

# The Impact of Sobriety Treatment and Recovery Teams (START) on Family Outcomes

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Families with child maltreatment and parental substance use disorders are a growing population with complex needs. The Sobriety Treatment and Recovery Teams (START) is an integrated model that pairs child protective service workers with family mentors and partners with treatment providers. This is a prospective naturalistic evaluation comparing rates of adult sobriety and child placement in state custody using provider-collected data merged with state administrative data sets. All families in the served and comparison groups had equal risks to child safety. Mothers achieved sobriety at 1.8 times the rate of typical treatment; children were placed in state custody at half the rate expected. These results support START as an effective integrated program.

## IMPLICATIONS FOR PRACTICE

- With adequate supports and timely access to treatment, many children can stay safely with their substance-abusing parents through treatment; keeping families together then promotes parent/child attachment and development of parental capability.
- Parents can achieve higher rates of sobriety than is often reported when more potent intervention models are implemented through child welfare.

Families with substance-abusing parents have pervasive and complex needs. Relapse; health problems; and the secondary effects of homelessness, criminality, and job loss complicate recovery and child safety (U.S. Government Accountability [formerly, Accounting] Office [GAO], 2003; Young & Gardner, 2002). Adult substance abuse may be triggered by childhood abuse or neglect (Dodge et al., 2009), and when coupled with poverty and mental health problems, it may further compromise the mother's ability to form attachments with her children (Bergin & McCollough, 2009). Thus, child abuse and neglect (CA/N), family violence, and substance use disorders (SUDs) are often linked across generations (Noll, Trickett, Harris, & Putnam, 2009) and associated with multiple contacts with child protective services (CPS; Barth, Gibbons, & Guo, 2006; Connell, Bergeron, Katz, Saunders, & Tebes, 2007). Without intervention, the cycle is often self-exacerbating rather than self-correcting.

Conversely, parental substance abuse does not constitute child maltreatment; many families with SUDs avoid child maltreatment or CPS involvement (Scannapieco & Connell-Carrick, 2007; Smith & Testa, 2002; Street, Whitlingum, Gibson, Cairns, & Ellis, 2008). Because families with SUDs most often neglect, rather than abuse their children, this absence of adequate parenting and the presence of child neglect may be under-

recognized (McSherry, 2007). Chronic child neglect is associated with substantial risks for impairments in self-regulation, development, and learning (Perry, 2002; Wilson & Horner, 2005).

Thus the true association between parental SUDs and child maltreatment is yet undefined. For families with both parental SUDs and substantiated CA/N, family problems and child risks are further compounded by poverty, domestic violence, mental health issues, social isolation, head injuries, poor parental capacity, and criminality (Ellerbe et al., 2011; Scannapieco & Connell-Carrick, 2007). Neglected children with parental SUDs experience more exposure to traumatic events (Sprang, Clark, & Staton-Tindall, 2010). The time frames defined by the Adoption and Safe Families Act (ASFA; U.S. Department of Health and Human Services [DHHS], 1998)—allowing families with children who have been removed and placed in foster care 15 out of 22 months to recover or face terminating parent rights—underestimate the strength of addiction, the complexity of family needs, and the time needed for recovery and learning sober parenting (Herring, 2000). Maltreated children of substance-abusing parents often remain in state custody longer and experience poorer outcomes than other children (GAO, 2003).

The introduction of ASFA has fortunately coincided with CPS-involved mothers entering substance abuse treatment more quickly and with more collaboration among the courts, child welfare, and substance abuse providers (Green, Rockhill, & Furrer, 2006). Unfortunately, Green et al. (2006) found that the rates of favorable discharge from any single treatment modality remained at 54–56% before and after ASFA implementation. Ryan, Marsh, Testa, and Louderman (2006) found that recovery coaches assisted parents with children in state custody access SUDs treatment more often and quickly, and the coaches also helped the parents reunify with their children. Integrated programs between CPS and SUDs treatment providers that embed strategies with evidence of effectiveness such as motivational interviewing, use of re-

covery coaches and peer or family mentors, colocation of services, and family drug court practices are producing more potent service delivery models with improved outcomes (Boles, Young, Moore & DiPirro-Beard, 2007; Cohen & Canan, 2006; Coll, Stewart, Morse, & Moe, 2010; Green, Furrer, Worcel, Burrus, & Finigan, 2007; Gregoire & Schultz, 2001; Huebner, Willauer, Brock, & Coleman, 2010; Lee, Esaki, & Greene, 2009; Marsh & Cao, 2005; Oliveros & Kaufman, 2011; Twomey, Miller-Loncar, Hinkley, & Lester, 2010).

## Sobriety Treatment and Recovery Teams

### Overview of Program

The Sobriety Treatment and Recovery Teams (START) program was initiated in a Midwestern state in 2006 in response to compelling statistics that showed, for example, that nearly 90% of children three years or younger in state custody were at risk for child safety because of parental substance abuse. The number of infants entering state custody whose primary reason for placement was parental substance abuse increased 12% within 10 years. A comprehensive evaluation of the state's service array (results available from this article's first author) in 2005 identified treatment services for trauma and SUDs among adults and adolescents as the highest need in the state, but with the least available services. To address these concerns, the state child welfare agency began an annual allocation of funds to support the START program. To lead the effort, the second and third authors were employed in CPS and behavioral health.

Historically, START developed in Ohio (Annie E. Casey Foundation, 2002; Young & Gardner, 2002) to foster integrative service delivery between CPS and SUDs treatment providers. START uses mutually-agreed upon tenets; contract expectations; cross-training and joint-training; intensive, monthly, direct-line meetings to deal with issues; and frequent communication about family needs and progress. Because START originated in an urban setting, serving families with at least one drug-exposed infant, START strategies were adapted in the present study's state to meet community needs, older children (families with children  $\leq 3$  years at report), and state statutes and policies.

Currently, START operates in two urban, one rural, and one Appalachian counties; non-START workers in the same offices also serve these counties. The four counties have a diverse profile with the percentage of children living in poverty varying from 58% in the Appalachian county to 15% in one urban county. Program evaluation was intended to guide START implementation by monitoring program fidelity with frequent feedback and program adjustments and to test the impact of START on outcomes. The present study is an evaluation of the impact of START rather than a cross-site comparison. Data

on program implementation are used in this study to describe the program and demonstrate the fidelity monitoring of START strategies.

### CPS START Strategies

Each START team includes a specially trained CPS social service worker paired with a family mentor. Family mentors are individuals with at least 3 years of sustained sobriety and experiences that sensitize them to CA/N. Family mentors escort parents to meet with treatment providers; guide them into recovery supports; and use their special knowledge to coach the parent on relapse prevention, sober parenting, and daily living. They bring a unique perspective to the CPS office that has influenced practice overall and changed the office culture (Huebner et al., 2010). During the typical 14.2 months that a START case is opened, family mentors spend an average of 52 hours in direct contact with family members, meeting with each family an average of six times per month, with more frequent contacts early in the intervention.

Cases accepted to START begin services within an average of 10 days from the initial report to CPS, to capitalize on the crisis that a CA/N investigation precipitates. Within 1–2 days of the referral, the START program is initiated with a family team meeting (FTM) that includes the family and relatives, the CPS investigative worker, the START team, and the SUDs treatment coordinator. At the initial FTM, all participants share in decision making to develop a plan to keep children safe, begin the substance abuse assessment process, explore family strengths and needs, and identify sources for meeting family basic needs. Ongoing coordinated case management occurs weekly with the START supervisor and SUDs treatment coordinator. CPS practice by the START team includes frequent in-home services and visits to parents and caretakers. Whenever possible, children are retained in the home by using intense wrap-around supports, family preservation strategies, and creative approaches to parental supervision by relatives. When children are placed in state custody or with relatives, parents have frequent visitation and structured training to promote attachment and develop parental capacity.

Fathers, including stepfathers and unmarried partners, are actively included in the program in contrast to typical CPS practice (Huebner, White, Hartwig, Werner, & Shewa, 2008). To engage fathers, the START team and SUDs treatment providers persist in finding and inviting fathers to participate, involve them in decisions, and provide treatment. Fathers or paternal relatives are considered as possible safe placements for children or sources of natural family supports. In families struggling with poverty, mothers are 4 times more likely to engage in substance abuse if the male partner has SUDs (McLanahan et al., 2003); consequently, START teams believe that an engaged father who could become a sober support in the family is an important part of the solution.

Parents (mothers and fathers) are provided a range of services to assist them in achieving sobriety, health, and self-sufficiency. Services received include domestic violence service (20%), legal assistance (50%), medical care (67%), academic or educational supports (42%), transportation (68%), child care (50%), or specialized parenting program (44%).

### **Substance Abuse Treatment Strategies**

Each START site is served by a regional community mental health center (CMHC) that configures treatment services differently, but provides START clients with access to a full continuum of care. Each client is assessed for a treatment level of care; 70% of all START clients are served in intensive outpatient treatment (IOP) at some point. A total of 23% of clients received one treatment modality (such as IOP or detoxification); 28% received two modalities; 18% received three modalities; and the remaining 30% received four or more treatment modalities. Only 30% of START parents required residential treatment. Most parents received some form of individual or family mental health counseling.

An essential expectation of the CMHC is that they offer quick access to assessment and treatment services for both mothers and fathers; 21% are assessed the same day as referral, 57% of all parents are assessed within two days, and 90% are assessed within 8 calendar days of referral. Once assessed, 50% of START parents (mothers sooner than fathers) begin active treatment sessions within 4–5 days.

IOP services are delivered using gender-specific services, trauma-informed care, and treatment for co-occurring disorders. Each CMHC has adopted one or more evidence-based practice for delivering treatment including, for example, motivational interviewing (Miller & Rollnick, 2002), the Matrix Model program (Rawson, Obert, McCann, & Ling, 2005), or Seeking Safety therapy (Najavits, 2002).

Treatment providers also administer random drug screens and share the results with CPS and the courts. All clients provide informed consent to release specific information between agencies. Although each START site collaborates with county judges and attorneys to develop court processes to complement the model, no consistent court practices are associated with the program as yet, and not all families have court involvement.

### **Methodology**

The present study was designed with comparison groups to examine impact in a contextual multivariate approach (GAO, 2009; Ripple & Zigler, 2003). This evaluation is a naturalistic study implemented using the practitioner–research partnership model, in which providers of services are actively engaged in the design, implementa-

tion, and interpretation of results (Hess & Mullen, 1995). All procedures for the study were approved through the state’s legal and research board.

### **Purpose**

The purpose of this outcome study was to test the impact of the START program on rates of parental sobriety and rates of child placement in state custody (foster or residential care). The specific research questions were:

1. Do parents served by START achieve higher rates of sobriety than similar clients served in treatment as usual?
2. Is the risk for child safety and placement in state custody equal between the START-served and non-START comparison groups?
3. Are children of families served in START more or less likely to enter state custody?
4. What, if any, are the cost offsets of START?

### **Sample**

The study sample included 322 families, 531 adults, and 451 children served by START. To assess rates of sobriety at case closure, 239 adults from 149 closed cases were studied. The children were on average 2.7 years old, with 47% being infants under 1 year of age at referral. Of the families, 70% included at least one male and one female, but only 23% were a married couple; 63% of fathers and 65% of mothers had never been married. Among parents, 22% were African American and 78% were White, with a few being Hispanic.

The median age of the fathers was 28 years old and 58% had at least a 12th-grade education. Among the men, 76% were birth fathers, with 5% being adopted or presumed fathers, and 19% were unmarried partners; 57% were employed full- or part-time at referral and 43% were unemployed. Data on 59 fathers from the Targeted Assessment Program (TAP; Ellerbe et al., 2011) showed that 14% reported having been in foster care, 22% reported childhood neglect, and 19% reported childhood physical abuse. As adults, 40% reported being in a serious accident, 43% reported having been beaten, and 7% reported being raped.

The median age of mothers was 25 years old and 58% had at least a 12th-grade education. All mothers were birth mothers, with 26% employed full or part time at referral and 74% unemployed. TAP (Ellerbe et al., 2011) data on 138 mothers showed that 15% reported having been in foster care, 38% reported childhood neglect, and 25% reported childhood physical abuse. As adults, 24% reported being in a serious accident, 42% reported having been beaten, and 37% reported being raped.

Of mothers and fathers, 85% were poly-substance users, with the following rates of usage: 53% marijuana, 45% opiates, 40% crack/cocaine, 31% benzodiazepines, 5%

methamphetamines, 22% a variety of other substances; most also used alcohol. TAP data showed that they often began marijuana or alcohol use first at an average age of 14.8 years.

### **Measures**

Three data sets were used: START Information Network (START-IN), investigation, and OOHC (out-of-home care). START-IN was used to track the families, adults, and children in the program, as well as families who were referred but not accepted due to full caseloads. The monthly “adult progress rating” from START-IN was used in this study as a measure of adult sobriety. Each month, the START team recorded the results of drug tests and the number of support groups attended. Based on these indicators, progress on CPS treatment goals, and weekly reports from the treatment provider on attendance, the parent’s status was rated on one of six anchors: “Throughout this entire month, the adult was unable to be located,” “Getting worse,” “No progress on goals,” “Making or maintaining progress on one goal,” “Making or maintaining progress on two goals,” and “Making or maintaining progress on all goals.” For analysis, the first three ratings were collapsed to indicate “relapse,” and the last three ratings were defined as “sobriety.” At case closure, monthly ratings were used to determine the rate of sobriety achieved by parents in START to answer Research Question 1.

The investigative data set included state administrative data for all families, with substantiated reports of CA/N in the START counties during the study’s time frame. The CPS investigation that led to the START referral for both “accepted” and “not accepted” cases was tagged in this data set based on common identification numbers. A comparison group was created by matching START-served cases to other cases based on the presence of at least one child age 3 years or younger, the same time frame for the referral (within 2 months), a substantiated finding, overall risk rating on the continuous quality assessment (CQA; described in the next paragraph), the presence of substance abuse as a risk factor, and a report from the same county or adjacent county with the same judge (for the rural Appalachian site). The investigative data set was used to answer Research Question 2 on the equivalence of the three groups: START-served, START referred but not accepted, and matched comparison.

The investigation data set included the results of the CQA, completed by CPS workers during investigation of reports for possible CA/N. Safety and risks were evaluated on seven 5-point subscales with cumulative risk scores varying between “0 = no risk” to a high of “28 = extreme safety risk.” The CQA cumulative risk scores in this study had an alpha coefficient of 0.79. Investigative workers also identified risk factors from a checklist of conditions as being present or absent in the case. The checklist of

risk factors had a Kuder-Richardson statistic (KR-20) of 0.866. State research supports the validity of the CQA, with higher risk scores predicting recurrence and entry to OOHC (available from first author of this article).

Data on placement in state custody for all children identified in the START-served and two comparison groups (referred but not accepted and matched) were extracted from the state’s child welfare data system. The resulting OOHC data set included all episodes of placement in state custody (including dates of placement and reasons for entry and exit). Because of careful attention to data quality and monthly cleanup and monitoring, a 100% match was achieved with the investigative data set for all START-IN cases and for cases in the OOHC data set. This data set was used to answer Research Question 3 on the rates of placement in state custody.

### **Data Collection Procedures and Analysis**

START leadership and staff began developing the program evaluation plan and data collection procedures before accepting their first client and embedded the data collection into START-IN’s Web-based system to implement the plan. The system is simple and user friendly; most of the data elements are dates, checklists, or rating scales with little narrative entry. START workers and mentors were trained on each data element, received frequent feedback about data quality from the first author, could download their own data to examine completeness or identify trends, and they frequently saw the data presented in meetings. START-IN data were checked against administrative data to confirm the CPS report date and identification numbers; data were cleaned monthly, resulting in very high quality with virtually no missing data.

Data analysis consisted of descriptive and group comparative statistics, including chi-square tests with categorical variables (e.g., group membership and gender) or one-way ANOVA tests with group and continuous dependent variables to test the significance of group differences. Statistical significance was set at or below the .05 level.

## **Results**

### **Rates of Sobriety for START-Served Families**

The adult rating of “sobriety” at case closure was used to identify parents who had or had not achieved sobriety. Among the 93 men and 146 women in closed cases, 40% of the men and 66% of the women achieved sobriety. Comparatively, the rate of “favorable discharge” from one treatment modality (any modality) for similar adults (referred from CPS and welfare services) in the state’s Treatment Episode Data Set (TEDS; DHHS, 2009) in CY 2010 was 37% for men and 37% for women. Thus, the rate of achieving sobriety for mothers in this study was 1.8 times higher than expected from TEDS data and higher than the 54–56% figures cited by Green et al. (2006). Although the

measure from TEDS is the best comparison available, it is not directly comparable to the START measure because it is based on whether or not the individual completed or was transferred from any substance abuse service. In the current TEDS data, it cannot be determined which adults were referred by CPS and which were referred by Temporary Assistance for Needy Families (TANF). The START measure of sobriety is more comprehensive, as it includes the results of multiple measures including progress on CPS and SUDs treatment goals.

Conversely, 37% of fathers and 16% of mothers had “fled” for at least one full month at case closure. *Fleeing*, defined as being rated “unable to locate for the entire month,” was common; 51% of fathers and 26% of mothers fled for at least one month during the START program, with 10 fleeing parents (of 89) returning to achieve sobriety in the program. The remaining 18% of mothers and 23% of fathers did not achieve sobriety at case closure, and some remained in treatment.

**Equality of Risk for START-Served and Comparison Groups**

The equality of the START-served (*n* = 322 families), matched comparison (*n* = 150 families), and referred but not accepted groups (*n* = 367 families) was tested using comparison statistics and the investigation data set. There were no significant differences between groups on the cumulative risk ratings found in the investigation. On the CPS report tagged in the investigative data set, the average cumulative risk rating was 19.3 (on a 0–28 scale), falling into the top 10% of all CPS reports in the very-high-risk category. Every case in every group included at least one child age 3 years and younger. The three groups had equal risks to child safety from mental health issues (~40%), parental criminal history (~75%), and domestic violence (~55%). The START intervention group was significantly more likely to have risks to child safety from poverty (80% vs. 75% for the other two groups). Thus, the groups were equivalent on these measures, and all were high-risk cases.

**Rate of Children Entering State Custody**

Rates of placement in state custody were compared for children in all cases opened for at least one month using the OOHC data set for 451 START-served children, 544 children referred but not accepted, and 359 children in

matched cases. Children placed in state custody (regardless of duration) during the time the CPS case was opened included 93 START-served children (21%), 125 children referred but not accepted (23%), and 150 matched children (42%). Thus the rate of child placement into state custody among the START intervention group was half the rate of the matched comparison group, but similar to the rate in the referred but not served group. This unanticipated finding suggests that the practices of START (finding alternatives to child placement in state custody, such as relative supervised placements, relative supports, and efforts to gain quick access to SUDs treatment) were adopted by non-START CPS workers in the county. Workers who were familiar with START reported that they admired START practices, learned case management strategies from the START team and family mentors, and began reconsidering placing children in state custody as the first protective action. Conversely, among matched comparison cases that were never referred, the rate of child placement into state custody is consistent with the state’s typical placement rate for similar cases and twice the rate of START-served children.

**Cost-Offsets of START**

Based on a survival analysis (available from the first author) of the 2001 OOHC-entry cohort, the average duration of placement in state custody (foster or residential care) for children 3 years old or younger was calculated at 15.8 months (479.5 days). To estimate the cost of placement, the number of days was multiplied by the average federal (Title IV-E program) daily rate for children age 3 or younger (\$31.28) in January 2010, resulting in an estimate of \$15,000 per child. In addition to the daily rate, the cost of foster care includes the cost of social service workers. The average cost of a social service worker was calculated at \$120,000 per year (includes average salary and fringe benefits of the social worker, plus 1/6 of supervisor, 1/8 of other administrative supports, 1/20 of managers, 22% overhead, overtime costs, and mileage). This cost was divided by 24 for the estimated number of children served annually. Additional costs were added for staff to recruit, train, and support foster parents; travel and training costs for staff were also calculated. The total cost, then, of state custody placement was conservatively estimated to be \$30,000 per child 3 years or younger (older children are more expensive). The cost of the

**TABLE 1.** Cost Avoidance Analysis

Group	No. children in study	No. children if 41.8% entered state custody	Actual no. children entering state custody	No. children diverted from state custody placement	Cost avoidance at estimated \$30,000/child
START <sup>a</sup>	451	189	93	96	\$2,880,000
Referred, not accepted	544	227	125	102	\$3,060,000
Total	995	416	218	198	\$5,940,000

Note. The cost of the START program, excluding the first year initiation costs, was \$2,676,188. <sup>a</sup> START = Sobriety Treatment and Recovery Teams.

START program, excluding the first-year initiation costs, was \$2,676,188 (Kentucky Division of Finance Management, personal communication, November 30, 2010). Table 1 displays the cost avoidance analysis.

As shown in Table 1, the cost avoidance for START-served children exceeded the cost of the program; for every \$1 spent on START, the state avoided \$1.07 in OOHC costs alone. When the children referred but not accepted were included in the cost-avoidance estimates because of the suspected spread of START practices, for every \$1 spent on START, the state avoided \$2.22 in OOHC costs.

## Discussion

This program evaluation of START outcomes considered family risks, parental sobriety rates, child placement in state custody, and cost avoidance—the results of which are important to public child welfare and SUDs treatment providers. Fidelity to the START model improved over time, with faster access time to treatment, timeliness of referral, more frequent family mentor contacts, and increased use of services and evidence-based practices. As the START program continues to evolve, we anticipate improved outcomes.

The parents served were in their 20s, were poor and unemployed, and had high rates of trauma and substance use spanning an average of 10 years. Nearly half of the children served were infants. The results show that many families, despite numerous challenges, achieved sobriety and retained custody of their children with a structured and integrated treatment model. Mothers in START achieved nearly twice the rates of “favorable outcome,” compared to similar women in the state. Fathers achieved sobriety rates much lower than mothers, suggesting that a more potent intervention is needed for fathers. The START team is intending to introduce evidence-based treatments targeted toward men. Comparing rates of sobriety is problematic because published rates of sobriety vary by study design and population. Rates of sobriety also vary over time, and those who achieve long-term recovery often cycle through recovery and relapse before stabilizing (White, 2008). To date, four families with closed cases have returned for additional START services. Families will be followed long term. Although 322 families received intensive START services, an additional 8,200 CPS parents in the state were estimated to be in need of services during CY 2010 based on having substantiated CA/N and substance abuse risks. This is an important and large population, with significant risks to child development, which warrants attention and the testing of integrated and innovated approaches to intervention.

Children receiving START services entered state custody at half the rate expected. The program is cost-effective based on foster care costs alone without considering other cost benefits that may result from parental employ-

ment, diminished criminal activity, and improved health outcomes (Harwood et al., 2002), which were beyond the scope of this study but should be included in future studies.

The practices of START seem to have generalized to other CPS teams. This is not surprising given that social workers in the same offices often share ideas and resources; we view this as a positive outcome. The family mentors, although initially viewed with skepticism by non-START workers, are now viewed as allies and experts; non-START workers consult with them for advice and education. On the other hand, this spread of practices could be viewed as “contamination” of the program evaluation and illustrates one of the difficulties in doing randomized control or working with an “unable to serve” group within the same office.

Uniquely, the present evaluation paired provider-collected data with administrative data sets that verified placement in state custody, identified family risk, and supported the matching of comparison groups. The merged data sets were used to test the impact of service delivery as recommended by Fluke, Edwards, Kutzler, Kuna, and Tooman (2000). These data sets can also support studies of subgroups of the served population, for example, fathers, families with infants, or urban versus rural sites, which were beyond the scope of the present study. As the sample size for START-served families increases, future studies will examine the impact of specific strategies, such as quick access to treatment, serving fathers, and the role of the family mentor on outcomes. Although the use of merged data sets is more time-consuming for the program evaluator, it is much more efficient and tolerable for practitioners who may resist redundant data entry. The use of merged data sets was an effective and informative method for this study.

## Limitations

The study design does not support causal conclusions. That is, there are multiple factors that may contribute to diverting children from state custody. For example, families receiving START services may be different from other families in their motivation for services, which was not measured in this study. With the intervention of START teams, courts may be more willing to retain children at home when providers are frequently in the home. Relatives may be more willing to care for children if parents are showing success in treatment, and they receive support from the CPS START team and providers.

Comparative group sample sizes, although unequal, were large enough to be robust to group size differences (Pedhazur & Schmelkin, 1991). This study is a point-in-time examination of START results that will be enriched by subsequent long-term follow-up. The definitions of some variables used in this study, although defined in CPS policy and training, are still somewhat ambiguous (e.g., risks due to income issues); future research will ben-

efit from improved definitional clarity as suggested by Feerick and Snow (2006).

## Conclusion

Despite limitations, this study examined important outcomes among a highly vulnerable group of families and children. START is a promising practice. A manual to guide implementation of START is in production, with the intent of providing direction and information for implementing specific strategies (e.g., family mentors) or the entire START model and supporting continued testing and replication of this study at other sites.

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