The Sobriety Treatment and Recovery Teams (START) Model is a child welfare led intervention that has been shown, when implemented with fidelity, to improve outcomes for both parents and children affected by child maltreatment and parental substance use disorders\(^1\). 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.

The START 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.

1. Identifying families affected by substance use disorders.
2. Providing timely access to assessment and treatment services.
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 systems.
7. Collaborating across service systems and court.

The START Model has been evolving and maturing since its inception in 1989, then known as the Alcohol and Drug Addiction Protection Team (ADAPT) in Toledo Ohio. 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, and Ohio) 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.


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(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

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;
- 12 basic tenets outline the program philosophy and collaborative values;
- 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 Protective Services (CPS) worker and Family Mentor dyad serve a families with co-occurring substance use, child maltreatment and 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.
- Caseloads for the START team of 12-15 families per worker/mentor dyad 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 abuse treatment; improve treatment completion rates; build protective parenting capacities; and increase the county, region and state’s capacity to address co-occurring substance abuse and child maltreatment.

Implementation requires a commitment of an agency or jurisdiction to a multi-year effort to achieve fidelity to the START Model. Consultation and technical assistance are necessary to support implementation. Please contact Tina Willauer at Children and Family Futures at [https://www.cffutures.org](https://www.cffutures.org) for additional information.


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