Touchpoints for Addressing Substance Use Issues in Home Visiting: Expanded Executive Summary of Phase 1 Final Report

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The Touchpoints for Addressing Substance Use Issues in Home Visiting (Touchpoints) project generated knowledge about how home visiting programs—including those funded through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program—can engage and support families on these issues. Funded by the Office of Planning, Research, and Evaluation (OPRE) within the Administration for Children and Families (ACF) in collaboration with the Health Resources and Services Administration (HRSA), the project was conducted by Mathematica and its partners, Dr. Ron Prinz of the University of South Carolina, Dr. Darius Tandon of Northwestern University, and Dr. Norma Finkelstein of the Institute for Health and Recovery.

This report provides a summary for researchers, federal staff, home visiting model developers, and program administrators indicating what is generally known and what needs to be learned about how home visiting programs can engage and support families on these issues. The report describes project findings around six touchpoints and four implementation system inputs through which programs can engage and support families to prevent, identify, and address substance use issues (Table ES.1).

What is home visiting?

Home visiting is a voluntary service in which "trained professionals meet regularly with expectant parents or families with young children in their homes, building strong, positive relationships with families who want and need support" (HRSA, 2018).

What is a home visiting program?

For this project, the term "program" encompasses the implementation of home visiting services at the local level.

What are substance use issues?

In this report, "substance use issues" means use of substances (including alcohol and legal and illegal drugs) now or in the future in a manner, situation, amount, or frequency that may cause harm to users or to those around them. This term encompasses substance abuse, substance misuse, and substance use disorder (American Psychiatric Association, 2013; Social Security Act of 1935; Substance Abuse and Mental Health Services Administration, 2016).

What are touchpoints?

For this project, touchpoints are activities involving direct interaction between home visiting staff and families through which home visiting programs can help prevent, identify, and address substance use issues among families.

What are implementation system inputs?

Implementation system inputs are organizational- and home visitor-level resources, infrastructure, and constraints that can support the delivery of home visiting.

Table ES.1. Touchpoints and implementation system inputs

Touchpoints	Implementation system inputs
1. Screening families for substance use issues	1. Home visit staffing (staff characteristics and staffing structure)
2. Educating families on substance use prevention, identification, treatment, and recovery	2. Professional development for home visitors on substance use issues
3. Serving families based on strategies designed to prevent and address substance use issues	3. Eligibility, recruitment, intake, and enrollment of families with substance use issues
4. Referring families to substance use treatment providers and related supports	4. Monitoring systems to track substance use-related inputs, activities, and outcomes
5. Coordinating with substance use treatment providers and related supports	
6. Providing case management related to substance use issues	

A. Background

Home visiting is generally a prevention strategy to support expectant parents and families with young children by offering them "resources and skills to raise children who are physically, socially, and emotionally healthy and ready to learn" (HRSA, 2019). The characteristics of the families served, the outcomes targeted, and the service components delivered vary by evidence-based home visiting model. Depending on the model, home visiting services may be offered to families before the birth of a child and any time up to a child's entry into kindergarten. As such, services are designed to optimize parenting practices during a critical period in which parents are motivated to pursue behavioral change (Kuo et al., 2013; Lee King, Duan, & Amaro, 2015). At the core of home visiting services is the strength of the relationship between the home visitor and the caregiver, whose trust in the home visitor permits broad conversations around wellness, including candid discussions of sensitive topics like substance use issues and the presence of violence or neglect in the home (Dauber et al., 2017a). In addition, a cornerstone of most home visiting models is the use of community partnerships, including referrals to services such as substance use treatment and adult mental health services; child welfare; child mental health; and health, housing, and nutrition services (HRSA, n.d.). When these referral systems are in place, home visitors can connect families to treatment services they need and coordinate with providers to support ongoing recovery (Dauber et al., 2017a). Moreover, new funding opportunities exist to expand home visiting programs due to legislation passed largely in response to the opioid epidemic. For example, in 2016, the Comprehensive Addiction and Recovery Act amended the Child Abuse Prevention and Treatment Act, requiring states to have a plan of safe care that includes home visiting services and other services and supports for the health and substance use disorder treatment needs of the families of substance-exposed infants (ACF, 2017).

What is the MIECHV Program?

The MIECHV Program encourages collaboration at the federal, state, and community levels to administer evidence-based home visiting programs and provide services to families based on families' needs.

What are the major components of home visiting services?

Home visiting services include three major types of activities: (1) assessment of family needs; (2) parent education and support; and (3) referral to, and coordination with, needed services (Michalopoulos et al., 2015).

Although home visiting programs can play an important role in engaging and supporting families to prevent, identify, and address substance use issues, several considerations are important to note. First, evidence-based models funded through MIECHV are not designed as substance use treatment interventions, nor can MIECHV funds generally be used for direct services with substance use treatment providers. Rather, home visitors may engage and support families to prevent and identify possible issues. When issues exist or are identified, home visitors may refer families to substance use

What are practices?

Practices are procedures, processes, and techniques to prevent, identify, and address substance use issues among families.

What are local implementing agencies (LIAs)?

LIAs are the agencies (such as community-based nonprofits or local health departments) that carry out the activities required to deliver home visiting services to families. They may implement one or more home visiting models.

Generally, states and territories that receive MIECHV funding distribute funds they receive to LIAs to carry out activities; Tribal MIECHV grantees typically use funds to carry out activities themselves.

What are active ingredients?

Active ingredients are the set of characteristics of home visiting programs that are needed to produce specific outcomes, whether for most participants or for certain families (Home Visiting Applied Research Collaborative, n.d.).

treatment providers and support them to connect with those providers and, if necessary, engage in treatment and other support services. Home visitors, however, may feel unequipped to address the topic of substance use with enrolled families (Duggan et al., 2018; Harden, Denmark, & Saul, 2010; McDaniel, Tandon, Heller, Adams, & Popkin, 2015; Tandon, Mercer, Saylor, & Duggan, 2008). Second, the prevention and reduction of unhealthy substance use is one of many outcomes that home visiting programs may seek to address. Home visitors often engage families to work toward a wide range of outcomes, including positive parenting, healthy child development, maternal health, and the economic self-sufficiency of families. Finally, because families dealing with substance use issues may be less likely to engage with community support systems, including home visiting programs, LIAs may be less likely to serve this population.

This document summarizes what is known and what needs to be learned about how home visiting programs can engage and support families around substance use issues. The final report presents detailed findings. The findings contribute to existing literature on home visiting and point to specific research areas that may warrant further investigation by stakeholders to better understand how to work with families to prevent, identify, and address substance use issues. Ultimately, research on these areas of interest can contribute to a better understanding of the touchpoints and practices (sometimes referred to as "active ingredients") that drive improvements in outcomes (Supplee & Duggan, 2019).

B. Research questions and methodology

Research questions

1. What are the conceptual touchpoints for how home visiting programs may prevent, identify, and address substance use issues among families (including pregnant women, children, parents, and other family members)? What implementation system inputs support programs to deliver the touchpoints?
2. What practices are used by home visiting programs to engage and support families to prevent, identify, and address substance use, based on information from select home visiting model developers, MIECHV awardee leaders, and Tribal MIECHV grantee leaders?
3. What is the state of evidence on practices for working with families with young children around substance use prevention and supporting families with substance use issues through treatment and recovery that can be applied to home visiting?
4. What research opportunities are available to help stakeholders (researchers, federal staff, model developers, and program administrators) understand how home visiting programs can engage and support families to prevent, identify, and address substance use issues?

This final report addresses four research questions from the synthesis of the Touchpoints project's Phase 1 tasks (see box). Project tasks included:

- Developing an overarching conceptual model to identify the pathways through which home visiting programs can engage and support families to prevent, identify, and address substance use issues
- Developing three detailed conceptual models to further delineate the pathways in the overarching conceptual model

- Conducting an inventory of practices used in home visiting programs to engage and support families to prevent, identify, and address substance use issues, based on information from select home visiting model developers, MIECHV awardee leaders, and Tribal MIECHV grantee leaders
- Conducting a targeted literature review of studies that addressed family substance use issues that can be applied to home visiting
- Consulting with key stakeholders to incorporate information and insights in all project tasks
- Assessing opportunities for future research on engaging and supporting families to prevent, identify, and address substance use issues through home visiting services

The remainder of this document provides a high-level description of study findings to each of the research questions.

C. Summary of findings

1. What are the conceptual touchpoints for how home visiting programs may prevent, identify, and address substance use issues among families? What implementation system inputs support programs to deliver the touchpoints?

The project team developed an overarching conceptual model to represent a comprehensive and broad range of relevant inputs, touchpoints, short- and long-term outcomes, and contextual factors representing opportunities for home visiting programs to prevent, identify, and address substance use issues among families. The project team also developed three detailed conceptual models that take a closer look at constructs in the overarching conceptual model that were identified as high priority by the project's expert consultants, federal staff, and technical assistance providers that support the states, territories, and Tribal entities that receive funding through the MIECHV Program. Taken together, the four conceptual models present the theoretical pathways through which home visiting programs can engage and support families to prevent, identify, and address substance use issues. Appendix A contains the conceptual models.

The overarching conceptual model was initially developed based on a conceptual framework created for the Maternal and Infant Home Visiting Program Evaluation (MIHOPE)—the national evaluation of home visiting programs under MIECHV—and the Institute of Medicine's continuum of care model. The project team refined the conceptual model based on findings from the inventory of practices and literature review, as well as feedback from the project's expert consultants, federal staff, and technical assistance providers. For this project, the team focused on touchpoints that can target working with families to prevent, identify, and address substance use issues, rather than touchpoints that broadly apply to working with families around substance use issues. For this reason, touchpoints of promotion, which are goals of home visiting programs generally (HRSA, n.d.), are listed in a box separate from the touchpoints of focus.

One of the three detailed conceptual models focuses on the implementation system inputs. The other two models focus on touchpoints: one on substance use prevention and the other on supporting families in treatment and recovery. The implementation system inputs model further delineates the pathways by which the constructs from the overarching model may influence the delivery of the touchpoints, identifying how the state-, territory-, or tribal-level entity, home

visiting model, and referral partners influence implementation system inputs and how the organizational- and home visitor-level implementation system inputs influence each other. For example, the state-level agency, such as an MIECHV awardee, may have priorities for ongoing screening of families for substance use issues that influence LIA-level policies and procedures for screening. At the same time, policies and procedures established at the LIA level may feed into decisions the MIECHV awardee makes.

The other two detailed conceptual models—the prevention model and the treatment and recovery model—are companion models that focus on how home visiting programs may deliver the touchpoints differently based on where a family is on the continuum of care. The prevention model is relevant to families identified as at risk for substance use issues, for whom the goal is to prevent the development of substance use disorders. With these families, home visiting staff may focus on screening, as well as coordinating referrals in the event of a possible substance use issue. The treatment and recovery model is relevant to families who have a member who is identified as having a substance use disorder, for whom the goals from a clinical standpoint are to initiate and engage the caregiver in treatment, reduce substance use, prevent drug overdoses, prevent the occurrence of the physical and mental health conditions that often co-occur with substance use issues, and prevent intergenerational substance use. With these families, home visiting staff may focus on coordination with substance use treatment providers. Programs may universally educate families on substance use issues and deliver strategies to prevent and address substance use issues, but the specifics may vary based on where a family is on the continuum of care.

2. What practices are used by home visiting programs to engage and support families to prevent, identify, and address substance use, based on information from select home visiting model developers, MIECHV awardee leaders, and Tribal MIECHV grantee leaders?

To understand some of the ways home visiting programs currently engage and support families to prevent, identify, and address substance use issues, the project team gathered information from 11 model developers, seven MIECHV awardee leaders, and two Tribal MIECHV grantee leaders. Model developers shared information about the policies and guidance they provide to LIAs delivering the models. MIECHV awardee and Tribal MIECHV grantee leaders shared information about statewide and tribe-wide policies and initiatives that are applicable to LIAs.[1] In addition, the model developers, awardee leaders, and grantee leaders shared information about particular LIAs or grantees that were engaged in efforts to address substance use issues. Although most of the practices described in this report are delivered by LIAs, the project team did not collect any information from LIAs directly (other than Tribal MIECHV grantees that are also implementing agencies).

The inventory findings shed light on the practices that programs use at each touchpoint to engage and support families to prevent, identify, and address substance use issues. For example,

[1] In the case of some Tribal MIECHV grantees, grantee leaders shared information about tribe-wide policies and initiatives that are applicable to themselves if they use MIECHV funds to carry out the activities required to deliver home visiting services to families rather than distributing the funds to LIAs to carry out activities. Most Tribal MIECHV grantees carry out activities themselves.

model developers and Tribal MIECHV grantee leaders described using standardized and non-standardized tools, facilitated discussions, and motivational interviewing as practices to screen families for substance use issues. Similarly, the findings describe the types of practices that support the implementation of the touchpoints, such as approaches to staffing for home visits and training for home visitors (Table ES.2). The inventory findings also highlight key information gaps. Information gaps are areas where more information is needed if stakeholders were to encourage LIAs to implement specific practices related to the touchpoints and implementation system inputs. The gaps fall into two categories: (1) areas where more information is needed about practices because the touchpoint or implementation system input was described in the inventory infrequently, and (2) areas where more information is needed about practices because the touchpoint or implementation system input was described in the inventory more generally. The key information gaps include:

- Understanding if and how home visiting programs include the provision of case management related to substance use issues—such as home visitors working with substance use treatment providers in discharge planning for families exiting treatment programs. This touchpoint was described least frequently by the select model developers, MIECHV awardee leaders, and Tribal MIECHV grantee leaders, which may indicate that many of them consider the touchpoint to be out of scope. However, the touchpoint may be relevant to some models, particularly those that exclusively serve families that self-report substance use issues.
- Gathering more information about MIECHV awardee and Tribal MIECHV grantee monitoring systems to track substance use-related inputs, activities, and outcomes. The inventory findings show that the select awardee leaders generally do not collect substance use-related data beyond model-developer requirements. ACF requires that the Tribal MIECHV grantees collect data on screening and referrals related to substance use issues. Of the two grantees in the inventory, only one grantee leader described tracking substance use-related information beyond these requirements.
- Understanding the specific practices LIAs use to screen families for substance use issues. Inventory findings show that LIAs set many of the policies related to screening for substance use and use a wide range of screening methods and tools. Detail is needed to understand how LIAs select the screening methods tools they use; whether screenings are implemented universally with all enrolled families; whether screenings are conducted at regular intervals or in response to a need identified by a family; and how the screening results are used to inform service delivery.
- Learning more information about how home visitors educate families on substance use prevention, identification, treatment, and recovery. All select model developers described home visitors providing education on substance use issues to families, but with variation in the extent of the education offered. Detail is needed about the content that home visitors provide to families and whether that content is tailored for families based on need.
- Similar to the information gap just discussed, professional development for home visitors on substance use was described by the select model developers, MIECHV awardee leaders, and Tribal MIECHV grantee leaders, but they collectively noted variation in the extent of the training provided. Detail is needed about the content and mode of home visitor professional development.

Table ES.2. Practices identified in the inventory as described by select home visiting model developers, MIECHV awardee leaders, and Tribal MIECHV grantee leaders, by touchpoint and implementation system input

Practice[a]	Model developers	MIECHV awardees	Tribal MIECHV grantees
Touchpoint 1. Screening families for substance use issues			
Using standardized and non-standardized tools, facilitated discussions, and motivational interviewing	X		X
Identifying, during home visits, nonverbal signals indicating that families may be experiencing substance use issues	X		
Implementing screening of newborns for developmental risks, including neonatal abstinence syndrome (implemented at the state level)		X	
Using a training system to provide guidance to home visitors on how to observe families during home visits (implemented at the state level)		X	
Touchpoint 2. Educating families on substance use prevention, identification, treatment, and recovery			
Providing verbal and/or written information during home visits	X		X
Linking families to support groups	X		
Touchpoint 3. Serving families based on strategies designed to prevent and address substance use issues			
Using motivational interviewing	X	X	
Linking families to support groups	X	X	
Supporting breastfeeding			X
Touchpoint 4. Referring families to substance use treatment providers and related supports			
Developing relationships with providers using LIA staff, advisory committees, and home visitors	X		
Developing and maintaining a database of available resources (implemented at the model developer level)	X		
Establishing protocols to document referral information (implemented at the model developer level)	X		
Using a task force to establish reciprocal referrals between LIAs, prenatal providers, and substance use treatment providers (implemented at the state level)		X	
Using a training to develop a community map of services and providers (implemented at the state level)		X	
Referring families to a program that provides vouchers to access a network of substance use treatment and recovery support providers			X
Touchpoint 5. Coordinating with substance use treatment providers and related supports			
Securing agreements such as memoranda of understanding with community service providers	X		
Employing social workers and mental health professionals on site for home visitors to coordinate with	X		
Requiring or encouraging frequent meetings between home visitors and community service providers to coordinate efforts	X		
Providing coordination support to families, including support scheduling appointments and securing transportation and child care	X		
Establishing protocols to report child abuse or neglect to child welfare agencies or to arrange for child visitation (implemented at both the LIA and model developer levels)	X		
Using a substance use liaison (implemented at the state level)		X	

TABLE ES.2 *(Continued)*

Practice[a]	Model developers	MIECHV awardees	Tribal MIECHV grantees
Using a task force to establish layering of services (implemented at the state level)		X	
Hosting conferences, summits, and meetings for stakeholders that include discussion on coordinating home visiting services and substance use activities (implemented at both the state and grantee levels)		X	X
Touchpoint 6. Providing case management related to substance use issues			
Requiring or encouraging home visitors to help with goal management around reducing or eliminating substance use (implemented at the model developer level)	X		
Requiring or encouraging home visitors to stay in close contact with substance use providers delivering services to families (implemented at the model developer level)	X		
Requiring or encouraging home visitors to work with families to further develop and maintain their relapse prevention plans (implemented at the model developer level)	X		
Extending families' enrollment period if they are still in progress with important activities (implemented at the model developer level)	X		
Using perinatal case management staff to work with home visitors			X
Implementation system input 1. Home visit staffing (staff characteristics and staffing structure)			
Requiring LIAs to hire or prioritize hiring home visitors with specific degrees or credentials, knowledge, or experience (implemented at the model developer level)	X		
Requiring or encouraging LIAs to hire home visitors who are culturally matched to families in the community being served (implemented at the model developer level)	X		
Requiring LIAs to assign a dyad of staff members per family (implemented at the model developer level)	X		
Establishing procedures to hire qualified home visitors, such as employing home visitors with personal experience in substance use recovery and child welfare issues		X	
Implementation system input 2. Professional development for home visitors on substance use issues			
Providing training that touches upon how substance use affects children and/or how to work with adults dealing with substance use issues (implemented at both the LIA and model developer levels)	X		
Providing training or encouragement to address personal biases (implemented at both the LIA and model developer levels)	X		
Providing guidance on substance use issues through supervision and peer interaction	X		
Using a learning management system including webinars on how to work with families dealing with substance use (implemented at the state level)		X	
Using infant and childhood mental health consultants to train home visitors on how to address substance use issues (implemented at the state level)		X	
Developing and maintaining an online resource repository that includes trainings on addressing substance use among families			X
Providing training on how to administer naloxone			X
Providing training on maintaining home visitor safety in homes where substance use might be an issue			X

TABLE ES.2 *(Continued)*

Practice[a]	Model developers	MIECHV awardees	Tribal MIECHV grantees
Implementation system input 3. Eligibility, recruitment, intake, and enrollment of families with substance use issues			
Establishing eligibility criteria to exclusively serve families who self-report substance use issues or to rely on LIAs to address substance use issues as needed (implemented at the model developer level)	X		
Using referral sources to recruit families, including family self-referral	X		
Requiring supervisors and program administrators to review referrals to determine families' eligibility (implemented at the model developer level)	X		
Implementation system input 4. Monitoring systems to track substance use-related inputs, processes, and outcomes			
Tracking data to assess performance toward achieving goals, which may explicitly or broadly include goals to address substance use issues (implemented at both the LIA and model developer levels)	X		
Collecting data on several measures related to LIAs' delivery of services to families dealing with substance use issues (implemented at the state level)		X	
Using a task force to discuss data collection and tracking (implemented at the state level)		X	
Tracking the number of staff who are trained to educate families on how to obtain and use an opioid overdose kit			X

[a]Unless otherwise stated, all practices are implemented at the LIA level.

Source: Touchpoints inventory of practices of select home visiting model developers, MIECHV awardee leaders, and Tribal MIECHV grantee leaders, January through September 2018.

Notes: Findings pertain only to those models, awardees, and grantees included in the inventory. Findings are not representative of the full group of models, awardees, and grantees that were active at the time of information gathering January through September 2018. In addition, findings are not based on comprehensive information. For example, the project did not include gathering information about LIAs' day-to-day activities working with families with substance use issues (with the exception of Tribal MIECHV grantees that are also implementing agencies).

Information was not gathered from home visiting model developers, MIECHV awardee leaders, and Tribal MIECHV grantee leaders systematically. However, the document review was systematic and included information synthesis to answer predetermined research questions related to the touchpoints and implementation system inputs.

LIA = local implementing agency; MIECHV = Maternal, Infant, and Early Childhood Home Visiting.

3. What is the state of evidence on practices for working with families with young children around substance use prevention and supporting families with substance use issues through treatment and recovery that can be applied to home visiting?

To identify evidence-based practices that can be applied to home visiting programs and to gather descriptive information about the touchpoints and implementation system inputs, the project team conducted a review of recent literature. Specifically, the literature review aimed to address the following questions: (1) What does research that addresses family substance use outcomes say about practices that home visiting programs may use to prevent, identify, and address substance use issues? (2) What does research say about service delivery models that address related outcomes? and (3) How are the touchpoints and implementation system inputs described in the literature?

In total, the project team reviewed 68 impact, descriptive outcome, and implementation studies. Sixty-four studies addressed family substance use outcomes and were related to either

(1) early childhood home visiting models, or (2) other service delivery models delivered in child welfare and physical and behavioral health services with families with young children at risk for or having identified substance use issues (referred to herein as "other service delivery models"). Four studies, recommended by the project's expert consultants and OPRE and HRSA, were on service delivery models that addressed related outcomes (including parenting, child safety, and permanency).

a. What does research that addresses family substance use outcomes say about practices that home visiting programs may use to prevent, identify, and address substance use issues?

Overall, the review indicated that there is little evidence on the effectiveness of practices that can be applied at each touchpoint and implementation system input. Most studies that measured effectiveness and reported on substance use outcomes addressed substance use within an overall model. Specific practices, such as referring, educating, treating, or preventing substance use, were not tested.

Impacts of home visiting models. Research indicates mixed effects of home visiting models on substance use outcomes, although some models have been effective with some outcomes in individual studies. Five studies reported positive impacts on at least one substance use outcome (Barlow et al., 2015; Green, Sanders, & Tarte, 2017; Kitzman et al., 2010; LeCroy & Krysik, 2011; Olds et al., 2010). All these studies enrolled parents prenatally or soon after the birth of a child; one enrolled pregnant American Indian teens. Four of them focused on outcomes of parents. The measure of parental substance use was different in each of the four studies and included illicit drug and marijuana use, alcohol use, receipt of substance use treatment, and impairment of role functioning due to use of alcohol or drugs. The fifth study, a 12-year follow-up of children enrolled in Nurse-Family Partnership, reported on subsequent substance use among children (Kitzman et al., 2010). These five studies with favorable impacts on substance use were conducted in a mix of urban and rural settings. The findings from the five studies provide some evidence of the potential of home visiting models to address substance use issues. However, these findings must be considered within the context of the findings from all of the impact studies on home visiting models identified in this review. Most of the other studies found no significant effects, and one study found a small significant negative impact on substance use (Michalopoulos et al., 2019).[2] Studies of three home visiting models—Family Spirit, Healthy Families America, and Nurse-Family Partnership—reported improved substance use outcomes. Appendix B contains more information on these studies.

Impacts of other service delivery models. Research on other service delivery models provides evidence on practices that can reduce substance use. Specifically, four studies tested service delivery models other than home visiting to address substance use among pregnant

[2] The authors of the study concluded that, because there is not a theoretical reason why home visiting programs would lead to increased substance use and previous studies have not found statistically significant increases in maternal substance use, "the totality of the evidence suggests that home visiting is not increasing the prevalence of substance use" (Michalopoulos et al., 2019, p. 59).

women and families with young children.[3] The four studies tested two therapeutic approaches—ecologically based treatment (EBT) and family behavior therapy (FBT); Screening, Brief Intervention, and Referral to Treatment (SBIRT) with motivational interviewing; and monetary incentives. Appendix B contains more information about these studies. Stakeholders may assess the appropriateness and feasibility of either incorporating these practices into home visiting services or encouraging home visiting model developers, LIAs, and home visitors to partner with organizations that offer services that use these practices. Despite the findings of each of the four studies, more information is needed about the efficacy of these models and practices in home visiting services.

b. What does research say about service delivery models that address related outcomes?

Research indicates that service delivery models that address related outcomes—such as parenting, child safety, and permanency—can improve parenting outcomes among caregivers with substance use issues and may improve substance use outcomes. Specifically, four studies tested attachment-based parenting programs and the use of peer recovery coaches or mentors. More research is needed, however, on the effects of these models on substance use. In addition, as with the other service delivery models, stakeholders need to consider the appropriateness and feasibility of coordinating with organizations that offer attachment-based parenting programs or peer recovery coaches or mentors to offer these services to families enrolled in home visiting programs.

c. How are the touchpoints and implementation system inputs described in the literature?

The review found that the touchpoints and implementation system inputs are generally described in the literature as theorized in the overarching conceptual model, but the literature lacks details. To illustrate, the inventory points to efforts to (1) recruit the families with the highest need by partnering with organizations serving these families, and (2) coordinate with external partners (such as through state-level task forces). However, the project team did not identify any studies in the literature review that focused on these topics. Overall, several studies described 8 of the 10 touchpoints and implementation system inputs.[4] Appendix B contains more information about how the touchpoints and implementation system inputs were described in the literature.

[3] These four studies do not represent the full literature on preventing or treating substance use, because the search terms focused on studies that were relevant to pregnant women and families with young children and had approaches relevant to home visiting services, such as services occurring within the home or within the context of a more coordinated service effort. As a result, the review did not include studies of medication-assisted treatment for substance use disorder, nor did it capture studies on behavioral therapies that were conducted before 2010 or with a population other than pregnant women and families with young children. For a broader discussion of evidence-based treatment for substance use, see *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* (U.S. Department of Health and Human Services, 2016).

[4] The project team did not collect, as part of the literature review, information on serving families based on strategies designed to address substance use issues or on monitoring systems to track substance use-related inputs, activities, and outcomes. The touchpoint emerged from information collected about other touchpoints as part of the literature review, whereas the implementation system input emerged from information collected as part of the inventory of practices.

4. What research opportunities are available to help stakeholders understand how home visiting programs can engage and support families to prevent, identify, and address substance use issues?

Findings from the inventory of practices and the literature review align with the constructs included in the overarching conceptual model. However, the project team found limited evidence on *which* touchpoints and practices relate to *which* outcomes, making it difficult for the conceptual model to fully reflect the pathways through which programs can engage and support families to prevent, identify, and address substance use issues. As such, the model serves as a framework for future research by identifying theorized pathways that require testing. The project team met with the project's expert consultants to gather input on (1) the constructs in the overarching conceptual model, and (2) the findings from the inventory of practices and literature review. Based on their input and the findings presented in this report, the project team developed research areas to guide future study. Research areas fall into two broad categories:

1. **Building the evidence base on practices that can be applied at the touchpoints.** Research areas include the use of screening results; the types of training that are most effective in equipping home visitors to offer education on substance use prevention, identification, treatment, and recovery to families; and practices to support families in making progress toward their goals.
2. **Exploring implementation system inputs.** Research areas include home visitor competencies and certifications for addressing substance use issues, the presence of substance use issues as a consideration for program eligibility, and the use of monitoring systems to track family retention in referred treatments.

Appendix C contains a list of research areas of interest for the touchpoints and implementation system inputs.

D. Next steps

Under the next phase of the Touchpoints project, the project team will seek input from OPRE, HRSA, and stakeholders on priority research areas. The team will then produce a series of brief study design reports that address specific research areas, engaging stakeholders to generate research questions and provide input on study designs. This process will help the team prioritize those research questions that are most feasible and of greatest interest to ACF and other stakeholders and that can be used for a variety of purposes at federal, state, or local levels. The project team will then pre-test potential measurement tools or data collection protocols. Next, the project team will develop a detailed study design that addresses one or more of the priority research questions and write a subsequent report summarizing this study design.

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APPENDIX A

OVERARCHING CONCEPTUAL MODEL AND DETAILED CONCEPTUAL MODELS

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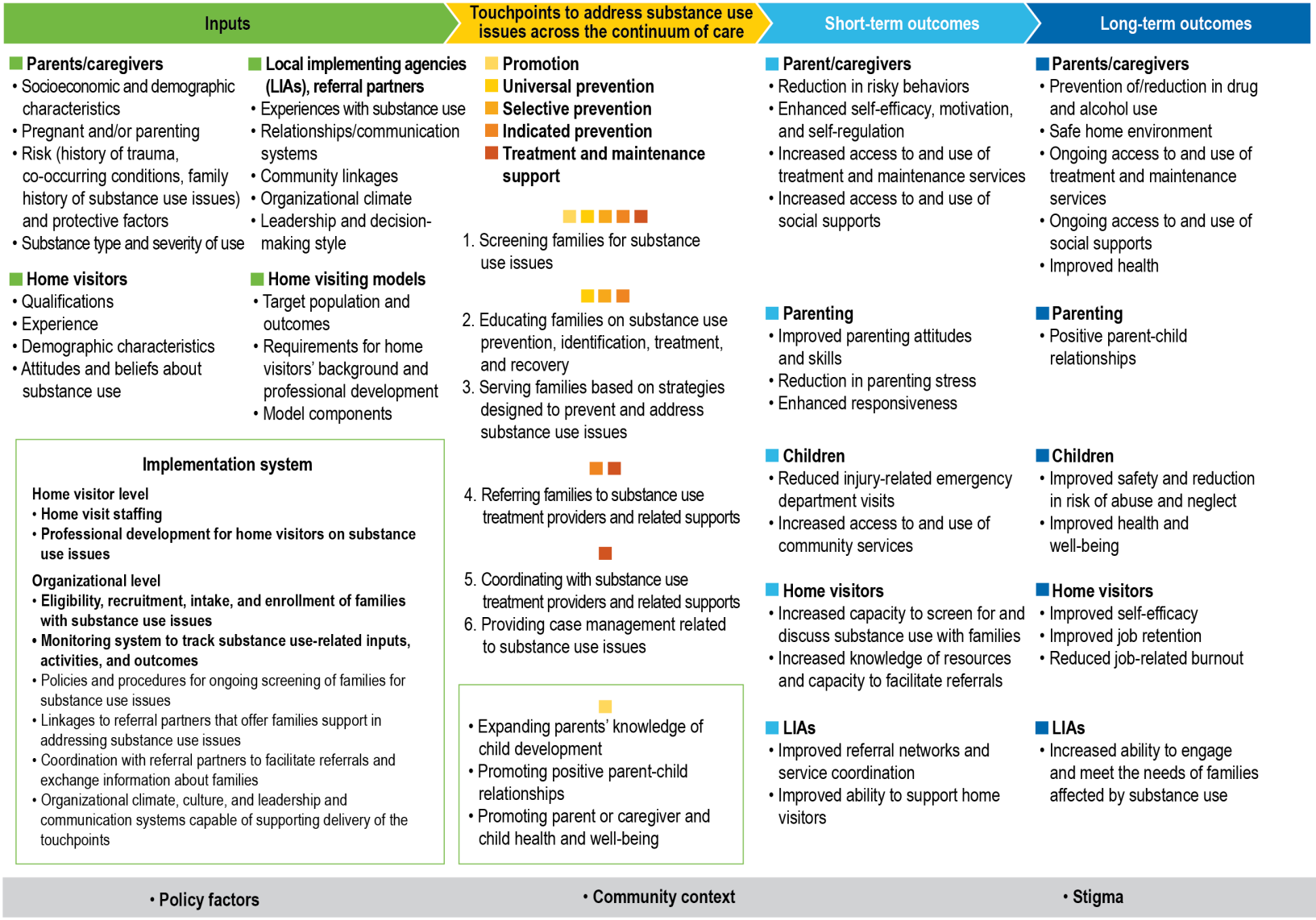
Figure A.1. Overarching conceptual model



Note: Touchpoints are activities involving direct interaction between home visiting staff and families through which home visiting programs can engage and support families to prevent, identify, and address substance use issues

Figure A.2. Detailed conceptual model on implementation system inputs

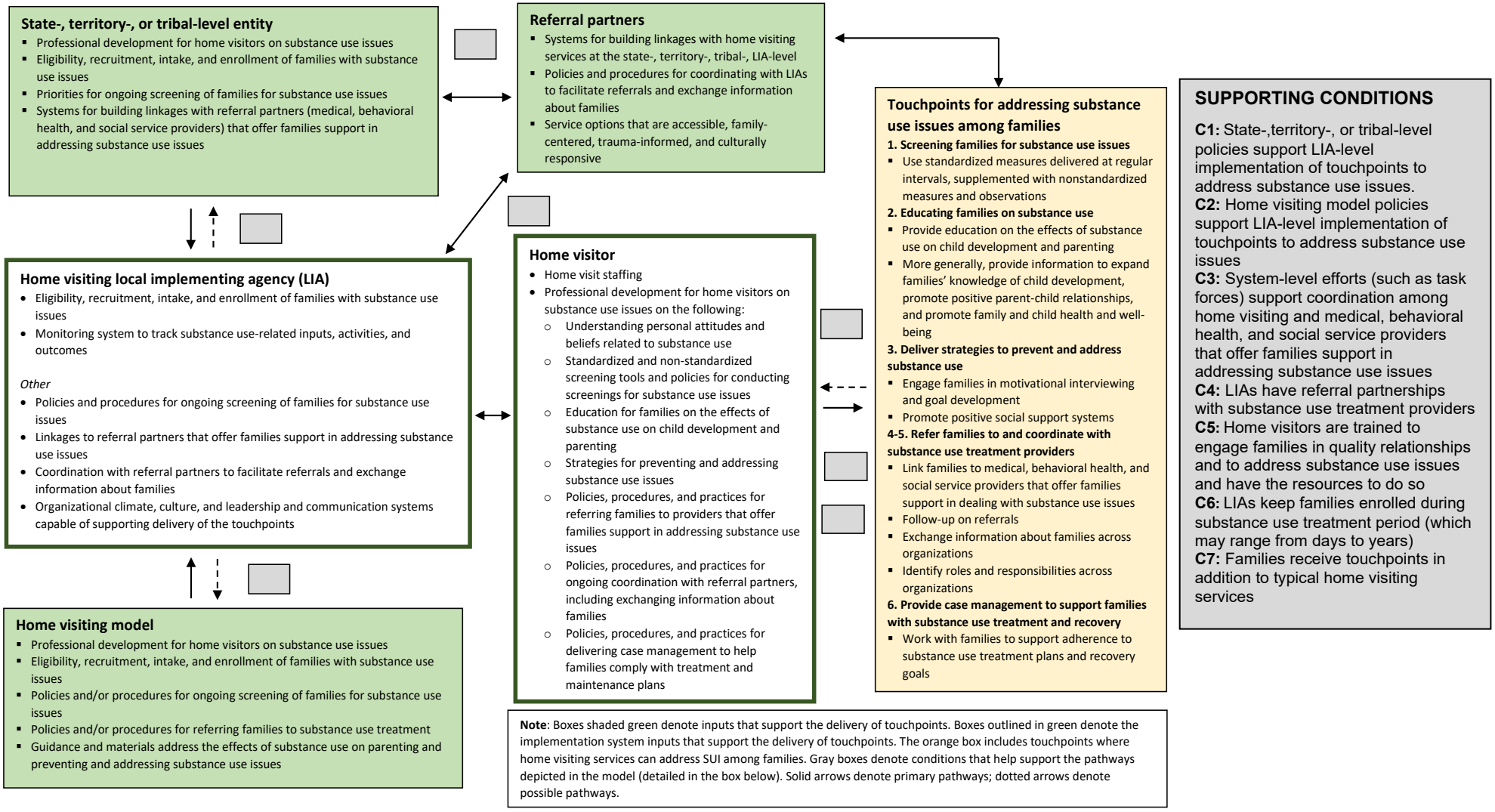


Figure A.3. Detailed conceptual model on prevention

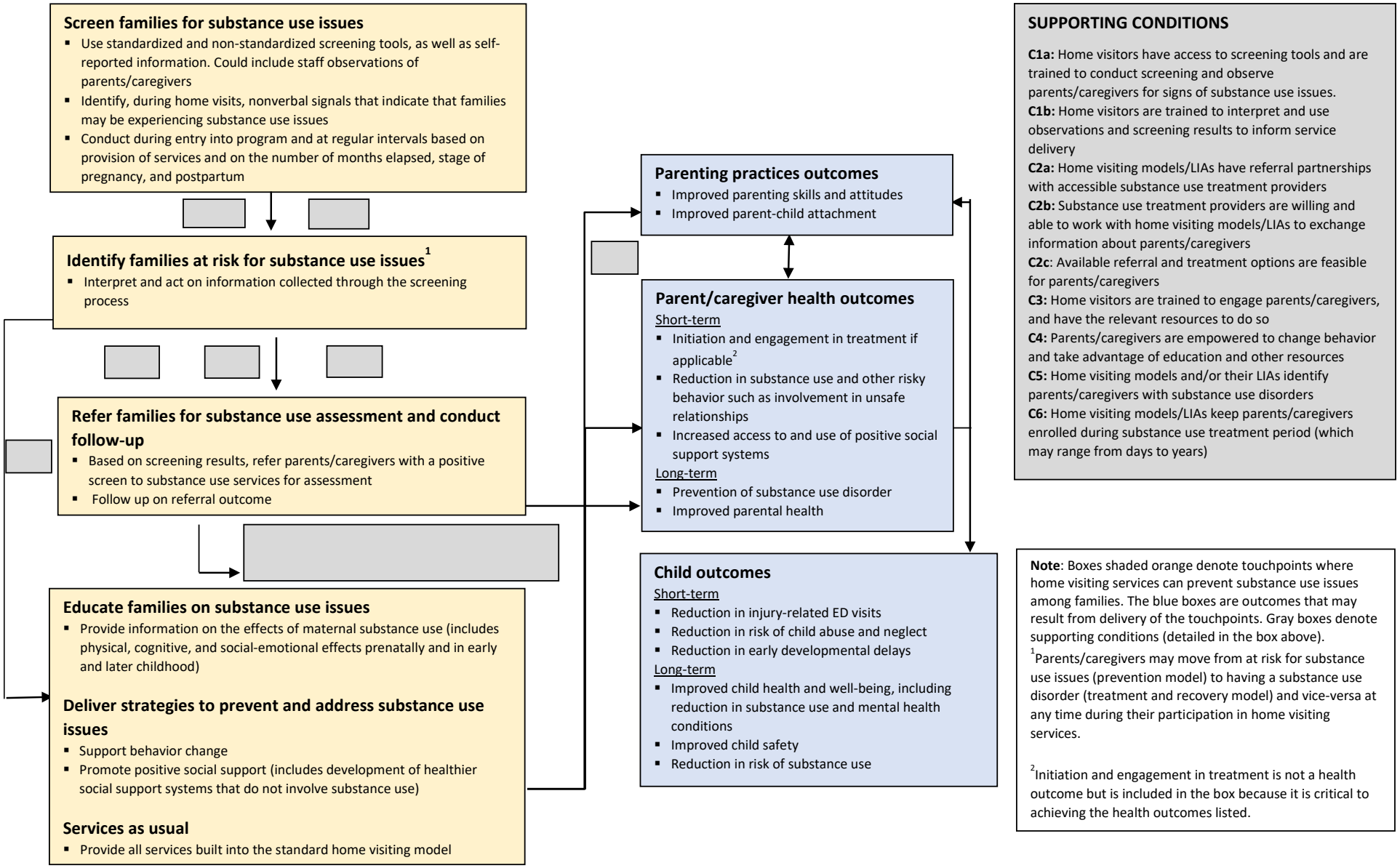
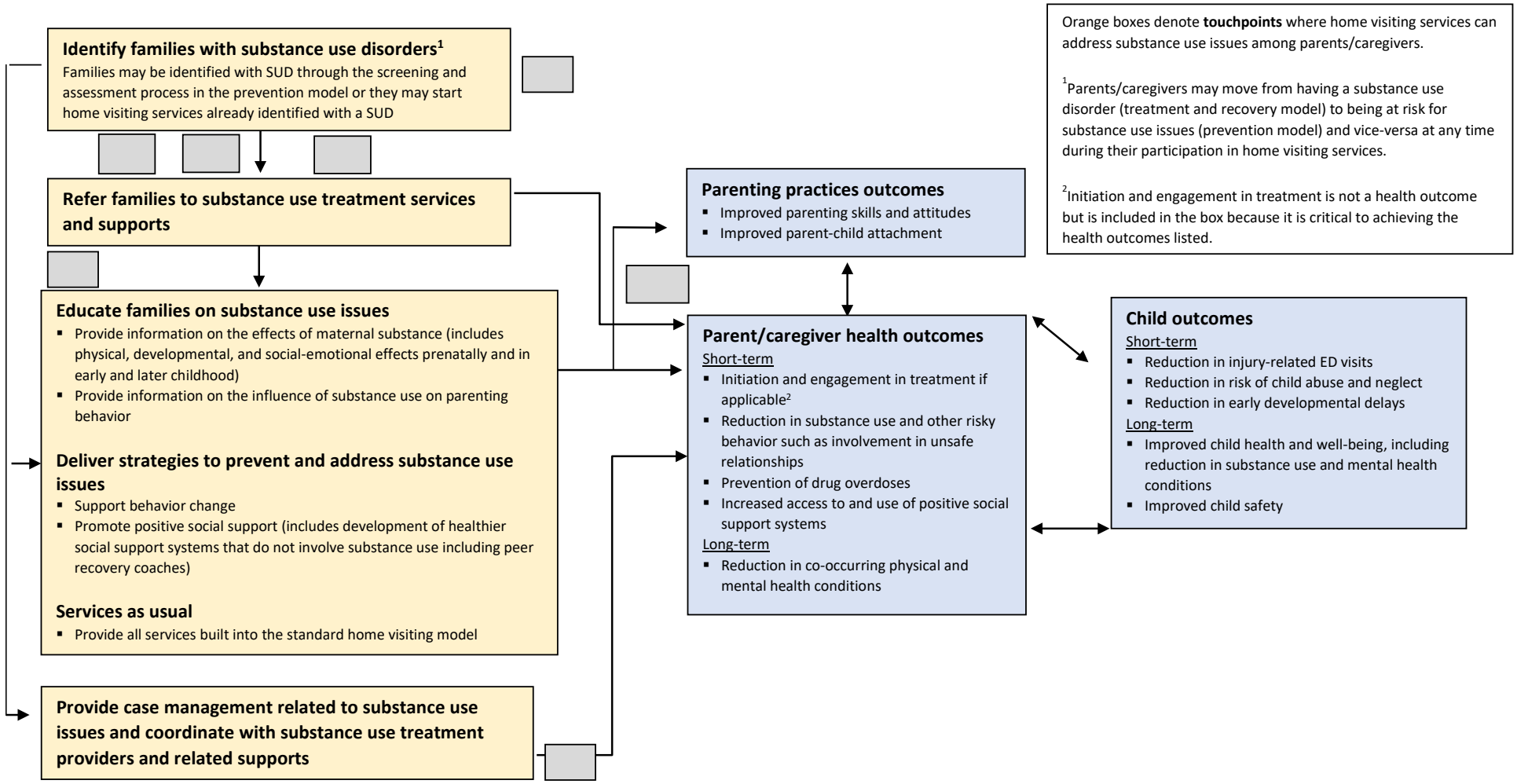


Figure A.4. Detailed conceptual model on treatment and recovery



APPENDIX B
INFORMATION FROM LITERATURE REVIEW

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Table B.1. Summary of studies of home visiting models reporting positive impacts on substance use outcomes

Study	Home visiting model	Population/context	Design	Sample size	Substance use outcome
Barlow et al., 2015[a] (follow-up 3 years postpartum)	Family Spirit	Expectant American Indian teens from four southwestern tribal reservation communities	RCT	322	Mothers in the intervention group had lower use in the past month of marijuana and illicit drugs compared to mothers in the control group. No statistically significant between-group differences were observed for alcohol use.
LeCroy & Krysik, 2011[a]	HFA; Healthy Families Arizona	Prenatal and new parents from a single program site in a large metropolitan area in Arizona	RCT	195	Mothers in the HFA group were less likely to report alcohol use at follow-up (one year after baseline data collection) compared to mothers in the control group.
Green et al., 2017[b] (follow-up 2 years post-enrollment)	HFA; Healthy Families Oregon	First-time parents (enrolled prenatally or within 3 months of a child's birth) with two or more identified risk factors from seven programs in Oregon; four serve primarily urban areas or mixed urban/rural, while three are primarily rural.	RCT	2,727	Treatment families were more likely to have received substance use treatment services, compared to families in the control group (although these numbers were small and the difference was only significant at < 0.1 level).
Kitzman et al., 2010[a] (12-year follow-up of children)	NFP	12-year-old, firstborn children of primarily African American, economically disadvantaged women who were randomized during pregnancy from Memphis, Tennessee	RCT	613	Children in the NFP group, compared with those in the control group, reported fewer days of having used cigarettes, alcohol, and marijuana during the 30-day period before the 12-year interview.
Olds et al., 2010[a] (12-year follow-up of mothers)	NFP	Primarily African American women from Memphis, Tennessee who were randomized during pregnancy (less than 29 weeks of gestation, with no previous live births)	RCT	613	Mothers in the NFP group, compared with those in the control group, reported less impairment in role functioning (at work, with friends, or with family members) due to use of alcohol and other drugs since the last interview at child age 9 years. No statistically significant between group differences were observed for alcohol, marijuana, or cocaine use.

[a]Effects, as documented by the Home Visiting Evidence of Effectiveness review.

[b]Effects, as documented by the Touchpoints project team.

HFA = Healthy Families America; NFP = Nurse-Family Partnership; RCT = randomized controlled trial.

Table B.2. Summary of studies of other service delivery models that address substance use issues

Study	Approach	Population/context	Design	Sample size	Substance use outcome
Slesnick & Erdem, 2013	Ecologically based treatment (EBT)	Homeless mothers with substance use issues	RCT	60	Mothers in the EBT group had reductions in the frequency of alcohol use at follow-up (9 months post-randomization) compared to mothers in the control group.
Donohue et al., 2014	Family behavior therapy (FBT)	Mothers reported for child neglect who also had a substance use issue	RCT	72	Mothers in the intervention group had decreased rates of hard drug use compared to mothers in the control group (at 6 and 10 months post-randomization).
Montag et al., 2015	SBIRT adaptation for AI/AN women of childbearing age	AI/AN women of childbearing age	RCT	263	There were no statistically significant differences in outcomes for the treatment and control groups.
Baker et al., 2018	Monetary incentives	Low-income women participating in a pre- and postnatal smoking cessation program	RCT	945	Women in the treatment group had higher smoking abstinence rates (at 6 months post-partum) compared to women in the control group.

AI/AN = American Indian/Alaska Native; MI = motivational interviewing; RCT = randomized controlled trial; SBIRT = Screening, Brief Intervention, and Referral to Treatment.

Table B.3. Touchpoints and implementation system inputs described in the literature

Touchpoints and implementation system inputs	Described in the literature
Touchpoints	
1. Screening families for substance use issues	Many studies described a process for screening families for substance use issues, with most noting the use of self-report screening tools. These studies described identifying whether an individual may be at elevated risk for substance use issues, may show predisorder signs but not qualify for a substance use disorder diagnosis, or may have a substance use disorder.
2. Educating families on substance use prevention, identification, treatment, and recovery	Few studies described educating families to prevent or address substance use; rather, substance use was addressed if identified as a need. One study described specific education to prevent substance use among families. A survey of Tribal MIECHV home visiting programs reported that many programs offered supplemental preventive services that focused on educating parents on the risks and impacts of substance use on infants and children (Novins et al., 2018). Four of the programs surveyed reported including tribal worldviews in their substance use education materials. In other studies, substance use was generally addressed if identified as a need.
3. Serving families based on strategies designed to prevent and address substance use issues	Several studies described preventing and addressing substance use issues among families by using motivational interviewing in goal development for behavior change or by engaging family and friends. Motivational interviewing is sometimes used in home visiting services to address substance use issues (Damashek et al., 2011) and engage families on a wide variety of challenges, such as service engagement, resource utilization, employment, education, depression, and intimate partner violence (Damashek et al., 2011; Dauber et al., 2017b). Motivational interviewing was a component of SafeCare+, Durham Connects/Family Connects, and the HELP enhancement.
4. Referring families to substance use treatment providers and related supports	Few studies focused on referring families to substance use treatment providers; studies typically discussed referrals to treatment in the context of SBIRT interventions or as part of efforts to coordinate services. Some studies described referrals made as follow-up to a screen and referral to treatment or SBIRT intervention, while others cited capacity issues among treatment provider agencies and the lack of specialized care and supportive services as significant barriers to successfully making referrals to substance use treatment. For example, Novins and colleagues (2018) found that Tribal MIECHV home visiting programs experienced challenges finding residential substance use treatment programs that allowed parents and their children to stay together while the parents engaged with treatment. MIHOPE stressed the importance of local programs' perceptions about the availability, accessibility, and effectiveness of services, which all may influence referral practices. In the study, less than half of all local programs reported having available, accessible, and effective services for treatment of substance use and mental health (Duggan et al., 2018).
5. Coordinating with substance use treatment providers and related supports	Few studies described forming close coordination among community service organizations in an effort to improve substance use outcomes for families. For example, according to MIHOPE, about a quarter of local programs reported having an MOU with at least one in-agency provider or outside provider for substance use and mental health treatment, a designated point of contact, and good or excellent coordination (Duggan et al., 2018). Another study compared the outcomes of families enrolled in a collaborative, higher-intensity home visiting service model—the Partnership Program—to clients enrolled in a referrals-only public health home visiting program (Haynes et al., 2015). In the Partnership Program, families benefited from coordinated service delivery from a family support worker (the home visitor) and public health nurse, as well as access to a mental health caseworker and child care provider, all of whom met monthly to discuss family progress and next steps.

TABLE B.3 *(Continued)*

Touchpoints and implementation system inputs	Described in the literature
6. Providing case management related to substance use issues	No studies discussed case management related to substance use issues in home visiting services, but case management was discussed in detail in the literature of other service delivery models. Case management in the context of substance use treatment typically includes assessment services, development of a care plan, linkages and referrals, monitoring and follow-up, and advocacy and support (Center for Substance Abuse Treatment, 2015). Many of these functions overlap with components of early childhood home visiting services, which include, among other services, assessment of family needs and referral to, and coordination with, needed services (Michalopoulos et al., 2015).
Implementation system inputs	
1. Home visit staffing (staff characteristics and staffing structure)	Home visit staff described in the literature were either paraprofessionals or health care professionals; some interventions used a team approach, including staff from multiple disciplines to address families' needs. Although no studies explicitly connected home visitor characteristics to the delivery of touchpoints, the project team found that studies described a range of characteristics of staff that delivered services to families, with variation largely driven by the staffing requirements for each model. Some models hired paraprofessionals to work directly with families, and others hired nurses as home visitors. Studies of other service delivery models described hiring therapists to work with families.
2. Professional development for home visitors on substance use issues	Studies found that, when home visitors received professional development on the topic of substance use, they were more likely to address the topic with families. However, few studies of home visiting models discussed substance use-specific training and supervision; studies of other service delivery models provided more detail on professional development but rarely discussed the content. Several studies found associations between providing professional development on the topic of substance use to home visitors and the rate at which they addressed the topic with families. For example, in a survey of 159 Healthy Families America and Parents as Teachers home visitors, greater substance use training was associated with greater knowledge and self-efficacy regarding substance use issues, and both training and experience were associated with home visitors addressing substance use issues in their current practices (Dauber et al., 2017a).
3. Eligibility, recruitment, intake, and enrollment of families with substance use issues	Studies of home visiting models were broadly targeted to families with low-incomes and living in high risk communities, whereas other service delivery models that focused on substance use outcomes typically had more targeted eligibility, recruitment, intake, and enrollment strategies for families with an identified or potential substance use issue. MIHOPE found that, in a sample of 88 home visiting programs, most (59 percent) considered, but did not require, substance use as an enrollment criterion, and only a few (2 percent) required the mother to report substance use (Duggan et al., 2018). Studies of the other service delivery models found high enrollment rates of participants with substance use issues; and, by design in some studies, all participants screened positive for substance use.

Note: The project team did not collect, as part of the literature review, information on monitoring systems to track substance use-related inputs, activities, and outcomes.

HELP = Home Visitation Enhancing Linkages Project; LIA = local implementing agency; MIECHV = Maternal, Infant, and Early Childhood Home Visiting; MIHOPE = Mother and Infant Home Visiting Program Evaluation; MOU = memorandum of understanding; SBIRT = Screening, Brief Intervention, and Referral to Treatment.

APPENDIX C
RESEARCH AREAS OF INTEREST

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Table C.1. Research areas of interest for the touchpoints and implementation system inputs

Touchpoints and implementation system inputs	Research areas of interest
Touchpoints	
1. Screening families for substance use issues	• Reach of screening and screening rates (including whether screening is universal or targeted and, if targeted, how many families are screened) • Screening tools used to screen for substance use and their validity (including which screening tools are used, whether they are standardized, and whether they are valid for their respective populations) • Selection of screening tools (including which personnel select the tools and their process of selection) • Processes and procedures for administering screening (including staff responsible, staff training, and frequency/timing of screening) • Organizational systems for tracking screening (including how the occurrence of screening and screening results are documented) • Use of screening results (including how screening results are used to inform service delivery) • Use of SBIRT in home visiting services to identify families with substance use issues and connect them with substance use treatment providers (including what an SBIRT workflow may look like)
2. Educating families on substance use prevention, identification, treatment, and recovery	• Content, mode, and dosage of education (including which types of educational content, such as content on behavioral and emotional regulation, and which modes of education, such as motivational interviewing, are most effective in preventing and addressing substance use issues) • Whether and how home visitors tailor education based on family needs (including whether home visitors offer different types of education to families based on their needs along the continuum of care) • Content of home visitor training on education strategies (including which types of training—such as informational training, reflective supervision, role playing, and observation-based feedback—are most effective in equipping home visitors to offer education to families)
3. Serving families based on strategies designed to prevent and address substance use issues	• Using motivational interviewing to engage families in goal development to change substance use-related behaviors (including how home visitors can best use motivational interviewing for screening and education) • Promoting positive social support (including strategies that encourage and support families to participate in positive social support systems regarding substance use issues) • Engaging relatives and friends in the process of working with families to prevent and address substance use issues (including strategies for effective engagement) • Promoting positive parent-child relationships by enhancing home visiting services with attachment-based parenting programs (including how attachment-based parenting programs and practices can be best incorporated into home visiting services to prevent and address substance use issues)

TABLE C.1 *(Continued)*

Touchpoints and implementation system inputs	Research areas of interest
4. Referring families to substance use treatment providers and related supports	• Strategies to facilitate the referral process (including whether and how home visitors help families make appointments with referral sources and follow up with families to confirm they have made appointments) • Referral networks with local treatment centers, mental health providers, and domestic violence programs to provide wraparound services (including whether and how organizational-level connections are developed and maintained)
5. Coordinating with substance use treatment providers and related supports	• Practices to promote coordination (including methods for establishing roles and responsibilities and information-sharing agreements across community agencies) • Practices to support families in making progress toward their service goals (including whether and how home visitors check in with families at regular intervals about their progress and, with family permission, share information across organizations about families' progress) • Coordination with peer recovery coaches to provide ongoing support to families during treatment and recovery • Coordination with medication-assisted treatment programs, behavioral therapies, and recovery support services • Financial or in-kind incentives to families to encourage specific behaviors or outcomes (including how families may be incentivized to enroll in substance use treatment and attend treatment sessions and appointments) • Other community-level factors that may facilitate or inhibit the effectiveness of referrals (including whether service deserts affect referrals)
6. Providing case management related to substance use issues	Given limited information on specific practices for this touchpoint in the inventory of practices and literature review, more information is needed to identify research areas of interest. This may involve considering an implementation study in consultation with federal stakeholders and experts.
Implementation system inputs	
1. Home visit staffing (staff characteristics and staffing structure)	• Home visitor education (including the last level of educational attainment and field of study) • Home visitor training in or experience with addressing substance use issues (including whether home visitors have previous professional experiences dealing with substance use issues) • Competencies and certifications for addressing substance use issues (including whether state-certified home visitors appear better equipped to help families address substance use issues) • Team approach, including staff from multiple disciplines (including whether home visitors work in dyads or groups with other professionals) • Cultural competencies of staff (including whether home visitors are culturally competent to work with families in a given community or of a particular race or ethnicity)

TABLE C.1 *(Continued)*

Touchpoints and implementation system inputs	Research areas of interest
2. Professional development for home visitors on substance use issues	• Home visitor training and supervision (including the types of training and supervision home visitors receive, such as reflective supervision, and the topics and strategies covered, such as substance use issues, opioid use disorder, neonatal abstinence syndrome, and FASD; SBIRT; motivational interviewing; and ongoing recovery support) • Supervisor training in reflective supervision, role playing, and observation-based feedback (including which types of training are most effective in equipping supervisors to oversee and guide home visitors in working with families dealing with substance use issues) • State-level initiatives (including guidelines about screening and other resources related to substance use issues, training in mental health, and an addiction helpline for home visitors to call)
3. Eligibility, recruitment, intake, and enrollment of families with substance use issues	• Referral networks with local treatment centers, mental health providers, and domestic violence programs to provide wraparound services (including whether referral networks facilitate the making of referrals and which procedures best allow organizations to share referrals with each other) • Presence of substance use issues as a consideration for program eligibility (including whether targeted home visiting models are more effective at serving families with substance use issues) • Differences in eligibility, recruitment, intake, and enrollment policies and procedures (including identifying policies and procedures that best recruit and enroll families affected by substance use issues)
4. Monitoring systems to track substance use-related inputs, activities, and outcomes	• Monitoring systems at the home visitor level that may facilitate interactions with families about substance use issues (including monitoring of families screened for substance use issues; results of screening or observation; delivery of education on the effects of substance use issues during home visits; families referred to substance use assessment and treatment; family engagement with referred treatments; family retention in referred treatments; and barriers to family engagement with, and retention in, referred treatments) • Monitoring systems at the state, territory, tribal, and home visiting model levels that influence LIAs and, in turn, the delivery of touchpoints (including which types of monitoring systems are most accessible and less burdensome to implement)

FASD = fetal alcohol spectrum disorders; LIA = local implementing agency; SBIRT = Screening, Brief Intervention, and Referral to Treatment.

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