

Challenges in Identifying and Supporting Human Services Participants with Substance Use Disorder

Human services programs face a number of barriers in supporting treatment for participants with substance use disorder, such as limited institutional relationships, fear of reprisal and stigma, workforce challenges, and availability of needed services.

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KEY POINTS

This report summarizes an environmental scan and series of key informant interviews describing the challenges that human services programs face in identifying participants with substance use disorders (SUDs) and subsequently referring them to treatment. The review focused on child welfare services, domestic violence services, Head Start, and Temporary Assistance for Needy Families. The results supported an [expert roundtable](#) held in September 2021, focused on identifying promising practices to screen participants for SUD and refer them to treatment. Among the main barriers these human services programs face in supporting participants with SUD are the following:

- Limited formal collaboration with SUD treatment providers, which can delay access to treatment, lead to referrals to treatment programs that are not well-matched to the client's needs, and other challenges.
- Barriers to formal collaboration, including financial disincentives, differences in priorities between SUD treatment providers and human services programs, and privacy rules.
- Participants' fear of reprisal for disclosing a SUD, and agency concern that participants will disengage from services as a consequence.
- Workforce challenges in human services programs, including limited knowledge or experience working with SUD treatment, stigma against people with SUD, and inconsistent follow-up to support participants in accessing and adhering to treatment.
- Limited access and availability of effective treatment.
- Limited supportive services to facilitate treatment, such as child care and transportation.
- Challenges of financing treatment and navigating private or public health insurance.

INTRODUCTION

People participating in human services typically experience multiple concurrent or sequential intertwined challenges. Substance use disorders (SUDs) are one of the most difficult to overcome, and if not addressed in a timely manner, SUDs can compromise participants' ability to meet their goals, such as maintaining healthy relationships, gaining and retaining employment, achieving self-sufficiency, promoting child school readiness and success, and sustaining child and family well-being. Many jurisdictions continue to lack systematic approaches to timely identification of SUDs, referrals to treatment and recovery support services, and formal collaborations that promote case planning and reduce barriers to SUD services (Knight et al., 2021).

Human services programs provide critical services to people and families dealing with SUD who face other challenges, such as interpersonal violence, concerns over child safety, and economic stability. These programs can contribute to helping our nation overcome the current overdose crisis. They have a role in the four key pillars of the U.S. Department of Health and Human Services ([HHS Overdose Prevention Strategy](#)): primary prevention, harm reduction, evidence-based treatment, and recovery support.

In September 2021, ASPE partnered with JBS International to hold an expert roundtable with the following goals:

1. Identify promising strategies to conduct SUD identification and treatment referrals within the unique circumstances of four human services programs: TANF, child welfare services, domestic violence services, and Head Start.
2. Identify the policy levers the HHS can use to increase effective and appropriate SUD identification and referral to treatment and supportive services within state and local human services agencies and programs.

This report summarizes results from an environmental scan of available research literature, as well as semi-structured interviews with experts in human services and substance use treatment services. This review was conducted to provide input into the roundtable. Recommendations on how human services programs can address the issues raised in this framing paper can be found in the convening summary which is found [here](#). The review's objectives were to identify existing practices and challenges human services programs face in identifying SUD in participants, referring them to evidence-based treatment, and supporting them through their time in treatment. The review focuses on four human services areas: child welfare services, domestic violence services, Head Start, and Temporary Assistance for Needy Families (TANF). Importantly, the interviews conducted were based on a purposive sampling strategy, and the results cannot be generalized to the entire field of service providers. Details on the methods can be found in the appendix.

“Failure to address the survivor’s substance misuse may mean she will leave in the back of a police car or an ambulance.”

– Domestic violence expert respondent

Human services participants with SUD face several barriers in obtaining and adhering to treatment, and those barriers interact with one another. Exhibit 1 shows the main barriers identified in this review as faced by the four human services programs. These barriers will be described in more detail below.

As much as it takes to overcome one barrier for a participant, additional barriers almost always follow. Staying on the road to recovery from SUD is difficult for participants—and for program staff helping them—with miles of speed bumps. Exhibit 2 illustrates an example pathway a parent involved in a human services system may encounter when seeking treatment. The example is meant to be illustrative and not comprehensive participants in other programs or with different co-occurring conditions and circumstances would likely face different barriers.

Exhibit 1. Barriers Faced by Human Services Programs in Identifying Participants with SUD and Referring Them to Treatment

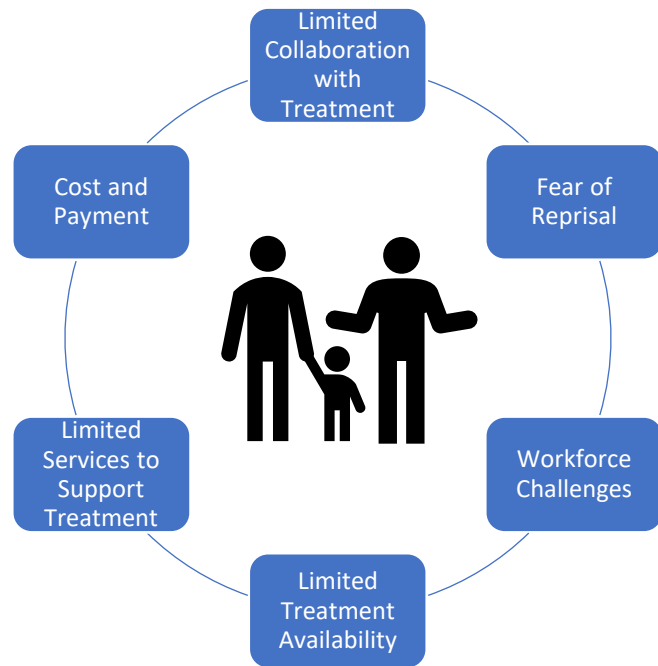
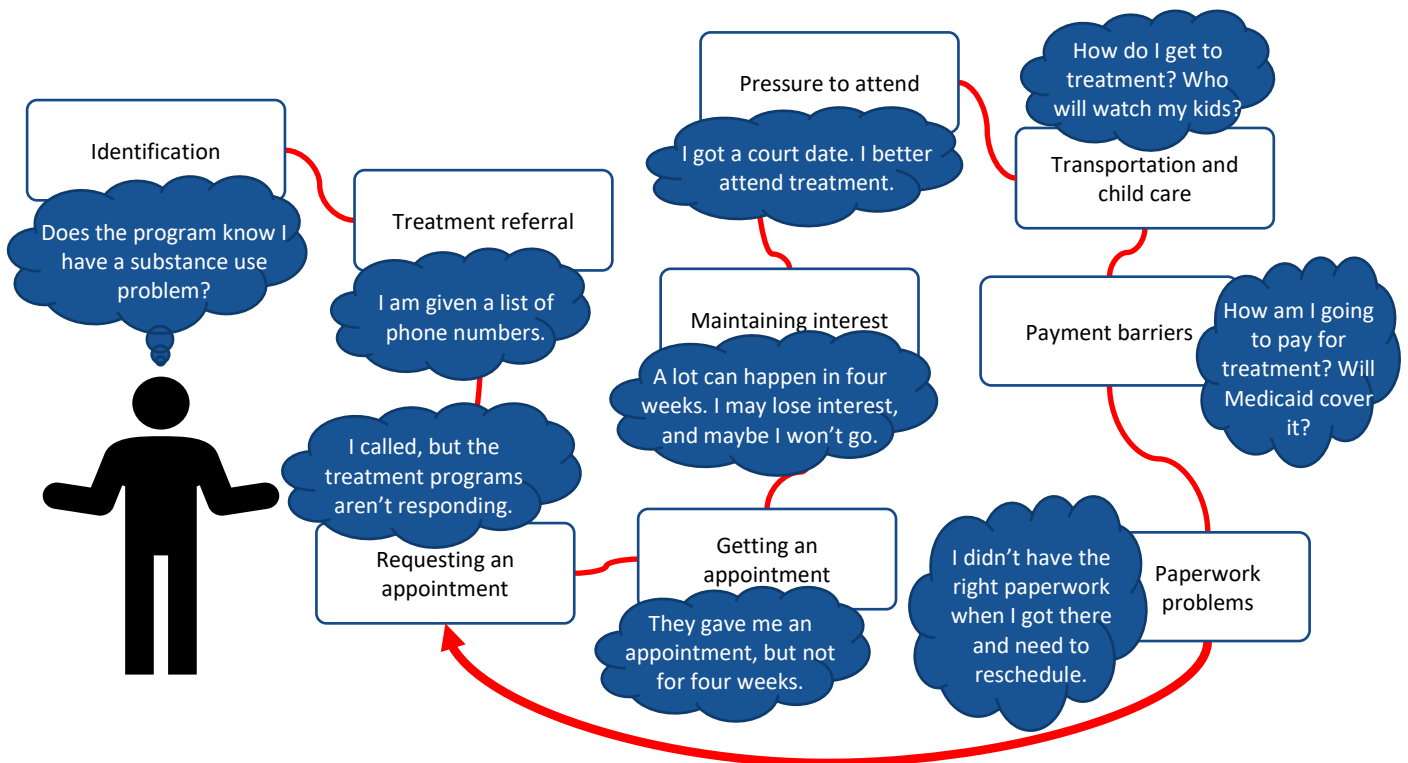


Exhibit 2. An Example Pathway to Receiving SUD Treatment for a Human Services Participant



APPROACHES AND BARRIERS TO IDENTIFYING HUMAN SERVICES PARTICIPANTS WITH SUD

Our review identified wide variation in substance use screening and assessment practices. While some differences occurred across the four human services areas, two common themes arose across all four programs: 1) approaches to screening for substance use disorders and 2) barriers to screening for substance use disorders.

APPROACHES TO SCREENING FOR SUD

Our interviews showed that the four program areas differed in how they screened participants for substance use.

Child welfare services. In child welfare services, screening for SUD can take place at different stages of a family’s involvement with the system. Caseworkers may suspect problematic substance use at the initial report, when the report is screened, during an investigation, or at other points during casework or case planning. Experts stated they believed there were missed opportunities in how child welfare agencies screen for SUD—in their experience, substance use screening was most likely to occur when it is expressly mentioned in the child maltreatment report or if evidence is directly provided to or is seen or heard by child protective services investigators. In many cases, the focus of substance use screening is to identify maltreatment risk and ensure child safety, with less emphasis on supporting the parent with SUD. Plans of Safe Care—which are intended to ensure the safety and well-being of an infant with prenatal substance exposure—can be a valuable tool to support parents and caregivers with SUD after identification, though experts did not mention these plans as commonly used. Experts felt that when substance use is finally identified in many cases, it may be too late in the process to address it in time to support family stability and child safety, minimize the likelihood of out-of-home placement, and maximize the likelihood of reunification.

“If we could identify and address substance misuse early, we could cut our caseload down to just about nothing.”

– Child welfare interview
respondent

Domestic violence services. In domestic violence services, SUD identification varied widely. A common domestic violence assessment instrument (Exhibit 3) asks the survivor about the *perpetrator's* illegal drug use and alcohol use disorder or problem drinking and not about the survivor's own potential use (Drabble, 2010). Others described informal approaches such as "opening a conversation" and using narrative questions about substance use prompted by each survivor's unique circumstances, leaving it up to the survivor to determine whether and how to address this topic.

Head Start. In Head Start, some programs have general substance use questions on their intake forms. For example, a common Head Start intake form asks participants whether they want any information about "Alcohol/Drug Abuse" (Exhibit 3). Another section of the intake form has an open-ended question about "obstacles" that could elicit a participant's disclosure about substance use: "Are there obstacles that would prevent you from becoming employed?"

TANF. Typical intake forms for TANF ask about alcohol and drugs in several different contexts: (1) as a possible exemption from the general work requirements (caretaker for someone, regular participant in a drug or alcohol program, whether anyone in the household including the applicant is living in a "drug or alcohol treatment or rehabilitation facility"); (2) whether the applicant is a "regular participant in a drug or alcohol program"; and (3) whether anyone in the household, including the applicant, has been found guilty of a drug-related felony after August 22, 1996. Respondents suggested that TANF-funded workforce staff, usually case managers, may be likely to have the capacity to perform necessary screening and assessment functions. However, with the increasing use of call centers, interviewees felt this method is impersonal and not conducive to developing the trust and rapport needed for substance use disclosure.

As for the timing of when to conduct a screening for SUD, TANF respondents suggested that screening should not be implemented during the initial cash benefits eligibility determination process. Instead, they recommended that identification of use (not necessarily through a true screening process) can occur during the workforce component, where recipients affected by substance use are more likely to demonstrate SUD-related behaviors (e.g., work absences, performance issues). Because recipients likely have developed a relationship with their case manager by that time, this may increase their readiness to disclose and address substance use.

BARRIERS TO SCREENING FOR SUD

Fear of reprisal and service disengagement. In research and interviews across the four program areas, we found that program participants fear that they could face negative consequences if their SUD is disclosed to programs, regardless of whether those consequences are real or perceived. Our interviews and literature findings showed that parents or caregivers involved in child welfare systems fear temporary or permanent loss of their children if a parent or caregiver discloses that they use or misuse substances (Dauber et al., 2017). Similarly, TANF recipients fear the loss of welfare benefits to support their families if a SUD is identified

Exhibit 3. Common Intake Questions Related to Substance Use

Domestic Violence Intake Assessment

Does the perpetrator use illegal drugs? By drugs, I mean "uppers" or amphetamines, "meth," speed, angel dust, cocaine, "crack," street drugs or mixtures.

Is the perpetrator an alcoholic or problem drinker?

Head Start Intake Form

Would you like information about any of the following?
Check all that apply.

- | | |
|---|--|
| <input type="checkbox"/> Child Support | <input type="checkbox"/> Literacy/ESL |
| <input type="checkbox"/> Legal Issues | <input type="checkbox"/> Alcohol/Drug Abuse |
| <input type="checkbox"/> Foster Care/Adoption | <input type="checkbox"/> Mental Health Resources |
| <input type="checkbox"/> Parental Rights | <input type="checkbox"/> Citizenship |

(Germain, 2018). In domestic violence and Head Start programs, program participants fear disclosing substance use to program staff because these staff are legally required to report suspected child maltreatment to child protective services (O'Brien et al., 2018) and substance use may be considered as maltreatment whether or not there are indications that children are at significant risk.

Relatedly, program staff may fear that participants may become disengaged in services if programs conduct screening for substance use or misuse. Some domestic violence and Head Start interview respondents reported that their staff perceive substance use screening and assessment as intrusive and a barrier to establishing a trusting relationship with parents and other service recipients. Respondents in all four human services areas questioned the value of cannabis screening given the severe consequences (e.g., loss of child custody or reunification, job loss) for parents with a positive screen who otherwise meet their individual program goals and fulfill parental responsibilities.

Perceptions about the role and benefits of screening varied among Head Start providers, with some acknowledging its utility while others expressed concern about overreach. For example, one Head Start respondent reported that their program considers parental substance use a factor that increases children's program eligibility, while another respondent viewed screening as "prying" and antithetical to building trusting relationships with children's parents, who may respond by withdrawing their children from the program.

Workforce challenges. Programs face workforce limitations in screening for SUD (Chuang et al., 2013). In all four program areas of focus, caseworkers can have difficulty integrating multiple screening tools that target different areas of need due to time constraints or the specific requirements of screening tools (e.g., questions that need to be administered completely and in a specific order). Within domestic violence services, Head Start, and child welfare services, SUD screening is impeded by lack of staff in general, and a pervasive lack of staff with the requisite training and clinical expertise to screen for substance use (Chuang et al., 2013).

Interviewees noted that within some child welfare offices, an unwritten yet widely understood "don't ask" policy was born out of workforce shortages, heavy caseloads, uncertainty about what to do if SUDs were identified, and pressure to close cases quickly. In some TANF offices, heavily automated eligibility processes result in staff not having direct contact with the recipients, making it even less likely that SUDs and other problems will be identified and addressed at early stages. A similar situation in some SUD intake processes limits warm handoffs and early engagement.

BARRIERS WHEN REFERRING PARTICIPANTS WITH SUD TO TREATMENT

Financial constraints. When patients are referred for treatment, financial constraints can impede collaboration. Specifically, collaboration typically is not a reimbursable service for human services or treatment programs. Agencies cannot always submit claims for collaborative activities, and as a result they may not be able to prioritize them. In some cases, funds can be used, though agencies may not be aware of the opportunity or may choose not to prioritize funds in this way. Experts stated that TANF agencies can pay for SUD treatment and ancillary services using federal TANF funds and related state funds claimed toward the TANF "maintenance of effort" requirement.¹ Some states have used this option to increase TANF recipients' access to treatment, avoid waiting lists, and support treatment programs specifically designed to meet the needs of recipients who are parents (Kenefick & Lower-Basch, 2012).

Privacy rules. Federal and state privacy rules—and program approaches to such rules—are another barrier to formal collaboration and referral. Treatment programs must follow data sharing rules under two federal

¹ To receive federal TANF funds and avoid a penalty, states must spend some of their own funds, known as "maintenance of effort."

policies, in addition to state-specific rules (Jost, 2006). The [Health Insurance Portability and Accountability Act](#) (HIPAA) restricts sharing of protected health information, and [42 CFR Part 2](#) restricts access to information related to a patient's SUD by entities that do not have a treatment provider relationship with the patient. Standards of care for substance use treatment include comprehensive case management to assist the individual with gaining and maintaining sobriety (Substance Abuse and Mental Health Services Administration [SAMHSA], [Treatment Improvement Protocol Series, #27](#)). As a result of these data sharing restrictions, many human services programs are unsure how best to devise case management plans that link their client to treatment and all the other human services systems necessary to bolster the person struggling with a SUD without violating privacy rules.

Recognizing the barriers that 42 CFR Part 2 presents to researchers and practitioners, in July 2020 SAMHSA published revisions to 42 CFR Part 2, simplifying the sharing of SUD information with entities that do not have a treatment provider relationship, such as social service organizations, if the patient has provided prior written consent (85 FR 42986).² The relative recency of the regulatory changes at the time of our data collection meant that the literature we reviewed had not yet incorporated these changes, and many of the experts we spoke with either were not aware of the change or had insufficient experience with its implementation, highlighting the importance of outreach and education along with policy change.

Differences in priorities. Interviewees described differences in priorities between systems as forming another barrier. In general, child welfare services, domestic violence services, Head Start, and TANF are concerned with the well-being of participants' family members in addition to the well-being of the participants themselves. SUD treatment programs, however, are often solely focused on the health and well-being of patients and less concerned with the family. This difference can result in the misalignment of treatment protocols with the broader needs that human services programs seek to address.

For example, in domestic violence services, some programs prioritize safety concerns over substance use. In general, domestic violence interviewees raised significant concern about a philosophical disconnect between the safety- and strengths-based approaches of domestic violence services and the "diagnostic," "labeling," and "pathologizing" approaches they believed to be used by SUD assessment and treatment staff. Some domestic violence respondents defined survivor substance use as a coping or self-soothing strategy that some survivors may not be ready to give up, especially in the early stages of involvement in domestic violence programs. As a result, some domestic violence respondents implemented harm reduction practices with recipients affected by substance use. They believed an empowerment approach, rather than a compliance approach (e.g., the individual co-determines what is critical for functioning and safety and the sequence for services without requiring mandatory screening, assessment, or SUD treatment participation), offers the best way to identify a survivor's SUD, address it, and refer the survivor for treatment.

Some domestic violence interviewees commented that a survivor's substance use frequently stemmed from a coercive partner, and they believed that removing the partner would end the substance use. Other interviewees noted, however, that this belief may be shortsighted, as it may not account for physical dependence as well as use that started before the relationship with the coercive partner. These domestic violence programs recognized the mortality risk their substance-using participants faced and began to stock naloxone, an opioid-overdose reversing medication.

Limited collaboration between human services and SUD treatment programs. A key barrier to referral is limited collaboration between programs. Our review found that strong collaboration across human services and treatment systems is critical to participants' successful admission and participation in treatment, and

² See <https://www.federalregister.gov/documents/2020/07/15/2020-14675/confidentiality-of-substance-use-disorder-patient-records>

recovery. Most interviewees stated that collaborative practices, especially multidisciplinary family team meetings and cross-system training, could really “push a family forward.” However, respondents across the four human services systems described a wide variation in the extent of collaboration between their human services programs and local SUD treatment programs. Few respondents reported strong partnerships with SUD treatment programs, and even fewer reported having formal agreements in place to support their interactions. Most characterized their SUD partnerships as largely based on personal relationships among various program staff across the systems. One staff departure in either system can jeopardize collaboration and partnerships.

Many Head Start respondents reported little to no collaboration with SUD treatment providers, even though some programs increased monitoring and support of families they believe are affected by substance use. One Head Start respondent said they provide in-home meal deliveries to “lay eyes on the kids,” and another conducts outreach to suspected drug dealers to enroll their unsupervised high-risk children in Head Start programming. TANF interviewees stated that collaboration between TANF and treatment services is predominantly financial in nature—focused on how SUD services can be paid for—and it is rare that caseworkers work directly with treatment providers to coordinate services, assess progress, or otherwise support recovery. One model TANF-funded program, the Targeted Assessment Program in Kentucky, emphasizes cross-system collaboration with SUD treatment as well as other human services. The program uses full-time, trained targeted assessment specialists, who engage participants, agency staff, and community partners, to facilitate referrals, collaboration, and service provision.

The limited amount of formal collaboration between human services and treatment providers has a number of consequences that affect the ability of human services programs to successfully screen participants for SUD and refer them to treatment.

- **Timeliness of services.** Access to SUD diagnostic assessments and treatment (if indicated) may not happen in a timely manner, which can negatively affect participant and family outcomes related to health and human services. It can also discourage participant engagement in treatment.
- **Referrals that are not well-matched to specific needs.** Human services program staff in general do not have expertise in SUD treatment, and without support from SUD professionals, the choice of where to refer a service recipient for diagnostic or treatment services may be somewhat arbitrary. For example, few interview respondents knew the name of a SUD assessment instrument or treatment model, let alone whether any were evidence-based. Some respondents who were aware of evidence-based assessments and treatments raised concerns that these practices typically cost more and serve fewer people. Relatedly, SUD treatment programs can have different eligibility criteria—for example, patients using medications for opioid use disorder, or with mental health disorders, may not be accepted. This can make referring to treatment confusing for program staff and can lead participants to have to search for multiple treatment providers before finding one that can treat them. Because of the combined lack of knowledge of SUD treatment modalities and limited use of structured screening tools, human services staff may not refer participants to the type of treatment they need to be successful in recovery.
- **Inconsistent support of participants seeking treatment.** Without a standard referral process, referrals of service participants to SUD-related services were frequently contingent upon practices of the individual staff member doing the referral. According to interviewees, while some staff may assist with eligibility requirements and financial information and even submit referral paperwork, others only provide a list of phone numbers from which service recipients were to choose. Such lists generally include no context, service description, eligibility requirements, or insurance/financing information.

- **Uncertainty about how to address complex conditions.** Human services participants generally have multiple needs, including economic and housing instability, food insecurity, and interpersonal violence. Participants with substance use problems can have even more complex circumstances related to their substance use. As a result, some interviewees noted that referrals to treatment were not always straightforward given the complex clinical profile of many individuals. They stated that it wasn't always clear which treatment services should take priority or in what sequence referrals should take place. For example, if a participant has severe trauma and an opioid use disorder, which service takes precedence? Interviewees were unaware of the availability of SUD treatment programs that provide simultaneous treatment for issues that compete with recovery pathways, such as mental health issues and toxic stress.
- **Siloed human services and treatment services.** People with SUD may engage with multiple human services and treatment programs, and such programs often operate in silos, with conflicting rules, policies, and appointment times. Siloed programs result in a lack of collaboration between human services programs, however, lack of collaboration between human services programs also reinforces siloes. This creates stress for participants and puts pressure on program staff as they support participants in navigating through the services. Interviewees said that often program staff presume that participants are uninterested, when in reality they may be dealing with competing requirements for participating in multiple programs. For example, a domestic violence survivor enrolled in SUD treatment may not be able to participate in a scheduled treatment program (e.g., every Thursday from 6 p.m. to 9 p.m.) as predictable schedules increase the risk of perpetrator violence.
- **Limited information sharing on participants.** Interviewees across the four human services areas stated that in most situations, after program participants have been referred to treatment providers, staff do not consistently hear about progress in treatment. Despite a few instances where human services programs receive treatment information through interagency case staffing (conducted predominately between child welfare and SUD providers), many interviewees across the four human services areas reported no formal information sharing processes with SUD treatment providers. Even with appropriate release forms, many respondents received minimal, nonspecific information about services, engagement, or progress after referral, owing to perceived or real barriers due to privacy policies, as described above.

BARRIERS TO PARTICIPANT ENGAGEMENT IN SUD TREATMENT

The environmental scan and interviews pointed to several barriers to consistent, successful engagement of participants with SUD in treatment in general, and many of these pose specific challenges to successful engagement with human services programs. Some of these barriers are related to the human services and treatment programs, while some are related to the specific circumstances of participants with SUD.

Workforce challenges. Generally speaking, the same human services workforce challenges related to SUD screening, outlined above, apply to the process of referring to treatment. As pointed out previously, the human services workforce generally does not have expertise in SUD, particularly how to identify and address the severity of substance use problems and associated challenges. As a result, caseworkers and other staff may be reluctant to address SUD because they don't know what, if anything, to do with the knowledge of a participant's substance use issue (Pilkinton, 2010). Interviewees stated that often program staff were inconsistent in how they followed up with participants to ensure they made their appointments with SUD treatment providers. For human services programs that did refer participants to treatment, staff were generally unaware of the wait time for an assessment/eligibility determination or the wait time for admission once eligibility was determined. Additionally, the workforce in many programs often experiences very high

annual turnover, especially in high-skill jobs, reportedly due to low wages, high caseloads, and high stress (Drabble, 2010). Finally, program staff may hold biases against substance use, creating stigmatizing interactions with participants.

Limited availability of treatment. In spite of large public investments in SUD treatment, there remains a shortage of evidence-based inpatient and outpatient SUD treatment in many communities and especially in rural areas (Haffajee et al., 2019; Joudrey et al., 2019). For example, national estimates in the 2015–2019 period found that 71 percent of adults with opioid use disorder had a need for treatment and did not receive it (Saini et al., 2022). What’s more, not all treatment providers accept Medicaid—the main source of health care coverage for human services participants—and may have high out-of-pocket costs (Flavin et al., 2020). While some populations, such as pregnant and parenting women, often received priority admission to inpatient and outpatient treatment, single fathers and caregivers did not benefit from such prioritization. Family-centered SUD treatment programs were described as direly needed but nearly nonexistent in many communities of which respondents were aware, or if present, these programs had limited capacity to take additional patients. Reflecting the lack of access described by interviewees, ASPE research has found that in 2019, counties with the greatest increases in foster care entry rates over the five prior years had the lowest availability of evidence-based treatment for opioid use disorder (Ghertner et al., 2020).

In terms of treatment engagement, access to recovery support staff or other supportive processes to facilitate treatment access and engagement is sparse. Even if a human services participant finds a SUD treatment program and engages in treatment, in most cases not enough monitoring, collaborative case planning, or clinical staffing is in place to reduce barriers and maximize treatment outcomes in the human services systems involved.

Telehealth for behavioral health services, an enhancement that emerged after the onset of the COVID-19 pandemic, could increase the availability of treatment as well as participation in treatment for some participants. Virtual delivery of human services also increased as a result of the pandemic, and research is needed to understand the extent to which it can facilitate or impede identification of SUD and referral to treatment.³ However, as described in more detail below, access to technology and comfort with virtual services may present barriers for specific groups.

Limited services available to support treatment uptake. Our review found that low-income people needing SUD treatment often face barriers that are not directly related to treatment but have consequences for their ability to follow through on a treatment regimen. We emphasize four areas.

- **Transportation.** Nearly all respondents described the availability of transportation as one of the most significant barriers, particularly in rural areas. This finding is in line with the research on SUD treatment barriers (e.g., Ali et al., 2022). Even when transportation can be covered by services such as Medicaid, the limitations of those services can be problematic for parents and caregivers. One respondent described how transportation paid for by Medicaid presents a barrier for some participants: eligible parents being taken by van to their SUD treatment or other medical appointments are not permitted to have minor children accompany them unless the children also have scheduled medical appointments. Moreover, depending on the number of competing van riders and associated stops each day, some parents can spend nearly an entire day getting to and from a one-hour SUD treatment appointment.

³ For more information on virtual human services delivery, see ASPE’s ongoing work in this area:

<https://aspe.hhs.gov/topics/human-services/health-health-care/behavioral-health/telehealth-virtual-service-delivery>

- **Access to technology, internet access, and computer literacy.** Access to treatment can depend on participants' access to the internet, including devices, as well as their own computer literacy. Depending upon the locale, some individuals had to complete their SUD intake using an online centralized intake system. During the COVID-19 pandemic, interviewees said that telehealth services for treatment could offset transportation costs. Interviewees also stated, however, that limited access to devices and the internet and limited computer literacy impeded completion of online intake forms and use of telehealth services. Participants may also feel that virtual services lack direct human connection or may distrust the technology involved. Some respondents reported that recipients of color were more significantly affected by these technology access barriers.⁴ Previous [ASPE research](#) found that Black, Hispanic, and American Indian/Alaska Native people were less likely to have internet access than White and Asian people, and that people in nonmetropolitan areas had less access than those in metropolitan areas (Swenson & Ghertner, 2021).

“Access to technology to enable individuals to apply online for SUD treatment (and TANF and child care) is often limited, especially for people of color, and it’s pretty intimidating.”

– Domestic violence interview respondent

- **Child care.** Interviewees stated that participants seeking SUD treatment may not have reliable or affordable child care options, which can affect parents' and other caregivers' ability to attend treatment programs regularly. Research supports the need for child care as a common barrier to treatment for low-income parents, particularly women (Frazer et al., 2019; Taylor, 2010).
- **Housing options free from violence and substance use.** Interviewees stated that adhering to treatment was particularly challenging for participants who experienced violence in their homes, or when substance use was prevalent in the home. Prior [ASPE research](#) found that survivors of intimate partner violence can also experience substance use coercion, where perpetrators of violence undermine and control their partners through substance use and actively keep them from meeting treatment and recovery goals (ASPE, 2020).

Cost of SUD treatment and complexity of payment. Once a treatment program was identified, human services program participants (along with program staff) have to figure out how to pay for such treatment. Interviewees felt that this was the most challenging part of the identification and referral process, more so than other barriers. They said that financial barriers frequently seemed insurmountable. The most common questions participants and services providers had to address were these:

- What (if any) insurance does the SUD treatment provider accept?
- Does the individual meet eligibility requirements for accepted insurance carriers, especially Medicaid?
- How will payment obligations be handled for the uninsured or underinsured, particularly in states that have not expanded Medicaid?

⁴ Previous ASPE research found that Hispanic, Black, and American Indian/Alaska Native people in poverty have less access to the internet than White and Asian people in poverty. See <https://aspe.hhs.gov/sites/default/files/private/pdf/263601/internet-access-among-low-income-2019.pdf>

Interviewees noted that when human services program staff are unaware of how the diagnostic assessment and treatment services were paid for or how to go about applying for insurance, they could provide little guidance as individuals navigated a complex and often bureaucratic system.

Few of our interviewees were aware of services funded by state [Substance Abuse Prevention and Treatment Block Grants](#) from SAMHSA.⁵ As a result, they had not considered whether they could access any SUD treatment programs funded through SAMHSA block grants for their participants needing treatment.

Another related challenge is how to pay for services related to co-occurring conditions, such as mental health services. Interviewees were unsure whether these services would be considered ancillary and reimbursable through Medicaid or other funding streams. Additionally, program participants may struggle with use of multiple substances, which is common among many people with SUD (Winkelman et al., 2018). Some SUD treatment options focus on specific substances, such as opioids, and program interviewees were unsure how to make referrals when participants used multiple substances.

CONCLUSION

This report identified the challenges human services programs face when trying to identify whether a participant has a SUD, and the difficulty in referring participants to treatment. The study focused on four human services programs: child welfare services, domestic violence services, Head Start, and TANF. Based on an environmental scan and key informant interviews, the paper outlined a number of barriers, including these:

- Limited formal collaboration with SUD treatment providers, which can delay access to treatment, lead to referrals to treatment programs that are not well-matched to the client's needs, and other challenges.
- Barriers to formal collaboration, including financial disincentives, differences in priorities between SUD treatment providers and human services programs, and privacy rules.
- Participants' fear of reprisal for disclosing a SUD, and agency concern that participants will disengage from services as a consequence.
- Workforce challenges in human services programs, including limited knowledge or experience working with SUD treatment, stigma against people with SUD, and inconsistent follow-up to support participants in accessing and adhering to treatment.
- Limited access and availability of effective treatment.
- Limited supportive services to facilitate treatment, such as child care and transportation.
- Challenges of financing treatment and navigating private or public health insurance.

Human services programs have an important role in the response to the continued overdose crisis. They can present opportunities to identify people with SUD and link them to effective treatment options, thereby reducing the risk of continued substance use and overdose. They can also mitigate the consequences of SUD on participants' families and communities. However, to do so, programs need to be able to effectively identify when a participant has a SUD, act on that information, and support participants in treatment when indicated.

⁵ The Substance Abuse and Prevention and Treatment Block Grant program's objective is to help plan, implement, and evaluate activities that prevent and treat substance abuse. It is authorized by the [Public Health Services Act](#).

This report focused on barriers programs face. Recommendations on how human services programs can address the issues raised in this framing paper can be found in the convening summary which is found [here](#).

REFERENCES

- ACF (Administration for Children and Families). (2018). Information Memorandum ACYF-CB-IM-18-02. <https://www.acf.hhs.gov/sites/default/files/documents/cb/im1802.pdf>
- ASPE. (2020). Understanding Substance Use Coercion as a Barrier to Economic Stability for Survivors of Intimate Partner Violence: Policy Implications. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. <https://aspe.hhs.gov/sites/default/files/private/pdf/264166/Substance-Use-Coercion-Policy-Brief.pdf>
- Ali, M. M., Nye, E., & West, K. (2022). Substance Use Disorder Treatment, Perceived Need for Treatment, and Barriers to Treatment Among Parenting Women With Substance Use Disorder in US Rural Counties. *The Journal of Rural Health, 38*(1), 70–76. <https://doi.org/10.1111/jrh.12488>
- Chuang, E., Wells, R., Bellettiere, J., & Cross, T. P. (2013). Identifying the substance abuse treatment needs of caregivers involved with child welfare. *Journal of Substance Abuse Treatment, 45*(1), 118–125. <https://doi.org/10.1016/j.jsat.2013.01.007>
- Dauber, S., John, T., Hogue, A., Nugent, J., & Hernandez, G. (2017). Development and implementation of a screen-and-refer approach to addressing maternal depression, substance use, and intimate partner violence in home visiting clients *Children and Youth Services Review, 81*, 157–167.
- Drabble, L. (2010). Advancing collaborative practice between substance abuse treatment and child welfare fields: What helps and hinders the process? *Administration in Social Work, 35*(1), 88–106. <https://doi.org/10.1080/03643107.2011.533625>
- Family Violence Prevention and Services Programs, 81 Fed. Reg. 76446 (November 2, 2016) (codified at 45 CFR Part 1370).
- Flavin, L., Malowney, M., Patel, N. A., Alpert, M. D., Cheng, E., Noy, G., Samuelson, S., Sreshta, N., & Boyd, J. W. (2020). Availability of Buprenorphine Treatment in the 10 States With the Highest Drug Overdose Death Rates in the United States. *Journal of Psychiatric Practice[®], 26*(1), 17–22. <https://doi.org/10.1097/PRA.0000000000000437>
- Frazer, Z., McConnell, K., & Jansson, L. M. (2019). Treatment for substance use disorders in pregnant women: Motivators and barriers. *Drug and Alcohol Dependence, 205*, 107652. <https://doi.org/10.1016/j.drugalcdep.2019.107652>
- Haffajee, R. L., Lin, L. A., Bohnert, A. S. B., & Goldstick, J. E. (2019). Characteristics of US Counties With High Opioid Overdose Mortality and Low Capacity to Deliver Medications for Opioid Use Disorder. *JAMA Network Open, 2*(6), e196373–e196373. <https://doi.org/10.1001/jamanetworkopen.2019.6373>
- Germain, J. (2018). *Opioid use disorder, treatment, and barriers to employment among TANF recipients* (OFA Report #1-2018). Office of Family Assistance, Administration for Children and Families, U.S. Department of Health and Human Services. https://peerta.acf.hhs.gov/sites/default/files/public/uploaded_files/Opioid%20Use%20Disorder%2C%20Trtmt%2C%20and%20Barriers%20Report_508.pdf
- Ghertner, R., Madden E., & Crouse G. (2020). Availability of Treatment for Opioid Use Disorder in Areas of High Foster Care Increases. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health

and Human Services. https://bettercarenetwork.org/sites/default/files/2020-05/oud_treatment_and_foster_care_entries_2019.pdf

Jost, T. S. (2006). Constraints on Sharing Mental Health and Substance-Use Treatment Information Imposed by Federal and State Medical Records Privacy Laws. In *Improving the Quality of Health Care for Mental and Substance-Use Conditions*. National Academies Press. <https://www.ncbi.nlm.nih.gov/books/NBK19829/>

Joudrey, P. J., Edelman, E. J., & Wang, E. A. (2019). Drive Times to Opioid Treatment Programs in Urban and Rural Counties in 5 US States. *JAMA*, 322(13), 1310–1312. <https://doi.org/10.1001/jama.2019.12562>

Kenefick, E. & Lower-Basch, E. (2012). Helping TANF Recipients Overcome Addiction: Alternatives to Suspicionless Drug Testing. Center for Law and Social Policy. <https://www.clasp.org/sites/default/files/public/resources-and-publications/files/Helping-TANF-Recipients-Overcome-Addiction.pdf>

Knight, E., Butcher, R. L., & Jankowski, M. K. (2021). Toward improved identification of parental substance misuse: An examination of current practices and gaps in one US state. *Maternal and Child Health Journal*, 25(9), 1353–1360. <https://doi.org/10.1007/s10995-021-03138-y>

O'Brien, J. E., Ermentrout, D., Li, W., Dababnah, S., Rizo, C. F., & Macy, R. J. (2018). Measuring substance use among system-involved IPV survivors: A research note. *Violence against Women*, 24(1), 101–119. <https://doi.org/10.1177/1077801216675744>

Pilkinton, M. (2010). TANF recipients' barriers to employability: Substance abuse and domestic violence. *Journal of Human Behavior in the Social Environment*, 20(8), 1011–1023. <https://doi.org/10.1080/10911359.2010.494940>

Substance Abuse and Mental Health Services Administration, Comprehensive Case Management for Substance Abuse Treatment, Treatment Improvement Protocol (TIPs) Series, #27. <https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4215.pdf>

Saini, J., Johnson, B., & Qato, D. M. (2022). Self-Reported Treatment Need and Barriers to Care for Adults With Opioid Use Disorder: The US National Survey on Drug Use and Health, 2015 to 2019. *American Journal of Public Health*, 112(2), 284–295. <https://doi.org/10.2105/AJPH.2021.306577>

Swenson, K. & Ghertner, R. (2021). People in Low-Income Households Have Less Access to Internet Services—2019 Update. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. <https://aspe.hhs.gov/sites/default/files/2021-07/internet-access-among-low-income-2019.pdf>

Taylor, O. D. (2010). Barriers to Treatment for Women With Substance Use Disorders. *Journal of Human Behavior in the Social Environment*, 20(3), 393–409. <https://doi.org/10.1080/10911351003673310>

Winkelman, T. N., Chang, V. W., & Binswanger, I. A. (2018). Health, polysubstance use, and criminal justice involvement among adults with varying levels of opioid use. *JAMA network open*, 1(3), e180558-e180558.

APPENDIX A. METHODOLOGY

This study was originally conducted to set the stage for an expert roundtable held in September 2021. The information obtained represents examples of practices around the country. Because a purposive sampling strategy was employed, the information cannot be generalized to the entire field. To meet this study's objectives, the identification and synthesis of information involved two stages: an environmental scan and key informant interviews.

IDENTIFICATION AND TARGETED REVIEW OF RELEVANT LITERATURE

Standard literature search procedures were implemented for each of the four human services programs using variations of the following search term categories: substance use (variation examples: substance abuse, drug addiction, substance use disorder), screening (variation example: identification OR assessment), referrals (variation example: warm hand-offs). This resulted in a total of 147 literature searches within five databases: APA PsycInfo, MEDLINE, Health Policy Reference Center, SocINDEX, and EBSCO SmartText Search. Citations that resulted from each search were triaged into review/do not review categories based on a title and abstract review. The three main reasons an item was not reviewed were that it was unrelated to a specific human services program or to SUD identification and referral, it was not possible to obtain (such as a dissertation), or it had an international context. Reports from the gray literature were identified by searching agency, network, or affiliated websites of the four human services programs. Review of relevant articles and reports with a targeted emphasis on SUD identification and referral practices (n=100) predominately yielded individual (e.g., fear of reprisal), workforce (lack of established procedures, staff reluctance), and system (lack of services) barriers and successes. The information obtained from this targeted review formed the basis for the development of key informant interview questions and protocols. Exhibit A1 shows the number of articles reviewed in the environmental scan. Appendix B provides a list of the literature included in the review.

Exhibit A1. Number of Articles or Reports Reviewed in Each Human Services Area, by Year of Publication

	<i>TANF</i>	<i>Head Start</i>	<i>Domestic Violence Services</i>	<i>Child Welfare Services</i>
<i>2018–Present</i>	1	0	3	2
<i>2000–2018</i>	9	2	13	25
<i>Gray Literature</i>	18	8	6	13
<i>Total</i>	28	10	22	40
<i>Grand Total</i>			100	

KEY INFORMANT INTERVIEWS

Three strategies were used to identify and recruit individuals for key informant interviews. First, the project team worked with a team at JBS International that served as a technical assistance provider to a grantee network of the Department of Justice's Office for Victims of Crime (OVC), called "Enhancing Community Responses to the Opioid Crisis: Serving Our Youngest Crime Victims."⁶ This collaboration identified individuals within that grantee network who (1) worked at an agency within one of the four human services programs; and either (2) worked to identify and refer individuals with SUD to treatment or (3) were knowledgeable about the processes and barriers to SUD identification and referral. Once individuals were identified, brief

⁶ See <https://ovc.ojp.gov/>

descriptions of their project and experience were submitted to the project team, followed by discussions to further vet potential participants and determine the final pool for recruitment. Potential key informants were contacted, the reasons for contact and the interview were explained, and if the potential informant agreed, a time for the interview was scheduled. To expand the interview pool beyond OVC, snowball and purposive sampling, whereby interviewees were asked to recommend colleagues outside of their agency who could speak to the topic at hand, was employed. One key informant was contacted (and participated) as a result of authorship of a key peer-reviewed journal article. Of the 79 individuals identified, 41 (52 percent of the total) participated. Semi-structured interviews, composed of questions in five categories (identification/screening, assessment, referral, barriers and specific solutions, outcomes and needed support) were conducted, recorded, and coded, with key findings highlighted. Exhibit A2 provides the number and characteristics of key informants.

Exhibit A2. Number of Individuals Interviewed in Each Human Services Area

Human Services Area/SUD Affiliation	Number of Interviewees*
Child welfare services	16
Domestic violence services	9
Temporary Assistance for Needy Families (TANF)	9
Head Start	9
SUD system affiliated	4
Sex	
M	6
F	35
Race/Ethnicity	
Caucasian	30
African American/Black	5
Hispanic	1
Asian	2
American Indian	2
Alaska Native	1
TOTAL NUMBER OF PERSONNEL INTERVIEWED	41

*Some of the 41 interviewees covered multiple human services areas.

APPENDIX B. LITERATURE REVIEWED IN ENVIRONMENTAL SCAN

Aarons, G. A., & Palinkas, L. A. (2007). Implementation of evidence-based practice in child welfare: Service provider perspectives. *Administration and Policy in Mental Health and Mental Health Services Research*, 34(4), 411-419. doi:10.1007/s10488-007-0121-3

Acs, G., & Loprest, P. (2001). *Final synthesis report of findings from ASPE's "Leavers" grants*. The Urban Institute. <https://www.urban.org/sites/default/files/publication/61806/410809-Final-Synthesis-Report-of-Findings-from-ASPE-S-Leavers-Grants.PDF>

Antelo, L., Waters, A. (2019). *Illicit substance use and child support: An explanatory study*. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//190071/ChildSupportSubstanceUseNoncustodialFathers.pdf

Anthony, E. K., Austin, M. J., & Cormier, D. R. (2010). Early detection of prenatal substance exposure and the role of child welfare. *Children and Youth Services Review*, 32(1), 6–12. <https://doi.org/10.1016/j.childyouth.2009.06.006>

Baydar, N., Reid, M. J., & Webster-Stratton, C. (2003). The role of mental health factors and program engagement in the effectiveness of a preventive parenting program for head start mothers. *Child Development*, 74(5), 1433–1453. <https://doi.org/10.1111/1467-8624.00616>

Bennett, L. W. (2008). Substance abuse by men in partner abuse intervention programs: Current issues and promising trends. *Violence & Victims*, 23(2), 236–248. <https://doi.org/10.1891/0886-6708.23.2.236>

Bennet, L. W., & Bland, P. (2008). *Substance abuse and intimate partner violence*. National Online Resource Center on Violence Against Women. https://vawnet.org/sites/default/files/materials/files/2016-09/AR_SubstanceRevised.pdf

Bennett, L. W., & Vincent, N. (2001). Standards for batterer programs. *Journal of Aggression, Maltreatment & Trauma*, 5(2), 181-197. doi:10.1300/j146v05n02_11

Bergeron, D. (2019). *Opioid misuse: Issues for head start children, families, and programs and OHS efforts [PowerPoint slides]*. Administration for Children and Families, U.S. Department of Health and Human Services.

Bland, P. J., Edmund, D. (2014). *Substance use/abuse in the context of domestic violence, sexual assault, and trauma*. National Center on Domestic Violence, Trauma & Mental Health. http://nationalcenterdvtraumamh.org/wp-content/uploads/2015/10/NCDVTMH_PatriciaBland_DebiEdmund_SubstanceUseDVSAtraumaCurriculum.pdf

Brook, J., Yan, Y., Lloyd, M. H., & McDonald, T. P. (2014). Screening for substance use disorders as a supplement to caseworker assessment among foster care-involved families. *Journal of Public Child Welfare*, 8(3), 239–259. <https://doi.org/10.1080/15548732.2014.903221>

Brownell, P., & Roberts, A. R. (2002). A Century of Social Work in Criminal Justice and Correctional Settings. *Journal of Offender Rehabilitation*, 35(2), 1. https://doi.org/10.1300/J076v35n02_01

California Institute for Mental Health. (2001). *The CalWORKS Project screening guide for substance abuse, mental health and domestic violence: Issues in welfare-to-work programs*. California Institute for Mental Health. https://www.cibhs.org/sites/main/files/file-attachments/screeningguide_0.pdf

Chuang, E., Wells, R., Bellettiere, J., & Cross, T. P. (2013). Identifying the substance abuse treatment needs of caregivers involved with child welfare. *Journal of Substance Abuse Treatment, 45*(1), 118–125. <https://doi.org/10.1016/j.jsat.2013.01.007>

Clark, C., Young, M. S., Jackson, E., Graeber, C., Mazelis, R., Kammerer, N., & Huntington, N. (2008). Consumer perceptions of integrated trauma-informed services among women with co-occurring disorders. *The Journal of Behavioral Health Services & Research, 35*(1), 71-90. doi:10.1007/s11414-007-9076-0

Clary, E., Ribar, C., & Weigensberg, E. (2020). Challenges in providing substance use disorder treatment to child welfare clients in rural communities. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. <https://aspe.hhs.gov/sites/default/files/private/pdf/263216/ChallengesIssueBrief.pdf>

Dauber, S., Ferayorni, F., Henderson, C., Hogue, A., Nugent, J., & Alcantara, J. (2017). Substance use and depression in home visiting clients: Home visitor perspectives on addressing clients' needs. *Journal of Community Psychology, 45*(3), 396-412. doi:10.1002/jcop.21855

Dauber, S., Hogue, A., Henderson, C. E., Nugent, J., & Hernandez, G. (2019). Addressing maternal depression, substance use, and intimate partner violence in home visiting: a Quasi-experimental pilot test of a screen-and-refer approach. *Prevention Science : The Official Journal of the Society for Prevention Research, 20*(8), 1233–1243. <https://doi.org/10.1007/s11121-019-01045-x>

Dauber, S., John, T., Hogue, A., Nugent, J., & Hernandez, G. (2017). Development and implementation of a screen-and-refer approach to addressing maternal depression, substance use, and intimate partner violence in home visiting clients. *Children and Youth Services Review, 81*, 157–167. <https://doi.org/10.1016/j.childyouth.2017.07.021>

DeSantis, J., Graham, E. (2009). *Early head start: Child welfare services initiative (Volume I)*. James Bell Associates. <https://www.jbassoc.com/wp-content/uploads/2018/03/Final-Synthesis-Volume-I-Early-Head-Start-Child-Welfare.pdf>

Derr, M., Douglas, S., & Pavetti, L. (2001). *Providing mental health services to TANF recipients: Program design choices and implementation challenges in four states (8736-403)*. Mathematica Policy Research, Inc. <https://www.mathematica.org/our-publications-and-findings/publications/providing-mental-health-services-to-tanf-recipients-program-design-choices-and-implementation-challenges-in-four-states>

Domestic Violence/Substance Abuse Interdisciplinary Task Force. (2000). *Safety and sobriety: Best practices in domestic violence and substance abuse*. Illinois Department of Human Services. <https://vawnet.org/sites/default/files/assets/files/2016-09/IllinoisManual.pdf>

Donohue, B., Holland, J., Lopez, K., Urgelles, J., & Allen, D. (2014). Examination of illicit drug use frequency using multiple drug assessment methods in mothers referred to treatment by Child Protective Services. *Journal of Family Violence, 29*(8), 911–919. <https://doi.org/10.1007/s10896-014-9646-x>

Donohue, B., Romero, V., & Hill, H. H. (2006). Treatment of co-occurring child maltreatment and substance abuse. *Aggression and Violent Behavior, 11*(6), 626-640. doi:10.1016/j.avb.2005.08.007

Downs, W. R. . P. D. (2001). *Alcohol problems & violence against women, Report of summary findings. Alcohol Problems & Violence Against Women, Report of Summary Findings*. U.S. Department of Justice. <https://www.ojp.gov/pdffiles1/nij/grants/188267.pdf>

Drabble, L. (2010). Advancing collaborative practice between substance abuse treatment and child welfare fields: What helps and hinders the process? *Administration in Social Work, 35*(1), 88-106.
doi:10.1080/03643107.2011.533625

Duggan, A., Fuddy, L., Burrell, L., Higman, S. M., McFarlane, E., Windham, A., & Sia, C. (2004). Randomized trial of a statewide home visiting program to prevent child abuse: Impact in reducing parental risk factors. *Child Abuse & Neglect, 28*(6), 623–643. <https://doi.org/10.1016/j.chiabu.2003.08.008>

Edelhoch, M., Liu, Q., Richardson, P., LaFever, S., & Schoenfeld, G. (2004). *Families on TANF in South Carolina: Employment assets and liabilities*. SC Department of Social Services.
<https://aspe.hhs.gov/system/files/pdf/73466/emp-assets-liab-223E.pdf>

Gardner, S. (2014). *State-level policy advocacy for children affected by parental substance use*. State Policy Advocacy and Reform Center. <http://childwelfareparc.org/wp-content/uploads/2014/08/State-Level-Policy-Advocacy-for-Children-Affected-by-Parental-Substance-Use.pdf>

Germain, J. (2018). *Opioid use disorder, treatment, and barriers to employment among TANF recipients (OFA Report #1-2018)*. Office of Family Assistance, Administration for Children and Families, U.S. Department of Health and Human Services.
https://peerta.acf.hhs.gov/sites/default/files/public/uploaded_files/Opioid%20Use%20Disorder%2C%20Trtmt%2C%20and%20Barriers%20Report_508.pdf

Ghertner, R., Baldwin, M., Crouse, G., Radcliff, L., & Waters, A. (2018). *The relationship between substance use indicators and child welfare caseloads*. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.
<https://aspe.hhs.gov/sites/default/files/private/pdf/258831/SubstanceUseCWCaseloads.pdf>

Goldberg, H. (2002). *Improving TANF program outcomes for families with barriers to employment*. Center on Budget and Policy Priorities. <https://www.cbpp.org/archiveSite/1-22-02tanf3.pdf>

Gregoire, K. A., & Schultz, D. J. (2001). Substance-abusing child welfare parents: Treatment and child placement outcomes. *Child Welfare: Journal of Policy, Practice, and Program, 80*(4), 433–452.

He, A. S. (2017). Interagency collaboration and receipt of substance abuse treatment services for child welfare-involved caregivers. *Journal of Substance Abuse Treatment, 79*, 20–28.
<https://doi.org/10.1016/j.jsat.2017.05.006>

Hollinshead, D. M., Corwin, T. W., Maher, E. J., Merkel-Holguin, L., Allan, H., & Fluke, J. D. (2017). Effectiveness of family group conferencing in preventing repeat referrals to child protective services and out-of-home placements. *Child Abuse & Neglect, 69*, 285–294. <https://doi.org/10.1016/j.chiabu.2017.04.022>

Hossain, M., Akers, L., Del Grosso, P., Shenk, M., Cavanaugh, M., & Azur, M. (2020). *Touchpoints for addressing substance use issues in home visiting: Expanded executive summary of phase 1 final report (OPRE Report 2020-26)*. Office of Planning, Research, and Evaluation, U.S. Department of Health and Human Services.
https://www.acf.hhs.gov/sites/default/files/documents/opre/touchpoints_expanded_executive_summary_march_2020_508.pdf

Hossain, M., Akers, L., Del Grosso, P., Shenk, M., Cavanaugh, M., & Azur, M. (2020). *Touchpoints for addressing substance use issues in home visiting: Phase 1 final report (OPRE Report 2020-27)*. Office of Planning, Research, and Evaluation, U.S. Department of Health and Human Services.
https://www.acf.hhs.gov/sites/default/files/documents/opre/touchpoints_final_report_march_2020_508.pdf

- Hostage, J. C., Brock, J., Craig, W., & Sepulveda, D. (2020). Integrating screening, brief intervention and referral to treatment (SBIRT) for substance use into prenatal care. *Maternal & Child Health Journal*, 24(4), 412–418. <https://doi.org/10.1007/s10995-020-02892-9>
- Hyucksun Shin, S., & Choi, S. (2007). State response to substance-abusing TANF recipients: The challenge for welfare policy. *Journal of Policy Practice*, 6(1), 65–83. https://doi.org/10.1300/J508v06n01_05
- Jones Harden, B., Denmark, N., & Saul, D. (2010). Understanding the needs of staff in Head Start programs: The characteristics, perceptions, and experiences of home visitors. *Children and Youth Services Review*, 32(3), 371–379. <https://doi.org/10.1016/j.chilyouth.2009.10.008>
- Kenefick, E., Lower-Basch, E. (2012). *Helping TANF recipients overcome addiction: Alternatives to suspicion less drug testing (TANF Policy Brief)*. The Center for Law and Social Policy (CLASP). <https://www.clasp.org/sites/default/files/publications/2017/04/520.pdf>
- Kerwin, M. E. (2005). Collaboration between child welfare and substance-abuse fields: Combined treatment programs for mothers. *Journal of Pediatric Psychology*, 30(7), 581–597. <https://doi.org/10.1093/jpepsy/jsi045>
- LaBelle, R., Weizman, S. (2019). *Applying the evidence: Legal and policy approached to address opioid use disorder in the criminal justice and child welfare settings*. O’Neill Institute. https://www.opioidlibrary.org/wp-content/uploads/2020/05/Applying-the-Evidence-Report-1_OUD_CJS.pdf
- Lee, E., Esaki, N., & Greene, R. (2009). Collocation: Integrating child welfare and substance abuse services. *Journal of Social Work Practice in the Addictions*, 9(1), 55–70. <https://doi.org/10.1080/1533256080253361>
- Legal Action Center. (2014). *Drug felony ban and TANF/SNAP eligibility*. Legal Action Center. https://www.lac.org/assets/files/TANF_SNAP_Drug_Felony_Ban_LAC_one-pager_2.pdf
- Loughran, H., Hohman, M., & Finnegan, D. (2010). Predictors of role legitimacy and role adequacy of social workers working with substance-using clients. *British Journal of Social Work*, 40(1), 239–256. <https://doi.org/10.1093/bjsw/bcn106>
- Markoff, L. S., Finkelstein, N., Kammerer, N., Kreiner, P., & Prost, C. A. (2005). Relational systems change: Implementing a model of change in integrating services for women with substance abuse and mental health disorders and histories of trauma. *The Journal of Behavioral Health Services & Research*, 32(2), 227–240. <https://doi.org/10.1007/BF02287269>
- McCarty, M., Falk, G., Aussenberg, R.A., & Carpenter, D. (2016). *Drug testing and crime-related restrictions in TANF, SNAP, and Housing Assistance (R42394)*. Congressional Research Service.
- McCollum, E. E., Stith, S. M., Miller, M. S., & Ratcliffe, G. C. (2011). Including a brief substance-abuse motivational intervention in a couples treatment program for intimate partner violence. *Journal of Family Psychotherapy*, 22(3), 216–231. <https://doi.org/10.1080/08975353.2011.602618>
- Merrill, J. (2004). Providing care coordination and treatment services for substance-abusing women in the Work First/New Jersey (TANF) program. *Journal of Health & Social Policy*, 18(3), 1–18. https://doi.org/10.1300/J045v18n03_01

- Morgenstern, J., Blanchard, K. A., McCrady, B. S., McVeigh, K. H., Morgan, T. J., Pandina, R. J. (2006). Effectiveness of intensive case management for substance-dependent women receiving Temporary Assistance for Needy Families. *American Journal of Public Health*. 96(11):2016-2023. doi:10.2105/AJPH.2005.076380
- Morgenstern, J., Hogue, A., Dasaro, C., Kuerbis, A., & Dauber, S. (2008). Characteristics of individuals screening positive for substance use in a welfare setting: Implications for welfare and substance-use disorders treatment systems. *Journal of studies on alcohol and drugs*, 69(4), 561–570. <https://doi.org/10.15288/jsad.2008.69.561>
- Morgenstern, J., Neighbors, C. J., Kuerbis, A., Riordan, A., Blanchard, K. A., McVeigh, K. H., Morgan, T. J., & McCrady, B. (2009). Improving 24-month abstinence and employment outcomes for substance-dependent women receiving Temporary Assistance for Needy Families with intensive case management. *American Journal of Public Health*, 99(2), 328–333. <https://doi.org/10.2105/AJPH.2007.133553>
- Morgenstern, J., Riordan, A., Dephilippis, D., Irwin, T., Blanchard, K., McCrady, B., & McVeigh, K. (2001). *Specialized screening approaches can substantially increase the identification of substance abuse problems among welfare recipients*. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. <https://aspe.hhs.gov/report/specialized-screening-approaches-can-substantially-increase-identification-substance-abuse-problems-among-welfare-recipients>
- Morgenstern, J., Riordan, A., McCrady, B., Blanchard, K., McVeigh, K., Irwin, T. (2001) *Barriers to employability among women on TANF with a substance abuse problem*. The Administration of Children and Families. https://www.acf.hhs.gov/sites/default/files/documents/opre/barriers_employ.pdf
- National Center on Domestic Violence, Trauma, & Mental Health. (2012). *Locating mental health and substance abuse for survivors: A reference sheet for domestic violence advocates*. National Center on Domestic Violence, Trauma, & Mental Health. <http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/Locating-Mental-Health-and-Substance-Abuse-Supports-for-Survivors.pdf>
- National Center on Early Childhood Health and Wellness. (n.d.). *Finding a mental health provider for children and families in your early head start/head start program*. National Center on Early Childhood Health and Wellness, U.S. Department of Health and Human Services. <https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/making-the-most-handout-5-finding-mh-provider.pdf>
- National Center on Health, Behavioral Health, and Safety. (2019). *Screening for substance use disorders: Head start can help*. National Center on Health, Behavioral Health, and Safety, U.S. Department of Health and Human Services. <https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/screening-substance-use-disorders.pdf>
- National Center on Substance Abuse and Child Welfare. (n.d.). *Summary of substance use services available to Department of Children and Family Services (DCFS) involved families*. National Center on Substance Abuse and Child Welfare, U.S. Department of Health and Human Services. https://ncsacw.samhsa.gov/files/Inventory_of_SA_Programs_for_DCFS_Families_508.pdf
- National Center on Substance Abuse and Child Welfare. (n.d.). *Understanding screening and assessment of substance use disorders - Child welfare practice tips*. National Center on Substance Abuse and Child Welfare, U.S. Department of Health and Human Services. <https://ncsacw.samhsa.gov/files/tips-screening-assessment-508.pdf>
- National Head Start Association. (2018). *A head start on treating our nation's opioid epidemic: Cutting off the cycle of substance misuse, addiction, and accompanying behavioral outcomes using proven programs*. National Head Start Association. <https://www.nhsa.org/wp-content/uploads/2020/07/A-Head-Start-on-Treating-Our-Nations-Opioid-Epidemic.pdf>

Nikolova, K., Postmus, J., Buttner, C., & Bosk, E. (2020). Working together to protect women and children from domestic violence: Factors influencing willingness to collaborate between organizations. *Children and Youth Services Review, 118*, 105503. doi:10.1016/j.childyouth.2020.105503

Oh, S., DiNitto, D. M., & Kim, Y. (2018). Substance use and use disorders and treatment receipt among adults in families receiving Temporary Assistance for Needy Families (TANF), 2003–2014. *Addictive Behaviors, 85*, 173–179. <https://doi.org/10.1016/j.addbeh.2018.06.014>

O'Brien, J. E., Ermentrout, D., Li, W., Dababnah, S., Rizo, C. F., & Macy, R. J. (2018). Measuring substance use among system-involved IPV survivors: A research note. *Violence against Women, 24*(1), 101–119. <https://doi.org/10.1177/1077801216675744>

Orange County Health & Domestic Violence Task Force. (2017). *Understanding and addressing the mental health and substance abuse needs of domestic violence survivors in Orange County*. Orange County Women's Health Project. http://www.ochealthiertogether.org/content/sites/ochca/Local_Reports/OCWHP_2017_Policy_Briefs_DV_MH_and_SA.pdf

O'Rinn, S. E., & Mason, R. (2014). Co-occurring intimate partner violence, mental health, and substance use problems: a scoping review. *Global Health Action, 7*, 1–17. <https://doi.org/10.3402/gha.v7.24815>

Parra, G. (2002). *Welfare reform and substance abuse: Innovative state strategies (No. 177)*. National Health Policy Forum. https://www.ncbi.nlm.nih.gov/books/NBK559764/pdf/Bookshelf_NBK559764.pdf

Pilkinton, M. (2010). TANF recipients' barriers to employability: Substance abuse and domestic violence. *Journal of Human Behavior in the Social Environment, 20*(8):1011-1023. doi:10.1080/10911359.2010.494940

Pollack, H. A., & Reuter, P. (2006). Welfare receipt and substance-abuse treatment among low-income mothers: the impact of welfare reform. *American journal of public health, 96*(11), 2024–2031. <https://doi.org/10.2105/AJPH.2004.061762>

Price, S. K., Coles, D. C., & Wingold, T. (2017). Integrating behavioral health risk assessment into centralized intake for maternal and child health services. *Health & Social Work, 42*(4), 231–238. <https://doi.org/10.1093/hsw/hlx037>

Radel, L., Baldwin, M., Crouse, G., Ghertner, R., & Waters, A. (2018). *Substance use, the opioid epidemic, and the child welfare system: Key findings from a mixed methods study*. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. <https://aspe.hhs.gov/sites/default/files/private/pdf/258836/SubstanceUseChildWelfareOverview.pdf>

Roberts, S. C., & Nuru-Jeter, A. (2012). Universal screening for alcohol and drug use and racial disparities in child Protective services reporting. *The Journal of Behavioral Health Services Research, 39*(1), 3–16. <https://doi.org/10.1007/s11414-011-9247-x>

Rogers, B., McGee, G., Vann, A., Thompson, N., & Williams, O. J. (2003). Substance abuse and domestic violence: Stories of practitioners that address the co-occurrence among battered women. *Violence Against Women, 9*(5), 590–598. <https://doi.org/10.1177/1077801202250454>

Schmidt, L., Zabkiewicz, D., Jacobs, L., & Wiley, J. (2007). Substance abuse and employment among welfare mothers: From welfare to work and back again? *Substance Use & Misuse*, 42(7), 1069–1087.

<https://doi.org/10.1080/10826080701409644>

Schoppelrey, S. L., Martinez, M., & Soo Mi Jang. (2005). Addressing substance abuse among TANF recipients: Current issues and approaches. *Journal of Human Behavior in the Social Environment*, 12(2/3), 111–126.

https://doi.org/10.1300/J137v12n02_06

Semidei, J., Radel, L. F., & Nolan, C. (2001). Substance abuse and child welfare: Clear linkages and promising responses. *Child Welfare: Journal of Policy, Practice, and Program*, 80(2), 109–128.

Stover, C. S. (2015). Fathers for change for substance use and intimate partner violence: Initial community pilot. *Family Process*, 54(4), 600–609. <https://doi.org/10.1111/famp.12136>

Stroul, B. A. (2019). *Relinquishing custody for mental health services: Progress and challenges*. The Institute for Innovation and Implementation, University School of Social Work.

<https://theinstitute.umaryland.edu/media/ssw/institute/Relinquishing-Custody-Issue-Brief-FINAL-August-2020.pdf>

Stuart, G. L., Moore, T. M., Kahler, C. W., Ramsey, S. E., & Strong, D. (2004). Cigarette smoking and substance use among men court-referred to domestic violence treatment programs. *The American Journal on Addictions*, 13(3), 319–320. <https://doi.org/10.1080/10550490490460283>

Substance Abuse and Mental Health Association. (2000). *Welfare reform: Employment strategies for overcoming substance abuse/mental health barriers*. Substance Abuse and Mental Health Association, U.S. Department of Health and Human Service.

https://peerta.acf.hhs.gov/sites/default/files/public/uploaded_files/Final%20Report_Substance%20Abuse.pdf

Tandon, S. D., Mercer, C. D., Saylor, E. L., & Duggan, A. K. (2008). Paraprofessional home visitors' perspectives on addressing poor mental health, substance abuse, and domestic violence: A qualitative study. *Early Childhood Research Quarterly*, 23(3), 419–428. doi:10.1016/j.ecresq.2008.02.002

Tandon, D., Perry, D. F., Edwards, K., & Mendelson, T. (2020). Developing a model to address mental health, substance use, and intimate partner violence among home visiting clients. *Health Promotion Practice*, 21(2), 156–159. <https://doi.org/10.1177/1524839919886293>

Tarshis, S. (2020). Intimate Partner Violence and Employment-Seeking: A Multilevel Examination of Barriers and Facilitators. *Journal of Interpersonal Violence*, 886260520962075.

<https://doi.org/10.1177/0886260520962075>

Timko, C., Valenstein, H., Lin, P. Y., Moos, R. H., Stuart, G. L., & Cronkite, R. C. (2012). Addressing substance abuse and violence in substance use disorder treatment and batterer intervention programs. *Substance Abuse Treatment, Prevention, and Policy*, 7. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3489609/pdf/1747-597X-7-37.pdf>

Timko, C., Valenstein, H., Stuart, G. L., & Moos, R. H. (2015). Substance abuse and batterer programmes in California, USA: factors associated with treatment outcomes. *Health & Social Care in the Community*, 23(6), 642–653. <https://doi.org/10.1111/hsc.12178>

Thompson, T., Mikelson, K. (2001) *Screening and assessment in TANF/Welfare-to-Work: Ten important questions TANF agencies and their partners should consider*. The Urban Institute.

https://www.urban.org/research/publication/screening-and-assessment-tanf-welfare-work-ten-important-questions-tanf-agencies-and-their-partners-should-consider/view/full_report

Thompson, T., Van Ness, A., O'Brien, C. (2001). *Screening and assessment in TANF/Welfare-to-Work: Local answers to difficult questions*. The Urban Institute. https://www.urban.org/research/publication/screening-and-assessment-tanf-welfare-work-local-answers-difficult-questions/view/full_report

Traube, D. E. (2012). The missing link to child safety, permanency, and well-being: Addressing substance misuse in child welfare. *Social Work Research*, 36(2), 83–87. <https://doi.org/10.1093/swr/svs043>

Traube, D. E., He, A. S., Limei Zhu, Scalise, C., & Richardson, T. (2015). Predictors of substance abuse assessment and treatment completion for parents involved with child welfare: One state's experience in matching across systems. *Child Welfare*, 94(5), 45–66.

US Government Accountability Office. (2001). *Welfare reform: moving hard-to-employ recipients into the workforce (GAO-01-368)*. GAO. <https://www.gao.gov/assets/240/231155.pdf>

US Government Accountability Office. (2004). *Welfare reform: Rural TANF programs have developed many strategies to address rural challenges (GAO-04-921)*. GAO. <https://www.gao.gov/assets/250/244037.pdf>

Welsh, J., Precey, G., & Lambert, P. (2008). Parents of children at risk—a multi-agency initiative to address substance misuse amongst parents whose children are at risk of neglect. *Child Abuse Review*, 17(6), 454–462. doi:10.1002/car.1050

Whiteside-Mansell, L., Johnson, D., Bokony, P., McKelvey, L., Conners-Burrow, N., Swindle, T. (2013). Supporting family engagement with parents of infants and toddlers. *The Research-to-Practice Journal for the Early Childhood Field*, 16(1), 20–44. <https://journals.charlotte.edu/dialog/article/view/42>

Young, N. K., Boles, S. M., Otero, C. (2007). Parental substance use disorders and child maltreatment: Overlap, gaps, and opportunities. *Child Maltreatment*, 12(2), 137–149. doi:10.1177/1077559507300322

Young, N. K., Gardner, S. L., Whitaker, B., Yeh, S. & Otero, C. (2005). *A review of alcohol and other drug issues in the state's child and family services reviews and program improvement plans*. National Center on Substance Abuse and Child Welfare, U.S. Department of Health and Human Services. <https://ncsacw.samhsa.gov/files/SummaryofCFRSs.pdf>

Young, N. K., Nakashian, M., Yeh, S. & Amatetti, S. (2006). *Screening and Assessment for Family Engagement, Retention, and Recovery (SAFERR)*. National Center on Substance Abuse and Child Welfare, U.S. Department of Health and Human Services. https://ncsacw.samhsa.gov/files/SAFERR_Introduction.pdf

Zapata-Alma, G. (2020). *Committed to safety for all survivors: Guidance for domestic violence programs on supporting survivors who use substances*. National Center on Domestic Violence, Trauma, and Mental Health. <http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2020/10/Committed-To-Safety-Final.pdf>

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