The Sobriety Treatment and Recovery Teams (START) Model: Implementation Manual

Chapter 2:

Getting Started: Site Selection, Readiness, and Pre-Implementation Planning

Produced in a Partnership with the Kentucky Department for Community Based Services and Children and Family Futures.

2018
SOBRIETY TREATMENT AND RECOVERY TEAMS (START) MODEL: IMPLEMENTATION MANUAL

PREFACE

The Sobriety Treatment and Recovery Teams (START) model is a child welfare led intervention that has been shown, when implemented with fidelity, to improve outcomes for both parents and children affected by child maltreatment and parental substance use disorders (SUD). START is specifically designed to transform the system-of-care within and between child welfare agencies and SUD treatment providers; it also engages the judicial system and other family serving agencies. It includes a complex array of strategies such as peer mentor supports, quick access to intensive SUD treatment, cross-system collaboration, intensive case management, and a family-centered approach.

Children and Family Futures (CFF) is the only national resource for providing technical assistance, training, and consultation on implementing START. CFF has extensive experience in providing technical assistance (TA) and capacity building to sites to implement programs and strategies designed to serve families affected by both child maltreatment and parental substance use disorders.

To be titled a START program, the practices of the model must be implemented with fidelity to the essential treatment components. The full START Model Implementation Manual is only available through formalized technical assistance and training. However, one chapter is included at https://www.cffutures.org/ for your information. This first chapter, entitled: Basic Tenets and Essential Elements of START: No More Business as Usual, covers the theoretical background of START, the essential implementation components, and a sample logic model. Please feel free to download chapter one of the implementation manual to learn more.

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- Leadership within the Kentucky Judicial System
- START Social Services Workers, Supervisors and Family Mentors
- Parents and their children and extended families
- The University of Kentucky, Targeted Assessment Project
- Cuyahoga County Division of Children and Family Services

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CHAPTER 2: GETTING STARTED: SITE SELECTION, READINESS, AND PRE-IMPLEMENTATION PLANNING

Summary: As a model that began in 1989, START has responded to changing times and local needs with adaptations to strengthen it while retaining the essential practices. The START model is a highly complex intervention that require technical assistance to implement. Before deciding to implement START, jurisdictions can assess their needs, understand the resources required, and evaluate their readiness for implementation. Although the START model can be adapted to fit local needs and practices, some fundamentals must be place. Ideas for improving your system before implementing START are included.

Lead Author: Lynn Posse, MA

2.1 Introduction: The Evolution of START

The Sobriety Treatment and Recovery Teams (START) model is a child welfare led initiative that has been shown, when implemented with fidelity, to improve outcomes for both parents and children affected by child maltreatment and parental substance use disorder (SUD); it is rated as a promising practice by the California Evidence-Based Clearinghouse for Child Welfare\(^\text{1}\). START is specifically designed to transform the system-of-care within and between child welfare agencies and SUD treatment providers; it also engages the judicial system and other family serving agencies. As jurisdictions consider the possibilities of implementing START, there are always questions about adaptations to accommodate local policies, culture, and need. The history of START development provides a glimpse into its evolution and adaptation of the model in response to changing times and conditions.

In 1989, the Alcohol and Drug Addiction Program Team (ADAPT) was established in Toledo Ohio. The ADAPT program grouped together promising practices between agencies with the goal of reducing foster care placements for families affected by parental SUD. In the mid 1990's, Cuyahoga County Department of Children and Family Services (CCDCFS) in Cleveland, Ohio, was motivated to find a way to serve the high number of referrals with parental substance use disorders primarily of crack cocaine. CCDCFS developed START based on the ADAPT model with the help of the Annie E. Casey Foundation (2008) and local treatment providers. As Family to Family's primary approach to the challenge of drug abuse in child welfare, START incorporated Family to Family strategies for supporting families, building community partnerships, and improving decisions. However, in 1996 while developing the START model, 11 infants prenatally exposed to cocaine died while remaining in their homes. The subsequent crisis in the child welfare system resulted in requirements that all infants with prenatal exposure to illicit substances be taken into foster care.

Although ADAPT used peer supports and collaborative practice to prevent infants with prenatal exposure from being placed in out-of-home care (OHC), the CCDCFS

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requirement for OOHC placement changed the goal of START to reducing the time to reunification for parents with their substance-exposed infants. In actuality, infants and children in START cases tended to remain in OOHC for longer periods due to the careful practices of the START teams and the START standard requiring six months minimum parental sobriety prior to reunification. The “six-month rule” was developed in collaboration with SUD treatment experts who strongly held that six months of sobriety was the very earliest that a parent could be considered stable enough to safely and competently care for their child. Although reunification in START required a longer period to enable parents to stabilize in their recovery, significantly fewer START-served children reentered foster care after reunification.

Nonetheless, START and Family to Family standard practice was aimed toward advocating for infants to remain in the home when safely possible. Consequently, START workers and supervisors documented the safety and protective factors present in specific homes. Over time, they convinced CPS leaders and the courts to allow specific children to remain with their parents in the home. With time, the strict requirement to remove substance-exposed infants was relaxed with more infants remaining with their parents, a focus very much in alignment with the Annie E. Casey Foundation’s goals.

In 2006, Kentucky examined statewide data to find high numbers of children affected by parental SUD and began an annual investment of $2 million state TANF MOE funds for a Substance Abuse Initiative designed to transform the system-of-care. When the Kentucky Department for Community Based Services (DCBS) adopted START in 2007, their expressed goal was to prevent removals and reduce the need for foster care among children from families with parental substance use disorders. DCBS leadership added treatment personnel, a liaison with the Division of Behavioral Health and recruited Tina Willauer, former START Director for Cuyahoga County, to head up the effort in Kentucky. START was initially implemented in three Kentucky sites with a rigorous outcome study designed to test the impact of START on reducing foster care entry and improving parental capacity and sobriety. Beginning in 2012, the outcomes of START have been published in numerous peer-reviewed journals and consistently show lower rates of OOHC placement and repeat maltreatment along with improved parental capacity and sobriety. However, like START in CCDFCS, START-served children who do require OOHC tend to remain in care longer than with usual CPS practice.

By the time Kentucky adopted START and later adapted it to more rural environments, the crack cocaine epidemic had mostly subsided, but the prescription opioid and subsequent heroin epidemics were exploding. Changing times called for adaptation, along with careful consideration of what is essential to the model’s success versus what can be changed without losing effectiveness. START has been implemented in seven diverse counties in Kentucky, in Indiana, North Carolina and New York. At this writing, many states are considering START as a model to fit their state and a few are launching the program. Throughout the manual we name and describe the essential elements of START along with potential adaptations to accommodate a variety of site-specific needs and practices.
2.2 Essential Components of START

START is a Child Protective Services (CPS) intervention for families with parental substance use and child maltreatment that helps transform the child welfare system-of-care. The primary goal of START is to keep children safe and reduce out of home placements, maintaining children with their families when safe and possible. START is an evidence-supported intervention with essential intervention strategies that must be implemented to achieve fidelity to the full model. The following list includes those essential practices and core implementation components of START.

1. START is initiated and driven by CPS for families with co-occurring substance use disorders and child maltreatment and is implemented in collaboration with SUD service providers.

2. A strong collaborative partnership with SUD treatment provider(s) is required to coordinate treatment services for the family. The collaboration is supported by written contracts and agreed upon START tenets.

3. The family is the client and the focus; family includes children, mothers, fathers, significant others, caregivers such as foster parents, and other relatives.

4. START must be based on principles implemented through shared decision-making with families, CPS staff and service providers that may affect child well-being.

5. START must be constantly evolving toward the use of best practices in CPS and SUD and co-occurring MH/trauma treatment.

6. START respects that children optimally belong with their family, seeks to promote parent/child bonding, and keeps children safely with family whenever possible.

7. START adheres to a rapid timeline that ensures early identification of eligible families after the initial CPS report and quick access to treatment services for SUDs and co-occurring mental health/trauma.

8. Substance use disorder treatment must be community based, intensive and of high quality.

9. CPS must adhere to the START Minimum Work Guidelines that represent a more intensive approach to service delivery than traditional CPS practice.

10. Family mentors are essential to START. They are people in long-term recovery from SUD with personal experience in the CPS system. They must be employed in, housed, and supervised by CPS.

11. One family mentor is paired with one CPS worker to form a dyad who shares a caseload of no more than 12-15 families.

12. START must be engaged in continuous quality improvement guided by program evaluation data.

2.3 Begin by Assessing the Needs in Your Jurisdiction

When a jurisdiction is deciding whether and where to use the START model, it helps to gather and reflect on jurisdictional data at the state, county, regional, or tribal level as appropriate. An initial consideration is your jurisdiction’s typical response to infants with prenatal substance exposure; are they treated as an alternative response (differential response) or as an investigation, or as an automatic placement in OOHC. There is wide variation across jurisdictions. Secondly, the following data will be helpful for leadership consideration:

- The number and percentage of cases, both referral and OOHC placement, with parental substance use as a risk factor, usually over a year’s time. Ideally, compare the last three to five years so that you can see trends.

- How many of these cases (and what percent) had infants with prenatal exposure (possibly defined as the CPS referral/report received within 30 days of birth)?

- How many of these cases had at least one child in the range of 0-3, 0-5, and 0-9 in the household?

- What is the rate of OOHC placement for CPS referrals with parental SUDs as a risk factor?

- The number and percentage of the cases described above with out-of-home care compared to cases without parental SUDs.

- The number and percentage of the cases above with repeat maltreatment and recurrence compared to cases without parental SUDs.

This information can help you determine if parental substance use is a significant factor in your reports, out-of-home care, and repeat-maltreatment cases. If you look at data across regions or counties, you should be able to see which areas have a higher number of cases with parental SUDs and where efforts to reduce OOHC might produce the biggest benefits. When examining the need, consider that all potential cases may not be eligible or served by START for several reasons, such as the referral coming from the investigation/intake team requires a longer time than START standards, or mental health issues are dominant, or START caseloads are full. For these reasons, smaller sites that may support only one CPS worker/mentor dyad should have at least 20 families in the previous year that meet the selection criteria for START:

- Case had substantiated (or alternative victim) finding for child abuse/neglect,

- Parental substance use was a primary risk factor,

- There was no active CPS case at the time of the CPS report,

- And at least one child age 5 years or younger (or an alternative cut-off age) with a focus on infants with prenatal substance exposure.

Although START can be implemented in smaller counties, a typical START team should be 3-4 worker/mentor dyads that can carry at least 30-45 total cases at a time. Look for

counties/regions with at least twice that many cases so that you would be sure to fill the caseloads. Empty or partially empty caseloads can cause a project to falter and ultimately fail.

START is designed for families with young children where child safety is most at risk. The selection criteria of child-age can be adjusted in order to widen the eligibility and have an adequate number of potential cases to fill caseloads. To set selection criteria based on child-age, the average number of reports per year for that county with SUDs as a risk factor per child age (e.g., substance exposed infants, one child 0-3, one child 0-5). There needs to be roughly twice as many referrals that meet the selection criteria based on the child-age range selected.

### 2.4 Consider Resources Required to Implement the Model

Table 2A outlines the resources needed or recommended to implement the START model. The costs of implementing START in a jurisdiction will depend on the resources that are already available and the additional cost of various elements in the jurisdiction.

**Table 2A: Resources to Consider for START Implementation**

<table>
<thead>
<tr>
<th>Resource</th>
<th>Description</th>
<th>Estimated Cost/Consideration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialized CPS Workers</td>
<td>Each worker carries no more than 15 cases</td>
<td>Salary and fringe per worker. Consider whether additional workers are necessary or if existing positions can be designated to the program. A case is defined here as one family.</td>
</tr>
<tr>
<td>Family Mentors (peer support)</td>
<td>One mentor paired with each START worker (the dyad)</td>
<td>These should be full-time positions with salaries and benefits. They must be stationed within the child welfare agency although they can be employed through a contracted agency. The tasks of family mentors are broader than those of peer recovery support workers hired by substance use or mental health treatment providers. These are likely to be new hires.</td>
</tr>
<tr>
<td>CPS START Supervisor</td>
<td>One supervisor for every 3-4 dyads</td>
<td>Salary and fringe per supervisor. Consider whether an additional supervisor/s are needed or if existing positions can be designated to the program.</td>
</tr>
<tr>
<td>START Director/Manager</td>
<td>Lead and manage the implementation of START</td>
<td>Full time if multiple START sites. Consider whether existing staff can assume this position or if additional staff are needed. May be combined with other duties if START is in one site only. May include assistant director if multiple START sites in one jurisdiction.</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Resource</th>
<th>Description</th>
<th>Estimated Cost/Consideration</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUD and MH consultation/management</td>
<td>Lead the collaboration with SUD/MH</td>
<td>Ideally employed by CPS but may be liaison from the SUD/MH administrative office. Depending on the scope of START, this could be a full-time or part-time responsibility.</td>
</tr>
<tr>
<td>SUD and MH assessment and treatment coordination</td>
<td>Coordinate access and service delivery in START sites</td>
<td>Most sites find the need to employ one or more person in START sites to coordinate assessment, access to treatment, attend family team meetings, and ensure holistic and high-quality SUD treatment. Usually an independently-licensed clinician with SUD and MH/trauma expertise.</td>
</tr>
<tr>
<td>Leadership at the local and state level.</td>
<td>Ensure funding and policy development</td>
<td>Usually no direct cost to the program.</td>
</tr>
<tr>
<td>Mileage/travel</td>
<td>For START workers and mentors and to support parents</td>
<td>Costs will depend on urban vs. rural, distance covered by staff, available public transportation, mileage reimbursement or agency vehicle use. There are expanded needs for more frequent home visits, transporting clients to the first four treatment appointments and attending local or regional meetings.</td>
</tr>
<tr>
<td>Intensive SUD treatment with an adequate array of services</td>
<td>Full continuum of services to meet parental needs (both mothers and fathers)</td>
<td>Cost is estimated at $5000-$8000 per parent served. Treatment that is covered by Medicaid, insurance, or contract, will reduce cost to the program. May need additional funds for services not covered by 3rd party. Intensive treatment determined by client’s level of need: for START, intensive outpatient services (IOP) are usually required (minimum standard of 12-15 hours per week including recovery and life-skills supports). Detoxification and residential services may also be needed.</td>
</tr>
<tr>
<td>Treatment for co-occurring mental health and trauma needs.</td>
<td>Individual and group therapy for co-occurring disorders</td>
<td>May be covered by Medicaid/insurance or included in the cost of SUD treatment. If not, budget for at least 30% of clients to receive this service at approximately $1500 per client. Access to psychiatric services, medication management, and medication-assisted treatment (MAT) are needed.</td>
</tr>
</tbody>
</table>

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Drug Testing</td>
<td>Weekly during intensive phase of treatment, then less frequently over time per team input</td>
<td>Cost depends of your drug test contract. Approximately 30-50 tests per individual parent over the life of the case. Consider cost of collection (time/salary/fee per observed urine collection), drug-test kits, and laboratory confirmation when necessary. Quick tests and &quot;admission of use&quot; forms are less expensive than lab confirmation on each test. ²</td>
</tr>
<tr>
<td>Flexible funds for families</td>
<td>Important but not an essential component of START</td>
<td>Approximately $1500 per family; may be covered by existing or new community resources first. Funds available to reduce/eliminate barriers to reunification, keeping children in the home, or accessing treatment. Examples include utility bills, gasoline cards, or bus tokens.</td>
</tr>
<tr>
<td>Evaluation</td>
<td>Provide information and coaching on fidelity and outcomes</td>
<td>Budget $25,000 to $75,000 per year. External evaluator may cost $50,000 to $75,000. Internal evaluator may cost less if using existing workforce. Internal evaluation is usually adequate and may offer more frequent communication and CQI efforts with the START team.</td>
</tr>
<tr>
<td>Data collection</td>
<td>Spreadsheets, secure websites, data-entry person</td>
<td>Depends on what systems you have available, whether you need a programmer for a web-based system, if staff need to be paid to enter data (such as for a provider).</td>
</tr>
<tr>
<td>Technical Assistance</td>
<td>Two years of TA by START consultants at minimum</td>
<td>During the exploration, installation, and initial implementation phases of START (usually requiring two years), sites should plan to have monthly phone consultation and at least three on-site visits by START consultants.</td>
</tr>
</tbody>
</table>

2.5 Assess Readiness for Implementing the Program

Several factors should be considered when selecting a site. The higher the readiness, the more quickly and smoothly a site will achieve full implementation. There are, however, certain conditions that suggest a need for remediation before considering START implementation.


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2.5.1 Barriers to Implementation

The following is a sample of significant implementation barriers that would require more extensive readiness preparation.

- Challenges in basic child welfare operations such as non-supportive leadership, very high rates of staff turnover and vacancies, challenges to complying with standards of practice, or unresolved scandals.

- Challenges within the judicial system such as automatic removals to OOH; mistrust or refusal of services such as medication-assisted treatment (MAT); or significant conflicts between judicial, treatment, and/or child welfare agencies.

- Challenges within the SUD treatment community such as lack of SUD treatment services locally. There must be local access to at least one operational IOP. To ensure that low-income families are able to receive services, there must either be publicly-funded treatment and drug testing options, or the CPS or other source must be identified to fund the services required by START clients.

- Challenges within the community such as severe lack of recovery resources such as self-help support groups.

- Stated unwillingness to consider changing the practices within child welfare, the judicial system and/or SUD treatment.

2.5.2 Assessing Readiness

The National Implementation and Research Network (NIRN) has guidelines and assessment process for readiness to change. A brief on readiness to change will also be helpful to sites considering START implementation. A formal readiness for change assessment can assist a jurisdiction in understanding if the need, resources, and capacity to implement the program are in place or need to be strengthened.

The following are examples of conditions that suggest a medium level of readiness for START implementation but indicate a need for additional preparation and time for implementing:

- The child welfare office is not routinely implementing family-decision-making strategies (family team meetings), has not established a collaborative partnership with SUD treatment providers, or struggles to implement best CPS practices. Generally speaking, the more sophisticated the office is with using best practices, the easier it will be to adopt START strategies.

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3 NIRN website. [http://nirn.fpg.unc.edu/](http://nirn.fpg.unc.edu/)

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• There may be perceived barriers to implementation such as staffing or uncertainty on how to change typical practice to align with START.

• There may be distrust or other challenges to the collaboration between child welfare agencies and SUD treatment providers. Our experience suggests that although child welfare and SUD treatment agencies perceive a strong collaboration, START implementation may challenge that perception and require additional time to change system practices for successful START implementation.

• There also may be some level of distrust between the courts and child welfare and SUD/MH treatment providers. There are often different priorities, practices, standards of operation, beliefs and values, and expectations of parents that need to be resolved. Stronger commitments by the staff in the three major systems to work together are indicative of more robust readiness to implement START.

Sites with high readiness to implement START might include the following sample capacities:

• The child welfare office is accustomed to using best practices and adopting new practices with evidence of effectiveness. Leadership is forward thinking and support staff in growth and trying new practices. Staff turnover is relatively low and staff are well-trained. Data is used to reflect on the effectiveness of practice and to support improvements. Collaborative efforts with community partners have been in place for years.

• There are multiple treatment options available in the community with resource-rich recovery supports such as self-help meetings, sober housing, sober social activities, housing, employment options, and vocational training. Treatment providers are accustomed to accommodating the specific needs of CPS cases.

• Sound judicial practices aligned with child welfare laws support well-reasoned decisions about families affected by SUD. The judiciary understands SUDs and recovery supports and is open to using court orders to support participation in treatment as recommended by treatment professionals and included on case plans.

2.6 What to Expect

2.6.1 Early and Ongoing Effects

Although implementation may require two to four years of work to achieve full fidelity to the START model, after a period of planning, sites that begin implementation are likely to see some immediate effects. For example, family mentors as they join CPS units begin to change the culture by creating an understanding of SUD, the potential for parents to enter into recovery and become productive citizens, and the needs of parents engaged in CPS (Huebner, Willauer, Brock & Coleman, 2010). They also begin to change the culture within SUD treatment and the community for many of the same reasons. Because the START model seeks to keep children safely with their parents when possible, the rate of entry into OOHC should decline, perhaps not optimally at first, but below baseline or historical rates (Huebner, Posze, Willauer & Hall, 2015). You
should begin to see parents more rapidly engaged in treatment and a growing appreciation of the importance of timely access to treatment services.

On the other hand, the START model is a time- and resource-intensive approach that can reap rewards if done well and over a period of years. It may take several years to begin seeing optimal outcomes of START with a team that implements START with strong fidelity. The team has a great deal of learning to do, START cases are open on average for 15 months, and children in closed cases must be followed for several years to track outcomes such as repeat maltreatment and foster care reentry. So a jurisdiction must make a commitment to the approach and to its implementation for several years.

### 2.6.2 Commonly Experienced Challenges

No matter how carefully a site is selected, there will be barriers to implementation to be worked through. The technical assistance provided that is required for full implementation is designed to assist sites in identifying and mitigating challenges. The following are some examples of issues that have arisen at various sites, along with ideas for working through them.

- **Staff turnover in the CPS and public or non-profit SUD/MH treatment programs can be challenging.** Because START requires specialized training and supervision, it is important to have a plan for on-boarding new staff and leadership commitment to filling vacancies quickly. Onboarding should include team-building activities, because the START model requires a great deal of team-oriented collaboration.

- **Loss of high-level leadership can impact any initiative, so it is important to engage leadership support and provide frequent updates to leaders at the state, regional, and local levels.**

- **Disagreements about treatment priorities and choices are likely as CPS staff learn about substance use disorders and best practices and then question their SUD treatment counterparts about their judgments, decision-making, and practices such as treatment of relapse and abstinence.** Sometimes the questions are simply clarification and part of the learning process.

- **Similarly, CPS may have disagreements with SUD treatment providers and the judicial system when they question decisions about child placement, the competency of extended-family members in caring for children, and safety issues.** Some disagreements can be remedied with team-building, education, and improved communication. Sometimes service quality does need improvement, and the START leadership and Technical Assistance providers have to guide and train team members and providers on the model and best practices.

- **Finding the right people for positions (credentialed, experienced, understand SUDs, collaborative, flexible, etc.) can be a challenge.** Many times the desire to ramp up quickly influences staffing choices, and the originally selected staff may end up leaving or being transferred off the team. The mentor hiring process can

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be arduous, but is important for selecting mentors who meet START criteria and are the best fit for the agency.

- Building good relationships with the courts is frequently an issue. It can be helpful to meet with the judge(s) to discuss the START model goals, practices, and positive outcomes. Generally, once judges see the benefit of START in terms of service intensity, informed court reports, and collaboration with treatment providers, they like working with START and support the recommendations of the team.

- The intake or investigations staff of CPS are key to the success of START because they identify parental SUD as a risk factor and refer potential cases to START within the model timeframes. Problems can arise from several sources, including territoriality, overwork, and turnover. The START supervisor must maintain close ties with intake/investigations, working through issues, educating new staff about the referral process, and responding quickly to referrals.

- Tensions between staff can be detrimental to this team-oriented model. While it is not uncommon on any unit to have personality conflicts, conflicts on the START team they cannot be ignored. The START supervisor and manager must be willing and able to direct and support staff in working through conflicts, including conflicts with staff at other agencies.

- Mentor problems are addressed thoroughly in the chapter on family mentors that is available with technical assistance. In short, issues with mentor boundaries, home-life interfering with work, and need for extra supervisory support are to be expected and START supervisors must be prepared to address them.

- In communities without a full array of services, services may need to be developed. For instance, an intensive outpatient program is necessary in the START site. Agencies vary in their ability to institute a new service; some may only need guaranteed referrals or start-up funds, while others may require stronger technical assistance. It is helpful for CPS to have SUD and co-occurring MH/trauma expertise available at least through consultation.

- Evaluation is an important component of setting up any evidence-based practice, both to monitor for and support fidelity to the model and to verify whether desired outcomes are achieved. Quite a bit of data entry is required for a proper evaluation. Training, checking and correcting entry errors, and time to enter data are all important resources.

- Transportation can be an issue, especially in non-urban areas. Consider including funds in the budget for bus tokens, gas cards, and staff travel. In rural areas with no public transportation, creative solutions may be called for, such as paying family members or neighbors to transport clients to treatment or picking up clients every day for treatment.

- Stigma against parents with SUD can show up in many subtle and direct ways. Staff may have had negative personal or work-related experiences, family members of START parents may undermine recovery efforts or reunification because of negative experiences with the parent, judges may approach the

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problems with more punitive actions, and internalized stigma can result in denial of the problem by the parent. Community stigma can be especially strong in rural areas, making it harder to grow a recovery community. When they are ready and coached well, the stories of START Family Mentors can be powerful for their clients and their families, co-workers, the court system, and the public at large. The technical assistance process will include an assessment of values within the START collaborative team with processes to begin addressing stigma and other beliefs that may impede progress.

- A current pervasive SUDs-related stigma is against medication-assisted treatment (MAT). Because MAT is an important part of the array of services for opiate and alcohol SUDs, staff, the courts, and treatment providers should be provided with fact-based training. When the facts about MAT are understood, opposition generally diminishes.

2.6.3 Rural and urban challenges

In Kentucky alone, START has been implemented in an urban area with over one million people, two smaller cities with populations around 50,000 to 100,000, and one very rural Appalachian county with a population of less than 15,000 people. Some implementation challenges were similar across sites, such as building trust among CPS and provider agencies. Other challenges existed only in the very rural site. It seems worth sharing our lessons learned here and directing you toward a related published article (Hall et al., 2015).

If a rural site is being considered, please reflect on the following considerations:

- Is there an intensive outpatient program (IOP) available in the community? Because START tries to keep children in the home with their parents, having access to an adequate level of SUD treatment in the community is important. Technical assistance will provide guidance on developing levels of care and IOP services. Under the best of circumstances, it can take 6-12 months to set up an IOP; it might be wise to set up the IOP first before implementing START.

- Is treatment of sufficient quality to produce positive results? Are there qualified therapists who are well-trained in SUD treatment working in the program or available for hire? Are they also able to identify co-occurring mental health and trauma issues? If not, time and resources must be available to train the available staff.

- Are there residential and detoxification programs nearby? Parents in need of these services are often unwilling or resistant to leaving their community even for a month, partly because they do not want to leave their children. Usually only about 20% of START clients require these residential or detoxification services, but only if there is a high-quality IOP in the community to provide intensive treatment.

- Transportation can be a very large barrier in rural areas. IOP services should be offered four to five days a week for those new to treatment, so transportation must be regular and dependable. Some rural programs use a combination of Medicaid transportation, rural public transportation vans, staff transports, and gas

cards to support family/friend transports. Again, this is important to work through prior to implementing the program as lack of transportation can make IOP services impossible and child removal inevitable.

- Can qualified staff be hired and retained? Qualified CPS staff can be difficult to find in some communities. For some treatment providers, the pay scale for professionals is not adequate to recruit and retain independently-licensed clinicians. Consider whether CPS funding is necessary to employ qualified staff.

- Are there self-help meetings in the community? Meetings might include Alchoholics Anonymous or other 12-Step groups, secular recovery groups such as SMART Recovery, or faith-based groups such as Celebrate Recovery. Ideally, there should be meetings at varying times of the day and days of the week. START Family Mentors, as people with at least three years of recovery, can help establish or expand meetings in the community if needed.

- Is child care available in the community so that parents can attend treatment and self-help groups? Lack of child care can be a significant barrier to treatment attendance.

- In contrast, advantages in very rural communities include tight-knit family groups that tend to provide for each other's needs, a higher prevalence of two-parent families, and staff with a high level of commitment to their community and a willingness to go above and beyond the call of duty.

While urban areas tend to have more treatment, recovery, and community resources, there can also be some disadvantages. For instance, there is more transience in urban centers, so it can be harder to find extended family for placement, and while there are more service options, the volume of those in need can produce long waiting lists.

2.7 Pre-Implementation Training and Practice Changes

The following ideas are suggestions for how a jurisdiction can improve their child welfare system while considering START implementation.

1) Develop a system of screening families that may be affected by SUD. Consider using an evidence-supported universal screening tool such as the UNCOPE during the assessment/investigation process in CPS. Early and accurate screening of mothers, fathers, and potential caretakers will be invaluable when implementing START and provide the jurisdiction with more accurate understanding of family needs. Also consider a concurrent post-screening referral process to a SUD and co-occurring MH/trauma treatment specialist for a full SUD/MH/trauma assessment when screen results warrant.

2) Improve the knowledge base and expertise of CPS staff in understanding SUD including relapse, drug testing, treatment options, referral processes and outcomes of treatment. The National Center on Substance Abuse and Child Welfare (NCSACW) has an on-line training tutorial for this work. The

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6 Available at [https://ncsacw.samhsa.gov/training/default.aspx](https://ncsacw.samhsa.gov/training/default.aspx)

*Sobriety Treatment and Recovery Teams (START) Model: Implementation Manual (2018).* Please credit author if reproduced or referenced.
Center for the Advanced Study in Child Welfare has a 5-hour on-line training curriculum on supporting parents in recovery.

3) Improve staff knowledge and skills related to parental and child trauma. Training in both SUDs and trauma provides CPS workers with the skills to engage and understand parents with SUDS and the impact of trauma on all family members including children. The National Child Traumatic Stress Center has on-line materials that may support this effort.

4) Begin to develop joint practice protocols and policies among SUD treatment, child welfare and the court to standardize screening and assessment of SUD among families in the child welfare system.

5) Strengthen your existing partnerships or create partnerships at the local, regional and state level with the SUD treatment providers, child welfare public and private agencies, and the judicial system including attorneys and judges. Consider hosting cross-training events between these three key partner groups that build understanding of the partners’ mandates, constraints, goals, populations served, and outcomes.

6) Engage with local, regional and state level staff, leadership and key partners in identifying their goals for working with families affected by parental substance use disorders and child maltreatment. What resources can they bring to the table? What change would they expect in CPS, SUD treatment, child and parent outcomes? How will you know if the change happens? What strategies might create the change they seek?

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2.8 References


