

WRITTEN TESTIMONY OF  
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CONSULTANT, CHILDREN AND FAMILY FUTURES  
*before the*

COMMITTEE ON WAYS AND MEANS  
SUBCOMMITTEE ON HUMAN RESOURCES  
U.S. HOUSE OF REPRESENTATIVES



*“Serving families with child maltreatment and substance use disorders: A decade of lessons learned”*

## **Introduction**

Chairman Buchanan, Ranking Member Doggett, and Members of the Ways and Means Subcommittee on Human Resources, thank you for conducting this hearing on our nation’s opioid epidemic and the effects of opioid and other substance use disorders on our nation’s child welfare and foster care system. My name is Tina Willauer and I am currently the Director of the Sobriety Treatment and Recovery Teams (START) program in Kentucky and a Consultant for Children and Family Futures.

I am honored today to talk to you about the efforts of Kentucky over the past decade to address the systemic and family issues arising from the co-occurrence of substance use disorders and child neglect and maltreatment. My entire professional career of more than 25 years has been dedicated to the effort of improving the lives of parents and children affected by substance use disorders. We know much more today about what actually works with this population of families and there are many programs across the country finding success with improved outcomes for children and families. I will be discussing the START program and what we have learned about implementation, strategies, improved outcomes, cost and opportunities to inform national efforts. The challenge and need is to bring evidence-supported strategies, systemic interventions and programs that work, like START, to scale and make them sustainable to keep families together and help parents gain competence.

## **START Brief Overview**

The Sobriety Treatment and Recovery Team Program (START) was initiated in 1989 as the Alcohol and Drug Addiction Protection Team program in Toledo, Ohio and later developed in Cleveland with the help of the Annie E. Casey Foundation (2001) and expanded to additional

communities in Kentucky under the Regional Partnership Grant program in 2007. It was developed to address the needs of families with infants affected by prenatal exposure during the crack cocaine epidemic. The goals were to keep children safe and reduce placement of these exposed infants within state custody. START was designed as an integrated program that incorporates multiple effective strategies such as family decision making and family preservation into a single program.

START is a child-welfare led program designed as an integrated treatment intervention for families with the co-occurrence of child abuse and neglect (CA/N) and parental substance use disorders (SUDs). START serves families that have substantiated CA/N, parental substance abuse as a primary risk factor for child safety, and at least one child five years or younger, are not currently receiving services through Child Protective Services (CPS), and are referred to START within 30 days of the initial CPS report. As an integrated intervention, implementing START requires intense collaboration between child welfare and SUDs treatment providers, including establishing shared values, common goals, common case plans, and joint responsibility for both parent and child outcomes.

This brief program description of START understates the amount of effort and values clarification that must occur prior to achieving fidelity to integrated practices between child welfare, treatment providers, and the judicial system. Infusing shared values, shared decision making, common case goals and shared responsibility for child and family outcomes into everyday practice in a way that essentially changes the paradigm for the system of care is an arduous and time-consuming process. Thus START is both a program with specific strategies to address the needs of parents and children AND a catalyst for reforming the service delivery system between child welfare, substance use and mental health disorder treatment, and the judicial system.

### **A START Success Story**

The story of Carrie is a classic example of how, with the right services in place, a family can safely stay together. When Carrie was a child, her family was well-known to CPS due to physical and educational neglect, sexual abuse, and parental substance abuse. Carrie was never removed to a safer setting, began using drugs and alcohol as a teenager, and ended up having a CPS report with her own first child due to her substance abuse. Carrie gave guardianship of her first child to a relative and had trouble trusting “the system” because of her past experiences with CPS. Carrie’s drug use then escalated to IV heroin supported by prostitution.

When her second child was born substance exposed, Carrie was referred to START by the CPS investigative staff. In START, her worker and family mentor worked hard to engage her. She received intensive child welfare services, peer recovery coaching, quick access to treatment services, coordinated treatment planning, and shared decision making between CPS, treatment providers and the family. Carrie was unable to abstain from heroin until she received medication assisted treatment. With methadone, Carrie completed addiction treatment, counseling for past trauma and domestic violence, parenting classes, and in-home family-based services. She attended 12-step meetings to support her recovery. Her baby received occupational, physical, and speech therapy for developmental delays. START’s collaborative model helped support

Carrie in getting the help she needed and participating in parent-child services, all while overcoming the stigma and discrimination related to her history of addiction and use of methadone. This case was successfully closed in the spring of 2015 with both children reunited with their mother. John, the father of the older child, received treatment is now drug-free, working, and has an active role in his child's life. Carrie delivered another baby in December 2015, this time drug-free! She continues to parent her three children.

### **START is an Evidence-Supported Intervention**

Since its beginning in Ohio, START has been fortunate to have increasingly rigorous program evaluation that has spurred scientific thinking in the START teams, improved implementation, and documented both program outcomes and opportunities to improve. Currently, START is listed on the *California Evidence-Based Clearinghouse for Child Welfare* as having promising research support

(<http://www.cebc4cw.org/program/sobriety-treatment-and-recovery-teams/detailed>), with continued studies underway to advance the level of evidence. START has operated in Kentucky since 2006 and has spread to implementation in Indiana in 2013 with two START sites and a third planned for 2016. New York City and the state of Georgia piloted START, and other states have inquired about embedding START into their systems. Because it is a complex intervention with multiple integrated strategies that transforms the system of care, it requires jurisdictions and their leadership to make a sustained commitment to implementing the program with fidelity over several years.

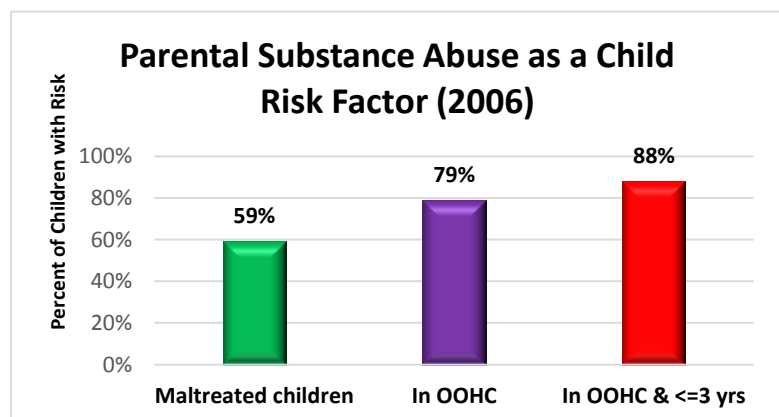
### **Purpose of This Testimony**

My written and oral testimony will:

- Illustrate the processes used in the past decade to achieve system reform in Kentucky.
- Describe how these efforts were augmented by the support of the Regional Partnership Grants and broadened through the Title IV-E Waiver program.
- Outline the outcomes of START including cost benefits.
- Depict effective START strategies and lessons learned to inform national efforts.
- Define national opportunities to expand best practices.

### **Kentucky's Persistent Efforts in the Past Decade**

In 2006, Kentucky's data showed that 59% of maltreated children, 80% of all children in Out Of Home Care (OOHC; also called foster care) and 90% of children three years and younger in OOHC had risks to their safety due to parental substance abuse. Kentucky was unique in the capacity to identify these trends because it has a fully approved

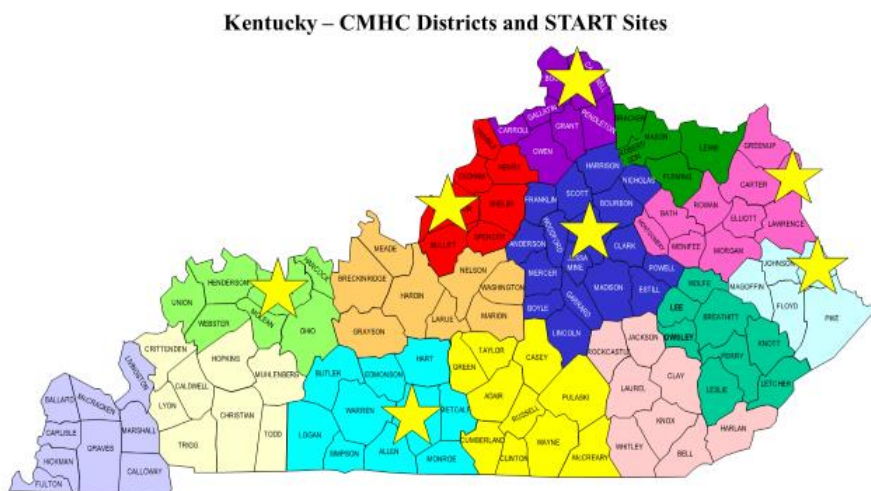


SACWIS system, leadership in using child welfare administrative data and the ability to integrate information from the CPS investigations (NCANDS data) including the State’s risk assessment with data on OOHC placement (AFCARS data) to describe family needs and risk factors. Families with both substantiated CA/N and substance abuse risks were likely to have four additional safety and risk factors including poverty, domestic violence, criminal history, and multiple adult partners in the home. Often there were multiple prior reports of suspected child abuse or neglect made to CPS.

At that time, Kentucky was one of a few states that did not pay for substance abuse treatment using Medicaid, and funding for substance abuse and mental health treatment had remained level for 15 prior years. Except in a few isolated urban areas, there were minimal SUDs treatment services available, with 454 mothers across the state on wait lists of four or more months to receive any treatment. Workers and the courts removed children and made referrals for parental SUDs treatment knowing that parents were unlikely to be able to access treatment; they waited for the family to fail because no one had a better alternative. The relationship between the Division of Behavioral Health (DBH) and the Department for Community-Based Services (DCBS) on a state level as well as between local DCBS offices and regional Community Mental Health Centers (CMHC) was marked by mutual blaming, distrust, philosophical differences, and competition for limited funds.

To begin to change that situation, the child welfare system invested \$2 million TANF MOE (state general fund dollars) in substance abuse treatment to jump-start collaboration with DBH and CMHCs in order to stimulate change and improve outcomes in both systems. This was the beginning of the Kentucky Substance Abuse Initiative.

The TANF MOE funding for START and the Substance Abuse Initiative has been augmented by two Regional Partnership Grants (RPGs) and more recently the IV-E waiver program. The START sites were placed in the State to be ‘hubs of influence’ in different CMHC regions with the intent that the efforts of START would transform the system of care in the hub site with improved collaboration and practices spreading through the regional DCBS and CMHC structure.



The goal was to establish an integrated treatment model between child welfare and the behavioral health system with increased court collaboration. The site in Daviess County

(Owensboro, semi-urban) is the newest site with Jefferson County (Louisville, urban) being the longest running and largest START site. Sites were established in Barren County (Glasgow, rural), Kenton County (Covington, urban), Boyd County (Ashland, semi-urban) and an RPG site in Martin County (Inez, rural Appalachian). Although it would be easier administratively to have the START programs more contiguous, the hubs-of-influence approach has been more effective in transforming the system of care in larger geographic areas.

In addition to START, Kentucky tried other approaches with different strategies including an RPG grant for the Families in Safe Homes Network (FISHN) program and Solutions (state funded), both in Eastern Kentucky. Each of these models taught us more about what works best. For example, the Solutions program provided SUDs treatment to mothers but not fathers, focused primarily on treatment rather than on changing CPS practice, and placed most children in OOHC.

**System reform was both stimulated and expressed through these efforts:**

- Contract agreements between DCBS and DBH with funds for treatment resulted in shared visions, infusing of best practices in both CPS and behavioral health, and rapid and more intensive treatment for parents.
- A common data collection system between DCBS and the CMHC on START clients included details of behavioral health treatment that supported fidelity to rapid access to treatment with more intensive services for parents. These data promoted shared accountability for fidelity to the model and shared understanding of both child and parent outcomes.
- Program evaluation efforts were embedded into START before it was implemented, using an empowerment model of evaluation. The internal program evaluation effort that worked with staff and providers to design and interpret results was an additional catalyst for change toward shared understanding and shared accountability.
- The quality of substance abuse treatment by START providers was improved with the introduction of high quality evidence-based practices such as Living in Balance and Seeking Safety.
- The Network for the Improvement of Addiction Treatment (NIATx) process was used in Kentucky to improve collaborative service delivery in both DCBS and the CMHCs.
- As part of In-Depth Technical Assistance provided by the National Center on Substance Abuse and Child Welfare (NCSACW), a series of statewide regional forums and drug summits strengthened specific practices like co-location of staff and consultation with the courts to improve the three-agency collaboration around parental substance abuse.
- Through expanded Medicaid funding and provisions of the Affordable Care Act (ACA) there has been a dramatic increase in access to behavioral health treatment services for child welfare engaged families: mothers, fathers, and children. The entire family unit is the focus of START. Because of a managed care system, the focus now is on entry into the appropriate level of care and type of service and the reduction of addiction symptoms rather than the completion of a treatment regime, making treatment more targeted to achieving results rather than compliance. The original two million dollars in state funds are now being used to fund other innovations in START and continue to augment treatment for the most needy.

- Fathers and significant partners in the family are all served by START, reflecting a shift in practice for CPS and treatment providers to understanding the value of fathers to families. Although we have a long way to go to provide optimal service to fathers, the inclusion of fathers has pushed the program to consider new ways of delivering services.
- Services to improve child well-being are an included standard practice in START, requiring collaboration with early childhood specialists in behavioral health, child development, and home visiting.
- Although it has taken a decade of concerted effort, policies and procedures are being rewritten in the three agencies - child welfare, behavioral health, and the judicial system - to reflect best practices in drug testing, placement of children in OOHC, behavioral health treatment strategies, and integrated service strategies. These changes in standards of practice and policy reflect system reform and ensure sustained performance improvement.

### **Regional Partnership Grants and IV-E Waiver Support**

We thank this committee for the vision of the IV-E Waiver program and their continued support of the Regional Partnership Grant (RPG) program in Title IV-B part 2 which provides services for children and their families affected by substance use disorders. The RPG was just the right program at just the right time to prepare us to deal with the crisis in child welfare due to parental substance use disorders. In total, 74 grants have been awarded under the RPG initiative in three rounds of funding.

Kentucky has been fortunate to receive two RPG awards to support START expansion into two additional counties, one a rural Appalachian county (Martin) with an epidemic of diverted opioid prescriptions and another in a semi-urban (67% urban) county (Davies). In addition to supporting two more ‘hubs of influence’ to transform the system of service delivery in the regional CMHC and to provide evidence-supported interventions to families, each START site teaches us more about what works under what conditions and improves implementation.

All states and tribes receiving RPG awards regularly participate in on-site and off-site training as ‘*communities of learning*,’ which has dramatically enhanced the capacity of professionals in Kentucky to respond to the substance abuse crisis. The best speakers in the nation were engaged to develop the capacity of states to identify trends in child welfare and substance abuse treatment, best practices for integrated programs, collaborative strategies, program evaluation strategies, funding options and sustainability, and a wide range of practice innovations. Participating in these learning communities helped Kentucky invest in a national effort and contribute to the nationwide learning organization. We developed expanded expertise in all three systems to improve program implementation, shared best program and evaluation practices, and actively collaborated with many other states. For Kentucky, the RPG and related efforts have influenced policy development, training programs for child welfare workers, the adoption of effective evidence-based practices, and the commitment to both the local and national effort.

Notably, the RPG program modeled at the federal level the collaboration needed to address the problem of parental substance abuse and child maltreatment. The Children’s Bureau and SAMSHA share the same goals for this initiative and model how shared projects, shared data,

shared goals, shared funding, and a shared vision can shape powerful programs. We strove to emulate that model at the state and local levels.

Importantly, the RPG initiative supported increasingly rigorous program evaluation of the START program and its strategies, which contributed to understanding what works with which type of client under what circumstances. To date, the RPG efforts produced six papers on START that in turn resulted in inclusion of START in the *California Evidence-Based Clearinghouse for Child Welfare* so that effective program information is shared nationally. Additional studies are underway. The RPG led to Kentucky's completing two years of In-Depth Technical Assistance (IDTA) through NCSACW that supported statewide collaboration efforts between child welfare, behavioral health, and the judicial system. These efforts helped evolve the system of care to one with far less contention and far more agreement on common goals and common strategies to improve lives of children and families affected by parental substance abuse.

Although Kentucky is fairly new at the IV-E waiver effort, these funds will expand START services in Louisville and Kenton County because of a large underserved population and implement START in Lexington (Fayette County) and possibly Madison County. The IV-E waiver will support rigorous testing of program effectiveness. Additionally, the IV-E waiver effort will allow Kentucky to use learning from START to apply the principles to the development of a new program to serve families in which the youngest child is under 10 years of age.

### **Outcomes and Cost Benefits**

In line with national findings from the RPG Program, the outcomes achieved by families in START align with the five R's: Parental *Recovery*, Children *Remain* at Home, *Reunification*, reduced *Recurrence* of CA/N, and decreased *Re-Entry*.<sup>1</sup>

#### **Recovery:**

Between 2007 and December 2015, START served 806 families including: 1,426 mothers and fathers and 1,643 children. Of the families served, 63% include a newborn, with 95% of newborns having documented substance exposure at birth.<sup>2</sup> An average of 3.1 substances were abused per parent, with 78% of mothers and 72% of fathers being polysubstance users. The risks to child safety were rated in the highest 10% of families by investigative workers. Despite these high risks, mothers achieved nearly twice the rates of sobriety (66% vs. 37%) than similar mothers served without START.<sup>3</sup> The measure of sobriety in START includes achieving three goals: progress in SUDs treatment including drug test results, engaging in community based

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<sup>1</sup> Young, N.K. (February 23, 2016). Examining the Opioid Epidemic: Challenges and Opportunities. Written testimony before the United States Senate Committee on Finance.

<sup>2</sup> Huebner, R. A., Willauer, T., Posze, L., Hall, M. T., & Oliver, J. (2015). Application of the evaluation framework for program improvement of START. *Journal of Public Child Welfare*, 9, 42-64.

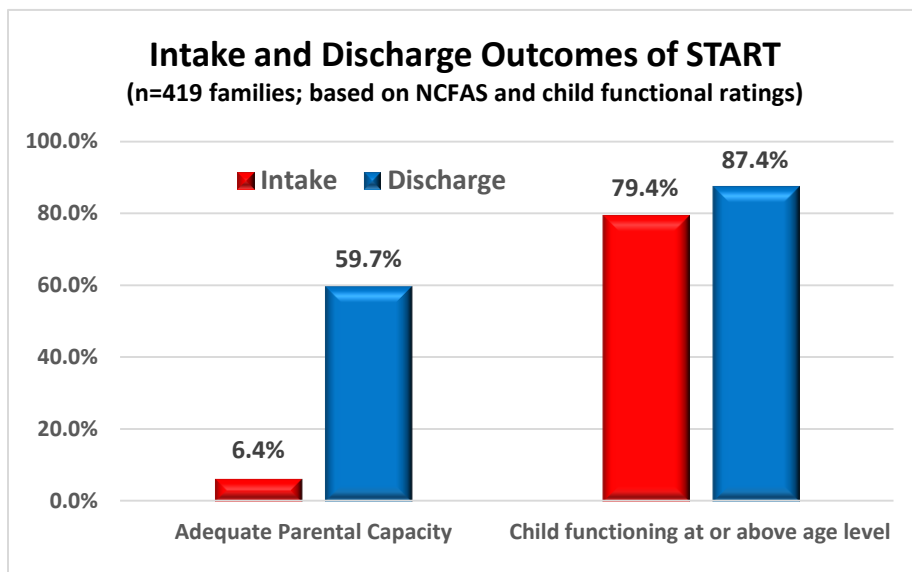
<sup>3</sup> Huebner, R. A., Willauer, T., & Posze, L. (2012). The impact of sobriety treatment and recovery teams (START) on family outcomes. *Families in Society: The Journal of Contemporary Social Services*, 93 (3), 196-203.

recovery supports, and improving parental capacity to care for children. The comparative measure from TEDS (Treatment Event Data Sets) includes only a favorable discharge from treatment. Thus, the measure of sobriety used in START is a higher standard. Unfortunately, we do not know how mothers treated in standard SUDs treatment fare in caring for children and committing to life-long recovery supports. Recovery in START also includes developing parental capacity to care for children that is displayed in this graph. Despite the high number of newborn children with substance exposure at birth, at close of the case, 87.4% of children were rated as functioning at or above age level.

**Children Remain at Home:** Children in families served by START were half as likely to be placed in state custody in OOH (21% vs. 42%) than children in the matched comparison group<sup>3</sup>. Interestingly, children in families referred to START but unable to be

served due to full caseloads, also entered state custody at a lower rate, suggesting a spread of practices within the county offices where START was active. Our **cost benefit analysis**<sup>3</sup> further demonstrated that cost avoidance on foster care costs alone amounted to \$2.22 for every \$1.00 spent on START.

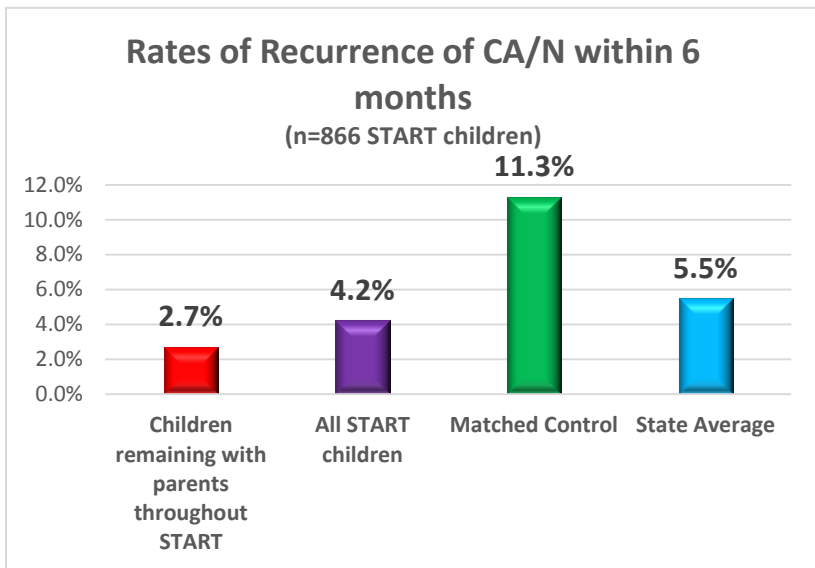
**Reunification:** When studying 420 families with 673 parents and 866 children in closed START cases using cluster analysis techniques, we found two groups based on short term outcomes for children and family. Forty percent of families retained custody of their children throughout the START program; this group was least likely to abuse opiates (46%) and made solid progress in improving parental capacity and attending recovery supports for the 11.6 months the case was open. In contrast, for 60% of families, children were removed at least briefly with 84% being placed in the temporary custody of relatives. This removal group was much more likely to abuse opiates (68-72%) and have significant deficits in parental capacity at intake. Of this 60%, more than half of the parents were reunified with their children at case closure and the other half had often fled, had frequent relapses, and failed to make progress in parental capacity. **Overall, at case closure 77.6% of children served by START remained with or were reunified with their biological parent.**<sup>3</sup> The group that achieved reunification had older children at removal, while those failing to achieve reunification had very young children at removal. Although speculative, we theorized that removing newborns or young infants before a parent/child bond





occurred may have been detrimental to reunification. In response we are strengthening the program with additional supports for parent/child attachment.

**Decreased Recurrence of CA/N and Re-Entry to OOHC:** The START program seeks to maintain children with their biological parents when it is safe by providing natural supports such



as relatives to assist the parent in caring for their children, frequent visits by family mentors and CPS workers, rapid access into an intensive treatment program, and involvement of the whole team including the parents and relatives in establishing a safety plan. The rates of recurrence of CA/N within 6 months are shown in this graph. Notably, children who remained with their parents throughout START had the lowest rate of recurrence while all START-served children have a much lower rate of recurrence

than all children in the state but especially for the matched control group where the rate was nearly three times lower. Because of this low rate of recurrence and the intensive case management with families, very few children ever re-enter OOHC; at last count there were six children who had re-entered OOHC.

### Lessons Learned: What Works for START

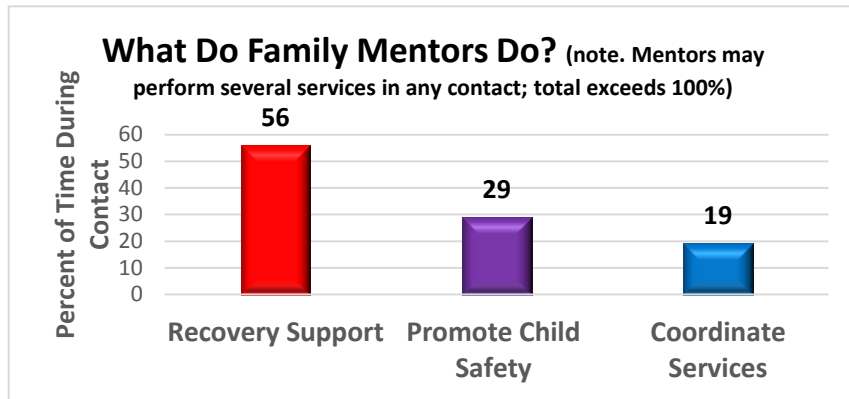
The findings of START and the related recommendations for national efforts are consistent with the nationally identified key ingredients of improved practice and policy leading to better family outcomes.<sup>4</sup> In this section, the lessons learned specific to START are discussed and include five of the seven key ingredients:

- Increased management of recovery services and compliance
- Earlier access to assessment and treatment services with expanded treatment options
- Improved family-centered services and repair of parent-child relationships
- Increased judicial oversight
- Responses to participant behavior—contingency management

Additionally, START was implemented in a rural Appalachian county and includes medication assisted treatment that engendered additional lessons learned.

<sup>4</sup> Young, N.K. (February 23, 2016). Examining the Opioid Epidemic: Challenges and Opportunities. Written testimony before the United States Senate Committee on Finance.

**Recovery Management and Cultural Change Are Essential:** Family Mentors are an essential component of START; they serve as peer recovery supports within the child welfare (rather than the behavioral health) system. Family mentors are full-time employees who have at least three years of sustained recovery and experiences that sensitize them to issues in child welfare. Most of Kentucky’s family mentors have direct experience with child welfare including loss of child custody at some point. These mentors work directly with a child welfare worker and the ‘dyad’ handles a caseload of 12-15 families. Family Mentors are critical to supporting parents through the behavioral health and child welfare systems. They transport parents to treatment and engage them in recovery supports. From our START data, we know that if a parent attends even one community recovery support group meeting that they are twice as likely to achieve sobriety. Mentors coach parents on sober living and sober parenting; they are persistent and can ‘talk and walk the talk’.

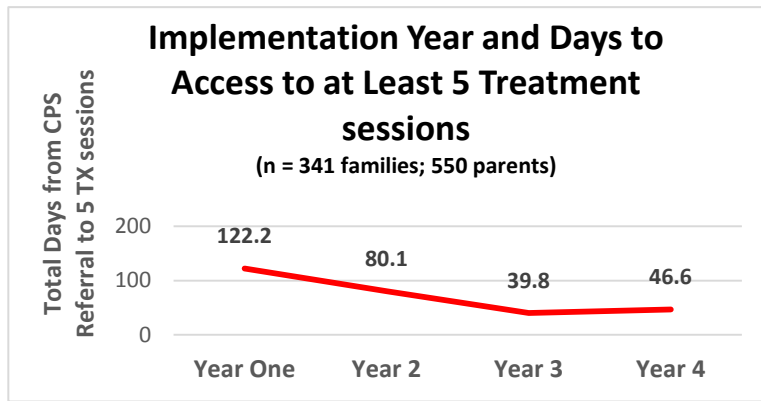


“It’s hard to stay sober in a substance abusing community. The counselor helped me learn that addiction is a disease, and how to deal with the substance abusers around me. We relapsed several times, but they keep working with us and helping us stay sober longer.” Mother in START.

Their presence in the DCBS offices working side by side with child welfare, behavioral health and the judicial system has been a primary catalyst for changing the culture and the community by reducing stigma, setting an example of what recovery looks like and demonstrating that recovery and worthy contributions to the community are indeed possible.<sup>5</sup> Moreover, the experience often reinforces the family mentor’s own recovery and several have earned college degrees through the tuition reimbursement program that is an employee benefit.

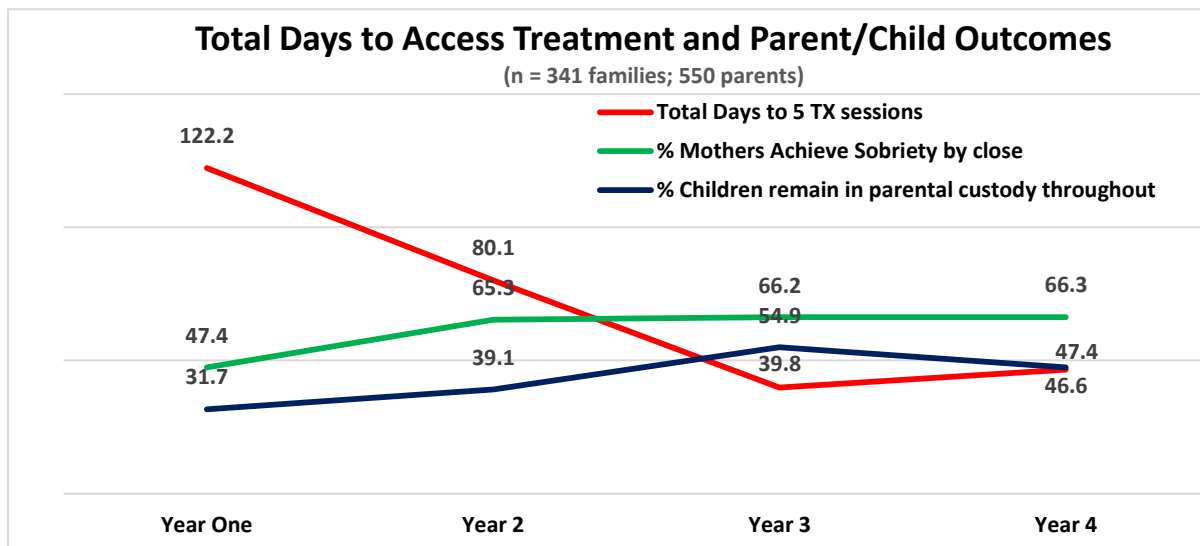
**Timely Access to Substance Abuse Assessment and Treatment Supports Better Parent and Child Outcomes.** START evaluation has found what all RPG sites have found, that it is critical to help parents into substance abuse treatment quickly.<sup>1</sup> START has a service delivery standard that specifies the number of days from CPS referral to at least the first five treatment sessions be within 45 days. Achieving this service delivery standard may seem relatively easy, but it is intensely difficult because it depends on complex collaborative efforts between CPS and treatment providers. To achieve full fidelity to the service delivery standards of START usually

<sup>5</sup> Huebner, R.A., Willauer, T., Brock, A., & Coleman, Y. (2010). START family mentors: Changing the workplace and community culture and achieving results. *The Source*, 20 (1), 7-10.



takes several years of persistent collaboration to transform the system of care. Most importantly, as parents gained access to services more quickly, mothers and their children achieved better outcomes as illustrated by the following graph.<sup>6</sup> As shown here, children were more likely to remain with their parent the more quickly the

mother accessed treatment. Rapid access is a critical strategy necessary to keep families safely together. Treatment, furthermore, must be comprehensive with evidence-based, trauma-informed substance use disorder services that serve the entire family and include medications for opioid use disorders when indicated.



**Comprehensive Family Services Tailored to Family Profiles Are Needed.**

We learned from our cluster analysis study<sup>2</sup> that families benefit differentially from treatment. One group of families (40%) retained custody of their children throughout treatment, achieved sobriety, and improved parental capacity, optimally benefiting from the services included with START. The other group all lost custody of their children at least briefly, but one sub-group achieved reunification while the other sub-group did not. Families with very young children at removal were more vulnerable to permanently losing custody of their children; 44% were

<sup>6</sup> Huebner, R.A., Posze, L., Willauer, L. & Hall, M. (2015). Sobriety Treatment and Recovery Teams: Implementation fidelity and related outcomes. *Substance Use & Misuse*, 50:10, 1341-1350, DOI: 10.3109/10826084.2015.1013131.

‘AWOL’ at case closure and failed to make progress in achieving sobriety or parenting capacities.

For the sub-group that lost custody of their children and were not reunified, more attention is needed to form a parent/child attachment with their young children or repair the parent/child bond with older children. Some parents may benefit from increased or more intensive judicial oversight and strengthened collaboration between agencies in helping these families voice their choices and understand consequences. Fathers involved with START are much more frequently

“They (START) weren’t discriminating against us as drug abusers. They were trying to keep us together. I knew that for once I needed to finish what I started”.  
Father in START

‘AWOL’ and achieve lower rates of sobriety, yet we know that when fathers are involved in treatment that mothers do better. Thus we need to include fathers actively in treatment that is specific to their needs; we are introducing father-specific interventions into START designed to improve outcomes for fathers. All of these findings support the notion that no single strategy or program is adequate to serve every family. Programs like START and others must engage in

continuous learning about those who fail to benefit and strive to create more comprehensive and effective family-based services.

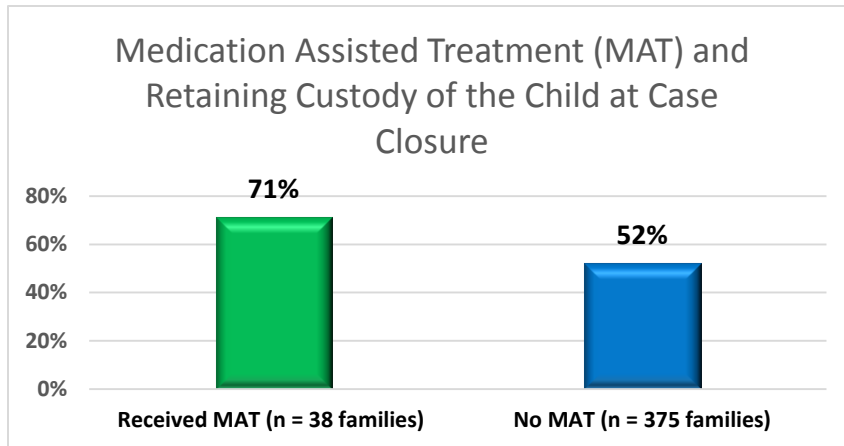
### **Rural Environments are Underserved and Require More Time to Build System Capacity.**

The first round of RPG awards funded a START site in Martin County, a rural Appalachian community, with extraordinarily high rates of CA/N and parental substance abuse. Adapting the START program to a rural area with virtually no pre-existing treatment infrastructure was a challenging, long-term but worthy process. In rural, underserved areas, longer start-up periods with additional funding may be needed to accommodate infrastructure development and leadership readiness. Implementation of programs like START in rural counties should be built incrementally through persistent attention, cross training, and collaborative meetings. Persistence and consistent messaging in a variety of venues from formal training through personal contacts was the most important strategy to replace mistrust and myths with knowledge of addiction, recovery, and a focus on child well-being. The challenges associated with program development in such areas should not impede attempts to address co-occurring addiction and child maltreatment. Without potent integrated interventions like START, families may be abandoned to poor outcomes. Our findings demonstrate the need for extended time and funding for infrastructure building in under-resourced areas, following which more comprehensive determinations of efficacy can be made.<sup>7</sup>

### **Medication Assisted Treatment (MAT) is Associated with Parents Retaining Child Custody.**

Parents who use opioids and are involved in the child welfare system are less likely to retain custody of their children than parents who use other drugs; opioid addiction is more difficult to

<sup>7</sup> Hall, M.T., Huebner, R. A., Sears, J. S., Posze, L., Willauer, T. & Oliver, J. (2015). Sobriety Treatment and Recovery Teams in rural Appalachia: Implementation and outcomes. *Child Welfare, 94*, 119-138.



treat than addictions to other substances and has recently resulted in high rates of overdose fatalities. Because of the way data are collected for START, we examined the prevalence and correlates of MAT utilization among parents in the START program with a history of opioid use, and compared child outcomes for families who received

MAT services to those who did not. Of the 596 individuals with a history of opioid use in the START program, 55 (9.2%) received MAT. Families where at least one member was receiving MAT were significantly more likely to have custody of their child at case closure; additional months of MAT increased the odds of parents retaining custody of their children.<sup>8</sup>

### Opportunities to Expand Best Practices to Scale Nationwide

In this section, recommendations for bringing best practices to scale nationwide are identified including those that align with two of the seven key ingredients of improved practice and policy leading to better family outcomes.<sup>9</sup>

- Collaborative approach across service systems and courts
- System of identifying families

**A New Paradigm for Collaboration between Child Welfare, Behavioral Health and the Courts.** The RPG program taught us what could be achieved through greater collaboration at the federal level. START has shown the power of collaboration at the State and local level. Collaboration, however, is a term that fails to capture the paradigm shift needed. The paradigm we seek is one of a shared vision for children and families, shared goals between systems, shared decision-making between agencies, mutual accountability for outcomes, and a replacement of the hopelessness associated with addiction with hope. Such a paradigm needs to be grounded in compassion for children and parents who fight shame, despair and trauma. Addiction is very powerful and requires more carrot and less stick than currently used; we need more collaboration to decide WITH families which is the best tool to use when. Such collaboration is difficult to achieve but can be modeled at the federal and state levels first. Strategies might include shared

<sup>8</sup> Hall, M. T, Wilfong, J., Huebner, R. A., Posze, L., & Willauer, T. (in review). Medication-assisted treatment improves child permanency outcomes for opioid-using families in the child welfare system.

<sup>9</sup> Young, N.K. (February 23, 2016). Examining the Opioid Epidemic: Challenges and Opportunities. Written testimony before the United States Senate Committee on Finance.

funding streams, cross-training, cross-system protocols, shared data sources, and long term commitment to difficult changes. We need to fully understand and integrate into our policies and funding the notion that treatment alone is not enough. Foster care for children is not enough. Court oversight is not enough. Working with mothers is not enough. Healing children is not enough. All of these strategies are necessary, but none are sufficient in isolation. Families are integrated, so must our approach be integrated. This is the most important national effort moving forward.

**Data Sharing Between Child Welfare, Behavioral Health, and the Courts.** Data are the ‘touchstone’ that has kept and keeps the entire START program focused on understanding and addressing important problems, agency practices, fidelity to new practices, and the services needs and outcomes of families. We appreciate the proposed rule for a *Comprehensive Child Welfare Information System*<sup>10</sup> that will facilitate collection and exchange of data between agencies to identify families in need of service. To achieve the aims of this proposed rule will require national training programs and convening groups to lead this effort, demonstrate best practices, explore logistics and policy implications, and explore the results of analysis. Integrated programs such as START will benefit from the intent of this proposed rule.

“START is one of the best collaboration efforts I have ever been involved in during my 35 years in the addiction treatment field. We have Child Protective Services, hospital social work departments, many different addiction treatment programs with different approaches all working together for the purpose of keeping families together and children safe in an alcohol/drug free home.” Diane Hague, LCSW, CADC

**Peer Recovery Supports Working in Child Welfare.** Engaging persons in sustained recovery with experiences that sensitize them to child welfare has been an effective strategy to change the culture within the three systems. Although there are challenges in employing family mentors with these credentials, the worth to parents, children, child welfare staff, behavioral health, and the courts cannot be overstated. There are various models of providing this support to parents but there needs to be standardized training, coaching and ongoing support for personnel such as START family mentors, exploration of best practices nationally, and a change in beliefs from one of fear to one of valuing the unique perspective and skills of these individuals.

**Increased Capacity for Expertise within Child Welfare Agencies for Program Evaluation and Application to Continuous Quality Improvement.** The IV-E Waiver effort has allocated a substantial portion of its funding to external program evaluation which is quite laudable and consistent with its aims. Future funding for embedding interventions with existing evidence of effectiveness into agencies will require different methods of program evaluation that include models that empower staff to be engaged in and contributing to continuous improvement of

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<sup>10</sup> Department of Health and Human Services, Administration for Children and Families. Proposed Rule Comprehensive Data Welfare Information System. Federal Register / Vol. 80, No. 154 / Tuesday, August 11, 2015 / Proposed Rules. Available at: <https://www.gpo.gov/fdsys/pkg/FR-2015-08-11/pdf/2015-19087.pdf>

programs with a reduced burden of data collection over time.<sup>11</sup> Agencies need to know that programs work, but they also need to know how such programs affect important results in the agency and how these can be modified to reflect changing conditions. Other models of program evaluation may be more efficient to test the impact of specific strategies, rather than entire programs, and to guide agency actions and continuous quality improvement.<sup>12</sup>

**Flexible IV-E Funding.** The ability of states to try new models of intervention and to support children in their homes depends on the ability to divert funds from foster care to other services. Services might include programs like START and other in-home service models. We highly recommend institutionalizing flexible IV-E funding options for child welfare so that states and communities have on-going access to funds to build these systems which prevent child placement and the trauma of foster placement.

### **Resources and Funding to Take Small Programs to Scale and Support Long-term Sustainability.**

The programmatic strategies of START have proved to be effective in achieving important family and child outcomes including preventing child placement, facilitating reunification, supporting parental recovery including parental competence, and reducing recurrence of CA/N and re-entry into foster care. Despite the number served, there are hundreds of unserved families in Kentucky and the START sites are unable to take all referrals due to full caseloads. We need additional sites to influence all the CMHC regions. But every county does not need nor can they support a full-scale START program. It may be helpful to apply START strategies, without necessarily the entire program, to serve more families. For example, expanding the use of family mentors will likely result in system and cultural changes and better engagement and retention in treatment.

### **Closing**

In the 25 years of my work in CPS and more specifically in START, I cannot think of a more important time in the midst of this opioid epidemic to better protect children and infants with prenatal substance exposure. We have more than a decade of evaluations and science in understanding what works to keep these children safe and to foster their well-being. This is a critical window to move financing of child welfare services to prevention so that families can stay intact whenever possible and so that parents can get the substance abuse and mental health treatment that they need to prevent their child from being placed in foster care. We know this saves foster care costs and reduces trauma to children. It is time to take the lessons of all of the prior Federal investments in these families and move them to scale by providing states with the funds and technical assistance needed to reform their systems and by allowing states the

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<sup>11</sup> Framework Workgroup (February, 2014). “A Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare.” Children’s Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

<sup>12</sup> Huebner, R. A., Watson, P., Dyer, L, Borsheim, C, & Caron, C. M. (in press). Building learning organizations within public child welfare agencies through internal research capacity. *Child Welfare*.

financing flexibility they need to prevent children from being removed from their birth parents whenever that is possible and in ways that ensure children are safe and families recover.