SOBRIETY TREATMENT AND RECOVERY TEAMS

Maryland initiated the implementation of the START model and its strategies in the following 13 jurisdictions to serve families to begin in 2019: Anne Arundel, Caroline, Carroll, Cecil, Dorchester, Frederick, Harford, Kent, Montgomery, Queen Anne's, Somerset, Talbot & Worcester.

The *Sobriety Treatment and Recovery Teams* (START) Model is a child welfare led intervention for families with children 0-5 years old 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[1]. The START model is specifically designed to transform the system-of-care within and between child welfare agencies and substance use disorder (SUD) treatment providers; it also engages the judicial system and other family serving agencies. The broad goals of START are to keep children safely with their parents whenever possible and to promote parental recovery and capacity to care for their children.

Implementation Partners:
START implementation is funded by Maryland's Social Services Administration (SSA) in partnership with the Behavioral Health Administration (BHA) and local Health Departments (HD). The model is locally administered by the above 13 Local Social Service Departments (LDSS). Technical Assistance and Evaluation is led by Children and Family Futures (CFF) and University of Maryland, School of Social Work, The Institute for Innovation and Implementation.

START Goals:
The model aims to mitigate systems issues that result in barriers to families being able to access services in a timely manner. It requires an approach to service delivery that involves cross-system collaboration and flexibility to meet the unique needs of this population. The practices of the START Model align with strategies considered to be effective for families affected by parental substance use disorders and child maltreatment which include:

1. *Early identification of families affected by substance use disorders.*
2. *Providing timely access to assessment and treatment services.*
3. *Increasing parent recovery services and engagement in treatment through peer support.*
4. *Focusing on family-centered services and parent-child relationships.*
5. *Increasing oversight for parents and children.*
6. *Sharing responsibility for parent accountability and program outcomes across service systems.*
7. *Collaborating across service systems and with the courts.*

The START Model has been evolving and maturing since its inception in 1989, then known as the Alcohol and Drug Addiction Protection Team (ADAPT). The development and testing of the START model began in 1997 in Cleveland, Ohio with the help of the Annie E. Casey Foundation. Kentucky began implementing START in 2007 and continues with six sites. The model has been adapted to fit the varying needs and policies of rural and urban jurisdictions in several states (i.e., Kentucky, Indiana, New York, North Carolina, Ohio and Maryland) to date.

Mothers who participated in START achieved sobriety at nearly twice the rate of mothers treated without START (66 percent and 37 percent, respectively). Children in families served by START were half as likely to be placed in state custody as compared with children in a matched control group (21 percent and 42 percent, respectively). This outcome also results in cost-effectiveness—for every $1.00 spent on START, Kentucky potentially avoided spending $2.22 on foster care.[2]

[1] California Evidence-Based Clearinghouse for Child Welfare (2016). *Sobriety Treatment and Recovery Teams (START)*. Retrieved from: http://www.cebc4cw.org/program/sobriety-treatment-and-recovery-teams/detailed

[2] Huebner, R. A., Willauer, T., & Posze, L. (2012). The impact of sobriety treatment and recovery teams (START) on family outcomes. *Families in Society: The Journal of Contemporary Social Services, 93 (3),* 196-203.

The START Model includes these key components:

- Cross-system collaboration with community partners, SUD treatment providers, the courts, and the child welfare system dedicated to building community capacity and making START work;
- Family-centered approach that fosters integrated systems-of-care between CPS, SUD treatment providers and the courts by addressing differences in professional perspectives;
- Shared decision-making among all team players, including the family;
- Early family identification, engagement and intervention upon receipt of the referral to CPS;
- Quick access to quality SUD treatment and frequent, intense and coordinated service delivery;
- A holistic assessment for all parents, addressing substance use, mental health, and trauma;
- A specialized Child Welfare worker and Family Mentor dyad serve families with co-occurring substance use and child safety risk factors with at least one child age 5 or younger.
- The Family Mentor brings real-life experience to the team and is a person in long term recovery with at least three years sobriety and previous CPS involvement. Family Mentors are rigorously screened, trained and supervised to provide START families with both recovery coaching and help navigating the CPS system.
- Capped caseloads for the START team to allow the worker/mentor dyads to support more intensive intervention;
- Sober parenting supports that include flexible funding for meeting basic needs such as housing, transportation, child care and in-home services;
- Child-focused services to promote attachment, reduce the effects of trauma, and provide developmental supports.
- Extensive evaluation to create a learning culture and identify opportunities to improve fidelity and family-centered outcomes.

Specific objectives of START are to reduce recurrence of child abuse/neglect; provide comprehensive support services to children and families; provide quick and timely access to substance use disorder treatment; improve treatment completion rates; build protective parenting capacities; and increase the county, region and state's capacity to address co-occurring substance use and impacted child risk factors.

The following includes some specific details related to the implementation of START in Maryland:

- START Family Mentors (individuals in long-term recovery) will be employed by the local HDs and co-located in the LDSS office where they will share cases with LDSS caseworkers.
- Treatment providers will be invited to partner with LDSS to provide quick access to substance use and co-occurring mental health/trauma assessments and treatment services. Communication protocols will be developed among partners to ensure families receive needed services while maintaining child safety.
- While not all cases will be court active, those that are may require additional court oversight to reinforce successful behaviors.
- Since infants exposed prenatally to substances are a priority population for Maryland START, birthing hospitals will be a key partner in identifying families in need of services.
- Additional families with children 0-5 may be identified during an LDSS investigation when substance use is a significant factor.

Implementation requires a commitment of LDSS to a multi-year effort to achieve fidelity to the START Model. Some of the 13 LDSS are prioritizing select strategies at initial implementation. Consultation and technical assistance are necessary to support implementation.

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