Kentucky’s Heroin Epidemic: Best Practices for Families and Children Impacted by Addiction

Kids Are Worth It
September 18, 2017
Presenters

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What we will cover today

• National and state context of substance use and child maltreatment
• Seven Key Ingredients of improved practice for families with substance use disorders
• The START model
• Research on the use of MAT with CPS families
• Practice guidance for working with families with opioid use disorders
Understanding the Need: National and Statewide Data
Number of Children in Out of Home Care at End of Fiscal Year in the United States, 2000 to 2015

Note: Estimates based on children in foster care as of September 30, 2015

Source: CFF analysis of AFCARS Data, 2000-2015
Prevalence of Parental Alcohol or Other Drug Use as a Contributing Factor for Reason for Removal in the United States and Kentucky, 2000 to 2015

Note: Estimates based on all children in out of home care at some point during Fiscal Year

Source: CFF analysis of AFCARS Data, 2000-2015

- Neglect: 68.1%
- Parent Alcohol or Drug Use: 39.3%
- Parent Unable to Cope: 19.0%
- Physical Abuse: 15.0%
- Inadequate Housing: 13.0%
- Parent Incarceration: 7.6%
- Abandonment: 6.3%
- Child Behavior: 4.7%
- Sexual Abuse: 4.9%
- Child Disability: 3.4%
- Child Alcohol or Drug Use: 2.9%
- Relinquishment: 1.4%
- Parent Death: 1.1%

Note: Estimates based on all children in out of home care at some point during Fiscal Year

Source: CFF analysis of AFCARS Data, 2015
Percent of Children with Terminated Parental Rights by Reason for Removal in Kentucky, 2015

- Neglect: 68.5%
- Parent Alcohol or Drug Use: 26.9%
- Parent Unable to Cope: 16.2%
- Child Behavior: 12.9%
- Inadequate Housing: 9.6%
- Physical Abuse: 8.7%
- Parent Incarceration: 6.6%
- Relinquishment: 4.5%
- Sexual Abuse: 4.1%
- Abandonment: 2.4%
- Child Disability: 1.0%
- Child Alcohol or Drug Use: 0.9%
- Parent Death: 0.6%

N = 2,585

Note: Estimates based on all children in out of home care at some point during Fiscal Year

Source: AFCARS Data, 2015
Number of Children who Entered Out-of-Home Care, by Age at Removal in the United States, 2015

N = 268,790

Note: Estimates based on all children in out of home care at some point during Fiscal Year

Source: CFF Analysis of AFCARS Data, 2015
Primary Substance at Admission
State of Kentucky, 2014

Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Based on administrative data reported by states to TEDS through January 5, 2016.

*This category includes admissions for non-prescription use of methadone, codeine, morphine, oxycodone, hydromorphone, meperidine, opium, and other drugs with morphine-like effects.
Substance Use and Child Maltreatment

• Between 60–80% of substantiated child abuse and neglect cases involve substance use by a custodial parent or guardian (Marlowe, 2012).

• Parents who use opioids and have CPS involvement are less likely to retain custody of their children than parents who use other drugs (Hall et al, 2016).

• Maltreated children of substance abusing parents remain in the child welfare system longer and experience poorer outcomes (GAO, 2003).
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
Recovery Support Matters

A Randomized Control Trial – Cook County, IL (n=3440)

Comprehensive Screening & Assessment + Early Access to Treatment = Positive Outcomes

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A Randomized Control Trial – Cook County, IL (n=3440)

Comprehensive Screening & Assessment + Early Access to Treatment = Positive Outcomes

We now know what works!!
Addressing the problem requires
a new way of
doing business!
Progress Since the Adoption and Safe Families Act (ASFA)

- National Center on Substance Abuse and Child Welfare
- Children Affected by Methamphetamine Grants (CAM)
- Prevention and Family Recovery (PFR)
- Adoption and Safe Families Act (ASFA)
- Regional Partnership Grants (RPG)
- RPG2
- RPG3
- Blending Perspectives and Building Common Ground Congressional Report Established 5 National Goals
- Substance Exposed Newborn Grants
- Family Drug Court Grants
- Fostering Connections Grants
- In-Depth Technical Assistance Substance Exposed Infants
- FDC Statewide System Reform Program

Source: Children and Family Futures
Development of Models – Testing Solutions

National Center on Substance Abuse and Child Welfare

Regional Partnership Grants
2007-2012 - 53 Grantees
2012-2017 - 17 Grantees
2014-2019 - 4 Grantees

Children Affected by Methamphetamine
12 Family Drug Courts

Source: Children and Family Futures
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

Source: Children and Family Futures
How Collaborative Policy and Practice Improves

We know more...

5Rs

Recovery
Remain at home
Reunification
Recurrence
Re-entry
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.
Sobriety Treatment and Recovery Teams
Program Overview
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
- START is also in Bloomington and Terre Haute, IN, and Asheville, NC
- 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 disorders and child maltreatment

- Combines best practices in child welfare, courts and substance use disorder treatment

- 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.
START: Essential Elements

• Early identification of families upon receipt of CPS referral.
• CPS Worker and Family Mentor paired and 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 parental substance use and child maltreatment
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
Quick Access to SUD Treatment

90% go from Referral to Intake in 8 days

May 18, 2011
Family Mentors

- A family mentor is a person in long term recovery 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.
Quick Access to SUDS Treatment and Parent and Child Outcomes

(n= 550 adults; 717 children -

Days SUDS Referral to Intake: 10, 20, 30, 40, 50, 60, 70

% Children Stay with Parent:

% Mother's Sobriety:

% Father's Sobriety:

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, $2.22 is saved on out-of-home placement costs

START MAT
RESEARCH PAPER
Background

- 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
Study Aims:

– **Aim 1**: Describe patterns of MAT utilization among parents with a history of opioid use who received START

– **Aim 2**: Compare child outcomes for families in the START program with a history of opioid use who received MAT services to those who reported opioid use but did not receive MAT
METHOD

• **Study sample**

  Closed START cases with at least one adult in the family with opioid use (served between 2007 – 2015)

• **Measures**

  • Demographics (age, gender, race, and county)
  • Substance use at intake (7 drug categories)
  • Household opioid use (one adult opioid user vs. two or more adult opioid users)

• **Medication-assisted treatment**
  
  — use of methadone, buprenorphine, and naltrexone
  
  — dichotomized as either no MAT (0) versus more than 1 month of MAT (1), as well as total months of MAT received during the START program
METHOD, cont.

• **Permanency**
  1. Child(ren) remained with parent(s) who received START services and parent(s) completed treatment goals;
  2. Child(ren) placed with one parent and the other parent did not complete treatment;
  3. Parents retained custody of some of their children but other children were placed elsewhere;
  4. Child(ren) placed with a relative;
  5. Parental rights were terminated;
  6. Custody was unresolved at START closure

• Ultimately, permanency was collapsed into 2 categories: child(ren) remained with parent vs. all other outcomes
METHOD, cont.

• Data Analysis

1. Individuals and families who received no MAT and those with at least 1 month of MAT were compared using chi-square tests for categorical variables and t tests for continuous variables.

2. Months of MAT, along with # of household opioid users and demographic variables gender, age, race, and county of residence were entered as independent variables into a multiple logistic regression model to identify correlates of permanency status at case closure.
RESULTS
Demographic characteristics of 596 opioid users (representing 413 families) in the Kentucky START program

<table>
<thead>
<tr>
<th>Variable</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>n</td>
<td>(%)</td>
</tr>
<tr>
<td>Men</td>
<td>204</td>
<td>(34.2)</td>
</tr>
<tr>
<td>Women</td>
<td>392</td>
<td>(65.8)</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>49</td>
<td>(8.2)</td>
</tr>
<tr>
<td>Hispanic/Other</td>
<td>6</td>
<td>(1.0)</td>
</tr>
<tr>
<td>White</td>
<td>538</td>
<td>(90.3)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-24</td>
<td>245</td>
<td>(41.1)</td>
</tr>
<tr>
<td>25-29</td>
<td>189</td>
<td>(31.7)</td>
</tr>
<tr>
<td>30 and older</td>
<td>162</td>
<td>(27.2)</td>
</tr>
<tr>
<td>County</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boyd</td>
<td>104</td>
<td>(17.4)</td>
</tr>
<tr>
<td>Daviess</td>
<td>3</td>
<td>(.5)</td>
</tr>
<tr>
<td>Jefferson</td>
<td>197</td>
<td>(33.1)</td>
</tr>
<tr>
<td>Kenton</td>
<td>212</td>
<td>(35.6)</td>
</tr>
<tr>
<td>Martin</td>
<td>80</td>
<td>(13.4)</td>
</tr>
</tbody>
</table>
Results, cont.

- Polysubstance use was common
  - Marijuana: 62.8%
  - Benzodiazepines: 43.3%
  - Alcohol: 36.4%
  - Cocaine: 27.4%
  - Barbiturates: 8.9%
  - Amphetamine: 8.7%
  - Methamphetamine: 7.9%
Results, cont.

- 55 individuals (9.2%) received at least 1 month of MAT. Range: 0 – 760 days of MAT
  - Average: 214 days (about 7 months)
    - About 1/3 received 3 months or less;
    - Another 1/3 received between 3 and 9 months;
    - Last 1/3 received between 9 months and 2 years

- All 55 people who received at least 1 month of MAT were White
  - 55 (9.2%) opioid users were races other than White
All children remained with parent: 71% at least 1 month of MAT, 52% with no MAT.

All other outcomes: 29% at least 1 month of MAT, 48% with no MAT.
## Multiple logistic regression model identifying correlates of children of opiate users remaining with their parents

<table>
<thead>
<tr>
<th>Variable</th>
<th>$b$</th>
<th>$SE$</th>
<th>Wald</th>
<th>$p$</th>
<th>OR</th>
<th>[95% CI]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (Women vs. Men)</td>
<td>-0.69</td>
<td>0.43</td>
<td>2.6</td>
<td>.10</td>
<td>.50</td>
<td>[0.2, 1.2]</td>
</tr>
<tr>
<td>Age, in years</td>
<td>0.02</td>
<td>0.02</td>
<td>0.87</td>
<td>.35</td>
<td>1.0</td>
<td>[1.0, 1.1]</td>
</tr>
<tr>
<td>Race (White vs. Other Races)</td>
<td>-0.41</td>
<td>0.35</td>
<td>1.4</td>
<td>.24</td>
<td>.67</td>
<td>[0.3, 1.3]</td>
</tr>
<tr>
<td>County: Boyd vs. Martin</td>
<td>0.47</td>
<td>0.40</td>
<td>1.4</td>
<td>.24</td>
<td>1.6</td>
<td>[0.7, 3.5]</td>
</tr>
<tr>
<td>County: Jefferson vs. Martin</td>
<td>0.08</td>
<td>0.37</td>
<td>0.05</td>
<td>.83</td>
<td>1.1</td>
<td>[0.5, 2.2]</td>
</tr>
<tr>
<td>County: Kenton vs. Martin</td>
<td>0.45</td>
<td>0.36</td>
<td>1.6</td>
<td>.21</td>
<td>1.6</td>
<td>[0.8, 3.2]</td>
</tr>
<tr>
<td>Household Opioid Users (1 adult vs. 2 or more adults)</td>
<td>0.65</td>
<td>0.23</td>
<td>8.3</td>
<td>.00</td>
<td>1.9</td>
<td>[1.2, 3.0]</td>
</tr>
<tr>
<td>Months of MAT</td>
<td>0.11</td>
<td>0.04</td>
<td>6.5</td>
<td>.01</td>
<td>1.1</td>
<td>[1.0, 1.2]</td>
</tr>
</tbody>
</table>

**Note.** For households with 2 or more adult opioid users, demographic variables were based on the adult who received the most MAT; if no adult in the household received MAT, demographic variables were based on the biological mother. Daviess county was excluded from the model because of the small sample size (n = 3). OR = odds ratio; CI = confidence interval.
DISCUSSION
Discussion

• A relatively **small** portion of opioid users (9.2%) in this sample of opioid users involved in the child welfare system received MAT

  – **Why?**

    1. **Capacity**
      – Need exceeds supply in 96% of U.S. states (Jones et al., 2015)

    2. **Access**
      – Some START counties have very limited treatment infrastructure (Hall et al., 2015)

    3. **Stigma**
      – MAT located away from other health services (Olsen & Sharfstein, 2014)
      – NA groups' right to limit those receiving MAT, “…to participate only by listening and by talking with members after the meeting or during break” (Narcotics Anonymous World Service, Inc., 1996, para. 6)
      – Nearly ½ of U.S. drug courts have policies that prohibit MAT (Matusow et al., 2013)
Discussion, cont.

• Previous studies have found that compared to individuals who are White, minority populations were less likely to:
  – engage in MAT (Baxter, Clark, Samnaliev, Leung, & Hashemi, 2011)
  – be retained in MAT (Mancino et al., 2010)

• Why?
  – Again, access
    • Mobile MAT better at enrolling African Americans than conventional clinics (Hall et al., 2014)
  – Social and cultural factors
    • “...long-held perceptions of methadone as a way to control and restrict users, Blacks and persons of color in particular...” (Eversman, 2015, p. 198)
Discussion, cont.

- 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 \(\text{(Condelli & Dunteman, 1993)}\), other drug use and criminal activity \(\text{(Simpson & Sells, 1982)}\), and risk of viral infection and STDs \(\text{(Greenfield & Fountain, 2000)}\)

*average length of START case
Limitations

1. Participants were not randomized to MAT

2. Possible that opioids were not the primary drug of choice for all individuals in the sample, and thus MAT might not have been warranted in all cases
   - Individuals who received MAT may have had more severe opioid use disorders than those who did not
     - If true, this could be a strength of the study - parents with opioid problems have been found to be less likely to retain custody of their children than parents who use other drugs (Choi & Ryan, 2007; Grella, Needell, Shi, & Hser, 2009)
CPS and MAT Providers Working Together
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?
  – Better outcomes
  – Child safety
  – Not our business how someone gets recovery
Barriers to using MAT

• Stigma, stigma, stigma
• Lack of communication between CPS and providers
• Bias toward abstinence-based approaches
  – CPS, BH, Courts
• Diversion, irresponsible prescribing, lack of oversight
• Access and expense
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
START MAT GUIDE
Our Practice Guide

• Documents our philosophy about MAT
• Gives guidance for BH assessment and CPS
• Spells out the various MAT options and who they might benefit
Our Philosophy

• All clients using opioids should be
  – Assessed with MAT in mind
  – Educated about MAT options
  – Supported in obtaining MAT
  – Supported in their continuation on MAT
    • Financially, legally, socially
  – Encouraged to continue until their MAT treatment team agrees they are ready to come off, if ever
  – Given psychosocial treatment as needed
Types of MAT: Naltrexone

- Vivitrol (injection) and Revia (oral)
- Opioid and alcohol
- No use for 7 days or will precipitate withdrawal
- Requires motivation. Compliance is better with injection
- Decreases pleasure of opioid or alcohol use, reduces cravings a bit so relapse less likely
- May be best for younger and less addicted
- Results not great for longer-term dependence
Types of MAT: Buprenorphine

• Suboxone, Zubsolv, Bunavail, generic (with and without naloxone)
• Partial agonist combined with antagonist to help prevent OD and IV use
• Opioid dependence for more than 1 year (daily heavy use, withdrawal if stop using, compulsive use). Some exceptions.
• Prescribed by a doctor, picked up at pharmacy, taken at home.
• Not as regulated as methadone
Types of MAT: Methadone

• Full agonist (binds with receptor sites)
• Dependence for a year or more plus multiple unsuccessful treatment attempts and unable to stop use. Exception for pregnancy.
• Consider if withdrawal occurs within hours of last use, multiple withdrawals a day, cycle through obtaining/using/withdrawing
• Dispensed only at licensed clinics. Lots of regulation. Daily on-site dosing until stable.
People on MAT also need:

• **Psychosocial treatment**
  – For recovery skills, co-occurring mental health and trauma, poly-substance use disorders
  – May be therapy, but may be detox from illicit substances, residential, or intensive outpatient

• **Recovery supports**
  – 12-step meetings (AA, NA, MA)
  – Other such as church, Celebrate Recovery, etc.

• **Other supports** – housing, vocational, etc.
Who doesn’t need MAT?

• Less than one year of dependence may respond to psychosocial treatment only. Mild disorder.
  – Unless pregnant, HepC or HIV, can’t stop, history of OD
  – If detox: medication during withdrawal is key to continuation in treatment

• Recent release from jail/prison where got treatment and have supports at home
  – Unless history of relapse upon release or Hep C

• If psychosocial treatment is available, intense enough, and client choice
Child Welfare Considerations

• Emphasize that MAT is a choice and is supported
• 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.
  – Include MAT supports on plan at closure
CPS Considerations (cont.)

• Case plan should include:
  – Take medication as prescribed
  – Don’t take more or less than prescribed
  – Don’t sell or give away medication
  – Don’t take other people’s medications
  – Sign a release of information for treatment plan, compliance, and drug test results
  – Safe storage (child safe locked box) or sober person hold medication in secure location
  – Random pill or strip counts, compare to # expected, with client or family member handling the meds
CPS Considerations (cont.)

• 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
CPS Considerations (cont.)

- Breastfeeding on MAT is okay – see guide
- Cost can be a barrier to getting and staying on the medication
- Relapse risk is high when medication is stopped before clinically indicated
- Include staying on medication in aftercare plan
- Discuss expense with client and their ability to afford it over time
What is non-Compliance?

• Using illicit substances, not taking as prescribed, diversion, missing doses/ counseling/ drug tests
• May need more psychosocial treatment to be successful with MAT
• Always communicate with provider about compliance concerns
Non-Compliance

• Methadone providers have written policies, non-compliance impacts privileges such as take-home doses
• Buprenorphine prescriber may not be as structured, so inquire
• Benzodiazepines with MAT can be deadly, so provider may be more strict (restricting take-homes, more counseling/doctor visits/drug tests, reducing dose, discharge from program)
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
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.
COLLABORATIVE PROVIDER LIST
Collaborative Provider List

- Assurance that MAT providers are following legal and best practice standards
- Working collaboratively with CPS to keep children safe
- Agreed upon criteria
- Client free to choose their provider, but educate about importance of collaboration for their CPS case and recovery
- Court can choose to require use of a provider on the list
Criteria

1. Open communication (releases, sharing of info)
2. Responds to concerns: over-sedation, diversion, illicit use
3. Drug tests, works to d/c illicit use
4. Provides/requires counseling and recovery supports
5. Does not charge cash if can file insurance
6. Policy about safe storage of take-home meds
Thank you!

Questions?
Acknowledgements

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START References:

- Adoption and Foster Care Analysis and Reporting System, FY’15.


- START is recognized on the California Evidence Based Clearinghouse for Child Welfare (CEBC):
  — http://www.cebc4cw.org/program/sobriety-treatment-and-recovery-teams/detailed