



National Center on
Substance Abuse
and Child Welfare



THE USE OF PEERS
AND RECOVERY SPECIALISTS
IN CHILD WELFARE SETTINGS

Acknowledgements

This Technical Assistance Tool was developed by the National Center on Substance Abuse and Child Welfare (NCSACW). NCSACW is a technical assistance resource center jointly funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Children's Bureau (CB), Administration on Children, Youth and Families (ACYF), U.S. Department of Health and Human Services. Points of view or opinions expressed in this guide are those of the authors and do not necessarily represent the official position or policies of SAMHSA or ACYF.

Contact Information

Website: <https://ncsacw.samhsa.gov/>

Toll Free: 1-866-493-2758

Email: ncsacw@cffutures.org



The Use of Peers and Recovery Specialists in Child Welfare Settings

INTRODUCTION

Families involved with the child welfare system who are affected by substance use disorders have complex needs that contribute to lower reunification rates and longer stays in out-of-home care for children.^{1,2,3} To improve outcomes for these families, a growing number of child welfare agencies and family court programs have integrated peers and recovery specialists into their service delivery models.

Peers and recovery specialists were introduced to support child welfare staff to address the needs of parents with substance use disorders. The peer role is unique because it pairs a parent with a person in recovery who may also have prior child welfare involvement. This shared history allows the parent to have a relatable ally with whom he or she can develop trust. Peers who have prior child welfare involvement may also serve as role models of successful reunification. Recovery specialists enhance support by child welfare staff by providing subject matter expertise in substance use disorders, expertise that is often modest or missing among the child welfare staff. Both types of staff, peers and recovery specialists, fulfill a variety of roles, many of which are overlapping.

This brief provides an overview of two models of support for families—support by peers with lived experience of substance use disorders and sometimes child welfare involvement, and support by professionally-trained recovery specialists. The brief also highlights implementation considerations gleaned from interviews with four programs that have demonstrated positive child welfare and recovery outcomes for families.

MODELS

While there once was a clear distinction in terms of roles and responsibilities between peer and recovery specialist models, it has lessened in recent years. The models are described separately here, but it is important to note that many of the

roles and responsibilities in child welfare settings may overlap between these two models.

PEERS

Peers understand substance use disorders and the recovery process because of their own life experience and can assist with engaging the parent in services to improve treatment and child welfare outcomes. Parents are often more comfortable confiding candidly with a peer because of their shared life experiences. Peers can reduce negative attitudes and stigma among agencies and community partners toward parents with substance use disorders.

RECOVERY SPECIALISTS

Recovery specialists, also sometimes referred to as substance abuse specialists and recovery coaches, are professionals with training and/or certifications related to substance use disorder treatment and recovery. These professionals may be placed in child welfare offices or at the court through agency partnerships. They may offer on-site substance use disorder consultation, substance use assessments, drug testing, and case management services to improve parents' access to, and engagement in, substance use treatment. Specialists often serve as formal liaisons and are responsible for building and enhancing the communication between agencies and the court. They may serve as a treatment broker or as a front-line service provider. Specialists can also serve as a consultant about the nature of substance use disorders as they interact with the various community partners and providers.

IMPLEMENTATION CONSIDERATIONS

The National Center on Substance Abuse and Child Welfare (NCSACW) interviewed four programs—two that implement peer supports and two that implement recovery specialists—to identify important implementation considerations for communities seeking to improve outcomes among families involved with child welfare who are affected by substance use disorders. The programs were:

- Connecticut Recovery Specialist Voluntary Program (recovery specialist model) (page 11)
- Illinois Alcohol and Other Drug Abuse Waiver Demonstration (recovery specialist model) (page 15)
- Kentucky Sobriety Treatment and Recovery Teams (peer support model) (page 18)
- Santa Clara County, California Dependency Advocacy Center (DAC) Mentor Parent Program (peer support model) (page 23)

These peer and recovery specialist programs have demonstrated positive outcomes for participating families, such as improved treatment completion and recovery rates for parents, less time children spent in out-of-home care, and improved family reunification rates.^{4,5,6} The programs offer unique and innovative solutions to barriers and provide valuable collaborative lessons. For more information about the programs' models and structures, roles and responsibilities, funding, qualifications, supervision, outcomes, and collaborative lessons, please refer to the detailed program summaries at the end of the document. *Appendix A: Matrix of Program Characteristics* (page 7) provides a side-by-side comparison of the programs across multiple implementation domains.

A selection of the implementation considerations that emerged during the interviews are summarized below.

GOALS AND TARGET POPULATION

Assessing the desired outcomes for families is an important step in developing a peer or recovery specialist program. Often the goals of these two programs overlap. Common goals among both peer and recovery specialist programs include timely access to, and retention in, substance use treatment services. Other common goals are to: 1) reduce time children spend in out-of-home care and associated costs; 2) remove barriers and improve linkages between child welfare services and substance use treatment agency staff; and, 3) improve the agencies' capacity to effectively provide services by improving communication and coordination between systems. Populations served by peers or recovery specialists generally include families affected by substance use disorders in which the children are at risk of being placed in out-of-home care or children who are in out-of-home care with a possibility of reunification.

FUNDING

Peer and recovery specialist programs can be financed through a variety of funding streams. Communities included in these profiles tapped into existing state and county funds, such as the State Departments of Alcohol and Drug Programs, Mental Health Services, Child Welfare Services, and County Boards of Supervisors' funds. Two sites also used federal funding under the [Title IV-E Foster Care and Adoption Assistance Program](#), waivers that were implemented by the Administration for Children and Families (ACF), which allowed states to use funds more flexibly to test innovative approaches for child welfare service delivery and financing. Of note, the end date for this federal program's waivers is September 30, 2019. Other examples of on-going federal funding which were used by these programs include ACF's [Regional Partnership Grants, Temporary Assistance for Needy Families \(TANF\)](#) and Office of Justice Programs' [Victims of Crime Act funding](#).

While the programs interviewed did not use this funding source, peer services can also be billable to Medicaid. In 2007, the Centers for Medicare and Medicaid Services issued a [Letter to State Medicaid Directors](#) authorizing them to offer peer support services as a comprehensive mental health and substance use service delivery system under Medicaid. To include peer supports in the state Medicaid plan, peers must be supervised by a mental health professional as defined by the state, must coordinate peer support with an individualized recovery plan with measurable goals, and must complete training and certification as defined by the state.⁷

QUALIFICATIONS, TRAINING, AND CERTIFICATION

Determining job qualifications is influenced by the program model, goals, and funding. If a program implements a peer model, then having lived experience of substance use disorders is required, and prior child welfare involvement may be preferred. For those that require this qualification, programs benefit from confirming that peers have 2-3 years of uninterrupted sobriety to ensure that they are stable in their own recovery before supporting others. Programs that implement a recovery specialist model often do not require lived experience, but some may prefer to hire staff who do have that experience. Other preferred

The Use of Peers and Recovery Specialists in Child Welfare Settings

qualifications for recovery specialists include having professional degrees or certifications (e.g., Bachelor's or Master's degree in a related field, drug and alcohol counselor certification).

The training and certification requirements for peers and recovery specialists vary by state. For a more detailed description and resources related to certification, see *Appendix B: Peer and Recovery Specialist Certifications (page 9)*. While training and certification are important for these programs, they may not include information specific to supporting families who are involved with child welfare services. Offering an orientation and ongoing training for peers and recovery specialists working in child welfare agencies and family courts can help ensure that they understand the child welfare system and the unique needs of families.

Initial orientation training for peers or recovery specialists can include motivational interviewing, substance use disorder treatment and recovery, effects of substance use disorders on parenting and on children, mental health and co-occurring disorders, medication-assisted treatment, and child development. Programs often offer ongoing or quarterly training for staff after the initial orientation.

NCSACW provides online training on substance use disorders and child welfare, including a [free online tutorial for substance use treatment and related professionals](#) on the child welfare and dependency court systems and how to best support the recovery of parents and families involved with child welfare services. NCSCAW's [free online tutorial for child welfare workers and related professionals](#) focuses on understanding substance use disorders and the treatment and recovery process. Both of these tutorials may provide valuable information for peers and recovery specialists as a part of their initial orientation or ongoing training.

ROLES AND RESPONSIBILITIES

As previously described, staff roles and responsibilities are shaped by the program model (peer versus recovery specialist). However, there is not always a clear distinction between the roles and sometimes responsibilities are similar. The following are common roles and responsibilities of both peers and recovery specialists:

- Arrange and accompany or transport parents to the first substance use disorder assessment
- Help to develop recovery capital (the internal and external resources necessary to begin and maintain recovery)
- Visit families in the home or community to provide support
- Monitor parents' treatment attendance and participation in self-help groups
- Assist parents with accessing services and overcoming barriers to recovery, such as housing, social service or health benefits, child care, education, and employment
- Offer parents assistance navigating the child welfare system
- Attend collaborative and committee meetings, including court staffings and sessions, family team decision making meetings, and other case meetings to speak on behalf of the family
- Serve as a liaison between substance use treatment, child welfare, and the court
- Help child welfare and court professionals understand substance use disorders, treatment, and the recovery process
- Serve as an advocate and speak on the parent's behalf

SUPERVISION

Supervision is a key element to any peer or recovery specialist program to ensure that staff feel supported, reduce secondary trauma and burnout, and promote self-care. Supervision is particularly important for persons with lived experience. The Substance Abuse and Mental Health Services Administration's [Bringing Recovery Supports to Scale Technical Assistance Center Strategy](#) provides the [Supervision of Peer Workers Toolkit](#) to help supervisors understand how to supervise peer support staff in agencies that serve persons with substance use disorders or severe mental illness. The toolkit includes a [slide deck with trainer notes](#), a [one-page self-assessment tool for supervisors](#), [resources](#), and more information on working with [peers](#).

As noted above, Medicaid requires that peers are supervised by a mental health professional to be eligible for reimbursement.

HIRING AND RETENTION

Programs also vary in terms of the agency that hires and oversees the peer or recovery specialists. In some cases, child welfare services may contract with case management or treatment agencies to provide recovery support to parents involved with child welfare. In other cases, staff may be hired and overseen by the child welfare agency or a legal services organization.

Similar to other work settings, competitive pay and employee benefits support recruitment of quality peer and recovery specialists. Recruitment and retention of staff may be challenging, and strategies may include posting flyers in the community, outreach to past program participants or graduates, posting to employment websites, and ensuring sufficient supervision after hiring.

COMMUNICATION PROTOCOLS AND INFORMATION SHARING

Peers and recovery specialists often coordinate and communicate with multiple agencies on behalf of the family, requiring information sharing protocols to dictate what information can be shared when and with whom. Peers and recovery specialists typically have parents sign a consent form and release of information upon participation in the program. A key difference between recovery support specialists and peer supports is recovery support specialists often develop reports to child welfare and court staff that are linked to court appearances and case staffing. Reports include information such as the parent's progress in treatment, attendance of meetings that are part of case plans, compliance with treatment, and drug testing results. Reports do not include any specific clinical information. Peer support staff typically do not develop reports to child welfare, however they do often speak on the parents' behalf during case staffings and family team meetings.

Many agencies benefit from having peers or recovery specialists participate in multiple meetings and staffings, including oversight committees and other collaborative planning meetings. Peers or recovery specialists can serve as the voice of the family and can offer a valuable contribution to family team meetings and case staffings.

CONCLUSION

There is much variation in how peer support and recovery support programs are implemented. When selecting and developing a program model, each community must identify the target population, prioritize program goals, and determine the most appropriate roles and responsibilities of staff to achieve those goals.

Regardless of the model, a high level of communication, coordination of services, and trust is required among participating agencies and staff for successful implementation of a peer or recovery specialist program. Engagement and buy-in from key stakeholders in child welfare, substance use treatment, court, and other community agencies is also an important component of a successful program.

Both peer support and recovery specialist programs have shown to increase treatment access and engagement, reduce time in out-of-home care, and reunify families more quickly. More information on program evaluations and outcomes can be found in the attached program summaries.

NCSACW offers training and technical assistance to implement peer support or recovery specialist programs and other models of collaborative practice to support families affected by substance use disorders. Visit the website at www.ncsacw.samhsa.gov, email at ncsacw@cffutures.org, or call toll-free at 1-866-493-2758 to learn more.

The Use of Peers and Recovery Specialists in Child Welfare Settings

APPENDIX A: MATRIX OF PROGRAM CHARACTERISTICS

| Table 1: Matrix of Program Characteristics | | | | |
|---|-------------|----------|----------|-------------|
| | Connecticut | Kentucky | Illinois | Santa Clara |
| Program Model | | | | |
| Peer Support (lived experience required) | | x | | x |
| Recovery Specialist (lived experience not required, specialized training or certification preferred) | x | | x | |
| Background | | | | |
| Years in Operation | 10 | 12 | 18 | 18 |
| Program Goals | | | | |
| Children remain with their parents | | x | | |
| Increase family reunification | x | | x | x |
| Increase safety and reduce time to permanency | x | | x | |
| Improve substance use treatment and recovery outcomes | x | x | x | x |
| Population Served | | | | |
| Families with parental substance use disorders and whose children who are at risk of entering out-of-home care | | x | | x |
| Families with parental substance use disorders and whose children are in out-of-home care | x | x | x | x |
| Number of families served per year | 450 | 121 | 315 | 400 |
| Roles and Responsibilities | | | | |
| Arrange and accompany or transport parents to the first substance use disorder assessment | x | x | x | x |
| Provide case management | x | x | x | x |
| Connect parents to substance use treatment programs | x | x | x | |
| Visit families in the home or community to provide support | x | x | x | x |
| Monitor parents' treatment attendance and participation in self-help groups | x | x | x | |
| Provide transportation if needed | x | x | x | |
| Assist parents with accessing services and overcoming barriers to recovery, such as housing, social service or health benefits, child care, education, and employment | x | x | x | x |
| Conduct random drug screenings | x | x | x | |
| Attend collaborative and committee meetings, including court staffings and sessions, family team decision making meetings, and other case meetings to speak on behalf of the family | x | x | x | x |
| Prepare reports on parents' progress to child welfare and court staff | x | | x | |
| Serve as a liaison between substance use treatment, child welfare, and the court | x | x | x | |
| Help child welfare and court professionals understand substance use disorders, treatment and the recovery process | x | x | x | x |
| Help the clients build trust and rapport with court attorneys | | | | x |
| Offer parents assistance navigating the child welfare system | x | x | x | x |
| Serve as an advocate and speak on the parent's behalf | x | x | x | x |
| Hiring | | | | |
| Employed by child welfare services | | x | | |
| Employed by a contracted services provider | x | | x | |
| Employed by a legal services organization | | | | x |

The Use of Peers and Recovery Specialists in Child Welfare Settings

APPENDIX A: MATRIX OF PROGRAM CHARACTERISTICS (CONT.)

| | Connecticut | Kentucky | Illinois | Santa Clara |
|--|-------------|--------------|------------|--------------|
| Qualifications | | | | |
| Lived experience of substance use disorders required | | x | | x |
| College degree and/or certification required | x | | x | |
| Supervision | | | | |
| Average caseload of families | 25 | 15 | 15 | 15-25 |
| Supervised by child welfare services staff | | x | | |
| Supervised by a licensed clinician | | | | x |
| Supervised by Contracted Services Provider Staff | x | | x | |
| Training | | | | |
| Initial orientation | x | x | x | x |
| Ongoing training opportunities | x | x | x | x |
| Funding | | | | |
| Federal funds (Title IV-E Waiver, Regional Partnership Grants) | | x | x | |
| State and local funds | x | | | x |
| Average pay for peer/recovery specialist | \$35k/year | \$13.30/hour | \$30k/year | \$16-19/hour |
| Provide benefits (e.g., medical, dental, vision, vacation/sick time, pension, tuition reimbursement) | x | x | x | x |
| Communication and Information Sharing | | | | |
| Provide reports to child welfare services and court | x | | x | |
| Has data sharing agreement to link individual-level data between systems | x | | | |
| Client signs release of information consent form | x | x | x | |
| Program Evaluation | | | | |
| Regularly collects, analyzes and reports data | x | x | x | x |
| Randomized control/experimental design study | | x | x | |

APPENDIX B: PEER SUPPORT AND RECOVERY SPECIALIST CERTIFICATIONS

The training and certification requirements for peer support staff and recovery specialists vary by state. This appendix aims to offer an overview of the information available on some of the peer and recovery specialist state certifications, but communities should consult with their individual states for state-specific certification requirements.

Also of note, peer and recovery specialist certifications may not include adequate, if any, information on supporting families who are involved with child welfare services. This knowledge is necessary for peers and recovery specialists working in child welfare agencies and family courts. Offering an orientation and ongoing training on substance use disorders and their effect on children and families involved with child welfare can help ensure that they understand the child welfare system and unique needs of these families.

PEER SUPPORT TRAINING AND CERTIFICATIONS

In 2015, the Substance Abuse and Mental Health Services Administration (SAMHSA) developed [Core Competencies for Peer Workers in Behavioral Health Services](#) to identify the critical knowledge, skills, and abilities needed by anyone who provides peer support services to people with or in recovery from a mental health or substance use condition. These competencies include: recovery-oriented, person-centered, voluntary, relationship-focused, and trauma-informed.

A [2016 Report](#) from the University of Texas at Austin School of Social Work provides state-by-state information on peer specialist training and certification requirements.⁸ The report indicates that as of July 2016, 41 states and the District of Columbia have established

programs to train and certify peer specialists and 2 states are in the process of developing and/or implementing a program.

Some examples of state-specific training and certifications for peer workers include:

- The [Maryland Addiction and Behavioral Health Professionals Certification Board](#) implements standards, testing, and training for certifying addiction counselors, co-occurring disorders professionals, criminal justice additions professionals, clinical supervisors, and peer recovery specialists and their supervisors.
- The [Rhode Island Peer Specialist Certification Guide](#) was developed to serve as a study aid to assist peer recovery professionals to prepare for and pass the Rhode Island Peer Recovery Specialist Certification Exam.
- [Alcoholism and Substance Abuse Providers of New York State \(ASAP\) and the New York Certification Board \(NYCB\)](#) provides a certified recovery peer advocate certification program.
- [Georgia's Certified Addiction Recovery Empowerment Specialist Academy](#) was developed to create a workforce of peers to provide recovery support services to the communities of Georgia.

RECOVERY SPECIALIST TRAINING AND CERTIFICATIONS

There is much more variation in terms of certification for recovery specialists when compared to peer support certifications. In the programs interviewed for this brief, qualifications required for the recovery specialist position included a college degree in a related field. The [State by State Guide to Addictions Professional Requirements](#) offers information on addiction/substance abuse counselor requirements by state.

References

- ¹ Kaplan, C., Schene, P., DePanfilis, D. & Gilmore, D. (2009). Shining light on chronic neglect. *Protecting Children*, 24, 1-7.
- ² Gregoire, K. A. & Schultz, D. J. (2001). Substance-abusing and child welfare parents: Treatment and child placement outcomes. *Child Welfare*, 80, 433-452.
- ³ Brook, J. & McDonald, T. (2010). The impact of parental substance abuse on the stability of family reunifications from foster care. *Child and Youth Services Review*, 31, 193-198. doi: 10.1016/j.childyouth.2008.07.010.
- ⁴ Hall, M., Huebner, R., Sears, J., Posze, L., Willauer, T. & Oliver, J. (2015). Sobriety treatment and recovery teams in rural Appalachia: Implementation and outcomes. *Child Welfare*, 94(4), 119. Available from <https://www.ncbi.nlm.nih.gov/pubmed/26827479>.
- ⁵ 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*, 9:1, 42-64.
- ⁶ Ryan, J.P., Peeron, B.E., Moore, A., Wictor, B.G. & Park, K. (2010). Timing matters: A randomized control trial of recovery coaches in foster care. *Journal of Substance Abuse Treatment*, 77, 178-184. doi: <http://dx.doi.org/10.1016/j.jsat.2017.02.006>.
- ⁷ Centers for Medicare & Medicaid Services (2007). CMS State Medicaid Directors Letter: Using Peer Support Services Under Medicaid. Baltimore, MD: HHS. <http://downloads.cms.gov/cmssgov/archiveddownloads/SMDL/downloads/SMD081507A.pdf>. Accessed September 11, 2018.
- ⁸ Kaufman, L., Brooks, W., Bellinger, J., Steinley-Bumgarner, M. & Stevens-Manser, S. (2016). Peer Specialist Training and Certification Programs: A National Overview. Texas Institute for Excellence in Mental Health, School of Social Work, University of Texas at Austin.

Connecticut Recovery Specialist Voluntary Program

PROGRAM HIGHLIGHTS

- **Model** – The Department of Children and Families and the Department of Mental Health and Addiction Services contract with Advanced Behavioral Health to hire and employ Recovery Specialists. Specialists may or may not have their own lived experience of substance use disorders.
- **Goals** – Recovery Specialists connect parents to substance use treatment services. They also conduct motivational interviewing and strengths-based coaching to improve the timeliness of child placement decisions and increase family reunification rates.
- **Population** – The program targets families with children in out-of-home care who have a possibility of reunification.
- **Engagement** – Recovery Specialists engage with the family on-site at the time of the initial custody hearing.

BACKGROUND AND PURPOSE

The Recovery Specialist Voluntary Program (RSVP) is a joint initiative of the Connecticut Department of Mental Health and Addiction Services (DMHAS), Department of Child and Families (DCF), Judicial Branch, and Advanced Behavioral Health (ABH), an Administrative Services Organization that manages mental health and substance use disorder services. The agencies developed RSVP in 2008 and modeled the program after the Specialized Treatment and Recovery Services (STARS) program in Sacramento County's Dependency Drug Court.¹

RSVP is a voluntary, intensive case management and recovery support program that engages and maintains parents in appropriate substance use treatment services and provides linkages to increase recovery supports. RSVP aims to improve parent engagement and retention in treatment, increase family reunification rates, and when reunification is not possible, improve the timeliness of child placement.

PROGRAM MODEL

RSVP targets parents whose substance use disorder was a contributing factor to their child's removal from the home. At the initial Order of Temporary

Custody Hearing, the Court Service Officer determines if a parent is eligible for the program. The officer then informs the attorney of the parent's eligibility. The attorney refers the parent to the Recovery Specialist, who is waiting at the court to meet with the parent right away. If the parent agrees to participate, enrollment in RSVP begins immediately and participation becomes a court order. Eligibility criteria for the program include:

- A substance use disorder was identified as a contributing factor to their child's removal
- There is the possibility of reunification (as determined by a DCF assessment)
- The parent will not be incarcerated for longer than 30 days
- The parent resides in an area served by RSVP (RSVP serves 4 out of the 6 DCF area offices and is in 7 juvenile court locations in both urban and rural areas)

RSVP has three phases, each lasting approximately 90 days. During each phase, parents are expected to attend treatment sessions, attend at least six support group meetings per month, meet with the Recovery Specialist, and provide random urine drug screens. However, as parents progress through the phases, the frequency of drug testing and contact with the Recovery Specialist reduces. The parent, DCF worker, treatment provider, and Recovery Specialist work together to monitor treatment progress and goals and assess readiness for phase progression and program completion.

- **Phase I** – Parents have two or more random drug tests per week and meet with their Recovery Specialist at least once a week if in residential treatment and at least twice a week if in outpatient treatment.
- **Phase II** – Random drug tests reduced to at least one time per week and parents meet with their Recovery Specialist at least once a week if in outpatient treatment and at least biweekly if in residential treatment.
- **Phase III** – Parents have at least two random drug tests per month and meet with their Recovery Specialist at least biweekly if in outpatient treatment and monthly if in residential treatment.

Connecticut Recovery Specialist Voluntary Program

At the time of intake, every parent is assigned a color which corresponds to a program phase. Parents call a toll-free number three nights per week to determine if their color is being called for a urine drug screen. If their color is called, they report to their designated RSVP office which was assigned to them at the intake appointment.

RSVP currently employs 20 Recovery Specialists. The program serves approximately 450 parents per year. The Recovery Specialists have a caseload of 15 parents, while supervisors have a caseload of 8-10 parents.

ROLES AND RESPONSIBILITIES

The primary roles and responsibilities of the Recovery Specialists are:

- Connect parents to the substance use treatment provider and offer engagement support, such as calling treatment providers with the clients to schedule an evaluation appointment and providing transportation to the treatment provider
- Monitor parents' treatment attendance and participation in self-help groups
- Provide motivational interviewing and strengths-based coaching to work on recovery plan goals
- Help clients advocate for themselves as they navigate the treatment and child welfare systems
- Assist parents with overcoming barriers to recovery and connect them to resources such as housing, vocational services, GED services, transportation, basic needs support (e.g., food bank, clothing bank), and recovery support (e.g., Narcotics Anonymous, Alcoholics Anonymous)
- Help parents build their recovery supports either through current family or recovery-oriented friends and connect them to recovery-oriented programs throughout the area they reside
- Conduct random urine drug screenings
- Attend DCF-related meetings such as Administrative Case Reviews, team meetings, Considered Removal Meetings
- Attend other meetings with the client, such as

NA/AA or other recovery-oriented meetings, substance use treatment provider meetings, discharge planning meetings, supportive housing meetings, and other court proceedings (e.g., eviction meetings, probation meetings)

- Prepare compliance reports for DCF and the court

IMPLEMENTATION CONSIDERATIONS

FUNDING

Since its inception, RSVP has been jointly-funded by DMHAS and DCF through a reallocation of existing state dollars to ABH to implement the program. Connecticut monitored the spending on toxicology over several years and recognized that they were spending less money than they had allocated for drug testing. They reallocated those funds to expand the RSVP program and hire additional Recovery Specialists to reach more families throughout the state. They also reviewed use of hair follicle tests to ensure tests were being done judiciously, which resulted in some change in practice and a reduction of hair follicle tests when they were not warranted.

The starting salary for new Recovery Specialists is approximately \$35,000 with full benefits.

STAFF HIRING, SUPERVISION, AND RETENTION

QUALIFICATIONS

Recovery Specialists are independent from DCF, DMHAS, and the court. They are employed by ABH, allowing them to act as advocates and resources for parents. The hiring qualifications for Recovery Specialists include a minimum of an Associate's Degree in human services or a related field and two years working in behavioral health services. Specialists are not required to have their own lived experience of substance use disorders or involvement in child welfare services, but some Specialists do.

TRAINING

All Recovery Specialists receive an initial orientation by ABH, which is a recovery-oriented training in motivational interviewing and other engagement skills. Recovery Specialists have access to a minimum of four trainings per year following orientation. Topics include:

Connecticut Recovery Specialist Voluntary Program

- Engagement skills
- Motivational interviewing
- Addiction and recovery
- Co-occurring disorders
- The effect of substance use disorders on parenting
- Child welfare and court processes
- Culturally and gender-specific service delivery
- Child development

RSVP also leverages trainings offered through the Connecticut Community for Addiction Recovery (CCAR), which is a centralized resource for recovery. CCAR provides recovery support services and promotes recovery through advocacy, education, and services. CCAR has a recovery coach training with a focus on working with individuals in recovery.

SUPERVISION

Recovery Specialists have individual supervision on a weekly basis. The supervision focuses on case planning for parents and families. The Regional Coordinators and/or Program Supervisor review all cases at least monthly. Supervision promotes engagement of parents in a culturally-sensitive and strengths-based manner. The supervision includes reviewing documentation, services, and recovery plan goals.

RECRUITMENT

Recruitment for the Recovery Specialist position is done via postings on career websites and referrals from current employees.

COMMUNICATION PROTOCOLS AND INFORMATION SHARING

Upon agreement to participate in the program, parents sign a Parent Agreement to allow RSVP to share treatment information with DCF and the court. Recovery Specialists speak with the child welfare social worker via phone or in person weekly. Communication with treatment providers happens bi-weekly at minimum, and more frequently if needed. The Recovery Specialist shares

only objective information including the parent's compliance with treatment, support group attendance, drug testing results, and any barriers with engagement in treatment. Specialists typically cannot testify in a court proceeding about the parents unless there is suspicion of child abuse or neglect.

The Recovery Specialist is part of the case conferences with the DCF worker, attorneys, and the parent. These meetings allow for the team members to review the Recovery Specialist's reports and discuss how the parent's progress affects the court case. The first case status conference is usually held 2 weeks after the Order of Temporary Custody Hearing. Additional meetings are held every 4 weeks. After the fourth meeting, they are scheduled every 6-8 weeks until the RSVP case has closed, or the child has been reunified.

Recovery Specialists participate in monthly Substance Abuse Managed Service System (SAMSS) meetings with representatives from DCF, DMHAS, treatment providers, and other community providers to jointly discuss parents' needs and develop an action plan for treatment and recovery supports.

PROGRAM OUTCOMES

In 2013, DCF, DMHAS, the Judicial Branch, and ABH executed a data-sharing agreement to link individual-level data from each agency to track involvement in and outcomes across the various systems and to better assess RSVP's impact. The University of Connecticut conducts an ongoing evaluation of the program. Positive child and family outcomes highlighted in a recent peer-reviewed journal article include:²

- 75% of RSVP parents successfully completed their initial treatment episode, staying an average of 88 days in treatment, which exceeded the 43% completion rate for adults statewide.
- The reunification rate was 27% for parents who did not fully comply with RSVP and 76% for those who were compliant for at least 180 days.
- 74% of children whose parents enrolled in RSVP had a permanent placement within 12 months compared to 49% of other out-of-home cases statewide.

COLLABORATIVE PRACTICE LESSONS

While developing RSVP, leaders from each of the systems (DCF, DMHAS, and the judicial branch) understood that collaboration was necessary to operate the program. To establish a strong collaborative relationship, the leaders had to develop an understanding of each other's organizational culture, values, and priorities. The leaders also had to account for the various, and sometimes conflicting, timelines for the court, child permanency decisions, and treatment.³ The team was able to overcome many of their differences

by developing a shared goal and implementing ongoing cross-systems training. Stakeholders also created an RSVP Core Management Team that is responsible for joint oversight of the program.⁴

Other factors that contribute to the successful collaboration between state agencies include the ongoing support from state commissioners and the annual celebration event. The celebration is an opportunity for all the stakeholders to get together and for families who have successfully completed the program and closed their DCF cases to share their experiences.

It is a huge celebration that helps everyone remember that these are real children and real families who benefit from the program.

References

¹ Boles, S. M., Young, N. K., Moore, T. & DiPirro-Beard, S. (2007). The Sacramento Dependency Drug Court: Development and outcomes. *Child Maltreatment*, 12, 161–171.

² Ungemack, J., Giovannucci, M., Moy, S., Ohrenberger, K., DeMatteo, T., & Smith, S. (2015). Making it work without a family drug court: Connecticut's approach to parental substance abuse in the child welfare system. *Child Welfare*, 94(5e), 107

³ Ibid

⁴ Ibid

Illinois Alcohol and Other Drug Abuse Waiver Demonstration

PROGRAM HIGHLIGHTS

- **Model** – This program is a recovery specialist model that uses “Recovery Coaches,” professionals employed by a social services agency contracted by the Department of Children and Family Services (DCFS). Recovery Coaches are not required to have their own lived experience of substance use disorders but many do have lived experience.
- **Goals** – Recovery Coaches serve as intensive and specialized case managers who aim to increase engagement in substance use treatment services and improve reunification and other family permanency and safety outcomes.
- **Population** – The program targets families with children who are in out-of-home care due, at least in part, to parental substance use disorders.
- **Engagement** – The program has placed a major emphasis on early engagement in treatment services to improve reunification rates. One of the core components of the program is a substance use disorder assessment service provided on-site at the courthouse. The assessment service also includes a mobile component in which a worker goes out into the field to complete the assessment at a parent’s home. This service reduces the time it takes workers to identify a substance use disorder and increases engagement and timely access to treatment.

BACKGROUND AND PURPOSE

The Illinois Alcohol and Other Drug Abuse Waiver Demonstration employs Recovery Coaches who support parents and families throughout the duration of the child welfare case and assist parents in accessing treatment services and achieving stable reunification. The program is funded through the [Title IV-E Foster Care and Adoption Assistance Program](#), which allows states to use funds more flexibly and test innovative approaches for child welfare service delivery and financing. The Title IV-E Waiver Program requires DCFS to conduct a program evaluation and submit findings annually to the Administration for Children and Families (ACF), Children’s Bureau (CB). The evaluation design is experimental in that parents are randomly assigned to either a control or experimental (demonstration) group. Parents who are randomly assigned to the demonstration group receive traditional services plus the enhanced services provided by a Recovery Coach. Parents who are randomly assigned to

the control group receive services as usual; this is not a “no treatment” intervention design.

PROGRAM MODEL

Eligible families include parents who have lost custody of their children and need an assessment to determine if referral to substance use treatment is necessary. Families are referred to the Juvenile Court Assessment Program (JCAP) at the time of their Temporary Custody Hearing or at any time within 90 days after the hearing. JCAP is an on-site substance use disorder assessment service located at the Juvenile Court building. This on-site screening service decreases the time it takes child welfare professionals and family court staff to identify substance use disorders and connect families to services.

Illinois added a mobile substance use disorder assessment unit to the waiver demonstration in 2013. This unit employs intensive outreach services by bringing the assessment to the parent’s home and establishing immediate contact as soon as temporary custody is determined.

Recovery Coaches are assigned to a parent immediately following the JCAP assessment. When a mobile assessment is completed, the JCAP staff obtain consent to share information with the Recovery Coach and the assigned Recovery Coach then contacts the parent. If the parent refuses services or drops out, the Recovery Coach will continue to work with the parent for a minimum of six months to engage or re-engage them in services. Recovery Coaches work with the parent throughout the court and substance use treatment process. They also remain involved with the family after the permanency decision to assist with the transition process.

Recovery Coaches meet with parents at least twice per month, but visits can be more frequent to meet the needs of the family. Drug testing occurs when the Recovery Coaches determine it is needed. Drug tests are needed when parents exhibit unexplained changes in behavior, mood swings, missed appointments, changes in attitude, or appearance of being intoxicated or in withdrawal (e.g., dilated pupils, sweating, shaking, agitation).

Recovery Coaches have an average caseload of 25 families and the program serves an average of 315 families per year.

ROLES AND RESPONSIBILITIES

Recovery Coaches monitor parents' substance use disorders and other family challenges; develop tailored care plans to ensure services are matched to a family's specific needs; and utilize linkage mechanisms (e.g. referral, onsite services or intensive case management) to increase access to services.

The primary roles and responsibilities of the Recovery Coaches are:

- Provide home visits in conjunction with or in addition to child welfare home visits
- Provide case management focused on substance use disorder treatment
- Assist parents with navigating the child welfare and substance use treatment systems and accessing mental health, domestic violence, and housing services as needed
- Provide consultations and connections with service providers
- Advocacy and speaking on the parent's behalf
- Provide regular written progress reports to the caseworker and the court

It is valuable for parents to have that one person who is consistently there throughout the process.

IMPLEMENTATION CONSIDERATIONS

FUNDING

DCFS submitted an application for a Title IV-E waiver project in June 1999 through the [Title IV-E Foster Care and Adoption Assistance Program](#). The ACF, CB, approved the application for a five-year demonstration on September 29, 1999 and implementation began on April 28, 2000. The CB has approved subsequent extensions of the Illinois Waiver Demonstration, with the most recent approval extending through September 30, 2019.

DCFS contracts with Treatment Alternatives for Safe Communities (TASC) to provide the Recovery Coach service and supervision.

The average salary for Recovery Coaches is \$30,000 per year with benefits. DCFS has a separate contract with Caritas Companies for JCAP to provide assessment and referral services to parents.

STAFF HIRING, SUPERVISION, AND RETENTION

QUALIFICATIONS

Recovery Coaches are professionals who have clinical expertise in working with parents with substance use disorders. A Bachelor's Degree is preferred for the Recovery Coach position, while supervisors are required to have Master's Degrees. Lived experience is not a requirement of employment, although several Recovery Coaches are in long-term recovery.

The team has lived experience, but not every team member has to have lived experience – the diversity strengthens the team.

SUPERVISION

Masters-level clinicians provide clinical supervision. Supervision focuses on the care of the parent and family, ensuring that services are clinically appropriate. Supervision also focuses on the personal and professional needs of the staff and offers support for any stress and secondary trauma the Recovery Coach may experience in the field. Team building exercises and stress relieving activities are also important components of the program's supervision.

TRAINING

TASC provides training on case management. In addition, Recovery Coaches are often sent to external training and conferences to stay current on best practices and innovative strategies related to working with families in child welfare affected by substance use disorders.

RECRUITMENT

Program representatives noted that maintaining the workforce has been a challenge, as there is competition for highly-qualified staff, especially clinically-trained staff with lived experience. To overcome this challenge, program representatives noted that they offer competitive salaries, provide ongoing training, and support workplace wellness.

COMMUNICATION PROTOCOLS AND INFORMATION SHARING

Recovery Coaches regularly complete progress reports to share with the child welfare caseworkers and court staff. The timing of the reports is linked to court appearances and case staffings. The Coaches provide reports at least once a quarter and before any major court appearances, such as the permanency hearing. Parents sign consents for release of information with JCAP to allow them to share information with the caseworker, Recovery Coach, court, and treatment provider(s). Recovery Coaches also obtain consents from parents to allow for continued sharing of information with child welfare and court staff.

PROGRAM OUTCOMES

As mentioned earlier, the Title IV-E Waiver Demonstration Project requires DCFS to conduct a program evaluation and submit findings annually to ACF, CB. The evaluation design is experimental, in that parents are randomly assigned to either a control or experimental (demonstration) condition. Parents who are randomly assigned to the demonstration group receive traditional services plus the enhanced services provided by a Recovery Coach. Parents who are randomly assigned to the control group receive services as usual. Findings from the program's October 2017 evaluation report include:

- The addition of a mobile assessment unit led to an increase in parent screening, an increase in the number of parents eligible for the program, and a decrease in the time between temporary custody and screening.
- Children of parents in the demonstration group achieved family reunification more quickly than those in the control group, typically within twelve months of the JCAP assessment. Families in the demonstration group took 5.6 fewer months (on average) to achieve reunification, compared to families in the control group.
- The demonstration and control groups did not significantly differ on the proportions of children that re-entered foster care and did not significantly differ on the proportions of children experiencing subsequent allegations of abuse/neglect. These findings indicated that reunifications in the demonstration group were

not premature and did not compromise safety.

- Recovery Coaches significantly increased the likelihood of achieving a stable reunification for families affected by substance use disorders.
- The use of Recovery Coaches eliminated racial disparities in family reunification. This outcome was likely due to the comprehensive assessment and provision of specialized services and support that addressed the family's unique needs. While previous research has shown that African American youth spend more time in foster care, this study found no racial differences with regards to time in care.
- Improved reunification outcomes were dependent on families being quickly assessed and connected to services, indicating that innovative services (like the Recovery Coach) are effective in improving family reunification—but only when delivered in a timely manner.
- As of June 30, 2017 (latest cost estimates available), the waiver demonstration has generated approximately \$10,587,174 in savings for the State of Illinois since 2000.

In addition, an earlier study found that the use of Recovery Coaches in child welfare significantly decreased the risk of an infant born with prenatal substance exposure. Fifteen percent of mothers in the demonstration group was associated with a second infant born with prenatal substance exposure compared to 21% of mothers in the control group.¹

Program representatives noted that their ongoing evaluation enables the team to assess what components of the program are effective and identify opportunities for improvement.

COLLABORATIVE PRACTICE LESSONS

The long-term collaboration between child welfare leadership, TASC, and the evaluator has contributed to the overall success and longevity of the project. These individuals were involved in the project since initial implementation and have remained committed to the work despite agency turnover. In addition, the evaluation has been useful in facilitating and maintaining buy-in from judges, federal partners, and other stakeholders.

References

¹ Ryan, J. P., Choi, S., Hong, J. S., Hernandez, P., & Larrison, C. R. (2008). Recovery coaches and substance exposed births: An experiment in child welfare. *Child Abuse & Neglect*, 32(11), 1072-1079. doi:10.1016/j.chiabu.2007.12.011

Kentucky Sobriety Treatment and Recovery Teams

PROGRAM HIGHLIGHTS

- **Model** – Child welfare employs Family Mentors, individuals in long-term recovery from substance use disorders and lived experience of the child welfare system. Family Mentors are paired with child protective services workers to implement a system of care for families.
- **Goals** – The program aims to keep children at home with their families through creative safety planning, quick access to substance use treatment, peer support, and collaborative practices with partners in the community.
- **Population** – The program targets families with a substantiation of child abuse and neglect, with parental substance use as a primary risk to child safety. Families must have one child under the age of six years.
- **Engagement** – Quick engagement in substance use treatment services is an essential element of the program. A substance use assessment is completed within 2 days of the first family team meeting and entry into substance use treatment occurs within 3 days of assessment.

BACKGROUND AND PURPOSE

The Sobriety Treatment and Recovery Teams (START) model was developed in Cleveland, Ohio in the 1990s and adopted by Kentucky in 2006 to support integrative service delivery between child welfare and substance use treatment providers. The program was developed in response to the high percentage of families involved in the child welfare system because of parental substance use. Another reason that supported the development of START was findings from a statewide survey which indicated that substance use treatment services were among the highest needed services, but the least available in the state.¹ Kentucky has received two Regional Partnership Grants (RPG), funded by the Administration for Children and Families (ACF), Children's Bureau (CB), to implement the START program. The program currently employs 27 Family Mentor positions across the following five START sites: Jefferson County, Kenton County, Fayette County, Boyd County, and Daviess County. The model has also been piloted in New York, Georgia, Florida, Indiana, North Carolina, and Ohio.

START is a child welfare-led program for families

with substance use disorders and substantiated child maltreatment whose children are at risk of entering, or currently in, out-of-home care. The START model pairs a child protective services (CPS) worker with a Family Mentor to implement a system of care for families.

START aims to keep children at home with their families through creative safety planning, quick access to substance use treatment, peer support, and collaborative practices with partners in the community. Program goals include:

- Ensure child safety
- Reduce entry into out-of-home care by keeping children in the home with the parent when safe and possible
- Among families with out-of-home placement, achieve child permanency within the Adoptions and Safe Families Act (ASFA) timeframes, preferably with one or both parents or, if that is not possible, with a relative
- Achieve parental sobriety in time to meet ASFA permanency timeframes
- Improve parental capacity to care for children and to engage in essential life tasks
- Reduce repeat maltreatment and re-entry into out-of-home care
- Expand the substance use treatment system's quality of care and service capacity as needed to effectively serve families with parental substance use and child maltreatment issues
- Improve communication, linkages, and the system of service delivery between child welfare and substance use treatment providers

PROGRAM MODEL

The START model is implemented by a collaborative team that includes a specialized CPS caseworker and Family Mentor dyad, substance use treatment providers, and a dedicated START supervisor at the child welfare agency. Other collaborative team members include mothers, fathers, and significant others with substance use disorders.² Each member of this specialized team participates in case planning and decision making.

Kentucky Sobriety Treatment and Recovery Teams

CPS investigative teams make referrals to START. Inclusion criteria for enrollment includes³:

- A substantiation of child abuse and neglect
- Parental substance use is a primary risk factor for child safety
- A least one child in the family is under the age of 6 years
- The referral was made within 30 days of the CPS report
- The case is not currently staffed by another team in child welfare due to a previously opened investigative report

Essential elements of the START model include quick entry into START services, access to substance use/mental health assessment, and treatment. The specific timeframes include:

- Referral to START within 10 days of report to CPS
- First shared decision-making meeting with the family within 2 days of referral to START
- Substance use and co-occurring mental health assessment including trauma by a treatment professional within 2 days of first meeting; treatment recommendations made within 1 day. Substance use treatment begins within 3 days of assessment, with a minimum of 4 treatment sessions in the first 10 days of treatment.
- Following the initial shared decision-making meeting, family team meetings occur at least every three months throughout the first year of the program. Family team meetings are also called when there is a relapse, family crisis, communication issue, and change in treatment plans, or any time a removal is considered.
- Family Mentors and CPS social workers meet with the family at least weekly for the first 90 days, either in the home, at treatment, or in the community. After 90 days, visits can be reduced to once every two weeks if the family is doing well.

Each CPS/Family Mentor dyad has a capped caseload of approximately 15 families to provide individualized services that best meet the needs of the family. Kentucky START receives approximately 121 family intakes per year.

ROLES AND RESPONSIBILITIES

The START program selected the title of Family Mentor to emphasize the teaching and guidance functions of the position that are important to child safety and adult recovery.⁴ The primary responsibilities of the Family Mentors are to facilitate early engagement in substance use treatment services, assist the family with overcoming barriers such as transportation and child care, and to support the family during the progression of the child welfare case. Some of the ways Family Mentors fulfill their roles include:

- Driving parents to their first substance use assessment
- Accompanying and/or transporting parents to the first four substance use treatment sessions to facilitate a warm handoff and support the family's engagement in services
- Visiting the family multiple times per week during the first 90 days of services to coach, support, and observe progress in parenting and recovery
- Helping the CPS workers understand substance use disorders and helping the parents navigate the child welfare system
- Connecting families to recovery supports, appropriate resources, and services

IMPLEMENTATION CONSIDERATIONS

FUNDING

Kentucky received two RPGs funded by the ACF to implement the START program. Temporary Assistance for Needy Families (TANF) has also been a funding source for START, and the program was able to expand services through the Kentucky Title IV-E Waiver. Substance use disorder treatment services are paid for by Medicaid or private insurance when possible. Other states have used Victims of Crime Act funds or their allocated state/local funds.

The total cost for a Family Mentor position in Kentucky is \$57,000 per year including salary, fringe, travel, phone, and indirect costs. The current hourly wage for family mentors is \$13.30/hour plus benefits such as a pension, health insurance, and tuition waiver.

Kentucky Sobriety Treatment and Recovery Teams

STAFF HIRING, SUPERVISION, AND RETENTION

QUALIFICATIONS

Family Mentors are contracted employees of the Kentucky Department for Community Based Services (DCBS), which is responsible for administering the state's child welfare system. Family Mentors all have lived experience of substance use treatment and personal involvement in the child welfare system. The qualifications for the position include:

- GED or high school diploma
- 2 years of previous work experience
- At least 3 years of uninterrupted sobriety

Experience with the child welfare system is a highly-preferred qualification for the Family Mentor position. However, the program has found it difficult to identify persons who are in long-term recovery and who have experience with CPS, particularly in rural jurisdictions or smaller communities. In these cases, START aims to hire individuals who demonstrate during their interview that they have a good understanding of how their substance use affected their children and parenting and can relate to someone whose substance use has affected their ability to parent.

To be eligible for the position, applicants cannot be on probation. The Family Mentor position is contracted through a state university that requires job candidates to complete any criminal sentence, including any probationary period, prior to employment. This requirement can be a barrier for recruitment in locales where judges sentence long probation periods for drug-related crimes.

TRAINING

Training for Family Mentors involves a briefer version of the orientation training for new child welfare workers. Training activities also include completion of the National Center on Substance Abuse and Child Welfare online tutorials, motivational interviewing, and cross training with substance use and mental health treatment provider staff on a variety of topics including medication-assisted treatment. Other training includes the Kentucky School for Alcohol and Other Drugs conference – a comprehensive annual training that takes places over four

days including sessions from substance use and mental health treatment, child welfare, and service providers across the board.

SUPERVISION

Child welfare supervisors oversee the Family Mentors and the CPS caseworkers. Supervision focuses primarily on case work; however, supervisors are trained to provide various levels of support based on the needs of the Family Mentors. Supervisors also help the Family Mentor and the child welfare worker to navigate their partnership. START holds a quarterly Family Mentor meeting that convenes the Family Mentors and their supervisors from all sites across the state to provide an opportunity to discuss any recurring or new issues and to provide ongoing support.

RECRUITMENT

To recruit Family Mentors, the START team conducts outreach to DCBS workers, community partners, and the recovery community. The team also distributes job flyers throughout the community, posts announcements on social media, and brainstorms as a group during monthly supervision calls and meetings with the team.

COMMUNICATION PROTOCOLS AND INFORMATION SHARING

Participants sign a release of information that allows Family Mentors, social workers, treatment providers, and court staff to share information among each other. Both Family Mentors and social workers enter notes about their contact with families in the Statewide Automated Child Welfare Information System (SACWIS) and a START database. Contacts and data must be kept up to date monthly, as this information is used for court reports and program evaluation.

Treatment providers send detailed reports to START staff on a weekly basis. The reports include information about how the parent is doing in treatment and data for the local evaluation. The data elements collected in the reports include:

- Attendance, missed services, and participation in substance use treatment services
- American Society for Addiction Medicine (ASAM) Levels of care for substance use treatment

There is often daily communication between the Family Mentor, social worker, and treatment provider so everyone is on the same page.

- Attendance of recovery support groups such as 12-step (AA/NA), Celebrate Recovery, and SMART Recovery
- Frequency and results of drug tests

PROGRAM OUTCOMES

Initial outcome studies of START were conducted by Dr. Ruth Huebner of Eastern Kentucky University and the Kentucky Department for Community Based Services during a RPG. The methodology included a quasi-experimental design with two matched comparison groups and a cluster analysis. Evaluation of START is currently ongoing, led by Dr. Martin Hall of the University of Louisville under a second RPG and a Title IV-E Waiver. The current methodology includes a randomized controlled trial and a quasi-experimental study using propensity score matching for comparison group formation. START outcomes have been described in several peer-reviewed journal articles demonstrating positive child welfare and recovery outcomes for families. START is currently listed as having promising research evidence on the California Evidence-Based Clearinghouse for Child Welfare. Positive outcomes of the program include:

- Children whose mothers participated in the START program are approximately 50% less likely to enter out-of-home placements than children from a matched comparison group.⁵ They are significantly less likely to experience recurrence of child abuse or neglect within 6 months or re-enter foster care at 12 months.^{6,7}
- Mothers who participated in the program achieved sobriety 1.8 times faster than mothers who participated in any treatment modality (e.g., residential, outpatient, etc.) without START.^{8,9}
- At case closure, 77.6% of children served by START remained with or were reunified with their parent(s).¹⁰
- For every \$1 spent on START, \$2.22 is offset in out-of-home placement costs.¹¹

A recent study found that the number of face-to-face visits between the Family Mentor and the family was associated with higher rates of families remaining together at case closure.¹² For each additional face-to-face visit, the likelihood of families remaining together increased by 9%. Intact families had an average of 14 more face-to-face visits with mentors than families separated at case closure. Face-to-face visits correlated with meeting with the parents in the home, reinforcing and teaching daily living skills, and reinforcing the child safety plan.¹³

COLLABORATIVE PRACTICE LESSONS

Initially, there were challenges with getting child welfare to recognize the benefits of implementing the family mentor/social worker dyad. Social workers were unsure about sharing a caseload with Family Mentors, especially with individuals who had prior child welfare involvement. This idea required a cultural shift within child welfare and ongoing trainings related to substance use disorders, treatment, and recovery. Supervision also became important to help navigate the caseworker/Family Mentor partnership and establish clear roles and responsibilities among team members. Evaluators of the START model found that successful collaboration between mentors, caseworkers, and supervisors involved sharing a common vision, developing working relationships, having an open mind when learning new information, and identifying the benefits of the partnership.¹⁴

Overtime, it became clear that the benefits of the family mentor/social worker dyad far outweighed the challenges. Employee interviews revealed that the dyad was more effective in engaging families compared to social workers alone.¹⁵

The relationship between the family mentor and the social worker is like a marriage.

References

- ¹ Huebner, R., 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. doi: <http://dx.doi.org/10.1606/1044-3894.4223>
- ² Huebner, R., Posze, L., Willauer, T., & 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
- ³ Ibid
- ⁴ Huebner, R. A., Willauer, T., Brock, A., & Coleman, Y. (2010). START Family Mentors: Changing the workplace and community culture and achieving results. *Source*, 20, 7-10 (Accessed [July 23, 2018] from: <http://ia.berkeley.edu/media/pdf/TheSourceSpring2010.pdf>)⁵ Huebner, R., 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. doi: <http://dx.doi.org/10.1606/1044-3894.4223>
- ⁶ Ibid.
- ⁷ Hall, M., Huebner, R., Sears, J., Posze, L., Willauer, T. & Oliver, J. (2015). Sobriety treatment and recovery teams in rural Appalachia: Implementation and outcomes. *Child Welfare*, 94(4), 119. Available from <https://www.ncbi.nlm.nih.gov/pubmed/26827479>⁸ Huebner, R., 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. doi: <http://dx.doi.org/10.1606/1044-3894.4223>
- ⁹ Hall, M., Huebner, R., Sears, J., Posze, L., Willauer, T. & Oliver, J. (2015). Sobriety treatment and recovery teams in rural Appalachia: Implementation and outcomes. *Child Welfare*, 94(4), 119. Available from <https://www.ncbi.nlm.nih.gov/pubmed/26827479>
- ¹⁰ Huebner, RA, Willauer, T, Posze, L, Hall, MT, & Oliver, J. (2015) Application of the Evaluation Framework for Program Improvement of START, *Journal of Public Child Welfare*, 9:1, 42-64
- ¹¹ Huebner, R., 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. doi: <http://dx.doi.org/10.1606/1044-3894.4223>
- ¹² Huebner, R. A., Hall, M. T., Smead, E., Willauer, T., & Posze, L. (2018). Peer mentoring services, opportunities, and outcomes for child welfare families with substance use disorders. *Children and Youth Services Review*, 84, 239-246. doi:10.1016/j.childyouth.2017.12.005
- ¹³ Ibid
- ¹⁴ Sears, J. S., Hall, M. T., Harris, L. M., Mount, S., Willauer, T., Posze, L., & Smead, E. (2017). 'Like a marriage': Partnering with peer mentors in child welfare. *Children And Youth Services Review*, 7480-86. doi:10.1016/j.childyouth.2017.01.023
- ¹⁵ Ibid

Santa Clara Dependency Advocacy Center Mentor Parent Program

PROGRAM HIGHLIGHTS

- **Model** – Mentor Parents are persons with lived experience of substance use disorders and child welfare involvement. All mentors graduated from the Dependency Wellness Court (DWC) and are employed by the Dependency Advocacy Center, the non-profit organization contracted to provide legal representation to parents involved in Santa Clara County’s child welfare system.
- **Goals** – The program aims to provide hope to parents participating in DWC, engage participants in recovery, help eligible families successfully reunify, and break the cycle of child welfare involvement.
- **Population** – The program targets families with substance use disorders and child maltreatment whose children are removed or at risk of removal.
- **Engagement** – Mentor Parents meet with all eligible parents during the first legal dependency hearing, when the parent is appointed a Dependency Advocacy Center Attorney. If a parent attends the first dependency legal hearing, a mentor will attempt contact twice per week for the first three weeks from the initial court date to support the parent and encourage them to participate in DWC and other substance use treatment services.

BACKGROUND AND PURPOSE

The Mentor Parent Program (MPP) is peer support designed for parents with substance use disorders participating in DWC whose children have been placed in protective custody or are at risk of removal from the parent’s custody. The Mentor Parents are graduates of DWC who have lived experience of substance use disorders and who have successfully reunified with their children. With this experience, the Mentor Parents are role models who provide hope that recovery is possible. Mentor Parents also provide specialized guidance in navigating the child welfare, treatment, court, and other systems.

MPP was originally developed to increase engagement in the Santa Clara DWC. Recruitment for the voluntary court program was challenging because parents were hesitant to commit to more intensive services and subject themselves to increased monitoring. To address this barrier, the former parents’ attorney law firm

developed the Mentors for Moms program. This program was so successful in increasing court engagement that the program was expanded to MPP to provide mentor services to both moms and dads in the dependency court.

PROGRAM MODEL

Mentor Parents are employed by the Dependency Advocacy Center, a non-profit legal services organization contracted to provide legal representation to parents involved in Santa Clara County’s child welfare system. The Dependency Advocacy Center receives petitions from the Department of Family and Children’s Services (DFCS) for all new cases in which DFCS has filed a petition and has requested court intervention. The MPP Manager and Mentor Parents review each petition and flag cases containing substance use disorder allegations. If these parents attend the court hearing held the following day, or subsequently contact the Dependency Advocacy Center requesting an attorney, they are appointed an attorney and connected to a mentor.

Mentor Parents review the court case plan and develop a Mentor Action Plan (MAP) with the parent. This plan includes resources and referrals based on the parent’s strengths and challenges. Mentors facilitate face-to-face meetings with the parents and attend all court hearings, statutory review hearings, and team decision making meetings. The mentors are required to meet with the parent once a month for 30 minutes to provide education, advocacy, and emotional support for the parent. Mentors use this time to review the MAP, assess progress, and identify barriers. They also interact with parents in the community to model effective parenting skills and connect parents to positive supports. Thirty days prior to the completion of the court case, the mentor and parent jointly develop a transition plan that includes information on positive supports, resources, and a contingency plan for parents to refer to during difficult times.

MPP currently employs seven Mentors (five women and two men). Mentor Parents carry an average caseload of 15-25 clients. The program also employs a Manager and part-time Clinical Supervisor. At any given time, there are approximately 100 active participants in DWC and each one has a Mentor Parent.

During this initial contact, the mentor shares their story with the parent, provides them with hope that all is not lost...and explains that this is one of the worst days, but it is not going to be like this forever.

ROLES AND RESPONSIBILITIES

Mentor Parents have the following roles and responsibilities:

- Meet with every eligible parent who is appointed a Dependency Advocacy Center attorney and encourage them to participate in the voluntary DWC Program
- Provide linkages to services and identify service gaps
- Facilitate access to treatment by helping parents overcome barriers (e.g., transportation, child care) and finding local resources (e.g., food and clothing banks)
- Monitor participants' progress and keep them engaged in services
- Provide case management by helping parents organize their schedules to accommodate all the requirements of the child welfare, treatment, court, and other systems
- Offer role playing so parents are more prepared and confident to interact with the judge and their social worker
- Provide support to the parent during team meetings and court hearings
- Train stakeholders and serve as a positive model of recovery and reunification

In addition to working with participants, Mentor Parents play a key role in educating DWC team members, child welfare staff, community and agency partners, and other service providers about parenting with a substance use disorder and effective engagement strategies with this population.

IMPLEMENTATION CONSIDERATIONS

FUNDING

Funding for the MPP has evolved over the years.

Initially, the Department of Alcohol and Drug Services (DADS) funded the program. In 2007, the program was expanded by the SAMHSA Children Affected by Methamphetamine (CAM) grant and then expanded again in 2009 with funding from the Santa Clara Department of Mental Health. Once the CAM funding ended, the Santa Clara Board of Supervisors sustained the CAM-funded portion of MPP due largely to the positive outcomes reflected in the CAM evaluation report. Ultimately, Substance Use Treatment Services (formerly Department of Alcohol and Drug Services) absorbed this cost into their own base budget. Currently, 76% of the program funding is from Substance Use Treatment Services, and 24% is from the Santa Clara Department of Mental Health.

The overall budget for MPP, including the Manager and Clinical Supervisor, is \$466,000. Mentor Parents are full-time, salaried employees with benefits (e.g., health care, vacation). The pay range is an hourly rate of \$16-19 per hour.

The mentors are the only ones who can tell new parents, "I have been in your shoes, I get it, I was able to do this, and you can do it too."

STAFF HIRING, SUPERVISION, AND RETENTION

QUALIFICATIONS

All Mentor Parents have lived experience of a substance use disorder and child welfare involvement. The mentors are parents who have:

- A minimum of 2 years sobriety and continue to be engaged in the recovery community
- Successfully reunified with their children
- Graduated from DWC
- Had their legal case dismissed for at least 6 months, so they are no longer involved in the child welfare system

Generally, we like to say around 6 months after the mentor' case has closed so that they have some time out of the system to make sure there is stability there, but not so far away from their own lived experience that they can't relate to parents with a current child welfare case.

SUPERVISION AND TRAINING

The Licensed Clinical Supervisor meets with each mentor every other week and facilitates weekly group sessions with all the mentors to discuss emerging issues and challenges.

The Clinical Supervisor also provides specialized training on a variety of topics, including motivational interviewing, self-care, and vicarious trauma. The trainings range from an hour to a half day and occur on a quarterly basis. Mentor Parents also participate in trainings provided by the DFCS, the Superior Court, Substance Use Treatment Services and various other agency and community-based organizations.

The MPP Manager oversees program operations and provides non-clinical supervision to each mentor on a consistent basis.

RECRUITMENT

Mentor Parents are successful graduates from DWC.

The Clinical Supervisor has been critical in the success and growth of the program.

COMMUNICATION PROTOCOLS AND INFORMATION SHARING

Since Mentor Parents are employees of the Dependency Advocacy Center, their communications with the parents are covered under client-attorney privilege. In addition, the mentors' process for sharing information is the same as the attorneys—information can be shared with outside parties if the parent provides explicit permission to do so. The parent signs a release of information when they agree to participate in DWC, however, these forms do not overrule the client-attorney privilege.

References

¹ Drabble, L., Wilson, J., & Soto, D. (2017.) Evaluation of collaborative services: Mentor parent project of the dependency advocacy center. San Jose State University School of Social Work

PROGRAM OUTCOMES

San Jose State University School of Social Work conducts an ongoing program evaluation of MPP. Findings from a May 2017 Research Brief¹ indicate that:

- Parents who received support from Mentor Parents improved in each of nine self-sufficiency domains, including housing, employment, transportation, life skills, family/social relations, community involvement, parenting skills, and substance abuse
- Parents who graduated from MPP and DWC were nearly six times more likely to reunify with their children compared to eligible parents who did not participate in either program

COLLABORATIVE PRACTICE LESSONS

Involving Mentor Parents in collaborative efforts (i.e., team meetings and staffings) is crucial. Mentors also attend Team Decision Making or Child Family Team Meetings when parents invite them to do so. Mentors participate in numerous committees, including the Center for Human Services Parent Partner Advisory Committee; Santa Clara County Office of Cultural Competency, Advisory Council; Santa Clara County Joint Foster Youth Task Force, and Birth Parent National Network. Having the Mentor Parents involved in these multiple meetings and committees has helped to shape the community's perceptions and views of parents with substance use disorders and child welfare involvement. The mentors are accepted as a vital part of the DWC team and their voices are respected in the community. They also provide training to foster parents, Court Appointed Special Advocates (CASA); the court, and social workers who serve families affected by substance use disorders.