Helping Families With Co-Occurring Substance Use and Child Maltreatment: Strategies and Best Practices

No One Left Behind: Building Supportive Communities and Families Affected by the Opioid Crisis
April 18, 2017
Tina Willauer
DISCLOSURE

• The speaker and members of the planning committee do not have a conflict of interest in this topic.

• There is no commercial support for this program.
Getting to Know You
What We Will Cover Today

• Collaborative strategies for working with families who have co-occurring substance use and child maltreatment

• Overview of the START model history, program elements and outcomes.

• START Implementation in Rural Appalachia: A Case Study
Understanding the Need: National and Statewide Data
Substance Use and Child Maltreatment

• An estimated 12 percent of children in this country live with a parent who is dependent on or abuses alcohol or other drugs (SAMHSA, Office of Applied Studies, 2009).

• Between 60–80% of substantiated child abuse and neglect cases involve substance use by a custodial parent or guardian (Young, et al, 2007)

• Maltreated children of substance abusing parents remain in the child welfare system longer and experience poorer outcomes (GAO, 2003).
Number of Children in Out-of-Home Care in the United States, 2010-2014

The percentage of children entering care that had parent drug abuse reported as a reason for removal increased from 22.1% in 2009 to 29.7% in 2014. This is the largest increase of any reason for removal.

Source: AFCARS Data, 2014
Age of Children who Entered Foster Care in the United States, 2015 (N=269,509)

Note: Estimates based on all children who entered foster care during Fiscal Year

Source: AFCARS Data, 2015
Progress Since the Adoption and Safe Families Act (ASFA) 1997

Adoption and Safe Families Act (ASFA)

National Center on Substance Abuse and Child Welfare

Regional Partnership Grants (RPG)

Children Affected by Methamphetamine Grants (CAM)

Prevention and Family Recovery (PFR)


In-Depth Technical Assistance SubstanceExposed Infants

Fostering Connections Grants

Family Drug Court Grants

Substance Exposed Newborn Grants

RPG 2

RPG 3

Blending Perspectives and Building Common Ground Congressional Report Established 5 National Goals

FDC Statewide System Reform Program

Source: Children and Family Futures
We now know *what works* for families affected by substance use disorders.
Key Ingredients and Strategies

1. Identification
2. Timely Access
3. Recovery Support Services
4. Comprehensive Family Services
5. Increased Judicial Oversight
6. Cross-Systems Response
7. Collaborative Structures

NCSACW, 2016
How Collaborative Policy and Practice Improves

We know more....

5Rs

Recovery
Remain at home
Reunification
Re-occurrence
Re-entry

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Majority of children at risk of removal remained in their parent’s custody. Most children in out-of-home placement achieved timely reunifications with their parent(s). Less than 5% of children had a re-occurrence of substantiated maltreatment within six months after RPG Program Enrollment. After returning home, very few children re-entered foster care. Parents/caregivers achieved timely access to substance abuse treatment, stayed in treatment (on average, more than 90 days), and reported reduced substance use.
Three Key Systems

- No one system, agency or entity has the resources needed to effectively address this problem.

- START is an integrated program that engages and partners with the behavioral health and court systems but is initiated and driven by CPS.
We know more...

The Importance of Early Identification and Timely Referral to Services
The Five Clocks Facing Families, Providers and CPS

- Adoption and Safe Families Act (ASFA)
- Temporary Assistance to Needy Families (TANF)
- Child’s developmental timetable
- Recovery process and substance use disorder treatment
- Time for staff to respond to the other four clocks
Time to Treatment Matters

Child Welfare – 12-month timetable for reunification

Conflicting Timetables

Treatment and recovery – ongoing process that may take longer

Early engagement in treatment is crucial. Strategies to improve timely access include:
• Screening and identification
• Service linkage and matching to parent need
• Warm hand-off to assessment

NCSACW, 2016
Since timely engagement and access to assessment and treatment matters:

How can identification and screening be moved up as early as possible?

NCSACW, 2016
A Model for Early Identification, Assessment, and Referral

Referral into CWS Hotline

CWS Safety and Risk Assessment

AOD Screening & Assessment

Timely Referral to Treatment

Detention Hearing

Jurisdictional-Dispositional Hearing

Typical referral to Treatment

Status Review Hearing

NCSACW, 2016
“Here’s a referral, let me know when you get into treatment.”

“They’ll get into treatment if they really want it.”

“Don’t work harder than the client.”

“Call me Tuesday.”
Questions and Considerations...

- How do treatment and recovery timelines work with or against permanency planning timelines, especially from the perspective of the child?
- Do families involved in child welfare have priority treatment access?

NCSACW, 2016
We know more...

The Importance of Engagement, Evidence Based Treatment and Recovery Support
Rethinking Treatment Readiness

Re-thinking “rock bottom”

Addiction as an elevator

“Raising the bottom”
Treatment operates within an acute vs. chronic disease model. This focus is the most likely reason for lack of continuing care services, a staple of disease management for any other chronic illness.

Like any other chronic illness that can be managed but not cured — substance use disorders require a period of continued monitoring and supports. Unfortunately, these post-treatment services are rarely available in adequate quantity or quality to forestall a relapse.

What is Recovery?

**SAMHSA’s Working Definition**

*Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.*

Recovery is not treatment!

Access to evidence-based substance use disorder treatment and recovery support services are important building blocks to recovery.
A recovery-oriented systems approach supports person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families, and communities to take responsibility for their health, wellness, and recovery from substance use disorders.

NCSACW, 2016
Recovery Support: Titles and Models

- Peer Mentor
- Peer Specialist
- Peer Providers
- Parent Partner

- Recovery Support Specialist
- Substance Abuse Specialist
- Recovery Coach
- Recovery Specialist
- Parent Recovery Specialist

YOU NEED TO ASK:
What does our program and community need?

Experiential Knowledge, Expertise

Experiential Knowledge, Expertise + Specialized Trainings

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Effective Substance Use Disorder Treatment

• Is readily available
• Attends to multiple needs of the individual (vs. just the drug abuse)
• Uses engagement strategies to keep clients in treatment
• Uses counseling, behavioral therapies (in combination with medications if necessary)
• Addresses co-occurring conditions
• Uses continuous monitoring

National Institute on Drug Abuse, 2012
EBPs for trauma survivors:

- Addiction and Trauma Recovery Integration Model (ATRIUM)
- Essence of Being Real
- Sanctuary Model
- Seeking Safety
- Trauma, Addictions, Mental Health, and Recovery (TAMAR) Model
- Trauma Affect Regulation: Guide for Education and Therapy (TARGET)
- Trauma Recovery and Empowerment Model (TREM and M-TREM)

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Aftercare and Ongoing Support

Ensure aftercare and recovery success beyond treatment:

– Personal Recovery Plan – relapse prevention, relapse response
– Peer-to-peer support – alumni groups, recovery groups
– Other relationships – family, friends, caregivers, significant others
– Community-based support and services – basic needs (childcare, housing, transportation), mental health, physical health and medical care, spiritual support
– Self-sufficiency – employment, educational and training opportunities
Questions and Considerations

• What strategies are used to engage and retain clients in treatment? With clients who drop out or miss appointments?
• Does the program use peer mentors, recovery support specialists or recovery coaches to engage and retain clients?
Medication Assisted Treatment: Strategies for Child Protective Services
MAT and CPS

• Roughly 2.4 million people met criteria for opioid use disorder in 2013, compared to 1.5 million people in 2003 (Jones, Campopiano, Baldwin, & McCance-Katz, 2015)

• CW-involved parents with opioid use disorders are an especially vulnerable population, characterized by housing instability, lack of social support, poverty, and educational deficits (Lundgren, Schilling, Fitzgerald, Davis, & Amodeo, 2003)

• Reunification rates are lower for parents with opioid problems than for parents with alcohol problems (Choi & Ryan, 2007; Grella, Needell, Shi, & Hser, 2009) and parents with cocaine problems (Choi & Ryan, 2007)
And Yet....

- Research and programming on opioid use and treatment for families in the CW system is especially lacking.
- MAT has been identified by the World Health Organization (2004) as the most effective treatment for opioid use.
Medication Assisted Treatment

As part of a comprehensive treatment program, MAT has been shown to:

- Increase retention in treatment
- Decrease illicit opiate use
- Decrease criminal activities, re-arrest and re-incarceration
- Decrease drug-related HIV risk behavior
- Decrease pregnancy-related complications
- Reduce maternal craving and fetal exposure to illicit drugs


Barriers to using MAT

• Stigma, stigma, stigma
• Access and expense
• Bias toward abstinence-based approaches
  – CPS, BH, Courts
• Lack of communication between CPS and providers
• Diversion, irresponsible prescribing, lack of oversight
Child Welfare Considerations

• Emphasize that MAT is a choice and is supported

• Cost can be a barrier to getting and staying on MAT

• Methadone and buprenorphine can be overly sedating.
  – Plan for childcare after dosing until sedation resolved
  – Discuss with the prescriber
  – Note that co-sleeping is especially dangerous with sedating medications

• Include on safety plans and case plans
• Case can be closed while client is on MAT if stable
  – Length of MAT determined by provider and patient
  – Unnecessary and unethical to require discontinuation or reduction. Can trigger a relapse.
  – Relapse risk is high when medication is stopped before clinically indicated.
  – Include MAT supports on aftercare plan at closure.
What does “success” look like on MAT?

• Medication assisted recovery:
  – Taking the medication as prescribed
  – Completely compliant with program requirements
  – Not using any illicit substances
  – Stability in work, family, community
  – No illegal behavior
  – Applying recovery principles to daily life
START and MAT

• We support the use of EBPs, including MAT
• Methadone, buprenorphine, naltrexone
  – ADJUNCT to treatment
  – Medication Assisted RECOVERY
• Why do we support MAT?
  – Child safety
  – Better family outcomes
  – Not our business how someone gets recovery
• **Study Aims:**
  • Look at MAT use of START clients with opioid use history
  • Compare child outcomes for START clients who received MAT services with those who did not

• **Study Sample:**
  • Closed cases between 2007-2015

• **Measures:**
  • Demographics
  • Substance use at intake
  • Household opioid use (one adult vs. two or more adults)
  • Medication Assisted Treatment
    • Use of methadone, buprenorphine and naltrexone
  • Permancy (collapsed into 2 categories
    • Remained at home with parent vs. all other outcomes
MAT and Child Permanency Outcomes

- All children remained with parent: 71% with at least 1 month of MAT, 52% with no MAT.
- All other outcomes: 29% with at least 1 month of MAT, 48% with no MAT.
MAT Study Results:

• Compared to families who received no MAT:
  – 6 months of MAT: 60% more likely to retain custody of children
  – 9 months of MAT: 90% more likely to retain custody of children
  – 14 months* of MAT: 140% more likely to retain custody of children

• Duration of MAT also positively associated with reduced illicit opioid use (Condelli & Dunteman, 1993), other drug use and criminal activity (Simpson & Sells, 1982), and risk of viral infection and STDs (Greenfield & Fountain, 2000)

*average length of START case
Making Improvements

- Education and training
- Collaborative meetings
- Case reviews that ALWAYS ask about MAT
- Financial support for MAT
- Research paper and presentations *
- Collaborative provider list *
- Practice guide *
- Legal brief
A Word About Naloxone

- Narcan (injection or nasal spray)
- Reverses overdose until get medical care
- Everyone at risk of OD should have a kit. Also family and friends.
- Consider whether your office should have a kit available.
Questions and Considerations

- What educational opportunities exist to educate the CPS workforce on benefits of MAT?
- How can practical service linkages be implemented between the CPS system, abstinence-based addiction treatment providers, MAT providers and the courts?

NCSACW, 2016
We know more....

The Importance of Family-Centered Approach
Child well-being occurs in the context of relationships. Adult recovery should have a parent-child component.
The parenting role of both women and men with substance use disorders is a complex matter that cannot be separated from their treatment.

Addressing the needs of both parents and children (individually and as a family unit) contributes to successful family outcomes.

Parents do better in treatment when their children remain with them.

Two-generation interventions for parents and children affected by substance use disorders also save money.

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Family Recovery

Needs

PARENTS
- Parenting skills and competencies
- Family connections and resources
- Parental mental health co-occurring
- Medication management
- Parental substance use
- Domestic violence

FAMILY
- Basic necessities
- Employment
- Housing
- Child care
- Transportation
- Family counseling

CHILD
- Well-being/behavior
- Developmental/health
- School readiness
- Trauma
- Mental health
- Adolescent substance use
- At-risk youth prevention

NCSACW, 2016
Parent-Child: Key Service Components

- Early and ongoing peer recovery support
- Quality and frequent visitation (Parenting Time)
- Developmental & Behavioral Screenings and Assessments
- Parent-Child Relationship Based Interventions
- Evidenced-Based parenting
- Trauma
- Community and auxiliary support

NCSACW, 2016
Children Need to Spend Time with Their Parents

- Involve parents in the child’s appointments with doctors and therapists
- Expect foster parents to participate in visits
- Help parents plan visits ahead of time
- Enlist natural community settings as visitation locations (e.g. family resource centers)
- Limit the child’s exposure to adults with whom they have an uncomfortable relationship

NCSACW, 2016
Questions and Considerations

- What services are provided to address the specific needs of children and other family members?
- Can children accompany their parent to treatment? If so, are there any restrictions on age and number of children?
- What evidence-based parenting or family strengthening programs are provided?
Collaborative Practice Implications

What system changes need to occur to support local, cross-system collaborative practices?

- Priority and timely access to effective treatment
- Address confidentiality
- Strengthen cross-system collaboration, communication, and training
- Enhanced understanding and acceptability of MAT
- Trauma training

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Collaborative Practice Implications

What do child welfare staff need from substance abuse and mental health treatment practitioners to more effectively make decisions about the safety, permanence and well-being of children they are charged to protect?

What do substance abuse and mental health treatment practitioners need from child welfare staff to more effectively assess and treat parents and children?
We can no longer say we don’t know what to do.
START
Sobriety Treatment and Recovery Teams
START History and Sites

- START adapted from model developed in Cleveland in 1990s with support from the Annie E. Casey Foundation.
- KY began planning for K-START began in 2006 and has evolved the model to fit the needs of KY families.
- START has been implemented in six unique counties in KY: Kenton, Jefferson, Boyd, Martin, Daviess and Fayette.
- IN START in Bloomington and Terre Haute.
- START has also been piloted in Bronx, NY and NW GA.
What is START?

- Child Protective Services (CPS) program for families with parental substance use disorder and child maltreatment.
- Integrative model that combines best practices among child welfare, family preservation and behavioral health.
- Helps parents achieve recovery and keeps children in the home with their family when safe and possible.
- START is recognized on the California Evidence Based Clearinghouse for Child Welfare.
What is START?

• Serves CPS involved families with a substance exposed infant and/or young children 0-5.

• Partners with substance abuse and mental health treatment for services.

• Rapid timeline to engage families in services quickly and keep children out of foster care when safe and possible.

• Represents different approach to working with families involved with CPS due to parental substance use concerns.
• Early identification of families upon receipt of CPS referral.
• CPS Worker and Family Mentor paired co-located under a CPS START Supervisor.
• Capped caseload of 12-15 families for each CPS worker/family mentor dyad
• Weekly home visits
• Non-punitive approach
• Quick access to substance abuse assessment and treatment—within 48 hours
Overall Goals of START

- Preventing foster care entry
- Child Safety and Well Being
- Parental Sobriety and Recovery
- Permanency for children
- Family stability and self sufficiency
- Improved system capacity for addressing co-occurring addiction and child abuse.
Eligibility Criteria

- Family has a new CPS case opening for substantiated CA/N due to substance abuse
- Family cannot have a current open CPS case, but may have a history with the agency
- Family has at least one SEI or young child (target population is based on jurisdiction data).
- Family must attend initial FTM/Safety Meeting
- Funding eligibility requirements.
START Timeline

First 30 days of a START Case

CPS Referral

Investigative Supervisor notifies START Supervisor

24 Hours—10 Days
(If Drug Exposed Infant, refer to START within 24 hours of receiving report)

Investigative Worker makes preliminary finding.

First FTM

≤ 3 Days

Investigative worker schedules first FTM and invites START

≤ 2 Days

Service Coordinator meets with parent to do assessment

≤ 1 Day

Parent begins intensive treatment

≤ 2 Days

Service Coordinator gives verbal recommendations to parent and CPS and makes referral to treatment *

≤ 10 Days

Parent in intensive treatment

FTM: 30 Day Case Planning Meeting to include provider and family

Note: All days listed are work days.

* Written treatment recommendations given to CPS within 5 days
Funding

• Multiple funding streams cobbled together:
  – Regional Partnership Grants
  – KY State General Funds
  – TANF
  – Medicaid
  – Casey Family Programs
  – Title IV-E Waiver

• The Challenge: Bringing programs that work “to scale” and then sustaining them for children and families!
START Strategies
Shared Decision Making

- Regular FTM’s to plan and make team decisions
- Includes parents, CPS worker, community partners, family supports
- No secrets and no surprises

- Family-driven, strength-based approach
- Each system knows their “role” but contributes info
- Helps with family engagement and “buy in” with plan
- SUD Assessment begins at first FTM
Using START Strategies:

- START attempts to maintain the children in the home whenever possible while working with the parents:
  - Protective factors
  - Safety planning
  - Wraparound supports
  - Quick access to treatment
  - Sober caregiver/supervisor
  - Weekly visits; close monitoring
Child Placement Philosophy

• Placement is a shared decision that includes the family.

• Most children in START remain in home but, if an out of home care placement is needed, plan will aim to:
  - Keep child in the same county/community;
  - Place w/safe relatives or in a home setting;
  - Place children with siblings;
  - Set reunification as goal;
  - Ensure regular visits and contacts with parents; and
  - Train and support foster parents or relative caregivers.
Quick Access to SUD Treatment

90% go from Referral to Intake in 8 days
Family Mentors

- A family mentor is a recovering individual who:
  - Has maintained sobriety for at least 3 years; and
  - History with child protective services.
- The unique change agent within START is the teaming of a specially trained CPS work with a family mentor.
- Family mentor engages family early and transports parent to first 4 treatment appointments.
- Provides accountability and recovery support to parents.
- Changes the office culture.
Behavioral Health Services

• Strong partnership between behavioral health service providers and CPS at state and local levels.

• Team works collaboratively to improve service delivery, overall practice and outcomes for families.

• Team and other community partners participate in ongoing joint and cross training.

• Use of evidence based practices.

• Weekly progress reports, close communication and crisis intervention in collaboration with START staff.

• Cross system data collection and sharing.
Using Evidence Based Practices

- Gender-specific groups
- Trauma-informed care
- Co-occurring Disorder Treatment
- Motivational Interviewing
- Cognitive Behavioral Therapy
- 12-step Facilitation Therapy
- Matrix Model
- Seeking Safety
- Relapse Prevention
- Living in Balance
- Helping Women/Men Recover
- Medication assisted treatment
Communication is Key

- Weekly BH progress reports
- Phone/email if client no-shows or has a positive drug test or other child safety concern
- Family Team Meetings – being on same page in front of the client/family
- Cross Training
- Case consults
- Service Coordination
- Direct Line meetings
- Advisory and/or contract meetings
- Team building
Quick Access to SUDS Treatment and Parent and Child Outcomes

(n= 550 adults; 717 children)

Main START Outcomes

- Women in START have higher rates of sobriety than their non-START child welfare-involved counterparts (66% vs. 36%)
- Children in START are 50% less likely to enter out-of-home placements than children from a matched comparison group
- At case closure, over 75% of children served by START remained with or were reunified with their parent(s)
- For every $1 spent on START, $2.52 is saved on out-of-home placement costs

START Video:

From Kentucky Educational Television (KET)
Filmed in Ashland, KY
October 2014
START in Rural Appalachia
Implementation and Outcomes
Four Kentucky START Sites: 3 State, 1 Grant Funded

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Jefferson (Louisville)</th>
<th>Kenton (Covington)</th>
<th>Martin (Inez)</th>
<th>Boyd (Ashland)</th>
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</thead>
<tbody>
<tr>
<td>Selection Criteria: At least</td>
<td>Infant-drug exposed</td>
<td>Child &lt; = 3 years</td>
<td>Child &lt; = 3 years</td>
<td>Child &lt; = 5 years</td>
</tr>
<tr>
<td>Child Population (2007 census est.)</td>
<td>170,787</td>
<td>40,409</td>
<td>2,885</td>
<td>10,259</td>
</tr>
<tr>
<td>Annual # child victims with</td>
<td>1794</td>
<td>435</td>
<td>217</td>
<td>200</td>
</tr>
<tr>
<td>substance abuse risks (SFY 2009)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% children living in poverty</td>
<td>19.0%</td>
<td>14.9%</td>
<td>58.1%</td>
<td>24%</td>
</tr>
</tbody>
</table>

November 1, 2012 • Alliance for Children and Families
Rural KY Appalachian counties:

- Poverty rates as high as twice the national average (U.S. Census Bureau, 2014)
- An epidemic of nonmedical prescription drug use (Hall, Leukefeld, & Havens, 2013; Leukefeld et al., 2005; Wunsch, Nuzzo, Behonick, Massello, & Walsh, 2013; Young, Havens, & Leukefeld, 2012)
- Annual rates of child abuse and neglect (CA/N) as high as 5.4 per 100 children (Kentucky Department for Community Based Services, 2012)
Background and Context

• **Barriers to treatment:**
  
  – **Distance** (Cummings, Wen, Ko, & Druss, 2014; Fortney, Rost, Zhang, & Warren, 1999)
  
  – **Cultural factors may also be influential**
    
    • Rural Appalachian values of individualism and self-reliance may play a role in limiting substance users’ identification of a need for professional treatment (Leukefeld et al., 2005)
    
    • Troubled history between Appalachians and absentee land-owning corporations (e.g., coal, timber) are thought to have fostered skepticism of outsiders (Keefe, 1988)
    
  – **Recent study:** *geographic discordance* — receiving treatment in a location that is both geographically and socio-culturally different — increased the odds of relapse and incarceration 12 months after treatment entry (Oser & Harp, 2014)
Method

• **2007:** Children’s Bureau awarded a Regional Partnership Grant (RPG) to the Kentucky Department for Community Based Services (DCBS), the state’s public child welfare system, to develop a START program in Martin County, Kentucky.

• **2008:** After 1 year of training and infrastructure building, the program began accepting families.

• **2 evaluation components:**
  1. Process evaluation
  2. Outcome evaluation
Process Evaluation and Fidelity Assessment

- Four key domains assessed:
  1. Community collaboration, measured by pre- and post-test Collaborative Capacity Instrument (CCI)
  2. Family participation in mental health services
  3. Type and duration of drug addiction treatment
  4. Amount of family mentor contacts
- Fidelity to quick-access service delivery standards
- Analysis of meeting and training notes
Outcome Evaluation

• Quasi-experimental design featuring families served by START in Martin County and a matched control group of families selected from two contiguous counties.

  – All three counties:
    1. Experienced high rates of substance use and CA/N
    2. Were served by the same family court judge and community mental health center
Outcome Evaluation

Four primary outcomes were assessed:

1. Children entering and exiting state custody.
   - Duration of the START program with follow-up to December 2012

2. Recurrence of child maltreatment.
   - Substantiation within six months of the first substantiation

3. Reentry into foster care.
   - Placed in foster care at any point during the evaluation period and then re-entered foster care up to 12 months later

4. Cost avoidance.
• **Obstacles encountered:**
  
  1. Limited infrastructure needed to establish fidelity to the START program model
     • Example:
       – No intensive outpatient addiction treatment, and only 1 recovery support group, when project was initiated
  
  2. Negative attitudes about collaboration
     • Example:
       – Tension and mistrust between the local addiction treatment provider and CPS agencies
  
  3. Early on, when 2 eligible cases were referred simultaneously, START workers selected the case with greatest need
Results: Process Evaluation

- 67 families served
  - 57 couples (85% of caregivers)
  - 66 biological mothers, 45 biological fathers
- Average adult age: 29.2 years
- Almost exclusively White (99.2%)
- Full or part-time employment at time of referral:
  - females (8.6%), males (42.4%)
Results: Process Evaluation

- Adults reported problematic use of 3.2 substances on average.

- Most commonly used substances were:
  - Opioids (76.6%)
  - Benzodiazepines (60.2%)
  - Barbiturates (38.3%)
  - Marijuana (38.35%)
Results: Process Evaluation

- 153 children served (79 girls, 74 boys)
  - 30% under 1 month old at time of referral
- 80.2% received developmental services
- 66.7% received educational services (e.g., Head Start)
- 69.3% received mental health services
- 80.4% received medical services
Results: Type and Duration of Addiction Treatment Services for START adults

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>n (%)</th>
<th>Average Number of Sessions</th>
<th>Average Months Duration</th>
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<tbody>
<tr>
<td>Detoxification</td>
<td>10.9%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Long-Term Residential Residential</td>
<td>40.3%</td>
<td>51.0&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.8</td>
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<tr>
<td>Intensive Outpatient Services</td>
<td>66.4%</td>
<td>25.4&lt;sup&gt;b&lt;/sup&gt;</td>
<td>6.7</td>
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<tr>
<td>Outpatient Services</td>
<td>52.1%</td>
<td>24.5&lt;sup&gt;c&lt;/sup&gt;</td>
<td>10.0</td>
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<tr>
<td>Case Management</td>
<td>86.4%</td>
<td>29.7&lt;sup&gt;d&lt;/sup&gt;</td>
<td>7.9</td>
</tr>
</tbody>
</table>

Note. N/A = not applicable.

<sup>a</sup>Residential sessions included at least 6 hours of programming per day.

<sup>b</sup>Intensive outpatient sessions included at least 2 hours of programming per day.

<sup>c</sup>Outpatient sessions included 1–2 hours of programming.

<sup>d</sup>Case management sessions were highly variable, ranging from 15 minutes to all day.
Results: Recovery Mentor Contacts in Closed Martin Co. Cases ($N = 67$)

<table>
<thead>
<tr>
<th></th>
<th>Average ($M, SD$)</th>
<th>Minimum #</th>
<th>Maximum #</th>
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<tbody>
<tr>
<td>Months Served</td>
<td>18.5 (11.4)</td>
<td>1.4</td>
<td>49.4</td>
</tr>
<tr>
<td>Number of Mentor Contacts</td>
<td>74.4 (44.5)</td>
<td>15.0</td>
<td>189.0</td>
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<tr>
<td>Total Mentor Hours Spent with Family</td>
<td>70.2 (40.3)</td>
<td>14.7</td>
<td>167.7</td>
</tr>
<tr>
<td>Intensity: Average Number of Mentor Contacts with Family per Month Served</td>
<td>4.5 (1.9)</td>
<td>0.9</td>
<td>11.5</td>
</tr>
</tbody>
</table>
Results: Participation in Mental Health & Psychiatric Services

Nearly 85% of adults served by START-Martin County received mental health services;

Only 22.5% of adults in the matched control group received services ($\chi^2 (1) = 166.2, p < .001$).
# Outcome Results for Children served by START-Martin County and Matched Control

<table>
<thead>
<tr>
<th></th>
<th>START-Martin (n = 153)</th>
<th>Matched Control (n = 345)</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children entering state custody, n (%)</td>
<td>49 (32.0%)</td>
<td>93 (27.0%)</td>
<td>$\chi^2 (1) = 1.3, p = .25$</td>
</tr>
<tr>
<td>Children discharged from state custody by 12/2012, n (%)</td>
<td>29 (59.2%)</td>
<td>68 (73.1%)</td>
<td>$\chi^2 (1) = .04, p = .84$</td>
</tr>
<tr>
<td>Recurrence of CA/N within 6 months, n (%)</td>
<td>7 (4.6%)</td>
<td>35 (10.1%)</td>
<td>$\chi^2 (1) = 4.3, p &lt; .05$</td>
</tr>
<tr>
<td>Reentered foster care within 12 months, n (%)</td>
<td>0 (0.0%)</td>
<td>9 (13.2%)</td>
<td>$\chi^2 (1) = 4.1, p &lt; .05$</td>
</tr>
</tbody>
</table>

*Note: CA/N = child abuse/neglect.*
Out of Home Care (OOHC) Cost Avoidance

• Of 153 children served by START, 49 (32%) were placed in OOHC.

• Given an OOHC rate of 40%, typical in KY, 61 children served by START might be expected to have been placed in OOHC were it not for the program.

  – Assuming OOHC costs of $30,000 per child, the difference of 12 children is a cost avoidance of $366,000.
Overcoming Barriers in Rural Appalachian (Martin) County

• “Pockets in Central Appalachia have 3x the national poverty rate, an epidemic of prescription drug abuse, the shortest life span in the nation” (Diane Sawyer, 2009)

• Treatment providers struggle financially in rural areas due to sparse and isolated populations that are a barrier to economy of scale; there are fewer credentialed individuals
Overcoming Barriers to START Implementation in Rural Appalachian (Martin) County

- Building community readiness and supports for sober living
- Overcoming myths about addiction, child abuse, accountability and treatment
- Creating hope that treatment can work
- Family mentors were a catalyst for change through education and developing recovery support groups and town hall meetings
- Went from 1 fledging recovery support group to 12 weekly 12-step or other recovery support groups
Lessons Learned

• Assess leadership readiness

• Survey community resources and infrastructure

• Develop realistic timelines
  – Longer start-up periods may be required to accommodate infrastructure development and leadership readiness

• Build incrementally and collaboratively
  – Certain START practices, such as keeping children with their family during treatment, were contrary to the belief that removing children motivates parents that are addicted toward sobriety

• Provide consistent messaging to dispel myths and mistrust
Conclusions:

- In spite of significant challenges, the 6-month recurrence rate of CA/N among children served by START was half that of children in the matched control group.
- Additionally, 0% of children served by START reentered OOHC, compared to 13% of children in the matched control group.
- Under-resourced areas with substantial needs should not be abandoned – instead, such areas should be targeted – but with the understanding that additional time and support may be required to ensure success.
The START program and its evaluation were partially supported by the Children's Bureau (An Office of the Administration for Children & Families, U.S. Department of Health and Human Services) under Regional Partnership Grant CU90045.

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Special thanks to all the DCBS and Behavioral Health agency leaders, addiction treatment providers, child welfare teams, technology and data managers, court personnel and many community partners who worked diligently to make the START program and evaluation possible.
References:


• START is recognized on the California Evidence Based Clearinghouse for Child Welfare (CEBC):  
Purpose: Support the efforts of States, Tribes and local communities in addressing the needs of pregnant women with opioid use disorders and their infants and families

Audience
- Child Welfare
- Substance Use Treatment
- Medication Assisted Treatment Providers
- OB/GYN
- Pediatricians
- Neonatologists

National Workgroup
- 40 professionals across disciplines
- Provided promising and best practices; input; and feedback over 24 months.

Understanding Treatment of Opioid Use Disorders in Pregnancy

III. Treatment of Opioid Use Disorders in Pregnancy

These resources offer guidelines for the use of MAT to treat opioid use disorders in pregnancy and the postpartum period. Included is information on dosing during pregnancy, breastfeeding while using MAT and the use of buccal morphine with pregnant women. Also included are resources on the treatment of other substance use disorders in pregnancy.

- Studies on the use of methadone and buprenorphine for the treatment of opioid use disorders during pregnancy:
  - Medication-Assisted Treatment During Pregnancy, Postnatal and Beyond: Discuss the needs of pregnant women seeking medication assisted treatment. Karol Kaltenbach, PhD presents findings from the Maternal Opioid Treatment: Human Experimental Research (MOTHER) project. Facilitated as part of a webinar series—see the textbox, National Center on Substance Abuse and Child Welfare.

The Use of Medication-assisted Treatment during Pregnancy: Clinical Research Update
https://cff-ncsacw.adobeconnect.com/p5okpdezt3l/

Treatment of Opioid Use Disorders in Pregnancy and Infants Affected by Neonatal Abstinence Syndrome
Please visit: https://ncsacw.samhsa.gov

What You Need To Know About Substance Abuse and Mental Health Disorders To Help Families in Child Welfare.

Helping Child Welfare Professionals Support Families With Substance Use, Mental, and Co-Occurring Disorders Training Toolkit

This toolkit is designed to help educate pre-service or in-service child welfare professionals about substance abuse and mental health disorders that exist among families in the child welfare system. It is intended to provide learning opportunities and baseline knowledge on substance abuse and mental health problems and interventions, motivate and facilitate cross-systems work, and incorporate cultural awareness and facilitate cultural competency in child welfare practice.

Don’t miss out on this valuable product!
Get your FREE toolkit today!

Modules can be downloaded individually or as a package at https://ncsacw.samhsa.gov/training/toolkit/.
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