

ASPE Research Summary

Strategies Rural Communities Use to Address Substance Misuse among Families in the Child Welfare System

Rural communities have been particularly hard hit by substance use. For instance, in 2012 rural areas had a 45 percent higher opioid overdose rate than urban areas (Faul, et al. 2015). Apart from higher risk of overdose, rural areas also have a lower availability of treatment for substance use disorder (Rigg et al., 2017). While opioids are the most frequently misused substance in some rural communities, others have high rates of methamphetamine use, and polysubstance use – the use of more than one illicit substance or use of illicit substances in combination with alcohol – is common (Admon et al. 2019, Dombrowski et al. 2016, MacMaster 2013). Child welfare agencies serving rural communities face unique challenges. In particular, rural counties had an average of 696 children per 100,000 enter the foster care system in 2018, relative to 499 for non-rural counties. A prior [ASPE brief](#) identified challenges that are unique to, or exacerbated by, rural locations. These include:

- long distances to services;
- limited availability of services and low diversity of program models and approaches;
- shortages of qualified staff; and
- less privacy in small communities.

This summary highlights how nine programs have addressed challenges to serving child welfare-involved parents with substance use disorders (SUDs), with a particular focus on their applicability to rural communities. It summarizes information from a longer research ASPE brief. This study did not assess program effectiveness. Rather, it summarizes the context in which the programs operate, their target populations, and how the programs blend funding and collaborate to help parents with recovery and help families reunify.

The programs listed in Table 1 offered various types of services, including:

- parent mentoring;
- case management;
- home visiting;
- treatment for opioid use disorders; and
- an array of SUD treatment and family services.

Table 1. Programs Studied

Program Name	Type of Program
Children and Recovering Mothers (CHARM) Care Collaborative in Burlington, Vermont	Cross-system collaborative to facilitate information sharing through monthly case review meetings
Iowa Department of Human Services Parent Partner mentoring program	Parent Partners mentor other parents through the recovery and child welfare systems
Kentucky Sobriety Treatment and Recovery Teams (START)	Cross-system collaboration model focused on team-based case management
Vermont Hub and Spoke Model	Hub and spoke system of medication-assisted treatment for OUD
Women in Recovery in Tulsa, Oklahoma	Dual generation, intensive outpatient SUD treatment and prison-diversion program
The Arizona Families in Recovery Succeeding Together (FIRST) Program	Intensive case management model for parents with substance misuse and child welfare involvement
Helen Ross McNabb Center (HRMC) Great Starts Program	Integrated model of child welfare services and substance use disorder treatment
HRMC Motivating our Mothers to Succeed, Silver Linings and Rise to Recovery models	SUD treatment program for pregnant and parenting women
Washington Parent-Child Assistance Program	Intensive case management for parents with substance misuse and child welfare involvement

Key Findings:

- **Clients' situations and programs' challenges were compounded by issues specific to their rural locations.** Rural communities and clients served by these programs were dealing with multiple disadvantages. Persistent, high rates of poverty and unemployment depressed the local economies in many rural communities. The effects of social and economic challenges such as housing instability, poverty, and criminal justice involvement are exacerbated by the more limited service infrastructure in rural areas.
- **Addressing transportation challenges is critical to connect clients with treatment.** The programmatic feature most distinguishing rural programs from those in other settings was the need to address transportation needs in the absence of public transportation. Some programs transported clients to a central site for program services, while others included home visiting or telehealth services, or offered program activities in several local sites to minimize clients' travel time. Others supported transportation by providing gas cards or paying for car repairs.
- **Medicaid is key to paying for treatment.** Medicaid was the primary funding source for SUD treatment services for most of the programs reviewed. Some programs also funded clients' transportation through Medicaid. While some programs relied on demonstration grant funding, often those funding sources were not reliable for sustaining a service array. Several programs believed that securing funding through mainstream programs, particularly Medicaid, was important for sustainability. However, having multiple funding streams ensured they were not completely reliant on any one source.
- **Various strategies enabled rural communities to mitigate staffing challenges.** Rural communities faced significant difficulties attracting sufficient staff with appropriate qualifications or experience. Programs felt it critical that staff be flexible in their approaches and that staff shared their organization's mission. They also believed that having staff with experiences similar to those of their clients helps earn clients' trust. Keeping caseloads low was essential because of the large distances between clients, requiring extensive local travel. In addition, with staff in the field much of the time, working alone without immediate access to consultation with colleagues, program-specific and ongoing training was valued and programs needed robust supervision and support for staff.
- **Partnerships are essential to supporting clients in treatment and recovery.** Coordinating services and sharing information on clients across systems are central to many of the programs reviewed. The level of partnership (statewide versus local) and types of partners varied depending on the design of the program and the type of organization implementing the program. Some programs have formal procedures for collaborating with community partners, whereas others rely on informal relationships. Several programs had institutionalized procedures to obtain consent from clients in order to permit sharing of information about family cases with key community partners.
- **Most programs lack evidence on program effectiveness.** Many of the programs did not yet have rigorous evidence supporting their programs, though some reported using some evidence-based therapeutic practices. Six of the nine programs monitor implementation fidelity across sites. Given increasing emphasis on supporting programs with evidence of effectiveness, particularly within the new Title IV-E Prevention Services Program, future funding within the child welfare system for these sorts of interventions will likely depend on further evaluation to enhance their evidence base.

This study highlights ways programs addressing both SUD and parenting issues can overcome the unique challenges to serving rural communities. The programs we examined are adapting their services to meet the particular circumstances of rural clients. Because few of these programs have been evaluated, their effectiveness is uncertain. Nonetheless, they offer insights that may be useful for the field and that merit further exploration through more rigorous study. Rural communities have been hit hard by the opioid crisis and the substance use crisis more generally, and the population involved in child welfare services is particularly impacted by the effects of SUD. As federal and state agencies, service providers, and other stakeholders continue to combat the crisis, it is essential that we learn how best to tailor interventions to the particular needs of rural communities.

This research was conducted under contract to the Office of the Assistant Secretary for Planning and Evaluation (ASPE) by researchers at Mathematica.

References

Admon, Lindsay K., Gavin Bart, Katy B. Kozhimannil, Caroline R. Richardson, Vanessa K. Dalton, and Tyler N. A. Winkelman. "Amphetamine- and Opioid-Affected Births: Incidence, Outcomes, and Costs, United States, 2004–2015." *American Journal of Public Health*, vol. 109, no. 1, 2019, pp. 148–154. doi:10.2105/AJPH.2018.304771.

Dombrowski, Kirk, Devan Crawford, Bilal Khan, and Kimberly Tyler. "Current Rural Drug Use in the US Midwest." *Journal of Drug Abuse*, vol. 2, no. 3, 2016, pp. 1–14. Epub 2016 Aug 17. PMID: 27885362; PMCID: PMC5119476.

Faul, M, Daily, MW Sugerman, DE, Sasser, SM, Levy, B, and Paulozzi, LJ. "Disparity in Naloxone Administration by Emergency Medical Service Providers and the Burden of Drug Overdose in US Rural Communities." *American Journal of Public Health*. 2015 July; 105(Suppl 3): e26–e32.
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4455515/>

MacMaster, Samuel A. "Perceptions of Need, Service Use, and Barriers to Service Access among Female Methamphetamine Users in Rural Appalachia." *Social Work in Public Health*, vol. 28, no. 2, 2013, pp. 109–118. doi:10.1080/19371918.2011.560820.

Rigg, KK, Monnat, SM and Chavez, MN. "Opioid-related Mortality in Rural America: Geographic Heterogeneity and Intervention Strategies." *International Journal of Drug Policy*, Volume 57, July 2018, Pages 119-129.
<https://www.sciencedirect.com/science/article/abs/pii/S0955395918301130>