STRATEGY BRIEF

STRONG FAMILIES

What is the National START (Sobriety Treatment and Recovery Teams) Model?

This brief was developed in partnership with Children and Family Futures. For additional information about START, visit: Sobriety Treatment and Recovery Teams. For additional information about substance use disorder and child welfare, see Casey Family Programs resources on the topic.

Families affected by substance use disorders and involved in the child welfare system face a variety of complex challenges. Children of parents with substance use disorder are more likely to be removed from parental care, less likely to be reunified, and experience lengthier out-of-home placements and delayed permanency.[1,2,3] This brief provides an overview of the Sobriety Treatment and Recovery Teams (START) program — an evidence-based child welfare service delivery model for families that is aimed at keeping children safely with their parent(s) whenever possible through achieving parental sobriety and recovery, and family stability.

casey family programs

The START model

START pairs a child welfare worker and a family mentor to support families identified during a child protection assessment or investigation as needing ongoing services due to parental substance use. (The model refers to the pairing as a *dyad*.)

When implemented with fidelity, START has shown improved outcomes for children and families. The model uses a variety of strategies — early identification of eligible families, rapid access to services, peer supports, intensive case management — to promote collaboration and systems-level change within and between child welfare agencies, substance use and mental health treatment providers, the judicial system, and other family-serving entities.

The goals of START are to:

- Ensure child safety and well-being.
- Prevent and/or decrease out-of-home placements.
- Increase parental recovery.
- Increase parenting capacity and family stability.
- Reduce repeat child maltreatment.
- Improve system capacity for collaborative, timely, and targeted services.

At the heart of the START model is the spirit of engaging families with compassion, understanding, equity, and hope for recovery. This philosophy is woven throughout — from supporting and holding each other accountable as a collaborative team, to empowering each member of the family unit.

Peer support

To form the START dyad, a caseworker is paired with a family mentor — an individual in long-term recovery who has lived experience with the child welfare system. Family mentors bring a unique and invaluable skill set by virtue of their recovery experience and willingness to share it with families and other team members. The mentors serve as both advocate and role model — a personification of hope and inspiration, a living example of recovery.[4]

Outcomes

START has undergone rigorous evaluation described in at least a dozen peer-reviewed publications. Outcomes from this collective body of evidence show that when implemented with fidelity:

- Children whose families were served through START entered out-of-home placement at half the rate of children from a matched comparison group (21% vs. 42%).[5]
- At case closure, more than 75% of children whose families were served through START remained with or reunified with their parent(s).[5]
- Mothers in START had higher rates of sobriety and early recovery than a matched comparison group (66% vs. 37%).[5]
- At 12 months post-intervention, more children whose families were served in START remained free from both out-of-home placement and recurrence of maltreatment as compared to children whose parents who received usual child welfare services (68.5% vs. 56%).[6]
- At 12 months post-intervention, more Black children whose families were served in START remained free of out-of-home placement and child abuse and neglect than Black children whose parents were served in treatment as usual (80.6% vs. 56%).[7]
- Parents in START who received medication for opioid use disorders (MOUD) retained child custody at a higher rate than those with opioid use who did not receive MOUD (75% vs. 52%). Every additional month of medication increased the likelihood of children remaining with their parents at the end of the case by 10%.[8]
- For every dollar spent on START, jurisdictions saved an estimated $2.22 on costs associated with out-of-home placement.[5]

Jurisdictions also benefit from structural and practice improvements throughout the course of START implementation, such as:

- Quick access to substance use disorder treatment services.
- More parents entering and staying in treatment.
- Improved collaboration with community treatment providers.
- Fewer children entering out-of-home care.

- Workforce skilled in engaging and supporting families affected by substance use disorder.
- Applying the spirit of START — engaging families with compassion, understanding, and hope — to all families served through the system.

Essential components

Replication of an evidence-based model requires having a well-defined structure and high standards of practice. START divides its 11 essential components into two fidelity categories: structural and practice.

Structural fidelity refers to the infrastructure and organizational foundation of the model, which are fundamental and must be in place to provide a framework for implementation. They include:

1. An effort that is **initiated by and based in child welfare** for families affected by both parental substance use and child maltreatment.
2. **Strong collaborative partnerships with treatment providers** for substance use disorders and co-occurring mental health issues, and other family-serving entities to develop a coordinated system of care.
3. **Family mentors** who are in long-term recovery from a substance use disorder with experiences that sensitize them to child welfare.
4. A family mentor paired with a child welfare worker to form the **START dyad**.
5. **Continuous quality improvement**, guided by program evaluation data.

Practice fidelity refers to services provided to children and families within START. They include:

1. A **rapid timeline** that ensures early identification of eligible families after the initial child welfare report, and quick access to and early retention in substance use disorder and co-occurring mental health services.
2. **Minimum work guidelines** — met by all START child welfare staff — that represent a more intensive approach to service delivery than traditional child welfare practice.
3. Current **best practices and evidence-supported interventions** used by all treatment providers for substance use disorder and co-occurring mental health and trauma treatment.
4. **Shared decision-making** with families, child welfare staff, and service providers.
5. **Keeping children safely with their parents or family** whenever possible or facilitating reunification as quickly as possible once parental recovery is stable and safety factors have been remediated.
6. A **family-centered approach**, focusing the entire team on promoting and nurturing the parent-child relationship and improving parenting capacity.

EVIDENCE-BASED PROGRAM RATINGS

START received a rating of "Supported" from the Title IV-E Prevention Services Clearinghouse in May 2022. The rating represents that START meets the criteria of having at least one study that achieved moderate or high ratings on research design and execution, and that it demonstrates favorable effects on child abuse and neglect outcomes. START is rated under two identified service areas: 1) Substance Abuse Programs and Services, and 2) In-home Parent Skills-based Programs and Services.

In February 2016, START received a "Promising" rating from the California Evidence-Based Clearinghouse for Child Welfare. START is rated as a family stabilization program with high child welfare relevance.

Implementation considerations and examples

START has been replicated and scaled for effective implementation in rural and urban, public and privatized, and state- and county-administered child welfare systems (This map shows current operational sites, along with the number and location of state and local affiliates.) While Kentucky currently is the only affiliate with published impact studies, other affiliates are beginning to see preliminary outcomes, such as fewer children entering out-of-home care, improved collaboration with treatment providers, more rapid access to services, and increased workforce skill in engaging families.[9] As START is a complex, collaborative model, implementation requires a commitment to a dedicated multi-year, cross-system effort. This effort begins with readiness and feasibility planning, followed by standardized training and individualized technical assistance necessary for START implementation and certification.

Affiliates of the National START Model are state and local jurisdictions that are certified or are engaging in technical assistance with a commitment to reach fidelity to the model. Affiliates have access to START proprietary materials, such as the START name, logo, manual, training, and guidance documents. Certified START affiliates have reached full fidelity and met all requirements of a three-step certification review. Some states with multiple local jurisdictions also request training and technical assistance to develop their own infrastructure — once all requirements are met, they may become Certified State Infrastructure START Affiliates. Affiliates in Kansas, Kentucky, North Carolina, and Ohio offer examples of effective implementation of START, along with unique considerations.

Kansas

Since 2019, START has been implemented in two regions (Kansas City and Wichita), totaling 15 counties. A private nonprofit, DCCCA, that provides both family preservation and substance use disorder treatment services contracts with the state to provide START to eligible families that caseworkers have referred for in-home child welfare services. The initial contract required quickly launching services, and subsequent training and technical assistance has focused on shifting to fidelity in practice. Kansas operates a state-administered, privatized child welfare system, which can result in complex barriers to fidelity. For example, START cases are transferred to another agency for services if a child removal occurs. Discussion is ongoing to resolve this barrier. Although it is too early for an impact evaluation, DCCCA has reported that START has successfully diverted some participating families from out-of-home care.[10]

Kentucky

START currently is available in seven counties in Kentucky, which is a state-administered child welfare system. State-employed supervisors and child welfare caseworkers team with family mentors employed by the University of Kentucky, with contracted START directors reporting to state child welfare leadership and overseeing local model implementation. As Kentucky is the original site of replication, adaptation, standardization, and rigorous outcome evaluation, the state selected counties with populations large enough for up to four dyads per team, funding them through Temporary Assistance for Needy Families (TANF) and State Opioid Response (SOR) grants. The state then added START to its Title IV-E prevention services plan. While the counties involved in the original launch reached full fidelity, staffing shortages have slowed the reaching of fidelity in expansion counties.

North Carolina

Buncombe county in North Carolina currently is using START. Training and technical assistance was originally provided to install a team of three dyads using county funds. But as a result of a Victims of Crime Act (VOCA) grant, the county expanded START to two

GETTING STARTED

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teams of three dyads each. The county's established family-centered and shared decision-making practice, plus the availability of a full array of substance use disorder treatment resources, allowed for faster attainment of full implementation despite staffing shortages. Based on this county's success and advocacy, the state plans to expand to nine additional counties and is considering adding START to its Title IV-E prevention services plan.

Ohio

Ohio operates a state-supervised, county-administered child welfare system. With support from state leadership, Ohio has plans to support a rapid expansion of START from the current 54 counties to all 88 across the state. Many of the counties participating in Ohio START have entered into memoranda of understanding with their behavioral health partners to support collaborative efforts, such as expediting access to substance use disorder and mental health assessment and entry into treatment. The program also encourages county child welfare agencies to partner with their local courts and community providers.

The state allocates funds to each county from sources such as VOCA grants, SOR grants, state general funds, and Title IV-E prevention services dollars from which counties then create their own budgets. Most counties began with one dyad and many are expanding to two or more. Counties with established leadership, a history of adopting evidence-based programs, and well-resourced communities move more quickly to full fidelity. To date, Ohio START has served over 1,000 families.

To learn more, visit Questions from the field at Casey.org.

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4 National Center on Substance Abuse and Child Welfare. (n.d.). The Use of Peers and Recovery Specialists in Child Welfare Settings. https://ncsacw.acf.hhs.gov/files/peer19_brief.pdf

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10 Per communication between Children and Family Futures and DCCCA on 11/22/22.

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