Sobriety Treatment and Recovery Teams (START)
Formative Evaluation
Synthesis of Focus Groups and Key Informant Interviews

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Background and Introduction

The initiation of Sobriety Treatment and Recovery Teams (START) began in the spring of 2006 as a replication of the START model from Cleveland, Ohio. Between spring 2006 and September 2007, community partners, leaders in both child welfare and substance abuse treatment, service providers, and DCBS staff designed the START model, hired and trained family mentors, dedicated CPS teams to START, and crafted policies and procedures to support the program. Three counties were initially chosen as START sites: Barren, Jefferson, and Kenton. Martin County, a fourth site, was added in October, 2007 with funding from the Children's Bureau through the Regional Partnership Grants. Selection criteria for each START site were based on percentage of referrals with identified substance abuse risk, ages of children, and number of substance abuse resources available. Table 1 displays the START sites and selection criteria with a few key demographics to show the differences in START sites.

Table 1
START Sites and Selection Criteria

Characteristics	***Barren (Glasgow)***	***Jefferson (Louisville)***	***Kenton (Covington)***	***Martin (Inez)***
Selection Criteria: At least	Child <=6 years	Infant - drug exposed	Child <=3 years	Child <=3 years
First family accepted	09/19/2007	11/07/2007	10/03/2007	09/15/2008
Child Population	9,227	170,465	40,432	3,096
CY 2008 # child victims with substance abuse risks*	76	1,590	339	187
% children living poverty**	27%	19%	15%	58%

Note. * CY2008 referral data may have duplicate children ** Data from Kids Count 2008.

The first clients were accepted into the START program on September 19, 2007. Martin County began taking clients September 15, 2008. The program in Barren County was discontinued on June 30, 2008, because of a state budget shortfall and low START case loads.

As of October 4, 2008, 183 families have been referred for START and 126 were accepted into START. The other 57 families were not accepted for START primarily because the program was full and unable to accept additional clients. At this point, 16 family cases have been closed after being open for START services an average of 5.9 months (range = 1.3 to 9.3 months).

Additional statistics on the roll-out of START are reported elsewhere. The purpose of this report is to present the findings and recommendations from a series of focus groups and key informant interviews initiated on September 22, 2008, in each of the START sites. Annual input from DCBS staff, substance abuse providers, community partners, leadership and clients using a

variety of input strategies (interviews, focus groups, surveys) are included as part of the comprehensive evaluation of START. This series of focus groups and key informant interviews was designed to assess program rollout after one year of operation in the three state-sponsored START sites. Martin County focus groups and key informant interviews, included in the federal grant K-START program evaluation, will be conducted in fall 2009.

Methodology

Participants

Arrangements for the focus groups and key informant interviews were made by the on-site START staff, regional leadership, or the START Director. All participants volunteered their information; their right to decline to answer any question or discontinue the interview was discussed prior to the interview. Although the interviewers often knew the participants, notes were recorded without names attached to maintain the anonymity of the participants. Clients were interviewed individually or with their immediate family members.

Table 2 displays the groups targeted for interviews either individually or in a small focus group format. Focus group composition and interviews varied by START site but each site had representation from the major groups.

Table 2
Focus Groups and Key Informants

Group	Specific Individuals Targeted
Key START Partners	Court Partners – Judge/s experienced with START or GAL.
	Community Partners - foster parents, faith-based initiatives, mental health providers, housing, transportation, FPP provider, TAP provider.
	Substance abuse providers
START DCBS Staff	Family mentors
	START workers
	START Supervisor
START Families	Families/Adults served by START
START Leadership	Tina Willauer, START Director
	Lynn Posze, MH/MR
	P and P Leadership
	DCBS Regional Leadership or Staff

Table 3 displays the number of participants by their job role and START site. In total, 48 people from many spheres participated in the focus groups and interviews. Interviews with START leadership have not been formally completed because of many ongoing meetings and dialogues that make such input redundant at this time. Interviews with leadership will be conducted in fall 2009.

Table 3
Number of Participants by Job Title and START Site

Focus Group & Key Informant Participants	Barren	Jefferson	Kenton	Total
START Supervisors	2	1	1	4
START Caseworkers	1	4	3	8
START Family Mentors	0	3	2	5
Clients served by START	1	1	3	5
Support workers from Intake and Investigation and Meeting Facilitator	0	2	0	2
Substance Abuse Treatment and Mental Health Providers	1	3	6	10
Court Personnel (Judge/ Law Clerk	0	0	2	2
Community Partners Participants represented Targeted Assessment Program (TAP), Homeless services, Emergency Assistance, HANDS (Child Nurse Visitation Program), Parenting Supports, Hospitals, and Recovery Center for Women	0	5	7	12
Totals	5	19	24	48

Focus Group Participants and Interview Content

For this first round of focus group, each informant or participant was asked the same basic questions. We decided to use the same questions for all groups to understand the experiences of each group within a similar context. Additional probes were included to fully explore and understand the participant response. The basic questions were:

1. Please tell us about your involvement with START. How much have you been involved, what is your role, what have you experienced?
2. Tell us about the strengths of START – the aspect that is most promising or gets you excited.
3. Tell us about the challenges, barriers or weaknesses of START. What bothers you?
4. Tell us about one thing you learned or changed in your life or practice since becoming involved with START.
5. If you could make one or two changes to START, what would they be?
6. Tell us a story about START that best portrays the program.

Data Collection and Analysis

Nearly all focus groups and interviews lasted for 50-60 minutes. Two people (Ruth Huebner and Joann Lianekhammy) conducted some of the focus groups and interviews, but most were completed by Ruth Huebner. Notes were taken by the interviewer and scribe, but verbatim transcripts were not produced. The results of the interviews were concept coded and grouped into themes across all interviews by the lead writer (Ruth Huebner). A draft write-up was sent to the persons participating in the interviews that then validated or correct the report; corrections were made to the final document to reflect their feedback. A final document was disseminated

for each site. For this analysis, the content of all focus groups and interviews was synthesized with the intent of compiling the wisdom of the persons interviewed to guide others wanting to initiate a START program.

Results

The following sections present findings and recommendations from a series of focus groups and key informant interviews. These findings were summarized into these five themes:

- The Logistics of START Implementation,
- Key Change Strategies,
- Challenges and Barriers to Anticipate,
- Perceived Results of START, and
- Future Opportunities for Improvement.

Each section communicates feedback from the participants' experiences in establishing START in Kentucky. The five themes were chosen to provide guidance in establishing new START programs, to identify key change agents that may affect outcomes, and suggest the need for evaluating these program aspects. We grouped the participant responses into broad categories and provided accompanying details.

Appendix A includes a listing of key dates in the initiation of START. Items with a * indication will be supported with examples included in appendices in this and future iteration.

The Logistics of START Implementation

The list below summarizes significant action steps taken in planning and rolling out the START program. These steps were identified to be critical in the implementation and operation of this new service offering. We tried to word these as needed strategies although some focus group participants identified problems when the strategy was omitted or weak. In this first section, we identified best practices based on both successes and challenges in implementing START.

Principle	Strategies
*Structure the START Model**	• Provide a visual guide to policy, practice and adaptations such as a flow chart defining START procedures for the first 30 days of a client's program.

Develop Selection Criterion For START	• Set eligibility criteria to identify families with the most need for services.
	• Anticipate the potential number of START cases based on referral information to ensure adequate referrals for sustainability. Consider:
	  • Age group of children of drug affected families served,
	  • Referral track, finding, and risk factors in the case, and
	  • TANF or other funding source eligibility/requirements.

Establish Leadership and START Hierarchy	• Appoint a state or regional Program Director to provide onsite guidance to help START teams implement the model with fidelity and solve issues. • Dedicate one supervisor solely to each START team. • Train START Supervisors to compensate for differences in Family Mentor's educational and professional background through coaching on CPS work/policy, checking for understanding, teaching them to set

Principle	Strategies
	priorities, and reviewing their work.
*Establish Dedicated Substance Abuse Treatment Services with Budget and Billing Methods**	• Collaborate between START and Substance abuse leaders to develop the Memorandum of Agreement (MOA) for specific expectations in treatment. • Include in the MOA specific needs and expectations to assure fidelity to START model and embed best practices into treatment. For example: • DCBS negotiated with Partners to provide access within 2 days to treatment and for tracking attendance for START client's first 5 sessions. • Expand substance abuse treatment capacity through additional funds dispensed to substance abuse providers to treat START clients. • Monitor budget spending. Ask providers to bill and track expenses monthly for each client and submit the reports to DCBS. This will inform budget needs and support cost benefit analysis at the client level. • Provide funding for random drug screens for clients and complete weekly • Provide wrap around funds to assist clients with food expenses, utilities, transportation, child care and other basic needs.
Gain START Buy-In from the Courts System	• Evolve courts understanding of a treatment oriented, less punitive approaches to dealing with drug affected families involved with CPS. • Discuss evidence based research concerning the importance of parent/child interaction during recovery presented with local judges and attorneys. • Co-train child welfare, substance abuse providers, and judges and attorneys to expand their substance abuse knowledge.
Develop Strong Community Partnerships	• It is essential to have a strong commitment from the Child Welfare leadership to gain the trust and dedication of community partners. • Community partner's active involvement in the design and initiation of START was essential to program development and buy-in. • START staff and Community partners developed protocols and other procedures for problem solving issues throughout implementation. • Group committees continue to meet regularly to develop partner trust, work through philosophical differences, and resolve START issues. • Discuss contracts and budgets with partners, outlined expectations, timeframes, communication protocols, and required data collection. • START staff continually strives to improve relationships with medical staff, judges and attorneys, and treatment providers. • Be prepared to be consistent and persistent.
Limit Case Loads	• START is designed for 12-15 cases; workers currently carry a maximum caseload of 15 families; this is an outside limit that constrains the model. • Substance abuse providers have lower billable hours when servicing to: : o Participate in community meetings with DCBS, courts, Probation and Parole, and other providers, and attend Family Team Meetings.
*Develop Worker Skills and START Teams**	• Developing CPS and Family Mentors teams: may take 12 – 18 months. • Staff members trained extensively on: history, philosophy, and model of the program, service delivery timelines, policies and protocols, and responsibilities of the supervisor, worker, and mentor role. • Team building workshops used to build rapport and foster communication. • CPS workers learn to defer to Mentors about treatment issues, while Mentors learn to defer to workers about court or child safety issues. • Mentors meet in statewide group to learn and support other mentors.

Principle	Strategies
Utilize Dynamic Learning	• Motivational interviewing training helped increase staff knowledge about substance abuse and how to work with addicts. • On-going substance abuse training provided to START staff throughout the year to increase their knowledge base. • Provide hands-on training for CPS workers such as shadowing other workers during home visits, observing family team meetings, and examining service provider appointments. • Provide on-site peer visits to see operation in existing sites. • Workers attend AA, CA, NA groups, shadow TAP (specialized assessment) workers.
Define and Develop a Continuum of Care	• TAP assesses clients on demographic, daily living, mental health, and substance abuse issues and then makes recommendations for services. • Clients meet with and receive assistance from DCBS, substance abuse providers, mental health providers, the medical field, and social service organizations during Family Team Meetings. • Community members find supports for housing, employment, training, parenting, education, transportation, and other provisions for clients.
Understand Mental Health Issues of START Clients	• Staff and providers must develop sensitivity in dealing with mental health issues which is prevalent among substance abuse populations. • Training offered by DMHSA on mental health issues such as Trauma Informed Care was available to substance abuse providers, START teams and Targeted Assessment Program (TAP) staff.
Coordinate Service Provisions to Families	• Substance abuse providers hired a service coordinator to ensure clients are linked with appropriate services at all stages of recovery. • A case coordinator built systemic supports around data to provide efficiency in managing cases and billing. • Coordinators serve as a liaison between service providers and DCBS and are critical in facilitating communication.
Collaborate with Existing Initiatives	• Embed planning in long-standing initiatives to build strong community partners, embed the team decision making model, and educate all about substance abuse issues. • Existing initiatives that facilitated START initiation included: Family to Family, Drug Affected Infant Task Group, and Neighborhood Place, and the Targeted Assessment Program (TAP).
*Establish Program Evaluation Procedures, Record Data, and Share Information**	• The START Program Evaluator identified key data points in collecting information on family, adult, and child demographics, adult progress and treatments, child progress, family functioning, and Family Mentor contact. • Forms with these key data points were updated and revised by the State START Steering Committee, then distributed to workers to record data. • A Program Evaluation Advisory Committee was established to ensure data measures fit project objectives, examine preliminary data to guide analysis, and assist in interpreting results. • Demographics, numbers served, drugs commonly abuse, and other descriptive data helped partners understand the population they serve. • Data presentations for Community Partners stimulated discussion and awareness around START issues, the CPS process, and client progress.

Principle	Strategies
Advice in Implementing START	• "Take it slow and do not get too upset with growing pains." • "It takes times and patience to get this going." • Talk about the issues before they become evident in service delivery.

Initiating a START program is hard work because it requires rethinking services by the courts, CPS, and substance abuse providers. It requires a high degree of commitment and a 'can do' spirit. But as one community partner put it: "There is a sense of pride in the effort of the group and the hard work of tackling a difficult problem and making progress."

Key Change Strategies

This next section outlines the focus group participants' feedback about their perception of what made a difference with START. We grouped these ideas into key change agents to summarize the practices or strategies that were identified as being critical to achieving positive outcomes. When initiating a START program, these key change strategies should be considered as essential and actively embedded into the program structure and program evaluation.

Key Agents	Strategies
Keep Children Safe: All change relies on this capacity	• Conduct safety meetings, create and implement child safety plans with all START clients as soon as possible for every child, and visit often. • Safety risks are reassessed any time there is concern for a child's well-being and safety. • Random weekly drug testing for adults monitors progress in recovery and holds the adult accountable to the team.
Family Mentors Make a Vital Difference	• Have a special rapport with clients, see signs that others miss, and can say difficult things to clients with credibility. • Support birth parents early through the CPS system and model sober parenting and provide role models for families. • Offer insights to the families to help keep the clients on track and increase the chances for recovery by relating to the client, being honest about their own experiences, and keeping them motivated. • Changed attitudes in all of CPS, about what it is to be a person in recovery. • Taught and continue to teach all CPS staff about substance abuse in realistic terms; they have earned the respect of their co-workers. • Follow-up with clients many times per week especially early, offers supports and tangible help through both systems. • Persistently engage clients that withdraw from interaction, transport people to appointments, and take clients in for random drug screens.
Rapid and Coordinated Access to Treatment and Retention	• CPS clients must wait long periods of time for substance abuse treatment, while START clients are slated to begin service within 2 days of referral. • Client TAP assessments completed within 2 days of entering START. • MOA calls for a minimum of 5 treatment sessions provided within 10 days of first referral for service. • Pre-treatment group prepares clients for more intensive treatment. • Investigative workers transfer clients rapidly so that families can build

Key Agents	Strategies
	relationships with START and share important case information/needs. • Rapid access and intensive treatment document reasonable efforts.
Access to Drug Screens	• Weekly drug screens help START teams monitor their cases, hold the client accountable, and help clients acknowledge their problems.
Mental Health counseling	• START teams and the TAP evaluation identify multiple client issues, mental health needs, and supports for sobriety. • Clients, community partners, and staff cite dealing with client issues of trauma and childhood history is important to maintain sobriety.
Innovation	• START continually and persistently strives to change the way of doing business in child welfare, substance abuse and the courts. • Community partners and DCBS staff believe that they gained the tools to transform the system of care from the status quo to a system more likely to succeed for clients and communities.
Intensive case management and FTMs	• All clients have a Family Team Meeting upon entry to START to coordinate the case plan and services, build a child safety plan, and make decisions about the best placement for children. • FTMS are facilitated to reduce client intimidation and a sense of being overwhelmed by the process. • The family, their START team, a TAP assessor, and a substance treatment provider are all involved in developing a case plan with the client. • Family strengths, goals of sobriety, and child well-being are emphasized.
Structured recovery supports	• Clients cited problems with their own flawed thinking in planning and organizing life due to years of addiction. They had no habits or skills. • Step by step guidance provided by family mentors, staff, providers and TAP help clients break down overwhelming situations to manageable steps. They learn to think and plan as functional adults.
Continued supports for recovery	• Sponsors provide alternatives to current life choices, step by step ideas on planning for ongoing recovery, and ideas for sober social supports. • Clients provided with AA manuals and binders with detailed service descriptions to help them better understand the treatment process. • Family Support coordinates services for START clients at times and provides some indirect funding to support client needs.

Community partners, courts, families and CPS staff all cited the immediate access to substance abuse treatment for families as a potent change agent that is vastly different than prior to START. "Just knowing that families can access what they need changes the entire case planning process." "Instead of cobbling together inadequate services and hoping for the best, families are given a real opportunity to get intensive and appropriate treatment with the supports needed to be successful."

Challenges and Barriers to Anticipate

Because of the multiple changes to the system of program delivery and the need for strong collaboration required for START, initiating a START program will engender challenges and barriers. In developing this list, we grouped together items that were cited by many respondents as barriers that seemed inherent in the change process. Some obstacles have been resolved and others are currently being addressed. The following list describes the challenges and barriers faced in START implementation and suggestions for problem-solving.

Challenge/ Barrier Description	Problem-Solving
Getting all Components of START Ready: • At one site, START CPS workers were hired and on board before the supports, mentors, and a protocol were in place. • The timing in assembling all components needed for START rollout was not aligned.	• A pre-START program was initiated and used to refine procedures and develop collaboration. • CPS workers took on pre-START cases and transferred some of those cases back to ongoing when START was ready.
***Issues with Money, Billing, and Resources*:** • START initiation was delayed due to slow development and dissemination of provider contracts. • Monthly reports on specific services to clients were cumbersome for providers and supplied data not ideal for required analysis. • Some providers failed to submit detailed bills for treatment.	• Held meetings with partners to co-resolve reporting issues. • Revised billing reports to be more efficient in tracking client treatment. • Provider contract language requires detailed expenditures for START clients. • START leadership meet regularly with budget personnel to ensure all START expenses were reconciled.
Budget and Case Load Issues: • START teams lower case loads created some concern when state budget shortages increased ongoing CPS caseloads. • State financial shortage reduced hiring of family mentors to complete START teams.	• Education and discussion for Non-START workers on START case intervention intensity, difficulty of work, investment and advocacy. START teams take 15 cases. • START teams share family mentors.
***Scheduling and Transportation Conflicts*:** • Appointments were scheduled rapidly with little notice and clients failed to attend. • Scheduled treatment conflicted with other client obligations such as child care, jobs, etc. • Many clients, especially those in rural areas, lacked transportation to get to their appointments.	• START staff transport clients and negotiate client schedules. • Case coordinator hired to manage cases, and schedule appointments. • Negotiated with vendors for transporting clients to/from treatments. • Purchase of a van to help transport clients at one rural site. • Negotiate flexible scheduling in provider contracts.
***Dealing with Co-occurring Substance Abuse and Neglect Issues*:** • Some investigative teams had limited knowledge about family substance abuse. • Some workers believed that addicts choose to abuse drugs over maintaining sobriety. • Tension among partners and providers from having little chance to collaborate in the past. • The medical community struggles with	• START promotes education on the reality of the disease to reduce stigma and promote understanding. • Community partner dynamics improved with more interaction between agencies. • Communication among partners became more open and frequent and less tense. • Medical community attends substance abuse trainings

Challenge/ Barrier Description	Problem-Solving
referring persons with addiction for services, prescribing addictive meds, etc.	• Best practices in treating addiction disorders discussed for all agencies.
***Disagreements over Treatment Provider Decisions*:** • DCBS staffs and community partners sometimes disagreed with other's opinions. • Partners and CPS specialists sometimes disagree on substance abuse treatment, CPS practice, and court judgments. • Providers fear for a child's safety without punitive consequences when adult relapses. • Providers deviate from START communication protocol at times. • Some concerns were raised about quality and level of substance abuse treatment.	• Disagreements are handled by specified protocol developed together before START initiation. • START values are discussed directly and agreement to accept these is sought. • Differences in ideas are an opportunity to discuss assumptions, values and improve collaboration and decision rules. • Drifting from protocol and treatment quality or level of care issues are addressed directly with the provider/team by the START Program Director. • Monthly meetings and joint case discussion help reconcile differences.
***A changed paradigm with uncertainty*:** • At one site, Family Support (FS) workers were uncertain about the purpose of START and wary of working with Family Mentors. • Court ruling held parent/child visitation contingent on clean drug screens. • Courts hesitated to work with START because they were uncertain whether START staff understood the strength of addiction when setting realistic goals for their clients. • Addiction was seen as a chronic disease with little hope of recovery by some medical providers.	• FS learned more about START with time and began to value Family Mentors as experts in substance abuse. • A third party facilitator was used to help resolve friction between entities. • Court's involvement in START allowed them to understand the model and level of expertise of staff. • Judges began to trust START workers to set visit schedules and frequency of parents/children contacts. • Medical personnel partner with START and gradually learn.
***Goal changing*:** • There was on-going dispute concerning the appropriate time to change permanency goals. • Perspectives vary from permanency goals changed too early and too late. • Some think goals should be changed when a client has a number of positive screens. • Others believe time is needed to recover from addiction and mental health issues.	• There is no set protocol for when to change permanency goals at this time. Individual cases are discussed using team decision making.
***Little On-Site Support*:** • START sites were/are isolated from other sites without direct on-going peer supports. • START sites faced different challenges according to geographic location and culture of the area.	• The Program Director provides onsite support and troubleshooting. • Site visits to other programs give workers a chance to interact. • Supervisors keep regular contact with one another by phone, email, meetings and conference calls. • Statewide worker and mentor meetings.
***Boundaries for Family Mentors*:**	• Issues addressed early and resolved on a

Challenge/ Barrier Description	Problem-Solving
• Initially, Family Mentors struggled with understanding their role and boundaries. • Some mentors over-stepped boundaries with treatment providers creating confusion about their role in START.	case by case basis. • Supervisors and CPS workers help mentors identify their roles, professional limitations, and how to set boundaries. • Staff met with Community Partners to clearly define mentor roles.
***Perceived Preferential Treatment*:** • Some providers believed there are double standards. Positive drug screens result in jail-time for non-START clients, but not for START clients.	• Finding the balance between consequences and supports is under discussion and requires much discussion and building trust between entities.
***Struggle for an Array of Services*:** • Limited access to 12-step programs. • Mental health issues were not routinely addressed by some substance abuse treatment providers. Conflict over the priority of MH or substance abuse treatment and have all providers consider MH needs. • Limited treatment resources for specific populations such as women, those in jail.	• Initiate recovery support groups. • Some mental health supports provided by, Family Mentors, CPS staff, TAP, and Treatment Providers. • Community Partners working to resolve gaps in services; Women's IOP opened in one area without this resource. • Expand providers to include MH providers.
***Struggle with START Team Morale*:** • Intensive, weekly contact with families engages START teams in a 'roller coaster' of emotion with family crises and workers are increasingly aware of the difficulty of reversing addiction. • START workers feel scrutinized by community partners, courts, and program evaluation. • Workers worry START will lose its funding because of unexpected state budget shortfall. • Workers are frustrated with the amount of data entry required for START.	• Supervisors and START teams meet regularly to discuss concerns. • Program manager assists sites with data entry and support. • Weekly contacts keep staff in touch with the frequent dynamics of change that might be missed with monthly contacts. • An information network was developed to allow workers the ability to enter data more efficiently in less time. Regular feedback helps them understand the story the data tells about the families they serve.

The tension between viewpoints among many groups and the difficult choices in substance abuse treatment and CPS work were persistent themes throughout the focus groups and interviews. This tension and ambivalence is summarized in these two statements. In START cases, courts and community partners are letting DCBS "set the terrain" and "try not to get in their way," but they are uncertain that DCBS staff is realistic about the strength of addiction and how very difficult it is to overcome. The community sees so many families with substance abuse and are particularly frustrated when they would like to 'pull the plug' on an adult or family with relapse so more families could get immediate benefit.

Perceived Results of START

Although START is designed to achieve specific child welfare and substance abuse treatment outcomes, the perception of results included a wide variety of outcomes. These perceived results are summarized in the following tables.

Results	Indications
New Ways of Working	• START model is very intensive, for example CPS staff visit the family at least once per week and services must be scheduled rapidly. • Staff learned to work with the family in their natural environments, saving clinician time and promoting transition when completing treatment. • CPS workers learned how to interact with clients and community partners differently. This expanded their professionalism and ability to tactfully negotiate and approach work with positive body language and strategies. • Courts became more comfortable and trusting of keeping a child at home and granting parent visitations as they better understand START engagement, the intense service delivery model, and safety plans.
Patterns of Involvement and Recovery are Emerging	• In some cases, the family is motivated to change and look at CPS as a help rather than a threat from the beginning. • Other time, at least 6 months is needed to engage the family. • Sometimes parents just go through the motions and do not change, using START as a way to stall the process of losing child custody. • Other times, clients follow all recommendations, attend treatment and make progress, only to relapse at 6-7 months. • Some clients truly do not see a need for services and are "virtually incapable" of understanding the need for treatment. • START staff estimates 1/3 to 1/2 of their cases have significant denial of substance abuse issues. • START provides optimal opportunity and supports with documentation of reasonable efforts for these cases.
Reduced Out-of-Home Care Placement	• Fewer children are in foster care because of START. After initial reservations, START teams with the Intake team kept more children at home using multiple supports and a well developed plan. • When child removal is necessary, placements in out-of-home care is shorter. • More children are placed with relatives. Clients have more contact with their children because they are with relatives and not in state custody. • Community partners have more awareness of the trauma of removal for children and the child's desire to stay at home with familiar adults.
Father/ Partner Involvement	• More fathers and male partners receive treatment through START. • START teams find they must engage fathers in order to make the program work because mother's need male/partners support.
Clients are Grateful and Recognize	• Community partners experienced START clients going out of their way to show their appreciation for the services they received. • One family receiving services expressed the desire for all families with

Results	Indications
the Benefits	CPS and substance abuse issues to have the opportunity to be in START. • Clients described working with Family Mentor, someone who shared their struggles, allowed them to deal with their shame and guilt of addiction. • Client perception of CPS workers improved and they now see workers as a support who shares the common goal of working to keep their kids safe.
Improved Relationship with Community Providers	• Results from a self-assessment tool measuring partnership perceptions showed almost all community partners, courts, substance abuse providers, staff and clients agreed or strongly agreed that START has improved the way agencies work together. • Community partners are viewing positive results in parent sobriety. • There is improved understanding and agreement between CPS and providers on why every decision was made in contrast to the norm. • Partners working together to identify gaps in services, resolve issues, and expand services. For example, a new IOP unit for women in one area and community partners engaging other partners in the efforts. • Courts are more trusting of START because of trainings, communication, and shared knowledge about CPS case plans provided by staff. • There is growing awareness of substance abuse issues among hospital personnel so they feel more comfortable referring cases because they know clients will be able to receive services.
Growing Community Awareness and Expansion of Practices	• Partners are experiencing a growing awareness of child neglect and substance abuse issues in their practice and community. • Trainings offered by DMHSA are well attended by community partners. • Diffusion of knowledge from substance abuse education is occurring throughout the child welfare agency. • Ongoing CPS workers have learned to utilize START teams as a resource for handling cases with substance abuse issues.

Changes in the way the community and system functioned was a theme throughout the focus groups. As one substance abuse provider said: "The START team promoted education that explained and normalized the situation and reduced the stigma of substance abuse to encourage workers, courts, and families to place a greater emphasis on the effects of substance abuse. All involved began to check their values at the door."

Future Opportunities for Improvement

Transforming the system of care for CPS and substance abuse requires continual ongoing efforts. The following section summarizes next steps in the evolution of the system after one year of operation and a total of two years of planning and operation.

Areas	Course of action
Continually Evolve the Treatment Model	• Community partners would like more facilities providing a full continuum of care for substance abuse, trauma, and MH services, but are limited by licensure and revenue issues at this time. • Continue to resolve differences in philosophy.

Areas	Course of action
	• De-stigmatize recovering addicts and work towards a strengths-based perspective in language and all aspects of practice.
Sustain START	• Create an informational video about the START program to present to legislators and other possible funding avenues. • Explore all funding options and monitor expenses to understand the full costs of START; Establish cost benefit analysis. • Establish work group to focus on sustainability.
Establish Protocol for START Cases	• Establish a protocol for different paths through child welfare, court systems, and substance abuse treatment based on conditions, ages of the children, progress, and other case-based factors. • Create a continuum of supports for the client beyond CPS involvement. • Establish a routine where substance abuse treatment providers address client mental health issues and provide supports for these issues. • Create a protocol for case management to make coordination and communication smoother. • Discuss possible START criteria based on type and severity of drug abused (example: cocaine over marijuana use; long and short term addiction).
Continue Problem-Solving	• Define ongoing supports and service delivery for the life of the case. • Review weekly reports from clinicians to improve scheduling and ideas for possible solutions to problems.
Provide More Trainings	• Provide more training that enrich worker's substance abuse knowledge, strengthen service delivery and promote community awareness. • Provide key training for all CPS workers, not just START workers. • Incorporate substance abuse training as a part of social work licensure. • Train all CPS staff in substance abuse recognition and treatment principles.
Further Work with Courts	• Evolve partnerships with courts to impose sanctions and change goals that are best for families with substance abuse issues.

A persistent theme in the focus groups was a desire to develop a long term continuum of care recognizing the relapse potential and chronic nature of addiction. START sets a short term expectation for access and retention for adults and child safety, but families need long term supports for sobriety.

Client Narratives

I. *A Mother's Story*

One mother, former START client, and her infant daughter were interviewed. Her comments are written in a story format.

Before the delivery, I dropped dirty and my baby was positive for marijuana. I went home and three weeks later, CPS came. At first when they came to my house, I was fearful because I had a history of drug abuse and incarceration. I used cocaine and marijuana and couldn't stop. I did not want CPS to take my baby away and I was ashamed that people would think badly of me. I went through a TAP assessment and the IOP program. Now I am six months clean and I thank (START) for this. I feel so much better and now have my baby and can watch her grow. I am grateful to CPS that helped me out. (Without START) it would just be a matter of time before she would be abused and neglected. The father, who was not using, did not know of my drug abuse. He is one of my supports; I want to stay clean now.

The IOP treatment helped me with anger management and learning how to express anger; I could never do that. The case managers and treatment specialists helped me structure my life. The process of START was exhausting. I was coming to IOP five days per week while trying to care for my baby. The first three months were hard and I was a first-time mommy. She (infant) came with me to treatment everyday.

I really liked the idea of have recovering addicts to help. They (mentors) know what it is like and make CPS more personal and credible; we have a better chance to make it with someone to identify with. Others learn from books, but I am not a book; mentors know what it is like. Now I see that it was a blessing from God that he sent CPS to my door. In 2003, I was incarcerated and met one of the family mentors in recovery; now they are on the other side of the table and I thought that if they could do it maybe I could. I was tired of using, but did not know how to quit. I was told by the judge to cut out cocaine. I spoke to counselors saying that I was going to get and stay clean and sober and not go back to prison, but I did not know how. With this child, I know that I do not want her to call anyone else 'mommy;' I knew that I wanted to get it right. So, I asked for help, utilized the tools and group time, took feedback and suggestions. Although I felt like using during the process, my main motivation was to keep my child.

I have a sponsor now and can tell her anything. The meetings are great; I thought I was alone with addiction. The START program was so great; a lot of people could have used it years ago when the idea was to get the addict out of the child's life forever. I had all the excuses, but now I am proud of myself and living life clean and sober. I stay in touch with recovery supports and walk to the meetings. I contact my sponsor 3-4 times per week by phone and read my big book to help me stay on track. I am getting mental health counseling and this has helped me see why I used drugs to cope.

The contrast in my life is very stark. Before it was hell; I was lonely, desperate, afraid, just existing, and numb. Now, I am alive, have feelings and they are good; I am loving life right now and so happy that I can't find the words right now. I eat everyday and enjoy life in general. Before I was sneaking and using drugs and a relationship without trust does not work. He found out I was using; the loss of trust comes back slowly and so does respect. But we have much more trust and respect now.

I am working on the GED, especially the math section. When I get my GED, I would like to be a nurse. I am trying to live within my limits right now. When I began, six months to a

year seemed like forever, but now it seems that it went quickly. I still have fear and know that next time it would be worse. If I was using; I would lose my child. I have a lot of things I want to do and now I can do them.

II. Seeing a Clear Picture with START

This next story also comes from a former client who shared her story of recovery during an interview.

When I first got into START, I did not like it because I had to do frequent drug screens and could not hide. The Family Mentor helped out so much with everything and I found out that there are people willing to help. I would call all stressed out and START would give me the support to keep going. Going to IOP was also very difficult and sometimes I was mad and angry when I came, but I left feeling so much better.

When I finally realized that they (START team) were just there to help me, I began to change. The guy I was dating got locked up and for once I could speak for myself. They were there to listen. She (mentor) helped me work through the alcoholism and drug abuse; she took me to my first AA meeting and knew exactly what I was going through.

Substance abuse treatment took $7^{1}/_{2}$ hours per week of my time. They gave me a big book - the AA big book and there were many in my treatment group. I had someone to talk to and this was a great experience for me. CPS and substance abuse providers worked together; they shared notes and they provided feedback. Now I just keep busy to stay sober and my sponsor is helpful; I pick up the phone and call. I don't dwell on my problems. I have been clean ever since January.

I now have the tools to deal with substance abuse and being a mother. I am not the only one with these problems and I wish that I could help one person in return. Now my children are my life, and they helped me to see how life should be for them. I wish that other people could have the advantage to take the program. If they do like I did and take it to the full extremes, they will learn to use their abilities.

I had nothing before START. Now I have a stable job, a car, a roof, and my children. Life gets tough and frustrating, but now I deal with it much better. I have three children ages 7, 4, and 3 years. My job is not much, but it keeps us going.

The children love me 10 times more. My 7-year-old says that he likes me much more. We are so much happier and play and laugh together, but he knows my role as a mom. Life is less chaotic. I talk to my mom and dad more often. They had worried so much about me, but now worry less saying that I have grown up. My family is very important to me.

My life went from chaotic to stable. I went to drinking parties every day; my life was trying to get money to drink, living day-by-day and not knowing if I was going to jail and losing children. Now I have a predictable schedule and I can see a clear picture. Before I was depressed, but now I do care. IOP helped schedule every single day of what I needed to do. This scheduling day by day helped me mentally to have a schedule in my head. I got a car and don't have to depend on others to haul me. I moved out the apartment and into a four- bedroom home in the county. My kids love it and they are outside playing lots and I planted mums. We have a dog. If you work for something you really want you will get it. I want to go back to school maybe next summer to finish up a surgical tech. It is me struggling, but I am making it. I get child support and food stamps. I earn tips from my job and I try to brighten their days.

This program helps you to keep the children in the home to keep the children with their mother and father. Children just want to be with their parents but they deserve so much better. We chose to bring them into this world so we need to take care of them.

Appendix A

Dates and Events for Implementing START

	Date	Important Events for START
2006	04/01/2006	Cleveland START Director Tina Willauer presents START program at conference in Nashville
	06/01/2006	DCBS begins planning for START program initiated in Barren County
	07/01/2006	Planning for START program initiated in Jefferson County
	07/01/2006	DCBS Commissioner Mark Washington visits Cleveland START site
	08/01/2006	Tina Willauer presents START info at Metro United Way in Louisville, Ky.
	08/01/2006	START planning initiated in Kenton County.
	12/01/2006	Commissioner Washington offers Tina Willauer position as START Director
2007	01/01/2007	START Evaluation Plan drafted for selected counties
	03/05/2007	Tina Willauer hired and begins working for DCBS
	03/27/2007	Hiring process for Family Mentors in Barren, Kenton, and Jefferson begin
	03/30/2007	DCBS changes job title "START Family Advocate" to “Family Mentor”
	03/30/2007	START case selection criteria set to identify in need of services
	04/10/2007	First round of Family Mentor interviews for Barren; 2 strong candidates
	04/16/2007	Kenton & Jefferson Family Mentor positions reposted due to little response
	04/23/2007	Meeting held with Training personnel to develop START curriculum
	04/26/2007	Staff asked to attend a “12 Step” meeting as part of their informal training.
	05/07/2007	Barren officially hires 2 family mentors
	05/09/2007	Kenton hires 2 family mentors
	05/11/2007	Kentucky applies for Access To Recovery (ATR) Federal grant.
	05/14/2007	Barren START teams (Social Workers and Family Mentors) now in place
	05/14/2007	Family Mentor interviews for all sites have been completed
	05/14/2007	Flowchart for the START program created as visual guide
	05/21/2007	Family Mentors in Kenton completes orientation for DCBS and EKU
	06/11/2007	START Expansion meeting for Martin county to discuss grant application
	06/22/2007	Kenton START Supervisor and staff present at the S.E. Family to Family Convening in Louisville, Ky.
	07/02/2007	All 3 Family Mentors in Jefferson hired and ready to begin training
	07/02/2007	Pre-START initiated in Jefferson; START CPS workers taken 21 open, ongoing cases which will be transferred once START officially begins
	07/13/2007	Kenton treatment provider changes Substance Abuse Director
	07/16/2007	Kentucky Housing Corp. expressed interest in serving START sites
	07/18/2007	FTM facilitator from Southern Kentucky Community Action agrees to facilitate some meetings for Barren START

	Date	Important Events for START
	07/20/2007	Kenton Memorandum of Agreement (MOA) with Department of Mental Health and Substance Abuse (DMHSA) signed and returned to DCBS
	08/03/2007	Barren treatment provider begins process of hiring staff to serve Barren START clients
	08/17/2007	Barren County START begins operation
	08/24/2007	Jefferson START criteria to only accept cases with drug exposed infants
	08/27/2007	Tina Willauer presents "Innovative Approaches to Tackling Substance Abuse" at AOC Summit For Children and participates as panel guest with several judges & attorneys
	08/29/2007	12+ staff from all Kentucky START sites visit to Cleveland START site
	09/05/2007	START presentation and panel participation concerning "Partners in Prevention" at Kentucky Kids Are Worth It Conference
	09/19/2007	Barren START accepts first client
	09/19/2007	Additional nine Kentucky START staff makes a site visit to Cleveland.
	10/01/2007	Federal grant awarded to Kentucky DCBS to initiate START program in Martin
	10/01/2007	Jefferson START begins operation
	10/03/2007	Jefferson START accepts first client
	10/15/2007	Kenton START begins operation
	10/26/2007	START Supervisor meets with the county attorneys and judges in Kenton County
	11/01/2007	Administration changes in Kentucky occur
	11/02/2007	Final budget for Martin K-START program approved
	11/07/2007	Kenton START accepts first client
	12/04/2007	Kenton hires new family mentor
	12/05/2007	Conference call with federal representatives and Martin K-START staff to discuss role of START Assistant Director as part of RPG grant
	12/05/2007	Barren meets with TAP and Lifeskills to go over case referral process
	12/12/2007	Tina's First site visit to Inez, Ky. (Martin K-START site)
2008	01/11/2008	Drug Exposed Infant Task force joins Jefferson START Advisory Group
	01/11/2008	Barren County family mentor resigns to take another job
	01/18/2008	Barren expands selection criteria for child age for this site to 0-6yrs (instead of 0-3yrs) in effort to increase case load
	02/01/2008	Interviews for Martin K-START CPS social workers completed
	02/01/2008	Transitions treatment provider distinguish START clients in need of different treatment path due to MH issues after attending Trauma Informed Care training (1/31/2008)
	03/24/2008	Treatment provider subcontracts for all START sites completed and signed
	03/27/2008	Federal representatives from Children's Bureau visit Frankfort and Martin County to assess K-START progress and provide technical assistance
	03/30/2008	RPG Grant Continuation application for K-START Year 2 submitted
	03/31/2008	Newly hired mentor in Kenton finishes training and able to accept cases
	03/31/2008	Northern Kentucky START staff and director begin work with Greater Cincinnati Health Foundation to expand and sustain START.
	03/31/2008	First invoice submitted by Division of MHMR

	Date	Important Events for START
	04/30/2008	Community partner relationships strengthening in Kenton
	04/30/2008	K-START Year 1 Semi Annual Progress Report for RPG grant submitted
	05/23/2008	Martin K-START family mentors hired
	05/27/2008	START Information Network (START-IN) goes live; data collection moves from paper to electronic format
	05/29/2008	K-START collaborates with other RPG federal grant recipient in KY; first official meeting held between KY River FISHN and K-START
	05/30/2008	Jefferson START Supervisor takes maternity leave for 2 months
	06/02/2008	START staff spoke at the Keeping Children Safe Community Spirit Program and a family mentor shared her story of recovery
	06/20/2008	Initial mapping of social network and resources completed by University of Kentucky researcher (START partner)
	06/25/2008	2nd Meet & Greet in Kenton; 20 partners attended to discuss collaboration and how to improve the gaps in service delivery
	06/30/2008	Barren County START site discontinued due to budget shortfalls
	06/30/2008	DCBS negotiates access to rapid and intensive services with Martin treatment provider
	07/01/2008	First Annual Regional Partnership Grantee Meeting held in Washington DC
	07/11/2008	Vendor selected for conducting Martin K-START drug screens
	07/23/2008	Bi-annual Family Mentors Performance evaluations completed
	07/30/2008	The Division of Mental Health and Substance Abuse (DMHSA) presents DCBS START program with the Innovative Initiative Award for 2008!
	07/31/2008	Jefferson supervisor back from maternity leave
	07/31/2008	Martin Family Mentors shadow and make linkages with community partners
	08/11/2008	Martin Mentors receive Mini-academy training
	08/12/2008	Jefferson START observes growing awareness of substance abuse and child neglect local hospitals; similar number of referrals made from hospitals.
	08/14/2008	Kentucky River FISHN Site visit (other RPG grantee)
	08/27/2008	DMHSA, DCBS, TAP and the KY Women's Coalition sponsored "Working Together" which is an in depth overview of DCBS, its policies and practices.
	08/31/2008	Kenton team and Tina present at the 2008 Annual KEYS Systems of Care Conference
	09/15/2008	Martin County - first client accepted to K-START