy & Milligan 2019).⁸ For many women in the programs, intergenerational drug use is a source of early childhood trauma and is linked with substance use onset as early as age 12.

Most clients rely on Medicaid to fund their substance use disorder treatment and other health treatment services. CHARM, KY START, PCAP, and HRMC programs cover most treatment services for their clients through Medicaid. However, HRMC respondents noted that there is a lack of funding to pay for services for fathers who are not covered through Medicaid (Tennessee has not expanded Medicaid). Two-thirds of the Vermont Hub and Spoke model's clients are enrolled in Medicaid and the rest have Medicare or private insurance. Reimbursement for services in Opioid Treatment Programs was not available through Medicare until January 2020 (Centers for Medicare & Medicaid Services 2019). Thus, the model covered most services through Medicaid even for clients with Medicare coverage. Although the Medicaid program is a key funding partner in the AFF model, not all AFF clients qualify for Medicaid, and AFF uses other state funds to pay for treatment. Most people in WIR are uninsured;⁹ the program uses a combination of private foundation and state funds to pay for treatment.

C. Key program features



The nine programs in our study focus on improving timely access to substance use disorder treatment, improving coordination across existing services through case management, and providing transportation to reduce barriers to treatment services. Two programs offer combined treatment and supportive housing to address multiple service needs.

Improving timely access to substance use disorder treatment is an explicit focus of three programs. Although all the programs in our study address access to treatment, a few (Vermont Hub and Spoke, KY START, and AFF) were designed to improve timely access to treatment for opioid use disorders. KY START and AFF established standards for how quickly their staff should engage with a client after receiving the referral from child welfare to focus on a timely assessment and entry into substance use disorder treatment. KY START expects staff to contact clients within 48 hours of the referral from child welfare. AFF expects case managers to engage a client within one business day of the referral.

Intensive case management helps clients engage in a range of services. Several programs in this study provide a case manager or peer mentor who helps clients understand the requirements for reunification (such as participating in treatment or obtaining stable housing), navigate multiple systems, and access services. Case management also aims to facilitate cross-system collaboration among the child welfare, substance use treatment, and criminal justice systems.

Transportation is a key support service to reduce barriers to treatment. The lack of public transportation systems is a major challenge to treatment and other services in rural communities. Six programs (AFF, both divisions of HRMC, Iowa Parent Partner, KY START, and PCAP) helped clients obtain transportation. PCAP advocates and AFF case managers met clients in the community and took them to various service appointments. PCAP advocates also helped clients learn how to use the bus system so clients are not dependent on PCAP to provide transportation

⁸ As reported during the initial assessment for clients served by AFF in fiscal year 2018.

⁹ In Oklahoma, adults with children under age 19 with incomes up to 41 percent of the federal poverty level may qualify for Medicaid (\$11,340 for a family of four in 2019) (Oklahoma Health Care Authority 2019). Oklahoma did not adopt Medicaid expansion.

indefinitely. KY START and AFF had funds to reimburse clients for transportation-related costs such as bus passes, gas cards, or car repairs.

Two programs offer transitional housing coupled with intensive outpatient treatment.

HRMC's Great Starts program provides transitional housing for mothers and up to three of their children, up to age 13, for six to nine months. Mothers receive 40 hours of individual and group intensive outpatient treatment each week along with parenting classes, help obtaining high school equivalencies and permanent housing, and a smoking cessation program. Child care is provided while mothers receive services.

WIR is a dual-generation service model that provides housing; substance use and trauma treatment and recovery support for mothers; reunification services, mental health services, parent education, and job training and placement for adults; and trauma therapy and school support to children. Women participate in the program for 18 months on average (participation ranges from 14 to 24 months). In addition, WIR provides workforce readiness training, job placement with local employers, and support for both women and employers during employment. For example, WIR staff help employers understand when women have parental visitation appointments in the middle of the workday, and staff connect with women if they appear to be struggling in a way that would jeopardize their employment. After graduating, women have lifelong access to the recovery supports through WIR's aftercare program.

Two programs adapted their services for rural areas. The Iowa Parent Partner program recognizes the need for transportation is greater in rural areas. It thus allows program staff to provide transportation assistance, but only for clients in rural areas. KY START expanded program eligibility to include children up to age 5 in rural areas because some sites did not have enough cases (the state initially limited enrollment only to parents with substance-exposed newborns).

The remaining programs did not need to make adaptations to meet the needs of families in rural areas, because they already provided services in the home or provided transportation. Several programs already brought the services to clients, wherever they were, to reduce the frequency with which clients had to travel to an office. In three programs (PCAP, AFF, KY START), case management included home visits. HRMC's Safe Baby Court program employed a mobile therapist to deliver services in the community.

D. Program staffing



Programs in our study use various staffing structures to meet their goals. For example, a case management program or a parent mentoring program will have a different staffing model than a program that offers clinical services or integrated child welfare and substance use disorder treatment services. A cross-system collaborative, such as the CHARM Collaborative, has a different staffing model, as its primary goal is to coordinate meetings and facilitate information sharing among the service delivery agencies.

Staff qualifications reflect the key responsibilities for each position in the program. PCAP, an intensive case management model for parents with substance misuse and child welfare involvement, requires sites to have a dedicated clinical supervisor, case managers, and an office assistant.¹⁰ Qualifications for case managers include having a bachelor's degree and community-based experience working with high-risk populations. In addition, to be able to conduct home visits with families, case managers are required to maintain current adult and infant CPR certifications. Programs that are part of larger organizations that offer an array of services, such as WIR and the Great Starts program at HRMC, have dedicated staff, such as a program coordinator and case managers, but can also draw on the organization's broader team

¹⁰ PCAP also requires sites to have an interviewer who administers a modified version of the Addiction Severity Index to clients as they exit the program, preferably an employee who has no other direct contact with clients.

of clinicians, such as bachelor's or master's prepared therapists, who serve clients across the organization. KY START employs family mentors (peers in recovery who often have had previous child welfare involvement), each paired with a child welfare caseworker to create a dyad. Substance use disorder treatment programs, including HRMC's Outpatient Substance Use and Specialty Services Division and the Vermont Hub and Spoke program, employ teams of clinical staff, such as substance use counselors who deliver various treatment modalities and case managers. Each opioid treatment program (hub) in Vermont has board-certified addiction specialists, physicians, and advanced practice, registered, and licensed nurses.

Program staff view flexibility and sharing the organization's mission as critical for staff who work with this population. Program staff emphasized the importance of hiring staff who share the organization's views on addiction and trauma. For example, PCAP looks for staff whose beliefs align with the program's mission and with the stages of change and harm reduction theories that guide the program's approach. Program staff said it is also important for staff to be flexible to handle unpredictable situations, open-minded, and able to establish boundaries with clients.

Programs feel that having staff with experiences similar to those of their clients helps earn clients' trust. These shared experiences enable family or parent mentors in KY START and the Parent Partners program to help clients navigate the recovery and reunification processes, especially clients who may be mistrustful of the child welfare system. Parent mentors also help clients access community resources and build a positive support network. KY START employs family mentors as peer recovery support specialists; they have at least three years in active recovery and a history of child welfare involvement. PCAP prefers that its case managers (also called advocates) have lived experience similar to their clients, namely, being in recovery themselves or having overcome adverse situations such as a family history with substance misuse. PCAP advocates who are in recovery themselves are required to have at least five years of sobriety and experience working with families. In Cowlitz County, Washington, a few PCAP advocates are former clients who completed the program, and other staff are in recovery.

Some programs serving rural areas keep caseloads low because of the large distances between clients in rural communities. Staff who provide high-intensity case management had 15 (KY START, Parent Partners) to 25 cases (AFF). Staff working in rural areas often had smaller caseloads because they had to spend more time driving to visit clients. Caseloads for other programs varied widely because of the variety in the types of programs included in this study. For example, agencies in the CHARM collaborative meet monthly to coordinate cases; because all services are delivered through the member agencies, CHARM staff do not carry a caseload. In the Vermont Hub and Spoke system, each two-person team (consisting of a nurse and a behavioral health clinician) has a caseload of 100 patients and appears to be primarily office-based.

Most programs provide initial program-specific training and ongoing training for staff. HRMC provides training on the evidence-based practices it offers, such as Seeking Safety and Nurturing Parenting. The Arizona Department of Child Safety, which operates AFF, establishes training requirements in its contracts with providers. For example, provider staff are required to complete a minimum number of hours of training on general topic areas, such as safe environments for substance-exposed newborns. The Vermont Hub and Spoke program offers ongoing training for clinicians in its system of care and training through a learning collaborative. The collaborative addresses topics such as safe prescribing, use of client assessment tools, relapse response, treatment plans, diversion control, and patient noncompliance (Brooklyn and Sigmon 2017). KY START accesses education, training, and technical assistance through the national START program. The Iowa Parent Partner program provides 11 trainings, which new Parent Partner staff must complete within the first year, on topics such as mandatory reporting, domestic violence, boundaries and safety issues, substance abuse, and mental health issues. Separate training for Parent Partner coordinators includes a Family Support Supervision course offered by the University of Iowa National Resource Center for Family Centered Practice and a two-day supervision training.

Robust supervision and support are key to staff retention. Three programs (HRMC, Iowa Parent Partner, PCAP) raised the importance of holding regular meetings for staff to discuss issues and get support from their colleagues. These programs also have an active supervision component in their models. WIR leaders emphasized the importance of staff having access to outstanding training, the opportunity to work with clients in the long term, a good salary, and a focus on treatment rather than productivity. The organization that operates WIR, Family & Children's Services, attracts and retains qualified therapists because it is able to offer clinical work aligned with what therapists went to school for and enables them to contribute to clients' recovery.

E. Key community partners



Coordinating services and sharing information on clients across systems are central to many programs in our study. Some programs have formal procedures for collaborating with community partners, whereas others rely on informal relationships. The level of partnership (statewide versus local) and types of partners varied depending on the design of the program and the type of organization implementing the program.

Several programs have written agreements or procedures for collaboration between the child welfare and substance use disorder treatment systems. All members of the CHARM Collaborative developed and signed a memorandum of understanding to establish a shared agreement of members' responsibilities for participation in the Collaborative. Members include community substance use disorder treatment providers, hospitals, and state health, child welfare, and human services agencies. KY START is a model operated by child welfare agencies that aims to improve collaboration across the substance use disorder treatment, child welfare, and court systems in each community to improve child welfare outcomes. After a START site is selected, START leaders formulate a collaboration plan to build relationships and achieve buy-in among local leaders across these systems. For example, judges are critical to the collaboration plan because the START model aims to keep children with their parents and out of state custody, when they can do so safely.

Across programs, the agency or organization implementing the program partnered with organizations with complementary expertise. In programs that operate statewide, staff emphasized that individual sites understand their communities best. Rather than prescribing the types of partners who should be engaged, individual sites identify local partners, such as public agencies, healthcare providers, and community- or faith-based based organizations, who can support their program or provide services that are tailored to clients' needs. HRMC, Vermont Hub and Spoke, and the organization implementing WIR are behavioral health treatment providers, and they partner with child welfare offices and other community organizations to address these needs for their clients. The Arizona Department of Child Safety partners with the state Medicaid agency to fund substance use disorder treatment for AFF clients and has regional contracts with service providers to operate the AFF program. In Mohave County, two local social service organizations, including a faith-based community service provider, make up the Arizona Partnership for Children. Different types of organizations, such as behavioral health agencies and family services and support centers, serve as the PCAP host agency in their county. Each PCAP site partners with local providers and agencies. In Cowlitz County, a federally qualified health center, which offers a range of medical and substance use disorder treatment services, is the host agency, and partners with the local child welfare agency, the housing authority, employers, a faith-based health care provider, and education institutions (Washington State Division of Behavioral Health and Recovery n.d.).

The programs use various strategies to engage and collaborate with community partners. The lead agency for AFF, the Arizona Department of Child Safety (DCS), uses active contract management to engage its contractors and service providers in the state. Active contract management, developed by the Harvard Kennedy School Government Performance Lab, is a collaborative approach to contracting whereby government entities use performance data and engagement strategies to improve interactions with their contractors to enhance the service

delivery system and client outcomes (Harvard Kennedy School n.d.). Respondents from other programs (HRMC, KY START, and PCAP) said that leaders and frontline staff across agencies meet to coordinate on cases and to refer clients to support services they need (such as housing). Some programs invite staff and leaders from their partner agencies to program staff meetings to develop rapport among staff and educate one another about their respective agencies. A few programs partner with local organizations to offer GED classes to their clients free of charge, because having a GED can help improve employment opportunities and wages.

Respondents from several programs stressed how important it is for their leaders to invest the time to build and maintain relationships with leaders from other community organizations to establish a successful collaboration. For example, program respondents said establishing a memorandum of understanding, which sets guidelines for information sharing among all collaborative members, was critical to formalizing the partnership among child welfare and key community partners for the CHARM Collaborative. However, the process took two years because all the participating organizations had their own legal review. The WIR program has spent several years cultivating relationships with employers, so the employers are willing to shift their hiring and employment practices to accommodate WIR clients' needs. For example, if a child visitation is scheduled in the middle of the workday, WIR helps the employer see the disruption as temporary and appreciate the benefits of continuing to employ the parent.

Multiple programs ask clients to give consent to share information about their case with key community partners.¹¹ For example, Great Starts (an HRMC program) obtains client consent to send weekly client updates to child welfare and the courts. The updates include results of random drug screens and treatment attendance reports. Sharing information in this way benefits the clients by fostering trust across agencies and helping all parties monitor client progress and child safety. Clients of CHARM also consent to have information shared with child welfare agencies. Because state statute allows child welfare to begin an assessment before the birth of a child, the CHARM Collaborative is able to involve child welfare in a proactive, nonpunitive approach before the child is born. PCAP case managers ask clients to sign a release of information form for the agencies they are involved with (such as substance use disorder and mental health treatment, and child welfare) so case managers can track appointments and find out whether their clients are engaged with the different entities.

A range of factors can affect the success of engaging community partners. Several program leaders said that partnerships hinge on obtaining support from key people. For example, in Knox County, Tennessee, HRMC was able to build on an existing relationship with a family court judge to implement Safe Babies Court when funding became available. Before choosing a new site for START implementation, KY START leaders first assess readiness for change among leaders in the key service systems (child welfare, court, and substance use disorder treatment). If they cannot obtain buy-in from key figures at a potential implementation site, program leaders forego implementation at that site because they anticipate they would not be able to implement key model components. For example, one essential component of START is immediate referral and access to substance use disorder treatment. Perceptions about medication-assisted treatment vary widely, including among family court judges who have the discretion to remove a child from parental custody when a parent is receiving medication-assisted treatment. If a family court judge automatically removes children from parental custody because a parent is receiving medication-assisted treatment, system transformation under the START model is unlikely.

¹¹ Federal law protects the confidentiality of alcohol and drug abuse patient records. The protections are codified as 42 U.S.C. § 290dd-2 and 42 CFR Part 2; they require patient consent for disclosure, with few exceptions.

F. Evidence supporting the programs



To understand whether the programs in this study could potentially be included as promising, supported, or well-supported by evidence in the Title IV-E Prevention Services Clearinghouse, we asked program staff about the evidence supporting their programs and their efforts to evaluate those programs. Although most programs did not have rigorous evidence of their effectiveness at the time of our data collection, staff described current and future data collection activities to monitor and possibly build evidence for their programs.

Only two programs in this study reported using individual evidence-based therapeutic practices as part of their service array. In HRMC's Family Treatment Services Division (which houses the Great Starts program), clinicians use a range of therapeutic practices, including Seeking Safety, Hazelden Co-Occurring Disorders Program, Child-Parent Psychotherapy, Eye Movement Desensitization Reprocessing, and Nurturing Parenting Program.¹² The WIR program reported using evidence-based substance use therapies, such as written exposure therapy, cognitive processing, and medication-assisted treatment as part of individual therapy, and cognitive behavioral therapy and Seeking Safety in group therapy. Although individual services may be evidence-based, more evidence may be needed to understand how specific combinations of services might affect client outcomes.

Seven of the nine programs studied did not have rigorous evidence supporting their programs. However, program staff collected data to assess and build evidence for their programs and to meet their funder reporting requirements. Five programs had been evaluated using a pre-post outcome evaluation or quasi-experimental design. One of these programs also conducted a randomized controlled trial. Staff in two of the five programs with previous evaluations reported conducting process studies to learn more about their programs.

At the time of data collection for this study, seven of the programs we studied were conducting further evaluations or had plans to do so. Two of those seven programs had evaluation requirements tied to their funding, which included the Administration for Children and Families (ACF) Regional Partnership Grant (RPG) and the Substance Abuse and Mental Health Services Administration (SAMHSA) Residential Treatment for Pregnant and Postpartum Women (PPW) grant. Staff from three other programs planned to conduct randomized controlled trials in the future (HMRC Family Treatment Services Division, PCAP, and KY START).

Programs seek and measure different outcomes. Most programs in this study collect data on outcomes they are most engaged in changing given their organizational role (child welfare or substance use disorder treatment outcomes), and few common outcomes exist. Only three programs collect outcome data on both child welfare and substance use disorder treatment. Six programs track additional outcomes, including: employment (HMRC, PCAP, AFF, WIR); criminal justice involvement (HMRC, WIR), trauma (HMRC); educational attainment (HMRC, PCAP); child well-being measures (HMRC, CHARM); safe and stable housing rates (HMRC); and use of health services such as emergency department visits and hospitalizations (Vermont Hub and Spoke). Reasons for collecting such disparate outcomes might include programmatic funding requirements around data collection, the program's substantive focus, resource and capacity issues, difficulty obtaining child welfare data for programs that are not housed in child welfare agencies, or some combination of these reasons. Because programs do not measure common outcomes, it is difficult to compare performance across programs and there is no agreement on which outcomes are the most important to measure. Common outcome measures for programs that serve child welfare-involved families struggling with substance use disorders would enable other organizations to compare outcomes when selecting new programs to implement.

Six programs monitor implementation fidelity. Staff from six of the nine programs said they monitor fidelity to their programs in some way, to assess whether the model is implemented as

¹² We did not independently assess whether these individual practices were evidence based.

intended. Two programs, KY START and PCAP, developed fidelity tools, along with a program manual, a training curriculum, supervision, and evaluation materials to support implementation. HRMC, which uses evidence-based therapeutic practices, monitors staff fidelity to the individual practices. Three programs monitor fidelity mainly through qualitative interviews with staff, tracking dosage and service use, and conducting case file reviews.

G. Funding needs and sources



Programs in this study use multiple funding sources to cover services necessary for parents involved in the child welfare system and struggling with substance use issues. This is typical of programs addressing these issues in all communities, not just those in rural areas.

All programs try to maximize existing funding streams. Some programs rely on funding from Medicaid and Temporary Assistance for Needy Families (TANF). The ability of programs to access these funding streams depends on the proportion of clients eligible for these programs, which depends on the state eligibility criteria. Medicaid is particularly important because it funds substance use disorder treatment, and more parents became eligible for Medicaid in states that expanded Medicaid eligibility under the Affordable Care Act. One program used TANF funding to support staff salaries and treatment services for parents who were not eligible for Medicaid or for services that Medicaid did not cover. Most programs supplement these funding streams with other federal, state, and local grants. For example, WIR receives funding from Oklahoma through a Pay for Success program, in which the state pays Family & Children’s Services at specific intervals after program enrollment for each participant who is successfully diverted from prison (Social Finance n.d.). Some programs also receive funding through federal grant programs, such as the SAMHSA Residential Treatment for Pregnant and Postpartum Women grant, the Substance Abuse Prevention and Treatment Block Grant, or ACF’s Regional Partnership Grant (RPG) Program.

Multiple funding sources help programs offer the array of services needed to assist families with parental substance use disorders involved in the child welfare system.

Serving families requires organizations to piece together funding streams to offer the range of services that parents need for treatment, recovery, and reunification. In particular, parents may need child care and transportation to receive treatment, and they may need housing if it is required for reunification. Organizations often need grant funding for services not covered elsewhere, such as transportation or child care. However, relying on flexible grant funding makes those services particularly vulnerable to discontinuation after grant funding ends. In addition, each grant or funding source may come with its own service, population, and reporting requirements, so the implementing organization may face challenges to meet competing priorities.

Respondents from state-led programs (Iowa Parent Partner, AFF, and Vermont Hub and Spoke system) said local sites and community coalitions acquire supplemental funding and local resources to help pay for the program or additional services, such as transportation. For example, to expand the Iowa Parent Partner program, the state required local sites to raise matching funds. In Vermont, community coalitions look for grants to support local initiatives, such as telemedicine or local response teams, to augment Hub and Spoke services.

Grants provide seed funding to establish new programs. To launch new programs or collaborations, organizations often start with initial seed funding to select a program, build partnerships, establish office space and processes, and hire and train staff. Organizations might find sources such as private, state, and federal grants to cover upfront costs to establish the program. Leaders of several programs said that their ability to link initial funding to improvements in family outcomes helped them secure state funding to support the program in the long term. For example, the George Kaiser Family Foundation provided the upfront capital to start the WIR

program and also funds ongoing program costs. The RPG program funded KY START in Martin County and expansion into Daviess County.¹³

Programs in rural areas include staff travel in their budgets. Programs in rural areas have to budget funds for travel costs for staff and clients. The Cowlitz County, Washington, PCAP purchased vehicles for its case managers or reimbursed them for mileage. AFF providers raised concerns about reimbursement when they need to travel long distances in rural areas; in response, Arizona DCS provides a travel stipend to provider organizations rather than limiting reimbursement to a case management visit.

Housing remains a persistent challenge in rural and urban areas. Respondents from nearly all the programs said that safe, affordable housing was the single largest challenge for their clients, especially as they try to meet child welfare requirements for reunification. However, supporting a housing program requires funding to build, rent or purchase, and maintain the physical infrastructure and to pay staff for 24-hour coverage. For example, supportive housing models in which clients live on site and participate in services have staffing requirements to ensure 24-hour coverage in the event of an emergency. Residential treatment centers have myriad requirements about hallway sizes and other regulations intended to support medical interventions. Several programs in this study addressed this need by partnering with the local housing authority or identifying funding for housing, but program leaders said that more housing is required.

Monitoring adherence to the program model is an ongoing program cost. As organizations consider implementing Title IV-E prevention services approved by the Title IV-E Prevention Services Clearinghouse to qualify for FFPSA funding, they will need to consider how they will assess adherence or fidelity of program implementation. Programs have to build in the initial and ongoing costs of monitoring and maintaining fidelity to achieve the positive outcomes in usual care (Feely et al. 2018). Both PCAP and KY START developed checklists to help other sites or organizations assess readiness for and feasibility of implementing the programs. In addition, PCAP case managers allocate one office day per week to complete and submit the monitoring data the program requires. PCAP also requires sites to hire an hourly employee to administer exit interviews to gather data for the program. KY START leaders recognize the importance of having sufficient time for planning and ongoing support during implementation, which are needed for fidelity to the START program model.

Only one program in this study had a concrete plan for FFPSA funding. Recent legislative changes, such as FFPSA and the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, provide opportunities to expand treatment options or funding to support parents with substance use issues. Within FFPSA, the Title IV-E Prevention Services Program will permit child welfare agencies to fund evidence-based substance use disorder treatment services, mental health services, and in-home parent skill-based programs in order to prevent the need for foster care placement. In addition, FFPSA allows states to use Title IV-E funds to pay up to 12 months of room and board costs for children residing in residential substance use disorder treatment programs with their parents. However, feedback from the programs we interviewed and visited suggest that local program leaders are not yet familiar with ways to leverage these opportunities. Only one program (KY START) had a plan to use funding through FFPSA.¹⁴ KY START plans to transition to FFPSA funding after Title IV-E waiver funding ends. Tennessee (where HRMC operates) and Arizona (where AFF operates) requested an extension to delay implementation of FFPSA and continue their current funding while they formulate plans for future funding. Staff from many programs had

¹³ KY START is no longer active in Martin County.

¹⁴ This is not unique to the programs in this study; as of February 2020, nine states and the District of Columbia submitted their Title IV-E Prevention Program five-year plan (Children's Bureau 2020).

not heard of the FFPSA. However, to be able to draw on FFPSA funding in the future, programs will need to conduct more robust evaluations to meet the FFPSA evidence requirements.

III. Conclusion

Although our findings from site visits and interviews with nine programs are not representative or widely generalizable, they offer lessons for programs seeking to address child welfare and substance use issues in rural areas.

Programs in this study support families involved in the child welfare system in rural areas by addressing key barriers to treatment and other services. To accommodate the lack of transportation in rural areas, several programs bring the services to the client, reducing the frequency with which clients have to find transportation to visit an office to receive services. Programs also identify volunteers from local community groups to provide transportation. One program provides stipends for providers who travel long distances to see a client, rather than using the same reimbursement rate for all visits regardless of the client's location. Respondents from nearly all the programs said that safe, affordable housing was the single largest challenge for their clients. Although several programs in this study are able to partner with the local housing authority or identify funding for housing, leaders across programs all said that more housing is needed. For some parents, navigating multiple service systems is a barrier to engagement in services. To address this, some programs employ family or parent mentors or case managers to help parents navigate the child welfare and treatment service systems. Staff at CHARM said their partnership helps identify and address client barriers through the collaboration among its member organizations.

Programs use robust training and supervision as strategies to retain staff. Given the shortage of a qualified workforce in rural communities, programs emphasize the importance of retaining the staff they have already recruited and trained. Staff at several organizations (HMRC, Cowlitz Family Health Center PCAP, and WIR) said that having engaged supervisors, structured supervision (weekly staff meeting), and robust training fostered staff retention. In addition, programs felt that finding staff who share the organization's mission can help with retention.

Important considerations for expanding or replicating these models include ensuring adequate service availability and securing appropriate funding to meet programmatic needs. Nearly all the programs studied had existing substance use disorder treatment services available locally for parents in recovery. Staff wishing to expand or replicate their services into new areas should consider whether treatment recovery supports are available locally. KY START leaders assess site readiness along multiple dimensions before expansion to help ensure sites are ready to implement the model with fidelity. They found that sites require a year of planning and then two years of intensive support to adhere to model fidelity (Huebner et al. 2015). Reviewing local substance use disorder treatment supports could be one element of readiness that program staff assess before expanding or replicating. Similarly, differences in policies and service delivery (such as whether children are removed from the home based on a parent's use of medication-assisted treatment) across jurisdictions could affect replication and expansion.

Funding is a primary concern for expanding or replicating programs. Programs that secure flexible funding can use it to cover concrete services to provide financial relief for parents. For example, the AFF program used flexible funding to pay for parents' car repairs or utility bills because sometimes eliminating a transportation barrier is sufficient for getting parents to stay in treatment and recover. Other programs use flexible funding to pay for transportation to or from substance use disorder treatment. Programs that offer supportive housing have additional funding considerations related to staffing and the physical infrastructure.

Programs successfully identified a combination of private, state, and federal funding to sustain their programs and indicate a need for additional flexibility with funds. The organizations supporting the programs in this study identified multiple funding sources to be able to offer, or help families connect to, the array of services needed. For example, programs

successfully obtained grant funds for the initial seed funding and used existing state and federal funding. Flexible funding sources helped programs pay for non-treatment supports that are important to reducing barriers to treatment, such as gas cards or car repairs.

Continued monitoring and evaluation of programs is needed to build the evidence base, especially in light of the transition to FFPSA. Leaders from some programs said that their grants' reporting requirements pushed them to collect data for the purposes of monitoring program fidelity and evaluating outcomes. In particular, KY START, the only program transitioning to FFPSA funding, benefited from having a five-year RPG grant to support individual and cross-site evaluations. Most other programs in this study, however, lack implementation and evaluation data that could qualify the program for review by the Title IV-E Prevention Services Clearinghouse. In addition, as programs seek to build more evidence, they will need to monitor implementation to be able to demonstrate their outcomes reflect adherence to the model. Most local program leaders in our study were unfamiliar with FFPSA and will likely require guidance on how to use these opportunities. Although program staff point to many ways that their clients benefit from their services, more data on outcomes and measures of fidelity will be needed to build the evidence necessary to meet the FFPSA evidence requirements.

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Appendix 1. Literature review methods

The literature review began with a search of a variety of databases containing relevant peer-reviewed articles. Databases included in the search were Academic Search Premier, which covers education, family support, labor, medical science, and ethnic studies; CINAHL, a database covering nursing, biomedicine, health sciences, alternative/complementary medicine, and consumer health; MEDLINE, which covers medicine, preclinical sciences, health care, health information science, and allied health sciences; PsycINFO, the American Psychological Association's comprehensive database of psychology; Scopus, which covers disability, health, nutrition, and statistics; SocIndex, which covers sociology, early childhood, sociological theory, demography, political and urban and rural sociology, social development, social psychology, substance abuse and other addictions, and more; and Education Research Complete and ERIC, both of which cover educational fields and related subjects. The project team also conducted a Google custom search to identify relevant grey literature—non-peer-reviewed reports and other materials produced by research institutes and government contractors. Search topics and key words for both searches included “rural areas,” “child welfare,” “human services delivery,” and “substance use,” for example. The study's broad definition of rural encompassed all non-urban areas. The team also reviewed articles recommended by subject matter experts and ASPE staff.

The literature reviewed represented a range of definitions of the term rural that were not always consistent. For this brief, we used a broad definition of rural that encompasses all non-urban and non-suburban areas. Each rural community is unique, however, and not every rural community faces the same challenges. In addition, although we are confident that our literature review and environmental scan encompassed the range of available literature, by focusing on published literature, our findings might not fully reflect current practice in rural areas that have not yet been studied. Recent federal investments have targeted treatment options in rural areas, and the impact of these investments might not be fully reflected in this brief. For example, the Health Resources and Service Administration recently invested more than \$111 million to enhance rural substance use disorder treatment options. Research does indicate that, in some respects, the availability of opioid use disorder treatment options in rural areas has improved relative to non-rural areas (Ghertner 2019).