

Office of the Assistant Secretary for Planning and Evaluation,
U.S. Department of Health and Human Services

Identifying and Supporting Human Services Participants with Substance Use Disorder: Roundtable Summary

Authors: Annette Waters and Robin Ghertner, Office of the Assistant Secretary for Planning and Evaluation
Pamela Baston and Kathleen Meyers, JBS International



HIGHLIGHTS

This brief summarizes discussions among experts participating in a roundtable focused on policies and practices to support human services programs in identifying substance use disorder (SUD) among participants, referring them to treatment and connecting them to recovery supports. The roundtable concentrated on four programs: Temporary Assistance for Needy Families, child welfare, domestic violence, and Head Start. Participating experts suggested the following key considerations:

- Clarify activities and expenses that are allowable by federal programs, to help state and local grantees best leverage funds to meet local needs.
- Reexamine reimbursement policies for human services programs related to substance use services.
- Consider universal screening for SUD followed by warm hand-off referrals when indicated for all program participants.
- Increase support for human services workforce in implementing assessment and referral services to address SUD among participants
- Reconsider punitive responses to substance use disclosure and support alternative approaches.
- Embed SUD specialists into human services programs to support navigation of SUD treatment and support systems.
- Increase formal and systematic collaboration and training across SUD treatment and human services systems, and among human services systems that serve participants with SUD.
- Elevate multiple pathways to recovery for people with SUD, including through harm reduction.

Experts pointed to the need to address equity implications of SUD identification policies and practices. They also identified possible unintended consequences of changes to identification practices. While collaborative case management can benefit participants with SUD, programs must consider the unique confidentiality concerns participants may have. Programs also need to effectively balance prevention, harm reduction, treatment and recovery services.

Introduction

Despite new public and private initiatives to combat the substance use overdose crisis, drug overdose deaths reached a record high in the first half of 2021, with more than 98,000 lives between June 2020 and June 2021.¹ Although much attention has been paid to fatal opioid overdoses—which have continued to climb—stimulant-related overdoses have also increased nationwide, indicating a stage of the overdose crisis characterized by polysubstance use.^{2,3} The consequences associated with substance use disorders (SUDs) increase the odds that a person and their family will interact with various human services programs. These same challenges also impede participants' ability to meet human services program requirements and goals, such as maintaining healthy relationships, acquiring and retaining employment, achieving self-sufficiency, promoting child school readiness and success, and sustaining child and family well-being.

Human services programs can play an important role in the four key areas highlighted by the HHS Overdose Prevention Strategy, including primary prevention, harm reduction, evidence-based treatment, and recovery support.⁴ In addition, human services can help address the consequences substance use has on child and family outcomes. For example, child welfare and domestic violence services might screen for substance use as part of investigations, and have the opportunity to refer people to treatment. Early care and education programs such as Head Start might identify potential parental SUD when working with children and screening for general family needs. Such programs often work to build strong and trusting relationships with parents that encourage proactively identifying needs and connecting parents with treatment options. Economic support programs that include employment services, such as Temporary Assistance for Needy Families (TANF), might identify SUD as a barrier to employment and economic stability, and subsequently have the opportunity to connect participants with treatment resources.

Despite being positioned to support participants with SUD, many programs are not well-equipped to do so. For example, previous Office of the Assistant Secretary for Planning and Evaluation (ASPE) research has found that child welfare agencies might misunderstand and be reluctant to support specific types of SUD treatment (in particular, medication for opioid use disorder), and that objectives and timelines for child welfare systems are not well aligned with those of SUD treatment providers.⁵ ASPE research has also found child support programs do not systematically identify parents with SUD, and do not have systems to address SUD when identified.⁶ Increased capacity among human services programs to quickly identify SUDs, refer clients to appropriate substance use services, and collaborate with other systems can not only help clients and programs meet their goals and focus on whole-person health and well-being but also reduce the consequences associated with substance use nationally.

¹ U.S. Department of Health and Human Services, Centers for Diseases Control and Prevention. "Provisional Drug Overdose Death Counts." 2021. Available at <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>.

² U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. "State and Community Efforts to Address Stimulant Use." Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, May 2021. Available at <https://aspe.hhs.gov/sites/default/files/private/aspe-files/265576/stimuse.pdf>.

³ Ciccarone, D. "The Rise of Illicit Fentanyl, Stimulants and the Fourth Wave of the Opioid Overdose Crisis." *Current Opinion in Psychiatry*, vol. 34, no. 4, 2021, pp. 344–350. doi:10.1097/YCO.0000000000000717.

⁴ See the [HHS Overdose Prevention Strategy](#) for more details.

⁵ Radel, Laura, Melinda Baldwin, Gilbert Crouse, Robin Ghertner, and Annette Waters. "Medication-Assisted Treatment for Opioid Use Disorder in the Child Welfare Context: Challenges and Opportunities." Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, 2018. Available at https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/185086/MATChildWelfare.pdf.

⁶ Antelo, Lauren, and Annette Waters. "Illicit Substance Use and Child Support: An Exploratory Study." Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, June 2019. Available at https://www.aspe.hhs.gov/sites/default/files/migrated_legacy_files/190071/ChildSupportSubstanceUseNoncustodialFathers.pdf?_ga=2.64519016.655201248.1635446273-584080800.1620669690.

To address these issues, ASPE partnered with JBS International to hold an expert roundtable with the following goals:

- Identify promising strategies to conduct SUD identification and treatment referrals within the unique circumstances of four human services programs: TANF, child welfare, domestic violence, and Head Start.
- Identify the policy levers the U.S. Department of Health and Human Services (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.

HHS aims to identify promising practices and policy options that effectively identify SUDs in clients and highlight processes that support referral and engagement in SUD treatment, behavioral health services, and human services. This work compliments parallel practices that are based in health and behavioral health systems and will aid human services programs in meeting their objectives for child and family stability, maintaining stable housing, and gaining and maintaining employment.

Experts discussed strategies and solutions during a two-day virtual panel, hosted September 21 to 22, 2021. The convening included a diverse group of direct services providers, program directors, researchers, agency leaders, and national policy experts from around the nation.

This document summarizes promising human service strategies and the discussion among these experts during the roundtable. We also detail participants' suggestions for policy and practice, informing researchers, policymakers, funders, practitioners, and other stakeholders about directions for improvement. The views and strategies arising from the panel do not necessarily represent positions or perspectives of HHS or ASPE and should not be taken as such. In a companion brief to this summary, we summarize an environmental scan and series of expert interviews that provide background to the roundtable.

Roundtable Approach

Expert panelist recruitment.

Expert panelists for the roundtable were recruited based on recommendations from the people interviewed as part of an environmental scan that framed the issues addressed in the roundtable. This snowball and purposive sampling process resulted in a list of more than 40 recommended participants. We selected 20 expert panelists based on their extensive knowledge in SUD identification, understanding of human services programs, and success at referring clients to treatment and human services. Expert panelists were national, state, or local experts in their respective program areas and had extensive experience serving human services clients with SUDs. In addition, grantees of the Comprehensive Opioid, Stimulant, and Substance Abuse Program, funded by the Department of Justice's Office of Victims of Crime (OVC), were also represented as expert panelists. JBS International was the training and technical assistance provider to OVC's grant cluster Enhancing Community Responses to the Opioid Crisis: Serving Our Youngest Crime Victims, and supported access to OVC grantees and subject matter experts who participated in the convening. Finally, experts from the substance use treatment system also participated in the convening.

Meeting format.

During the two-day virtual convening, expert panelists gathered from a range of programs or agencies that provide services related to child welfare, domestic violence, Head Start, and TANF programs. The panelists collaborated to identify practice and policy strategies to mitigate the impact of SUDs on service systems and on the clients they support.

Experts participated in a series of discussions using a World Café design. In this design, participants are grouped by subject matter expertise, and circulated through virtual meeting rooms covering different topics, each with an assigned facilitator and notetaker. The four main topics of the World Café discussions were (1) best practices in SUD identification and referral in the context of human services programs, (2) service identification and integration, (3) financial resources, and (4) policy and practice adaptations. The World Café encompassed a general introduction to a topic (for example, best practices in SUD identification and referral), followed by a structured round of conversations focused on various aspects of the topic area. Facilitators rotated through each round to exchange diverse perspectives on the given topics and to identify potential solutions to ongoing challenges. Expert panelists carried key ideas, themes, solutions, and questions with them as they were exposed to information from previous rounds.

Throughout the convening, experts from the substance use treatment system were invited to reflect on the outcomes of the discussions from the perspective of their field. This component ensured that expert findings and suggested strategies remained grounded in the constraints, opportunities, and observations from the substance use treatment field.

The detailed meeting agenda can be found in Appendix B, and the list of participants can be found in Appendix C.

Considerations Suggested by Participating Experts

This section describes the eight major considerations raised by experts in the roundtable. Experts from the four program areas generally agreed on many points, though there were important differences across the program areas. Not all areas placed the same priority on considerations. See Appendix A for a table indicating which considerations were particularly emphasized for each program area.

Identify how jurisdictions can combine federal funding streams to support SUD identification, treatment, and referral activities to meet local needs.

Federal funding streams and requirements for health and human services programs are complex, and it takes time and training for staff at the state, tribal, and local levels to fully understand them. Expert panelists noted that developing and implementing successful innovations require program staff to acquire a detailed understanding of what is and is not permissible within a given program area or funding stream. In the absence of a solid understanding of funding uses, staff might be more inclined to stick to the status quo. As a result, panelists believed that some programs implemented at the state and local levels and in tribes do not fully take advantage of the flexibility the federal government allows. This is particularly the case for longstanding programs such as TANF, where panelists expressed that states do not always take full advantage of how funds can be used to support SUD-related activities.

Box 1. Kentucky's Targeted Assessment Program (TAP)

TAP began as a partnership between the Kentucky Cabinet for Health and Family Services, Department for Community Based Services (DCBS), and the University of Kentucky Center on Drug and Alcohol Research. In fiscal year 2019, TAP was expanded in selected, high-risk counties impacted by the opioid epidemic to include the TAP Opioid Use Disorder Project, through a State Opioid Response Grant, with funding from the Substance Abuse and Mental Health Services Administration. The TAP model identifies substance use and other barriers and helps TANF recipients and TANF-eligible parents engage in treatment. The TAP Opioid Use Disorder Project co-locates 15 Targeted Assessment Specialists at DCBS offices in 12 counties. TAP uses trauma-informed, strength-based, stigma-reducing interventions, including case management and supportive services; holistic, ongoing assessment of barriers and strengths; individualized service planning; and pretreatment support to resolve internal barriers to service engagement.

Expert panelists also expressed the need for more proactive federal guidance on allowable activities, as state and local staff may be reluctant to pursue activities that are not explicitly reimbursable. For example, panelists agreed that activities (such as SUD specialists described in Consideration 5) to coordinate and align human services programs and SUD treatment could be allowable for federal reimbursement. However, these activities are often funded by shorter-term and categorical grants, making them less sustainable. TANF experts pointed out how [Kentucky's Targeted Assessment Program](#) combines funding from TANF and other sources to support treatment for TANF recipients and TANF-eligible parents (see Box 1). Human services programs can also benefit from learning more about how their programs can be coordinated with substance use services from other funding streams. Panelists from the SUD treatment sector pointed out that states could align their use of Substance Abuse Prevention and Treatment Block Grants with human services programs to better integrate services.

Orient programs and services towards the whole person and family, rather than on service requirements.

Expert panelists discussed ways federally-funded services often focus on meeting the narrow requirements of service provision, rather than being centered on the holistic health and well-being of participants and their families. In particular, service reimbursement policies do not always align with policy priorities related to substance use-related services. Billing codes may be outdated and not allow funding the latest evidence-based practice or may not be sufficiently flexible to address families' needs. Experts in child welfare and TANF emphasized that state programs need to coordinate services and billing with their Medicaid offices to ensure sustainability of program services to support treatment and recovery. Some panelists pointed out that some state Medicaid services do not take advantage of all flexibilities available from the federal government, and as a result may not be well-adapted to parents' needs. For example, transportation to treatment services might not have car seats, childcare might not be available during treatment, and the hours when services are available might not align with when parents have child care available. In child welfare services, the title IV-E Prevention Program reimburses public child welfare agencies for certain evidence-based SUD prevention and treatment services for families with children at risk of entering foster care. However, the reimbursement policies for state agencies based on statutory requirements for demonstrating effectiveness might not be flexible enough to fund adaptations of evidence-based services to accommodate different cultural values of certain communities.⁷

Experts also described how existing federal and state reimbursement policies may inhibit innovation and cross-systems collaboration, and grantees need to be creative in how funding streams are coordinated together to serve their participants holistic needs. Even when a certain activity might be allowable within a given funding stream, implementation might be delayed or might never happen because "there is not a billing code for that." One child welfare program spotlighted during the roundtable – the Northwest Florida (NWF) Health Network – found it could increase SUD-related services by adapting payment mechanisms. In order to increase access to services, NWF Health Network contracted for dedicated therapists to work with parents involved with the child welfare system with SUD. The contract was with a local SUD program and funded by a Hurricane Michael Disaster Grant through the Substance Abuse and Mental Health Service Administration. By using this funding source, the organization was able to specify the type of services that they needed and the methods for service delivery. This change enabled therapists to spend more time reaching out to parents and attending critical meetings with child welfare staff and courts. In panelists' experience, implementing novel programs that might require combining budget streams is easier for state and local agencies that have programmatic staff working closely with budget and finance staff.

⁷ For more details, see Program Instructions [ACYF-CB-PI-18-09](#), and [ACYF-CB-PI-18-10](#), and Information Memorandum [ACYF-CB-IM-21-04](#). Tribes have additional flexibilities that expand the types of evidence that may be considered to establish the evidence base for programs funded by tribal child welfare agencies. Tribes are also exempt from requirements that apply to states regarding the proportion of program funds that must be spent on interventions meeting the highest evidence standards.

When federal and state human services programs have inflexible billing and payment infrastructures it can be difficult to scale up promising practices, especially those that start at a local level. Many of the innovative programs discussed during the convening began among private providers and nonprofits funded through state or local contracts and grants. Panelists noticed that in some states that have privatized local components of health and human services, the flexibility given to providers provides greater opportunities for innovation. The downside to this can be that service provision can be disparate and uneven across localities. Consequently, panelists felt that if the federal government and states can support more flexible billing and payment infrastructure, states might be empowered to publicly run services to attain a comparable level of innovation, while also bringing services to the state and national level.

Consider universal screening for SUD followed by warm hand-off referrals when indicated for all program participants.

If implemented appropriately, when people seek human services universal screening could identify problematic substance use, lead to effective testing when necessary to determine the severity of substance use, and facilitate the subsequent delivery of needed services. Additionally, panelists in child welfare, Head Start, and TANF encouraged universal screening to mitigate bias and potential inequitable outcomes because it has the potential to treat participants of all backgrounds the same for both screening purposes and connecting them with follow-up services. In particular, effective universal screening can help parents involved in child welfare systems who may have problematic substance use, in that it can connect them to services and support to reduce child maltreatment risk. Experts from child welfare expressed that their staff often struggle with a sense of “racing against the clock,” where parents with SUD may need to engage in treatment services quickly in order to avoid the risk of termination of parental rights based on the timelines under the [Adoption and Safe Families Act](#).

Panel experts emphasized there are challenges to implementing universal screening that agencies will need to address. Agencies need to reduce redundancy in screening across human services and intrusiveness, build trusting relationships with participants, and eliminate punitive responses that may arise from the screening process, such as denying participants access to human services or beginning a child welfare investigation that could lead to a child’s separation from their caregivers. Panelists expected that universal screening would lead to increased identification of people with SUD-related needs, and as a result they stated that universal screening can only be successful when sufficient treatment services exist that are culturally appropriate and embody equity principles. Human services programs screening for SUD must have collaborative relationships with treatment providers to ensure a warm hand-off between program staff. Ideally the relationships between human services and treatment programs would be formalized so that services are not contingent on personal relationships between caseworkers. For example, programs can co-develop participant needs assessments and work together to identify, provide, and refer to supportive services.

In addition, panelists emphasized that universal screening can only be successful when agency responses to positive screens are not punitive. Without addressing these challenges, universal screening will not effectively identify the real treatment needs of participants and reduce inequities.

Increase support for the human services workforce in implementing assessment and referral services to address SUD among participants.

Expert panelists recognized that many human service workers have significant and challenging workloads and that asking them to incorporate SUD-related activities into their casework, including developing new expertise, might be unreasonable. Panelists identified three categories where increased support is needed:

- *Compensation.* In many cases, staff are being asked to do tasks that people with a master’s degree in social work typically do, without the skills acquired through that degree and without commensurate compensation. Experts felt that this contributes to

high rates of workforce burnout and turnover, which impedes developing, implementing, and establishing new program ideas. Increased access to training and skills development, as well as increased financial support for the human services workforce (potentially through higher reimbursement rates for services), could increase staff retention rates. One panelist commented, “We are a poverty-fighting program that pays poverty wages.”

- *Improved staff supervision.* Panelists from child welfare, domestic violence, and Head Start discussed the importance of improved supervision practices for staff to improve program outcomes and reduce staff burnout. Head Start panelists noted the important role supervision plays in supporting program staff, who are frequently members of the communities that the program serves and might share similar struggles. One approach mentioned was [reflective supervision](#), a regular, collaborative reflection between a service provider and their supervisor. Within the context of SUD identification and referral to treatment, systematized and consistent reflective supervision would offer more opportunities to discuss particular cases. Panelists recognized that large caseloads and time pressure can limit opportunities for supervisory practices that can support staff.
- *Addressing limitations of restrictive hiring.* Domestic violence expert panelists indicated that restrictive hiring practices (for example, requiring individuals hired as peer supports not to have experienced domestic violence within the previous three years) create barriers to expanding the workforce. Comparable hiring practices are also common among programs that employ peer supports who have SUD experience (for example, in recovery for at least two years). Examining the rationale for these practices (for example, time needed to develop coping skills to limit re-traumatization or to manage drug use triggers) is required to achieve a balance between expanding the peer workforce and ensuring the safety of peers within it. Experts recommend engaging peers in these discussions and offering clinical supervision of the peer workforce to provide guidance on the services they deliver and assess how peers are faring in a complex and stressful field they care about.

Reconsider punitive responses to substance use disclosure and support alternative approaches.

Panelists discussed the need for a culture shift in many human services and behavioral health programs to consciously eliminate punitive responses and stigma related to substance use disclosure. The panelists proposed a few areas for action:

- *Adopt terminology about substance use that is not stigmatizing and pejorative.* Experts across human services areas recognized that terminology regarding substance use, substance misuse, SUD, and persons with use disorder can have serious policy and practice implications. They agreed that morally charged language (for example, substance abuse rather than substance use) reinforces stigma and can contribute to the punitive responses that often occur after disclosure. Although participants generally agreed that certain terms are problematic and should be eliminated across health and human services programs and policies, they didn’t agree on specific replacement terms, other than person-first language. Experts affirmed that any efforts on recommended terminology should include input from people with SUDs.
- *Address participants’ fear of reprisal.* One of the main barriers among human services programs to effectively identifying SUDs and referring for treatment is the service recipients’ real or perceived fear of reprisal. Although the form of reprisal varies by human services system (for example, removal of children or loss of welfare benefits), fear is pervasive. The consensus among the expert panels is that policy reviews are needed to identify and eliminate punitive responses to substance use disclosure while simultaneously considering safety planning for the individual and their dependents. Policy

reviews should examine eligibility criteria to ensure that having a SUD does not result in clients being denied access to human services to support treatment and recovery.

- *Adapt or eliminate policies on substance use screening that can lead to out-of-home placement.* Child welfare and domestic violence expert panelists discussed the persistent belief that parental substance use is synonymous with child maltreatment, reinforced by the common use of punitive measures following positive tests of parental drug toxicology. These panelists called for eliminating state, local, and tribal policies or practices that allow positive drug toxicology tests, with the absence of other risk factors, as the sole

Box 2. NWF Health Network

[NWF Health Network](#) provides all the child welfare services (except child protective services investigations) in a 12-county region of the Florida Panhandle. NWF Health Network has a SUD program in partnership with [Chemical Addictions Recovery Effort](#) (CARE) to address specific problems related to increased substance use within families residing in Bay County. The SUD program is co-located within a Dependency Case Management (DCM) unit and consists of behavioral health therapists, specifically trained in child welfare, and peer specialists, who work with parents to improve engagement, help the family access basic needs, and receive ongoing support. To better support information sharing between dependency case managers and CARE, NWF Health Network added a child welfare specialist position, which is responsible for referrals to CARE. and for ensuring appropriate information sharing, including information from investigations, past child welfare history, criminal history, and other evaluations. Co-location has allowed for improved treatment components, including immediate access to SUD assessments, the provision of co-occurring treatment of SUD and mental health issues (e.g., depression and anxiety), and improved reunification and relapse prevention planning.

justification to remove children. In particular, panelists experienced that in many jurisdictions, a parent's use of medication for opioid use disorder led to a mandated report to child protective services, even though this treatment is regarded as the gold standard for people with opioid use disorder. In particular, panelists felt that mandated reporting of mothers and newborns in the absence of other risk factors can have negative consequences for the parent and the infant. There is considerable confusion in the field around implementation of provisions in the Child Abuse Prevention and Treatment Act requiring that health officials notify Child Protective Services of infants prenatally exposed to substances so that a Plan of Safe Care may be developed. Importantly, this notification does not necessarily need to be a maltreatment report and the Plan of Safe Care can be used as a mechanism for assuring referrals to behavioral health and parenting support services to prevent removal in cases in which

maltreatment risk is not high. However, in practice some states frequently place these children in foster care even when maltreatment risk is relatively low. Panelists advocated for increased involvement of public health agencies and hospitals in the development and supervision of Plans of Safe Care.

Embed SUD specialists into human services programs to support navigation of SUD treatment and support systems.

Although panelists asserted that all human services program staff should receive training regarding substance use and available support services, panelists recognized that it is unrealistic to expect human service staff to be experts in SUD identification and referrals to treatment. Co-locating SUD specialists within human services programs would set the stage for the SUD specialist to identify SUDs, lead referral activities, and guide the coordination between SUD service providers and their designated human services program. Panelists believed that better program outcomes can be achieved with participant navigators—staff who go above and beyond warm handoffs and have trusting relationships with program participants. Peer recovery

specialists often play this navigation role; SUD specialists who are co-located within human services programs could also fulfill this role. The SUD specialists could fill several important roles, including tracking SUD services available locally and developing a repository of contacts in case of position turnover. Specialists could also model strengths-based, stigma-reducing interactions and interventions for other staff. In tandem with formal and ongoing training, SUD specialists can help prepare and support other human services staff to be comfortable around participants struggling with substance use issues. Experts from three programs during the roundtable described how close collaboration with SUD specialists can improve outcomes. NWF Health Network in Florida has a SUD program co-located with child welfare services. It has also created a new child welfare specialist position that focuses on referrals to treatment and ensuring appropriate information sharing (see Box 2). Head Start of Yamhill County, Oregon, embeds home visitors into its programs to serve as support for skill development and crisis, and uses a strength-based approach to build trust and respect with families (see Box 3). Women in Transition in Philadelphia, Pennsylvania, serves victims of domestic violence, and has onsite recovery management counselors, using an empowerment approach when providing services to participants (see Box 4).

Box 3. Head Start of Yamhill County (HSYC)

[HSYC](#) is an early childhood development program that provides comprehensive, family-focused services for children. The program has expanded its eligibility requirements to include key risks for high-risk families, such as those who experience an SUD or domestic violence. Staff aim to build relationships with families, using a strength-based approach to build trust and respect over time. These relationships allow families to feel comfortable and safe to disclose information pertaining to parental SUD and other risk factors. HSYC participates in a coordinated care organization (CCO) within its local community, which is a network of all types of health care providers who share financial responsibility and risk of the families they serve. This coordinated care model ultimately allows the CCO to provide more patient-centered, team-focused care to help reduce health disparities. HSYC has two center-based classrooms, called “Duration Classes,” that focus on children referred by home visitors or whose families have specific risk factors, including SUD. Teachers and staff in these classes are trained in trauma-informed care, including [Teacher-Child Interaction Training. engagement](#). Families have access to home visitors for crisis support, as well for self-sufficiency and parenting skills development.

Increase formal and systematic collaboration and training across SUD treatment and human services systems, and among human services systems that serve participants with SUD.

Box 4. Women in Transition (WIT)

[WIT](#) offers free and confidential domestic violence and substance use recovery support services to people of any gender identity and sexual orientation and who are ages 14 or older, in Philadelphia, Pennsylvania. Support services offered at WIT include telephone and crisis counseling, peer support groups, substance use intervention and recovery support, and community education trainings, among others. WIT has partnered with dozens of SUD treatment programs throughout Philadelphia to provide an 8-week peer support group, focusing on the intersection of DV and substance use. Philadelphia's Department of Behavioral Health and Intellectual Disability Services funds WIT's intervention and recovery support services. WIT has two onsite Recovery Management Counselors, who use an empowerment approach when providing SUD identification, referral, and ongoing recovery management services to WIT clients who use substances or have an SUD.

Panelists expressed the need for greater collaboration on SUD services at the staff and institutional level. They recognized that human services agencies at the federal and state levels and in tribes have increased their focus on systems integration and cross-agency collaboration. Jurisdictions across the country have developed novel solutions to SUD identification, referrals to treatment, and associated human services. Even so, panelists felt that collaboration across agencies in many state and local jurisdictions was informal and often inadequate. Panelists suggested that collaboration across systems in states, localities, and tribes should be more formal and systematic, which could begin with activities such as joint staff trainings, joint development of needs assessments, and alignment of funding streams. Collaborative

activities are often poorly funded or funded by short-term grants (such as with one-year planning grants). Instead, funding needs to be allocated to prioritize and realize cross-systems collaboration within and between health and human services programs. Panelists outlined several approaches to increase collaboration:

- *Federal agencies should model the type of collaboration needed at the state and local levels.* Panelists noted that federal human services and behavioral health programs often operate in silos, which makes it more difficult for state and local staff to identify complementary funding and to braid resources.
- *Implement federally sponsored peer exchange across state, local, and tribal jurisdictions.* Panelists indicated that the federal government is well positioned to highlight and share innovations across human services areas and geographic regions, and to assess how evidence-based programs can be best brought to scale. Those working in human services programs value the opportunity to learn from their peers and exchange ideas—such as through federally sponsored policy academies, email lists, video content, and spotlight presentations.
- *Ensure cross-system staff training on system-specific and behavioral health topics within and between respective systems in state, tribal, and local jurisdictions.* All staff should receive training, from the person greeting an individual at the door to the person working in a back office, and training should include stigma-reduction curricula, motivational interviewing, trauma-responsive and healing-centered care, strength-based practices, and mental health first aid. Trainers should include people with lived experience within the health and human services systems to co-develop or co-deliver the training. Staff across human services programs should be trained to use the same or similar language to make service coordination easier and clearer for people receiving services. This would also help combat philosophical differences within and between systems.

Elevate multiple pathways to recovery for people with SUD, including through harm reduction.

Some expert panelists discussed the importance of human services programs in elevating multiple pathways to recovery for program participants with SUD. These pathways include harm reduction—an approach to reducing negative consequences of substance use for people. Additionally, while abstinence is one potential strategy, it may not be the most appropriate or effective for many participants with problematic substance use. The ethos of harm reduction centers on individual autonomy and implementing overdose prevention and other risk mitigation strategies when complete cessation is not possible or realistic. For example, in the form of overdose prevention strategies, harm reduction might be what keeps an individual alive between when a need is identified, a referral is placed, and a treatment slot becomes available. Or perhaps an individual's substance use does not rise to the severity of a SUD, and harm reduction strategies prevent use from escalating.

Harm reduction and treatment both have a place in addressing substance use; it is not an either-or situation, despite the reality that they are sometimes pitted against one another. As human services programs consider integrating and implementing these strategies more broadly, program staff need a greater understanding of what harm reduction is; how it is implemented; what to expect from it; and how the prevention, harm reduction, treatment, and recovery sectors of the SUD field collaborate.

Equity Implications and Addressing Unintended Consequences

Expert panelists emphasized that existing and new efforts to address SUD in human services have equity implications for program outcomes. In addition, any changes can have unintended or inequitable consequences on other aspects of program implementation. Human services programs and SUD treatment programs need to collaborate to ensure equitable participation, service delivery, and outcomes for people with SUD. In particular, experts agreed that critically examining current practice and policy is needed to understand the extent to which the current system achieves and promotes equity. At one level, experts suggested agencies critically review former participant files—including those who were successful and not successful in treatment—coupled with a simulated program walk through to determine if racial or other disparities exist in program access and outcomes. At the systems level, experts described the need for a policy review to assess the degree to which equity considerations are embedded in the workforce, partnerships, and selection and delivery of best practices. At the federal, state, tribal, and local levels, a critical review of funding design, award processes, and service reimbursement will help determine if there are racial and other disparities in programmatic opportunities and financial allotments. Panelists suggested that third parties should conduct these reviews to ensure objectivity and credibility in the review process, and the reviews should involve people with experience living with SUD who are participating in the respective human services programs. Evaluators should summarize results to indicate areas where equity is missing and the populations most impacted (for example, indigenous populations), followed by recommendations for change (for example, program locations, operating hours, and staff composition).

Expert panelists remarked that practices and policies regarding SUD identification and subsequent referrals to treatment must align to ensure equitable outcomes and mitigate unintended consequences. For example, if practice improvements occur before policy improvements, the odds of unintended consequences might grow. Increases in SUD screenings absent of policy changes could increase inequitable access to evidence-based SUD treatment. More SUD screening within human services programs might frustrate clients and staff, causing a decrease in screening if there are insufficient treatment options available to meet the demand for treatment. Also, punitive responses to a client having a SUD could pose a barrier to clients seeking treatment. Panelists highlighted two areas of particular concern: confidentiality and balancing types of substance use-related services.

Confidentiality concerns in collaborative case management.

Although all participating panelists representing human services programs valued collaborative practice, varying philosophies regarding privacy and confidentiality arose during the discussions. Expert panelists specializing in domestic violence prevention emphasized the need for complete privacy because of safety concerns for participants. In contrast, child welfare, Head Start, and TANF experts noted information sharing is critical for case planning, service delivery, and collaborative practice. Without appropriate policies, trainings, and monitoring, unintended consequences of limited collaborative practice, inadequate service delivery, inappropriate use and sharing of information, or safety risk could result.

Experts identified the need for future program-specific policy development and research in several issues related to confidentiality. First, work should identify and address the unique privacy and confidentiality needs of each human services program area. Second, programs should develop standard operating procedures and policies to ensure information is protected and used exclusively for intervention purposes, and not for enforcement or penalization.⁸ Programs and policies should improve how participants are brought into the decision-making process for how their information is shared and used. Finally, expert panelists across all human services areas noted the need for continued privacy and confidentiality training to minimize confusion.

Balancing prevention, harm reduction, treatment, and recovery services.

Expert panelists emphasized that the continuum of care for persons with SUD should include harm reduction along with the traditional approach of prevention, treatment, and recovery. The panelists stated that it was important to accurately assess the substance use strategies and services needed for clients and their families. Expert panelists noted that no one approach should exclude others—for example, harm reduction efforts should include treatment and vice versa. An exclusionary approach fails to recognize that persons with SUD have changing services needs and go through different stages of recovery in a nonlinear fashion. Limiting service delivery can hinder necessary and appropriate care.

As policies shift to be more inclusive of harm reduction and multiple pathways to recovery, expert panelists argued that human services programs must understand their role in those pathways. Programs need to align their services with each other and adapt those services to address the needs of participants with problematic substance use, wherever they are on their pathway to recovery. Effectively supporting participants also requires engagement with a comprehensive set of behavioral health services that meets participants where they are. Additional research is necessary to determine which harm reduction approaches work best across the severity continuum, how treatment and harm reduction can best work together, and how harm reduction affects families. Without further consideration and evaluation of the timing and role of various approaches, people with a SUD might be pigeonholed into one service system, which can limit responsiveness to individual needs and access to services.

Conclusion and next steps

Changing the course of how human service programs and agencies identify SUDs and refer participants to appropriate treatment requires concentrated efforts from several stakeholders—leaders in human services, leaders in the substance use treatment system, federal and state policymakers, and local programs implementing services. Despite numerous challenges, expert panelists universally felt that change was possible. Expert panelists recognized that human services programs are front and center in addressing the substance use epidemic. These programs are well-situated to transform how human services and SUD treatment systems work together to connect people to the help they need. Aside from the considerations suggested

⁸ Panelists did not mention the need for data sharing related to research and evaluation. This omission might have been a result of the focus of the roundtable—service delivery—rather than an intention of panelists.

during the roundtable, panelists pointed to two immediate areas for next steps for national, state, and local stakeholders.

Promote sustained, meaningful relationships among human services programs, and between human services programs and SUD services. Human services programs and substance use treatment programs need opportunities for continued information sharing, spotlighting of promising practices, and jointly strategizing on supporting participants along the continuum of prevention, harm reduction, treatment, and recovery. Panel experts recognized the benefits of sharing experiences and expertise across their program areas. Panel experts also noted that other systems should be included when appropriate, such as education, health, criminal justice, employment services, and housing, among others. They also noted that nongovernmental systems—such as private health insurers—might also have a role to play. Opportunities for information sharing could include email lists, chat rooms, webinars, and resource repositories. Work groups or panels including multiple areas in human services, substance use treatment, and other fields, could be formed to investigate program and policy alignment. Research at the nexus of program interaction could be beneficial as well, to identify promising practices, potential for evidence-building and scaling, as well as practices that do are not effective. Nongovernmental organizations could support these efforts, for example, by hosting roundtable discussions within and between human services areas to discuss allowable activities and expenses within funding streams. The roundtable discussions might help highlight policy innovations, comparable to the policy innovation spotlights included in the convening.

Elevate models of effective systems collaboration. Expert panelists recommended that existing federal, state, and local models of systems collaboration between human services programs and substance use treatment programs be highlighted and brought to scale. As part of this work, research is needed to explore the extent to which identified models effectively meet human services and treatment goals, and what makes them effective. This work can also identify whether these models can be adapted in other places or at differing levels of government.

Appendix A. Considerations from Experts in Specific Program Areas

This table indicates which program areas each of the major considerations were raised by. Check marks indicate that experts from that program area discussed a consideration. If a check mark is not present, it does not mean that the program area disagreed with the consideration or thought it was irrelevant.

Consideration	Child Welfare	Domestic Violence	Head Start	TANF
Identify how jurisdictions can combine federal funding streams to support SUD identification, treatment, and referral activities to meet local needs.	✓		✓	✓
Orient programs and services towards the whole person and family, rather than on service requirements	✓	✓	✓	✓
Consider universal screening for SUD followed by warm hand-off referrals when indicated for all program participants.	✓		✓	✓
Increase support for the human services workforce in implementing assessment and referral services to address SUD among participants		✓	✓	
Reconsider punitive responses to substance use disclosure and support alternative approaches.	✓	✓		✓
Embed SUD specialists into human services programs to support navigation of SUD treatment and support systems.	✓	✓	✓	✓
Increase formal and systematic collaboration and training across SUD treatment and human services systems, and among human services systems that serve participants with SUD.	✓	✓	✓	✓
Elevate multiple pathways to recovery for people with SUD, including through harm reduction.			✓	✓

Appendix B. Meeting Agenda

Day 1. Tuesday, September 21, 2021

All times listed reflect Eastern Standard Time

- 10 to 10:15 a.m.** **Welcome, introduction, and project purpose**
- Robin Ghertner, M.P.P.**, Director of Data and Technical Analysis, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services
- Rebecca Haffajee, J.D., Ph.D., M.P.H.**, Acting Assistant Secretary for Planning and Evaluation, Principal Deputy Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services
- Stacy Phillips, D.S.W.**, Victim Justice Program Specialist, Office for Victims of Crime (OVC), US Department of Justice
- 10:15 to 10:20 a.m.** **Housekeeping announcements**
- Annette Waters, Ph.D.**, Senior Social Science Analyst, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services
- 10:20 to 11:35 a.m.** **Spotlight on human services area innovations**
- A representative from each services area will deliver a 15-minute presentation, highlighting a practice or policy innovation that has improved substance use disorder (SUD) identification and referral to treatment and human services. A 15-minute Q&A will follow.
- **Child welfare**
 - **Domestic violence**
 - **Head Start**
 - **Temporary Assistance for Needy Families (TANF)**
- 11:35 a.m. to 12:00 p.m.** **Framing paper overview and level setting**
- Pamela Baston, M.P.A., MCAP, CPP, Project Director, JBS International
Kathleen Meyers, Ph.D., Senior Research Scientist, JBS International
- 12:00 to 12:50 p.m.** **Lunch**
- 12:50 to 12:55 p.m.** **Introduction to the World Café process and assignments**
- Sophia Shepard, Research Assistant II, JBS International
- 12:55 to 2:55 p.m.** **World Café breakout sessions**
- **Breakout Room 1:** SUD Identification and Referral Best Practices
 - **Breakout Room 2:** Services Identification and Integration
 - **Breakout Room 3:** Financial Resources

- **Breakout Room 4: Policy and Policy Adaptations**
Facilitators will cycle through each breakout room, composed of five to six people representing their service area. Facilitators are experts in the topic areas and will provide a list of core questions on each breakout topic to ensure that the group addresses the important issues under discussion. After each round, there will be a five-minute comfort break.

2:55 to 3:55 p.m.

Preparation of World Café breakout session reports

Designated human services area facilitators and participants will synthesize information across the breakout groups for presentation to the entire group.

3:55 to 4:00 p.m.

Day 1 wrap-up, Day 2 preparation

Pamela Baston, M.P.A., MCAP, CPP, Project Director, JBS International

Day 2. Wednesday, September 22, 2021

10 to 10:15 a.m.

Welcome, Day 1 recap, and Day 2 goal

Robin Ghertner, M.P.P., Director of Data and Technical Analysis, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services

Jennifer Cannistra, M.S., J.D., Deputy Assistant Secretary for Policy, Administration for Children and Families, U.S. Department of Health and Human Services

Miranda Lynch-Smith, M.S., Deputy Assistant Secretary for Human Services Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services

10:15 to 11:15 a.m.

World Café breakout session reports and syntheses

Each human services area will present a 15-minute report.

11:15 to 11:35 a.m.

SUD system response

SUD system representatives will respond to the World Café breakout session reports.

11:35 to 11:45 a.m.

Q&A

Kimberly Walsh, L.S.W., M.P.A., JBS OVC Project Director, JBS International

11:45 a.m. to 12:30 p.m.

Lunch

12:30 to 1:30 p.m.

Human services program breakout sessions: Emerging policies, current recommendations, and next steps for developing practice and policy improvements

- **Child welfare**
- **Domestic violence**
- **Head Start**
- **TANF**

Each services area will address ways to improve SUD identification and referral to treatment and human services within their system of care.

1:30 to 2:00 p.m.

Preparation of human services program reports

Breakout groups will synthesize information for presentation to the entire group.

2:00 to 2:15 p.m.

Comfort break

2:15 to 3:15 p.m.

Human services program reports and synthesis

Each human services area will present a 15-minute report.

3:15 to 3:45 p.m.

Q&A, wrap-up, and next steps

Kathleen Meyers, Ph.D., Senior Research Scientist,
JBS International

3:45 to 4:00 p.m.

Closing

Elaine Voces Stedt, M.S.W., Director of the Office on Child Abuse and Neglect, Children's Bureau, Administration on Children, Youth, and Families, Administration for Children and Families, U.S. Department of Health and Human Services

Robin Ghertner, M.P.P., Director of Data and Technical Analysis, Office of the Assistant Secretary for Planning and valuation, U.S. Department of Health and Human Services

Appendix C. Participant List

Amanda Wexler, New York City Government

Ann Cameron, Inter-Tribal Council of Michigan

Ann Wing, NWF Health Network

Barbara Ramlow, University of Kentucky

Carolyn Castro-Donlan, Castro-Donlan Consulting

Christina Love, Alaska Network on Domestic Violence and Sexual Assault

Clifton Connor, Center for Family Services

Corey Holcomb, Community Action, Alger-Marquette

Don Winstead, Winstead Consulting

Gabriela Zapata-Alma, National Center on Domestic Violence, Trauma, and Mental Health

Irene Lindsey Brantley, Women in Transition

Janice Thomas, NWF Health Network

Jennifer Wlodarczyk, Ohio START

Jodi Russell, Florida Department of Children and Families

Lawrence Gendler, former judge for Sarpy County Juvenile Court

Rosanne Cupoli, The Spring of Tampa Bay

Suey Linzmeier, Yamhill Head Start

Tara Joyner, Gaston County Health and Human Services