Ohio START (Sobriety, Treatment and Reducing Trauma) is an evidence-informed children services-led intervention model that helps public children services agencies (PCSAs) bring together caseworkers, behavioral health providers, and family peer mentors into teams dedicated to helping families struggling with co-occurring child maltreatment and substance use disorder. Ohio START is based on strategies of the Sobriety, Treatment and Recovery Teams (START) model that began operation in Cuyahoga County (Cleveland) in 1997 and was adapted by the state of Kentucky in 2006.

This *Ohio START Practice Manual* documents program background and logistics and is designed to help current and future Ohio START teams with implementation and education of current and future staff. This document complements, but does not replace, the *Sobriety Treatment and Recovery Team (START) Model Implementation Manual* that covers the specifics of implementation, a full explanation of strategies, and program theory and evaluation design of the national START model. Information on access to the *START Model Implementation Manual* and required technical assistance is obtained through the Child and Family Futures at [https://www.cffutures.org/](https://www.cffutures.org/).
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CHAPTER 1: OHIO START BACKGROUND

Overview

A report by the Public Children's Services Association of Ohio (PCSAO) found that half of children taken into custody in 2015 had parental drug use identified at the time of removal, and 28 percent of children removed that year had parents who used prescription opiates, heroin and/or fentanyl. On July 1, 2013, 12,654 children were in agency custody. Five years later in July 2018, the number nearly surpassed 16,000. The opioid epidemic is considered largely responsible for this 28 percent increase of children in custody. These increases challenge the fiscal, personnel, and foster home resources of the state, resulting in a devastating impact on the system.

Children of parents with substance use disorders have a higher likelihood of entering the foster care system and experiencing trauma due to their parents' drug abuse. Many have witnessed their parents injecting drugs, overdosing, experiencing withdrawal, and even death. As a result, these children may have significant trauma that also leaves them more vulnerable to mental and behavioral health issues and further trauma later in life. To address their mental health needs, significant and ongoing therapeutic interventions and treatment foster care placements are sometimes required. Ohio START was piloted as a response to the opioid crisis but serves families affected by all types of substance use disorders.

The Ohio Sobriety, Treatment and Reducing Trauma (START) Model is an adaptation of the national Sobriety, Treatment and Recovery Teams (START) Model, an evidence-informed child welfare led intervention for families that has been shown, when implemented with fidelity, to improve outcomes for both parents and children affected by child maltreatment and parental substance use disorders. Sobriety, Treatment and Recovery Teams (START) began operation in Cuyahoga County, Cleveland, Ohio in March 1997, and was replicated in Kentucky in the spring of 2006. The START program in Kentucky resulted in about half as many children returning to foster care due to parental addiction. Parents involved in the Kentucky program were also found to have twice the sobriety rate. Kentucky START has been rated as “Promising Research Evidence” on the California Evidence-Based Clearinghouse for Child Welfare.

1 Summarized from: http://www.pcsao.org/programs/opiate-epidemic
The national START model is specifically designed to transform the system-of-care within and between child welfare agencies and behavioral health providers; it also engages the judicial system and other family serving agencies. The broad goals of both models are to keep children safely with their parents whenever possible and to promote parental recovery and capacity to care for their children. The overall goal of this program is to stabilize families harmed by parental drug use so that both children and their parents can recover and move forward with abuse-free and addiction-free lives. Ohio START integrates community partners to ensure the seamless provision of wraparound services.

Ohio START is being led by the Public Children Services Association of Ohio in partnership with the Office of Ohio Governor Mike DeWine, the Ohio Department of Job and Family Services, the Ohio Department of Mental Health and Addiction Services and the Ohio Attorney General’s Office. Ohio START implementation funding has been provided by a Victims of Crime Act (VOCA) grant from the Ohio Attorney General’s Office and a State Opioid Response (SOR) grant from OMHAS. In addition, Casey Family Programs, United Healthcare, PhRMA and HealthPath Foundation of Ohio have provided generous grants to support the program. OMHAS has dedicated CURES funding through the Institute for Human Services to support the training program and technical assistance led by Children and Family Futures. The effectiveness of Ohio START is being studied by The Ohio State University’s College of Social Work and the Voinovich School of Leadership and Public Affairs at Ohio University.

Ohio County Public Children Service Agencies (PCSAs) dedicate program funding to support the needs of children who have been victimized due to parental substance use and provide them with specialized treatment, such as intensive trauma counseling, for any resulting behavioral or emotional trauma. The program also funds victim services for parents with underlying victimization that may be contributing to their addiction. Parents of children referred to the program receive substance use disorder treatment with the goal of assisting parents on a path to recovery from addiction.
The Ohio START program was piloted in 2017 in 17 counties in southern Ohio, expanded in 2018 to 15 additional counties and continued to expand in 2019 with 14 more counties. START now operates in 46 counties across the state and will be continuing to expand to more counties in the coming years. Current participating counties include: Allen, Ashland, Ashtabula, Athens, Auglaize, Brown, Butler, Carroll, Clinton, Cuyahoga, Delaware, Erie, Fairfield, Fayette, Franklin, Gallia, Hardin, Hamilton, Harrison, Highland, Hocking, Jackson, Lorain, Lawrence, Licking, Lucas, Mahoning, Medina, Meigs, Mercer, Morrow, Ottawa, Pickaway, Portage, Richland, Ross, Seneca, Stark, Summit, Trumbull, Tuscarawas, Union, Vinton, Warren, Wayne, and Williams.
Key Components of Ohio START

- Cross-system collaboration with county public children services agencies (PCSA), behavioral health providers, courts, and other community partners, dedicated to building community capacity and making Ohio START work;
- Family-centered approach that fosters integrated systems-of-care between the PCSA, behavioral health providers and the courts by addressing differences in professional perspectives;
- Shared decision-making among all team players, including the family;
- Early family identification, engagement and intervention upon receipt of the referral to the PCSA;
- Quick access to quality SUD treatment and frequent, intense and coordinated service delivery;
- A holistic assessment for all parents, addressing substance use, mental health, and trauma;
- A specialized caseworker and family peer mentor dyad serve families with co-occurring substance use and child maltreatment;
- The family peer mentor brings real-life experience to the team and is a person in long term recovery with previous children services involvement. Family peer mentors are rigorously screened, trained and supervised to provide Ohio START families with both recovery coaching and help navigating the PCSA system;
- Capped caseloads for the START team to allow the worker/mentor dyads to support more intensive intervention;
- Sober parenting supports that include assistance with meeting basic needs such as housing, transportation, childcare and in-home services;
- Child-focused services to promote attachment, reduce the effects of trauma, and provide developmental supports;
- Evaluation to create a learning culture and identify opportunities to improve fidelity and family-centered outcomes.

Ohio START Objectives

- Reduce the number of children being placed in out of home care and the recurrence of child abuse/neglect;
- Provide comprehensive support services to children and families;
- Provide quick and timely access to substance use disorder treatment, and;
- Build protective parenting capacities.
Seven Effective Strategies Initiated Across Ohio START Sites

The practices of Ohio START align with the seven strategies shown to be effective for families affected by parental substance use disorders and child maltreatment. All Ohio START sites are initiating practices that align with the seven strategies listed here and illustrated with Ohio START practices:

1. **A system of identifying families affected by substance use disorders.**
   Ohio START: Screening, of children and parents for trauma, and parents for substance use during intake and investigation or assessment.

2. **Timely access to assessment and treatment services.**
   Ohio START: Establish Memorandum of Understanding (MOU) or other formalized agreements with behavioral health treatment providers.

3. **Increased management of recovery services and compliance with treatment.**
   Ohio START: Employ family peer mentors, persons in sustained recovery from addiction, in each county site. Family peer mentors and caseworkers have increased contact with the family compared to a typical child welfare case.

4. **Focus on family centered services and parent-child relationships.**
   Ohio START: Implement family team meetings and shared decision-making practices. Provide treatment services for both parents and children.

5. **Increased administrative and judicial oversight.**
   Ohio START: Use START service delivery practices specified in guides such as the activities, timeframes, and minimum work guidelines for increased intensity of contacts.

6. **Cross-system response for participants — contingency management.**
   Ohio START: Use START case management practices including response to relapse.

7. **Collaborative approach across service systems and court.**
   Ohio START: Establish a governance structure at the state and at each local site that includes a collaborative cross-agency team.
Ohio START Case Flow Description

Each Ohio START case follows a timeline in order to implement the model to fidelity. Timelines are put in place in order to get wraparound, priority behavioral health treatment, a key component to the program. A diagram of the Ohio START timeline can be found in the Appendix (pg. 39). Below are descriptions on each step throughout the process:

**Child Abuse/Neglect Report Screened in by Local Public Children Services Agency (PCSA)**

- Day 1 of the Ohio START timeline is when the PCSA screens in the report for an assessment/investigation.

**Family Eligibility for Ohio START Decision (UNCOPE)**

- During the subsequent safety check, the county PCSAs will use the UNCOPE to identify caregiver substance abuse.
- The children involved with this program must have at least one parent that has substance use disorder (SUD) and has mistreated the child. The child and the family will be identified by the PCSAs through the screening and assessment process.
- The goal for identification and referral of families to START is from 24 hours up to 14 days or less of PCSA screening in the CA/N report.
- This includes families where the child remains in the home, where the child is removed from the home, and those referred to alternative response.
- **NOTE:** If parent(s) is in out-of-area SUD residential treatment, please refer to the additional Supporting Information Timeline & Case Flow Description for guidance.

**Ohio START Caseworker Obtains Release of Information from Parents**

- The family will be offered to participate in Ohio START and if they accept, they will sign the appropriate release of information.

**Schedule & Conduct Initial Shared Decision-Making Meeting (SDMM)**

- The initial shared decision-making meeting, also known as the “safety meeting” or “initial family team meeting”, will occur within 4 days of the referral to and acceptance into the START program.
- The purpose of this meeting is collaborative development of the safety and service plans, keeping children in the home when safely possible.
- The PCSA caseworker will schedule an initial SDMM meeting with the family. The meeting should include the START PCSA caseworker, family peer mentor (FPM), and, if possible, treatment provider(s), and any other identified informal (i.e. family supports) and formal (i.e. community partners) supports.
During this meeting, the Ohio START caseworker, FPM, and treatment provider(s) will meet the parent(s). The Ohio START supervisor may attend the meeting with the caseworker. The Ohio START program should be explained to the family, along with the different roles of the PCSA caseworker and FPM. Staff should engage the family in participating in a SUD/mental health (MH) assessment and the importance of following through with the recommendations regarding treatment. Any concerns/barriers (i.e. transportation, childcare, legal assistance, etc.) to accessing the SUD/MH assessment and/or treatment should be discussed and a plan created to overcome them.

**Weekly Face-to-Face Home Visits**

- Families will receive intensive case management services with the case worker/family peer mentor dyad. The family will have weekly face-to-face visits from each for the first 60 days of the case.
- First home visit must be within one week of the initial shared decision-making meeting.
- For weekly face-to-face home visits, visits will occur by the caseworker and FPM; however, visitations of the dyad may differ by county (e.g. FPM and caseworker go on weekly visits together and FPM may go on additional visits alone or the caseworker and FPM conduct their required weekly visits separately but will go out together if needed). This may be decided at the county level and for each family. For purposes of fidelity to Ohio START:
  - Minimum of first visit must be caseworker and FPM together;
  - It is recommended that the caseworker and FPM continue to visit together, as needed, to establish roles and relationships;
  - Caseworker and FPM will both be expected to make weekly visits either together or separate;
  - Caseworkers and FPM will work together in terms of scheduling visits and
  - Caseworkers and FPM use a team approach with the family, whether visits are made together or separately.
- After 60 days, a minimum of twice per month (biweekly) face-to-face contact with parent(s).
  - **NOTE:** After 60 days, please refer to the Supporting Information Timeline & Case Flow Description document for additional guidance.
Chapter 1: Background

**Treatment Provider Meets with Parent(s) to do SUD/MH Assessment & Complete ACE Screening**

- If the UNCOPE screen resulted in targeted referral for the parent(s) for further assessment, this referral should be made within 4 days of the SDMM.
- The behavioral health provider will complete a comprehensive SUD/MH Assessment with the parent(s) and administer the adult trauma screen (ACE) as agreed to in the MOU between the agencies.
- Family peer mentor may accompany and assist the parent(s) with transportation to the initial behavioral health assessment. Please Note: VOCA funds cannot be used to pay for transportation to treatment sessions.

**Assessor Gives Verbal Treatment Recommendations to Parent & PCSA-Referral Made to Treatment**

- The behavioral health assessor will give verbal treatment recommendations to the parent(s) and the PCSA within 1 day of assessment and written treatment recommendations provided to the PCSA within 5 days of assessment.
- Recommendations are based on American Society of Addiction Medicine (ASAM) Patient Placement Criteria and include treatment as needed for SUDs, MH, and trauma. The parent(s) will be referred for treatment within 1 day of the SUD/MH assessment.

**Parent Begins Intensive SUD Treatment**

- Within 3 days of the SUD/MH assessment, the parent(s) begin intensive treatment at an appropriate level of care. Intensive in Ohio START is defined as at least two sessions per week for the first two weeks, which is inherent in treatment level 2.0 or higher. For level 1.0 or less, treatment intensity may decline after the first two weeks if the need for continued or increased intensity is not noted.
- Quick access to SUD treatment is priority, but parents with co-occurring mental health/trauma issues should receive concurrent treatment when possible.

**Parent in Intensive SUD Treatment**

- The parent(s) should receive 4 treatment sessions within the first 12 days of treatment. The FPM should transport the parent(s) to the first 4 treatment sessions to help with treatment engagement. Please Note: VOCA funds cannot be used to pay for transportation to treatment sessions. If the parent(s) does not want to be or cannot be transported by the FPM, the FPM should accompany the parent(s) to the treatment session or meet the parent(s) at the treatment facility to do a warm handoff and support the parent(s) as they begin treatment.
FTM: 38 Days After CA/N report screened in by PCSA

- FTMs should include, PCSAs, FPM, BH provider, and family, will be held at critical points within the case plan to align treatment and case plan such as:
  - Within 38 days of CA/N report screened in by PCSA
  - 3, 6, and 9 months into the case
  - Child safety concern/possible removal
  - At relapse
  - When crises occur
  - When treatment recommendations change
  - Within 30 days prior to case closure.

*Note:* Please refer to Supporting Information to Timeline Narrative & Case Flow Description regarding ongoing communication, support services, case closure and discharge from START.

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Ohio Sobriety Treatment and Reducing Trauma (START) Supporting Information to Timeline Narrative & Case Flow Description

**Participation in Ohio START if parent is in residential treatment, particularly if treatment is far away:**

- Family will be eligible to participate in Ohio START if parent(s) enter residential treatment if the UNCOPE screen is conducted and the family agrees to participate in Ohio START prior to leaving for the residential treatment program.
- While the parent(s) are in the residential treatment program, the Ohio START team should engage with parent(s) as much as possible. This includes attending team meetings at the residential facility, meeting or having phone calls with parents(s) and coming up with a plan for parents(s) upon discharge, including establishing local supports upon return to the community for transition and a safety net.
- The required START activities (e.g. trauma screen, weekly visits for the first 60 days etc.) will begin upon parent(s) discharge from the residential treatment program.
- For parents(s) with short term jail sentences, the same protocol will apply.

**After 60 Days of Ohio START Case Initiation:**

- After 60 days, a minimum of twice per month (biweekly) face-to-face contact with parent(s), one of these biweekly contacts per month will occur in the home with the parent(s).
- Family peer mentor to visit children in foster care or relative placement with the case worker at least quarterly. Monthly is preferred when possible.
- The team will refer parents/families to parenting supports to address parenting in recovery, bonding between parents and children, and parenting skills.
Children’s Trauma Assessment Center (CTAC) Trauma Screen:

- A trauma screen for the child(ren) will be administered within the first 30 days of referral to Ohio START.
- The PCSA will also ensure that children are screened for developmental and social-emotional delays, and are linked with needed services, with a special emphasis on referrals to trauma-informed services and supports for the child.
- The children services caseworker will conduct the child trauma screen CTAC and refer for further assessment to the behavioral health provider, as appropriate.

Ongoing Communications Will Include:

- Written weekly reports of treatment attendance/progress, as appropriate,
- Monthly direct line and teaming meetings, and
- Monthly case reviews.

Case Closure:

- In order to complete the Ohio START program, parent(s) must demonstrate sobriety, as proven through random drug screens. It is recommended that they have maintained sobriety for at least six months.
- **Discharge from Ohio START program prior to successful case closure if family is not participating in Ohio START.**
  o After 30 days of missed contacts with the Ohio START program, the agency should hold a family team meeting with all interested parties and discuss the attempts to engage the family and the plan for the case moving forward. The team can decide to leave the case in START to continue to try to engage family or the team can decide to transfer to another caseworker and end the family’s participation in START. This will be individualized on a case by case basis and may depend on capacity to serve families in START.
CHAPTER 2: SYSTEM OF IDENTIFYING FAMILIES AFFECTED BY SUBSTANCE USE DISORDERS AND TRAUMA

Overview

Strategy Definition: This strategy refers to procedures for identifying families with potential substance use disorders during the Child Protective Services (CPS) intake/referral triage and during the investigation or assessment phase of the CPS response to allegations of child abuse/neglect. This strategy also includes improving the knowledge base and expertise of child welfare staff in understanding, identifying, and responding to parental substance use. Ohio START counties screen parents for substance use disorder and screen both parents and children for trauma.

Purpose: Early identification of parental substance use as a risk factor for child safety facilitates more rapid access to parental assessment and treatment. Identification of traumatic experiences in the parent and child also help facilitate recovery and may help discover some of the underlying reasons for the substance use disorder in parents and behavior issues in children.

Ohio START Practices: Designated caseworkers screen all adult members of the family for substance use (fathers, mothers, and partners living in the home) using the UNCOPE screening tool, and, when appropriate, initiate a referral to a substance use disorder treatment professional for assessment of the parents’ need for treatment. Caseworkers also screen all members of the family, including children, for trauma. Workers use the ACE questionnaire for adults and the Child Trauma Assessment Center tool for children. The results of the screening should be communicated with child welfare staff assigned to the family, as well as with behavioral health providers. Screening of potential foster parents or relative caregivers should also be conducted as appropriate. Screens for both substance use and trauma should be administered to the family upon acceptance to Ohio START in order to begin treatment and recovery plans as soon as possible.
Parental Substance Use Screening Tool: UNCOPE

All cases in Ohio START are required to screen families for substance use using the UNCOPE. UNCOPE is an acronym with every letter standing for a different problematic behavior pertaining to substance use:

- Used drugs more than intended,
- Neglected responsibilities,
- Wanted or needed to cut back,
- Experienced objections to use by others,
- Preoccupied with drug use,
- Or used drugs to relieve emotional discomfort.

The UNCOPE is a self-report screening measure, meaning a caseworker will ask the parent these six behavioral questions and the parent reports back their own habits with substance use. The parent will either answer ‘yes’ or ‘no’ to these six questions, and if they answer ‘yes’ to two or more answers, it suggests possible substance use disorder. If a parent answers four or more questions with a ‘yes’ response, it strongly indicates a need for a substance use disorder assessment. The UNCOPE can be administered through direct questions or self-report paper/pencil responses. The UNCOPE has been shown to have adequate sensitivity and correlation to DSM (Diagnostic and Statistical Manual of Mental Disorders) criteria for substance use disorder.

To be eligible to participate in Ohio START, the participant must have a score of 3 or higher. If the threshold of 3 is not met, but there are other concerns, professional judgment may be used to make a referral to Ohio START. For example, because the UNCOPE is a self-reporting tool, some parents may not accurately describe their substance use, or a child may be born positive, but the mother indicates a score less than 3. In these cases, the worker would use their discretion on whether the family should be eligible for Ohio START. The results of the UNCOPE are then entered into the needs portal. An example UNCOPE can be found in the Appendix.

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Screening for Trauma in Parents and Children: ACE and CTAC

All Ohio START parents are required to complete the Adverse Childhood Experiences (ACE) Questionnaire. The ACE Questionnaire is a self-report measure of trauma during the first 18 years of life. There are 10 question items that are answered as ‘yes’ or ‘no’ and the sum of the yes ratings equals the number of traumatic experiences. If an Ohio START participant scores 4 or higher, there should be a targeted referral for further assessment, either as part of the substance use disorder assessment or a separate behavioral health assessment, depending on established local protocols. The measure stems from the national ACE Study, one of the largest ongoing investigations conducted on the links between childhood maltreatment and later life health and well-being⁵.

All children in the Ohio START program are assessed for trauma using either the Children’s Trauma Assessment Center (CTAC) Screening Checklist for ages 0-5 years or for ages 6-18 years⁶, which is administered by a child welfare caseworker. The measure has two domains: the first is a checklist of traumatic events or conditions that the child has been exposed to; the second is a checklist of behavior, moods, school problems, or attachment issues that suggest a response to trauma. Scores of 4 or more exposures to trauma events or conditions, or multiple behavioral indicators all suggest a need for further assessment by a behavioral health professional. This does not preclude that there may be a child that does not reach the threshold, if the overall child’s profile is of concern, this should direct the caseworker to refer for a further trauma assessment.

Examples of both the ACE and CTAC can be found in the Appendix.

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⁵ Information on this study at: https://www.cdc.gov/violenceprevention/acestudy/index.html
⁶ Henry, Black-Pond, & Richardson (2010), rev: 3/2016 Western Michigan University Southwest Michigan Children’s Trauma Assessment Center (CTAC)
Required Training for Screening of Substance Use and Trauma for START Team Members

**Screening and Intervention of Substance Use Disorders (UNCOPE and ACE)**

This in-person workshop was designed to assist workers with using evidence-based screening tools (UNCOPE) and (ACE), to interpret the results, provide feedback to the parent and offer recommendations to seek further assessment for treatment services. Participants also became familiar with the assessment process, DSM V criteria, treatment levels-of-care, Medication-Assisted Treatment and realistic expectations for aftercare, relapse and/or recovery.

**Child Trauma Screening (CTAC)**

The Southwest Michigan Children's Trauma Assessment Center (CTAC) developed a screening tool for children who have experienced trauma and adverse childhood experiences. With proper training, this tool supports appropriate triaging of services and/or referrals. This training assists workers with how to use the CTAC screening tool, interpret the results, provide feedback to the family and offer recommendations for further assessment for treatment services.

**Additional information regarding training can be found in Ch. 10 Training Guide**
CHAPTER 3: TIMELY ACCESS TO ASSESSMENT AND TREATMENT SERVICES

Overview

**Strategy Definition:** Timely access to treatment is defined by how quickly a person seeking treatment can gain access to treatment services. In the START model this refers to initiating behavioral health assessment and treatment services as quickly as possible following the Child Protective Services (CPS) referral/or report.

**Purpose:** Timely access to appropriate treatment is associated with better parent and child outcomes. When parental substance use is identified as a child risk factor, it is imperative to have prompt access to further assessments to determine the nature and extent of the substance use disorder and any mental health issues including exposure to trauma and domestic violence. The CPS report of suspected child neglect or abuse constitutes a crisis for parents and the family and, as a crisis, may greatly enhance their readiness to enter treatment. Timely access to parental treatment supports child safety.

**Ohio START Practices:** Service delivery and case management services begin as soon as a family is identified as needing services—even before the child welfare investigation is completed. In order to identify families early and get them into treatment as soon as possible, Ohio START uses the UNCOPE to determine if a client may have a substance use disorder. Families are then accepted into the program and are assessed by a behavioral health provider and subsequently matched to the appropriate level of behavioral health care in a timely manner. The behavioral health assessment specifies the severity of the substance use disorder, the intensity and structure of recommended parent treatment, the clinically appropriate modality, and any additional service needs. After assessment, the parent/s and children are supported as they participate in creating a plan to ensure that barriers are resolved, and family members can access treatment services. In order to ensure families have timely access to treatment services, the children services agency is recommended to enter into a Memorandum of Understanding (MOU) agreement with behavioral health providers. These formal MOU agreements are established to give families with children services involvement priority access to assessment and treatment based on a family-centered approach and so that substance use disorder treatment providers have enough

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information about families referred by children services to conduct high-quality assessments.

**Ohio START Timeline**

As a main strategy for the Ohio START program, timely access is paramount; therefore, an Ohio START specific timeline outlines the essential tasks and services that should occur within a certain amount of time. The timeline should be a goal each Ohio START team works toward and achieving this goal will take time and effort and is not expected to be fulfilled right away. The timeline also specifies how quickly services are delivered and is a major component of fidelity to the START model. Once the PCSA report is screened in for suspected child neglect or abuse, the following are expected to happen:

- The goal for identification and referral of families to START is from 24 hours up to 14 days or less of PCSA screening in the CA/N report. If the 14-day timeline is unable to be met, identification and referral must occur within 30 days of the report being screened in.
  - Parents are screened for substance use using the UNCOPE.
  - If the family meets the selection criteria, they are then referred to Ohio START.

- The first shared decision-making meeting (SDMM) with the family and the Ohio START team occurs within 4 business days of referral to Ohio START.

- The trauma screens should occur within the first 30 days of referral to Ohio START.

- Referral for targeted SUD/MH assessment should be made within 4 days of the SDMM and within 3 days of the SUD/MH assessment, parent should begin treatment

**A visual of the START timeline can be found in the appendix.**
CHAPTER 4: INCREASED MANAGEMENT OF RECOVERY SERVICES AND COMPLIANCE WITH TREATMENT

Overview

**Strategy Definition:** Recovery is defined as “the personal process of change in which Ohio residents strive to improve their health and wellness, resiliency, and reach their full potential through self-directed actions”, Ohio Administrative Code Section 5122-29-15(C). The term “recovery supports” refers to a range of treatment services, community resources, and people that are critical for helping a person with a substance use disorder establish a drug-free lifestyle and improve the economic and social well-being for themselves, their children and their families. Recovery supports may include, treatment services for a substance use disorder or trauma, community-based recovery support groups, housing, transportation or employment. The first step toward recovery for many persons with a substance use disorder is active participation and compliance in treatment services.

**Purpose:** Parents affected by substance use disorder have a related brain disorder that impairs their long-term planning, social interaction, motivation, and daily functioning. To establish parenting and adult functioning in the case of new parents, or to re-establish a drug-free lifestyle requires structure, supportive services, trauma-informed practices, medical and behavioral health services, and people willing to guide and coach.

**Ohio START Practices:** As the name implies, the Ohio Sobriety, Treatment, and Reducing Trauma (START) provides a system-of-care to support parental recovery and thus child safety and family well-being as primary outcomes. Although multiple practices are aimed at recovery, an essential component of Ohio START is the use of family peer mentors who use active parent engagement, accountability and behavior change strategies to support parents’ work toward recovery and stability. Dedicated children services staff and family peer mentors make weekly visits to families for the first 60 days of a case allowing for increased management and compliance to treatment. It is recommended that treatment agencies provide a minimum of twice monthly reports on attendance, engagement, progress in services and drug testing. There are also formal processes in place to ensure that children services case plans and substance use disorder treatment plans are coordinated, reviewed and adjusted on a regular basis.
Family Peer Mentors (FPM)

The Ohio START model adopted the use of family peer mentors as an essential cornerstone of the overall initiative. A family peer mentor is an individual with a minimum of two years in long term recovery from a substance use disorder and experience with the child welfare system. A family peer mentor provides peer support to help families navigate through the child welfare and other systems while also providing hope and motivation to promote healing to keep children safe and families together. Family peer mentors serve families referred to the PCSA due to child maltreatment with substance abuse being the primary risk factor and serve as a member of the local START team along with the child welfare caseworker, child welfare supervisor, and behavioral health service provider. The goal of the entire team is to keep children safe and families together.

Research has shown that peer recovery support services, like family peer mentors, may be associated with increased access and retention in substance use disorder treatment, reduced rates of relapse, enhanced parent engagement and satisfaction, and for children decreased time in foster care and improved family reunification rates. A full discussion of the role of peer recovery support services in child welfare is beyond the scope of this document; additional information is available in published studies.

The family peer mentor positions are employed through either behavioral health or through the children services agency, depending on the preference of each county and will have a caseload of no more than 10-12 families.

**Current family peer mentor job description and caseworker/FPM role responsibilities can be found in the appendix.**

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### Integrated Peer Supporter Training. Provided through OhioMHAS

Completion of this training package is required to be a certified peer supporter. It is coordinated with resources from OhioMHAS and scheduled in regions based on the number of recruits available. This training is for individuals with a lived experience of mental health and/or substance use disorders. Sixteen hours of pre-course work are a prerequisite to the 40-hour Integrated Peer Supporter Training needed for a certificate. The training is 40 hours of in-person training over the course of a 5-day period. Attendance for all training is mandatory to receive the certificate, there are no opportunities to make up work.

### Child Welfare - 101

The training focuses on a basic understanding of child welfare rules, mandates and timelines and helps the peer supporter and SUD provider understand their essential role within the team. This training gives the peer supporter or SUD treatment provider the opportunity to demonstrate their understanding of the child welfare system and how they can assist their client by supporting their engagement in the child welfare case plan.

### Engagement Skills - Motivational Interviewing

Participants use the theory and practice exercises from the online course to further develop skills. Participants demonstrate their ability to employ strategies for resolving ambivalence and dealing with resistance; identifying traps in helping; applying principles of motivational interviewing to avoid pitfalls; identifying change talk and how to operationalize individual goals. Motivational interviewing skills are applied in case studies and participants received feedback through peer and self-evaluation. It is highly recommended that Ohio START caseworkers and family peer mentors attend this training together.

**A full description of all required trainings for family peer mentors and other staff can be found in Chapter 10: Training Guide.**
CHAPTER 5: FOCUS ON FAMILY CENTERED SERVICES AND PARENT-CHILD RELATIONSHIPS

Overview

**Strategy Definition:** START is designed to be a family-centered intervention\(^{11}\), meaning that service delivery is driven by collaboration between agencies that balance the concern for child well-being with compassion and treatment for parents with substance use disorders\(^{12}\). Collaboration is intended to support a shared vision for children, parent and family relationships, respect for the input of families in decision making, and mutual accountability for outcomes\(^{13}\). When family-centered services are delivered optimally, each family member has a tailored case plan that is shared between agencies and includes individual and family services.\(^{14}\) Family-centered treatment is timely and responsive to the needs of parents and children and delivered in the context of parent/provider and parent/child relationships.\(^{15}\)

**Purpose:** Because parental substance use disorders affect children and family relationships, a parent’s progress in recovery must include repairing these family relationships and improving child wellbeing. Traditionally, substance use disorder treatment providers focused on the adult while child welfare agencies focused on the child. Less attention was paid to the adult as a parent in a relationship with their child/ren and in a family with parenting responsibilities. This fragmented and sometimes conflicting service delivery system put children at risk for longer stays in out of home care and less stable reunifications with parents.\(^{16}\)

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**Ohio START Practices:** When substance use disorders and trauma are identified, SUD treatment and early intervention services for children are delivered using evidence-informed practices and programs. Once it is established that the parents and children are receiving treatment services, it is crucial that the family receives services. When children are placed out of the home, parenting time for families is flexible, frequent, structured and responsive to the developmental stage of the child. Families are engaged in identifying their strengths and challenges, planning for the safety of children, and assuming responsibility for their choices. *Family team meetings* between the family, children services staff, behavioral health provider, and other community supports are regularly held to discuss the treatment/service needs; progress; and strengths of the parent, child and family.

**Family Team Meetings**

An initial meeting, known as the shared decision-making meeting, happens when the family meets with all partners on the Ohio START team to officially volunteer for the Ohio START program, develop a case plan, safety plan, and discuss all other elements of the family’s START case. Family team meetings begin within 30 days of referral to Ohio START and continue at various points throughout the life of the children services case. These meetings are opportunities to engage the parents and extended family and Ohio START partners regarding the family’s well-being, treatment, and safety. Participants in the meeting may include family members and informal support system such as relatives or friends, and all members of the local Ohio START team: the behavioral health treatment provider, the children services investigative worker, the children services Ohio START caseworker, and the family peer mentor. The purpose of these meetings is to foster collaborative thinking in the development/modification of the case plan. The team engages the family in decision-making and strives to empower the parents and extended supports to take ownership of the treatment plan and the safety of the child(ren).

Additional principles of family team meetings can be found in the Appendix.

**Frequent Contacts to Promote Parent/Child Relationships**

The *Ohio START Minimum Work Guidelines* specify the need for more frequent (compared to usual children services practice) contacts between the parent, caseworker, and family peer mentor and between parents and their children. These more frequent contacts and visits serve to monitor child safety; coach the parent in sober parenting, recovery and daily living; and support the parent/child relationship. Families will receive at least weekly home visits for the first 60 days of the case. Following the initial 60 days the team will conduct a minimum of two face-to-face contacts monthly. When children are placed outside of the parent’s home with relatives or in foster care, attempts will be made to provide weekly visitation between parents and children to enhance bonding and develop parenting skills and
confidence. The first visit between parents and child/ren is to occur within five days of child’s removal from the birth family.

**Services and Support for Developing Parenting Capacity, Sobriety, and Resilience from Trauma**

Ohio START is designed to keep children safely with their parent(s) whenever possible and avoid child removal by front-loading services to the entire family, including trauma-informed services and supports. Behavioral health partners provide these services. The START team refers parents/families to local parenting services that address parenting in recovery, bonding between parents and children, and overall parenting capacity.

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**Training for Implementing Family-Centered Services**

**Family Team Meetings**

A full-day training designed as a joint training for child welfare, behavioral health practitioners, and community partners. This training was required for all child welfare staff in Ohio START, and strongly recommended for all other Ohio START team members: family peer mentors, behavioral health staff, and supervisors and administrators in both child welfare and behavioral health. These partners participate in a teaming process with families and county agencies to serve the behavioral health needs of those in the Ohio START program.

This training provided an overview of the teaming process of the family team meeting to meet the needs of the family including preparing families and providers for participating in family team meetings; basic structure and guidance for facilitating family team meetings; and guidance for handling challenges that may arise in the teaming process.

**A full description of all required trainings for START staff can be found in Chapter 10: Training Guide**
CHAPTER 6: INCREASED ADMINISTRATIVE AND JUDICIAL OVERSIGHT

Overview

**Strategy Definition:** To assist parents in the recovery process, a more frequent, strength-based, non-punitive approach can encourage parents to fully engage in treatment services and to develop their parenting capacities. More intense oversight supports timely revisions to the case plan, ensures that services match needs, and holds the entire team accountable for progress. This strategy also includes increased monitoring of the program at a leadership level to ensure that the program is meeting family needs and achieving desired results.

**Purpose:** Parents with substance use disorders and involvement with children services may have a history of conflicted relationships and mistrust of persons of authority including those who work in the children services and/or court systems. Increased administrative oversight by the children services, the family peer mentor, treatment team and sometimes the judicial system can provide structure and help build a working relationship with the parents. It is important to use a non-adversarial approach so that parents hear a clear and consistent message about how to be successful in recovery and achieve their case plan goals.

**Ohio START Practices:** Increased contact and continuous monitoring of participants, along with the treatment and access to support services promotes a far greater likelihood of success than can be achieved through traditional child welfare services or dependency court. Increased contact and oversight of parents and families are a part of previous strategies but is a component that is successful to recovery on its own. The Ohio START program promotes efficient communication across systems and with the court system, specifically with family drug treatment courts. Contact with families is more intense at the beginning of the intervention and during times of crisis or change. This includes regular home visits, family team meetings, and transportation to treatment or other appointments.

**Frequent Contacts to Monitor Service Delivery and Progress**

The Ohio START Minimum Work Guidelines specify the need for more frequent (compared to usual children services practice) contacts between the parent and children services caseworker and more frequent family team meetings. Specific to this strategy, as well as the previous strategy, these more frequent contacts allow families to receive intensive case management services with the case worker/family peer mentor dyad with at least weekly home visits for the first 60 days of the case. These visits may include case management staff
and behavioral health treatment provider. Following the initial 60 days the team will conduct at a minimum of twice per month (biweekly) face-to-face contact with parent(s), one of these biweekly contacts per month will occur in the home with parent(s) and one will include the child. Frequent contact and regular communication about the case management are designed to respond to changing needs or conditions with alterations of service delivery that will assist the parent in recovery. In the event of a crisis, relapse, or reunification, the Ohio START Team will return to weekly face-to-face contact.

**Ongoing Drug Testing and Monitoring of Progress in Treatment**

A strong collaboration with streamlined communication between children services and substance use disorder treatment providers is a hallmark of START and embedded in Ohio START. This intensive coordination and communication provide the oversight required to deliver services and keep children safe. Contracts with treatment providers specify the requirement of random drug testing as recommended by the substance use disorder treatment provider. In order to complete the Ohio START program, a parent must demonstrate sobriety, as proven through random drug tests. Weekly written updates on progress in substance use disorder treatment are to be requested and sent to Ohio START children services caseworker assigned to the family. Family peer mentors are also to submit written reports on progress in service delivery via the Needs Portal. The Ohio START caseworker is responsible for all court filings, reports and contacts with judicial system representatives in the same manner as he or she would be in all other cases.

**Increased Judicial Oversight**

The START model is a child-welfare led initiative that works closely with the courts but does not require court involvement for all cases. Thus, the relationship between each Ohio START county and their court partners may vary. However, the courtroom, officers and attorneys can be a critical component of the family’s therapeutic experience and earlier and frequent judicial interaction with parents can improve outcomes. Ongoing judicial supervision communicates to families that someone in authority cares about them and is holding them accountable. Ohio START is embedded in counties that support additional collaborative efforts and links with these efforts when available.
CHAPTER 7: CROSS SYSTEM RESPONSE FOR PARTICIPANTS – CONTINGENCY MANAGEMENT

Overview

**Strategy Definition:** Responses to parent behavior should be therapeutic, motivational, and designed to communicate clear expectations for progress in recovery. Contingency management is a well-established evidence-based strategy in substance use disorder treatment that includes concrete behavioral expectations for parents. A collaborative approach to contingency management includes judicial staff, parents and families, children services staff and treatment providers who agree on expectations. Responses to parents’ meeting or failing to meet expectations should be consistent, but flexible enough to account for the unique individual circumstances of each family.

**Purpose:** The purpose of responding to behavior is not to punish, but to enhance the likelihood of treatment participation and to resolve other factors in the children services case plan that may be barriers to achieving sobriety, child safety, and reunification. Responding necessarily includes both positive feedback about successes and progress and correctional feedback about struggles, lapses or relapses. Parents who have concrete expectations are more likely to make conscious choices about their response to conditions and understand the consequences of their behavior.

**Ohio START Practices:** Responses to a parents’ behavior must avoid adjusting their time with his/her child(ren) as a punishment. Implementing responses to parents’ behavior must take into consideration the impact on other family members, particularly children. Effective and efficient communication across systems is a cornerstone of contingency management so, for example, if reunification is no longer feasible, alternative and timely permanency can be achieved for the child(ren). Protocols are in place to ensure prompt responses to various client behaviors such as relapse, such as increased caseworker and family peer mentor visits. Responses are based on factors specific to each parent and family situation. Response standards should include processes describing how the team will react to meet changing parents and children’s therapeutic needs for additional or alternative treatment. Develop a formal system of phases or stages with defined and targeted benchmarks and parent behaviors that delineate accomplishments and are understood by parents.
**Ongoing Case Management**

Because of changing conditions or events in the case, the shared case/treatment plan identifies up-front how the team intends to respond. This management plan then guides case decision with behavioral health, families, the child welfare team, and others including court personnel. Contingency management includes guidelines for responding to parental relapse, identifying achievements that indicate progress, considerations in child permanency needs, and criteria for case closure for example. Guidelines are tailored based on parental risk and protective factors, local service array and resources, and the skills and experience of the team.

**Ongoing Family Team Meetings**

Family team meetings are the venue for shared decision making. No single agency can make wise decisions in isolation; thus, the team and the family and extended family should convene for making decisions about child safety and needs for placement, child permanency planning, changes in service needs, or in crisis situations like parental relapse. In the case of crisis, family team meetings can occur more frequently or in a different setting to meet the needs of the family in crisis.

**Connecting Parents and Children to Community-Based Services**

To achieve sobriety and early recovery, families will likely need additional community-based services such as housing, transportation, job training and employment. Provision of evidence-supported interventions for improving parenting skills can be helpful especially if a program designed for parents with substance use disorders is delivered. Children may also require trauma, developmental, educational, or behavioral health services. The family peer mentor plays an integral role in connecting families to these services.

**Child Safety Planning and Placement**

Other options to foster care placement may include having a sober caregiver move into the family home or the family moves in with safe relatives or friends. Contingency plans are developed so the parent and team know how to respond to different conditions and what is expected of the parent. In the case that a child must be placed outside the home, it is important to keep the child in the same county/community so that the parents have frequent visits and to place children with their siblings and safe relatives.
Responding to Parental Relapse

Preventive strategies include developing plans for relapse prevention early in the case that specifies with the parent who to call and where to seek help, child safety and care, and emergency contingency. Family peer mentors may recognize the early warning signs of relapse and intervene before a relapse. Drug testing should be frequent and random with protocols between children services and behavioral health to specify who is to be tested, the type of specimen collected, procedures for random testing, the window of detection, the drug testing method, and cutoff levels.

Nonetheless, parental relapse is considered a crisis where timely responses are critical to ensure child and parent safety. Children services and behavioral health need to communicate immediately when learning of a relapse. In response, the team should convene a family team meeting for decisions and planning. A relapse should be approached as an opportunity for the parent to grow and learn about their triggers and needs rather than a time to punish the parent. Removal of the child from parental custody is not a predetermined response to relapse, but a team decision based on assessing child safety. After a relapse, the Ohio START caseworker and family peer mentor return to weekly home visits until the family is stabilized. The ongoing treatment needs of the parent are addressed and the family peer mentor reengages the parent in treatment and community-recovery supports.

Decisions about Case Closure

Planning for case closure and child permanency is an ongoing process. If children are removed from parental custody, the desired goal is reunification that is supported by regular, frequent contact with their families. The START model standards specify the need for six months of sustained parent sobriety before a case is closed or children are reunified. Other factors to consider include the parents’ involvement in ongoing recovery supports, their parental capacity to care for their children and complete daily living tasks, the child’s readiness and needs, and resources and supports for the transition. The transition needs to be gradual beginning with unsupervised overnight visits and should include ongoing supports and services after reunification.
Overview

**Strategy Definition:** Collaboration refers to an approach or process of intensive work between agencies through meetings, joint projects, formal agreements, and forging common procedures. Collaboration also refers to a continuum of outcomes that range from agencies exchanging information to agencies working together to fundamental change the system of service delivery. The ultimate goal of collaboration is to create a seamless system of care and service delivery within and between agencies that focuses on the entire family’s needs, with shared processes and beliefs, joint accountability and shared decision-making.

**Purpose:** No single system or agency has the authority, capacity, resources, or skills needed to respond to the array of challenges faced by families affected by substance use disorders and child abuse/neglect. Cross-system collaboration, a cornerstone of system reform efforts, starts during the planning process. Establishing a structure and collaborative processes for making policy, program and resource allocation decisions leads to expanded capacity, better outcomes, and institutionalization of effective practices within the larger systems. Collaborative practice at both the case and system levels is imperative to sustain efforts over time.

**Ohio START Practices:** Frequent and routine multidisciplinary treatment team meetings are conducted to discuss families’ progress, service needs and adjustments to case plans. Cross training is provided between substance use disorder treatment providers, children services, judicial staff and other service providers that address each partner’s mandates, constraints and goals, as well as effective methods of working.

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Effective collaboration among multiple systems to support families requires the mobilization of community-based organizations and family support systems to meet families’ long-term recovery and aftercare needs. Agencies share responsibility for monitoring and achieving common family and child(ren) outcomes.

**Consistent Expectations for Collaborative Practices**

In April 2017 PCSAO released guidelines for Ohio START to county Public Children Services Agencies (PCSAs) participating in the initiative. These guidelines included specific expectations for the PCSAs to formalize collaborative practices to:

- Create strategic partnerships with other county agencies, including juvenile or family drug courts, Alcohol Drug and Mental Health Boards, and behavioral health providers.
- Execute a MOU with behavioral health providers and juvenile/family court to implement Ohio START and establish collaboration between the PCSA, behavioral health provider, and the juvenile/family court.
- Participate in project meetings.
- Collect required data for PCSAO and evaluation team.
- The PCSA case worker will work jointly with the behavioral health provider, a family peer mentor, and the juvenile court to best deliver intensive wrap-around services to a child and his or her family.
CHAPTER 9: LOGISTICS: MOU’S, REPORTING, AND EVALUATION

Overview

To achieve fidelity to the START model, there are various protocols and procedures put in place to ensure the program is meeting the needs of families. For many families, timely access to treatment services and sharing of information is crucial to entering recovery, that is why the Ohio START program requires entering a Memorandum of Understanding with PCSA and at least one behavioral health provider. The MOUs between the PCSA and behavioral health provider allow both entities to share information about a family to make sure they are receiving the appropriate wraparound services. Another way to keep track and ensure families are receiving services, is through the reporting of services. Using the reporting tool designed by The Ohio State University College of Social Work, Ohio START teams within each county are taught how to use the Needs Portal. The Needs Portal is a tracking and reporting system that allows caseworkers, family peer mentors, and behavioral health providers to input various information related to a family’s case, such as UNCOPE, ACE, and CTAC scores, face-to-face meetings, treatment sessions, etc. The data entered into the Needs Portal by each county allows the evaluation team to accurately measure how successful this program is for Ohio START families.

Memorandum of Understanding (MOU)

Each county Public Children Services Agencies (PCSA) site implementing Ohio START enters into a Memorandum of Understanding (MOU) with PCSAO. Each PCSA also executes MOUs with behavioral health treatment providers and juvenile/family courts. Counties are expected to complete the MOU process as a foundation for collaborative treatment. The MOU with partners clarifies the exchange of information process with procedures for securing informed releases of information. The MOUs also specify the need for exchange of information essential to coordinate treatment between the agencies such as parent drug test results, safety concerns and weekly reports of treatment attendance/progress. In addition, the MOU reinforces the need to work collaboratively and provide coordinated wrap-around services, and intensive case management to achieve the purpose of the Ohio START program. These MOUs clarify the roles and responsibilities of each entity to ensure the seamless provision of intensive wrap-around services to families.
Budget and Reporting

The MOU a PCSA enters with PCSAO describes certain budgeting and reporting measures that are set in place. For each grant cycle, each county participating in Ohio START must create a budget for the upcoming year and submit it to PCSAO for approval. Budgets are not set in stone, and can be revised, but must be resubmitted and approved by PCSAO. Along with a yearly budget, PCSAs are required to send PCSAO a monthly report detailing finances and a narrative of activities performed. The purpose of the monthly report is to ensure that Ohio START PCSA’s are developing and implementing their program and for PCSAO to be up to date with what is happening in each county.

Evaluation and Needs Portal

Evaluation of the Ohio START program is conducted by The Ohio State University College of Social Work and the Ohio University Voinovich School of Leadership and Public Affairs. Although children services cases are already tracked through SACWIS, not all aspects that need to be evaluated can be accessed from there. Therefore, the evaluation team has designed the Needs Portal which can track the needed data.

Training and assistance for the Needs Portal is administered by The Ohio State University and can be scheduled any time. Please contact needsportal@osu.edu for more information.
CHAPTER 10: OHIO START TRAINING GUIDE

All members of the Ohio START team (CW supervisor, caseworker, family peer mentor, behavioral health supervisor) are required to attend certain trainings on the Ohio START program and practices used. The role of each person determines the trainings that are required for their position. Below is a list of all trainings and who is required to attend:

Children and Family Futures Foundational Trainings:

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<thead>
<tr>
<th>Training</th>
<th>Description</th>
<th>Participation</th>
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<tbody>
<tr>
<td>Ohio START Foundations #1: START Basics.</td>
<td>Training components specific to this strategy included: using universal screening tools for substance use and trauma screening, developing protocols for quick access to treatment, and information sharing with treatment partners and courts.</td>
<td>Required for all administrative and supervisory staff in child welfare and behavioral health.</td>
</tr>
<tr>
<td>Ohio START Foundations #2: Working with Family Peer Mentors.</td>
<td>The training focused specifically on the family peer mentor recovery support process along with hands-on examination of the structure and support that needs to be in place for recruitment, hiring, training and preparation of the family peer mentor, including: clarifying the family peer mentor function and role, preparing the way for working with team members, and providing supervision and support. The training provided Ohio START teams an opportunity to assess their implementation and receive hands-on technical support to develop an action plan for moving their program forward.</td>
<td>Required for all leadership staff: child welfare and behavioral health supervisors and administrators and suggested for child welfare START staff.</td>
</tr>
<tr>
<td>Ohio START Foundations #3. Case Management and Practice</td>
<td>This interactive workshop will explore the “nuts and bolts” of START practice throughout the life of a case. Outcomes for families in START have shown higher rates of parental sobriety, less reliance on foster care and a decreased incidence of repeat child maltreatment and return to out-of-home care compared to non-START families. The START model achieves these positive outcomes by using a variety of best practice strategies found to be effective with families with co-occurring substance use and child maltreatment. This training will review these key practices, including the cross-system collaboration necessary to deliver comprehensive family-centered services, increased oversight and monitoring, shared decision-making, and strategic information sharing.</td>
<td>Required for all administrative and supervisory staff in child welfare and behavioral health; recommended for all child welfare staff in Ohio START.</td>
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## Ohio START Trainings

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<tr>
<th>Training</th>
<th>Description</th>
<th>Participants</th>
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<tbody>
<tr>
<td>Screening and Intervention of Substance Use Disorders (UNCOPE and ACE).</td>
<td>This in-person workshop was designed to assist workers with using evidence-based screening tools (UNCOPE) and (ACE), to interpret the results, provide feedback to the parent and offer recommendations to seek further assessment for treatment services. Participants also became familiar with the assessment process, DSM V criteria, treatment levels-of-care, Medication-Assisted Treatment and realistic expectations for aftercare, relapse and/or recovery.</td>
<td>Required training for child welfare and behavioral health providers and recommended for family peer mentors.</td>
</tr>
<tr>
<td>Child Trauma Screening.</td>
<td>The Southwest Michigan Children's Trauma Assessment Center (CTAC) developed a screening tool for children who have experienced trauma and adverse childhood experiences. With proper training, this tool supports appropriate triaging of services and/or referrals. This training assists workers with how to use the CTAC screening tool, interpret the results, provide feedback to the family and offer recommendations for further assessment for treatment services.</td>
<td>Required training for child welfare and behavioral health providers and recommended for family peer mentors.</td>
</tr>
<tr>
<td>Family Team Meetings.</td>
<td>This full-day training was designed as a joint training for child welfare, behavioral health practitioners, and community partners. This training was required for all child welfare staff in Ohio START, and strongly recommended for all other Ohio START team members: family peer mentors, behavioral health staff, and supervisors and administrators in both child welfare and behavioral health. In addition to training on the basics of FTMs, the course also covered topics important to the team in working with parents affected by substance use disorders.</td>
<td>Required for all child welfare staff participating in family team meetings. Recommended for all Ohio START staff and family peer mentors.</td>
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<tr>
<td>Training</td>
<td>Description</td>
<td>Participants</td>
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<tr>
<td>Child Welfare - 101.</td>
<td>The training focuses on a basic understanding of child welfare rules, mandates and timelines and helps the peer supporter and SUD provider understand their essential role within the team. This training gives the peer supporter or SUD treatment provider the opportunity to demonstrate their understanding of the child welfare system and how they can assist their client by supporting their engagement in the child welfare case plan.</td>
<td>Required course for family peer mentors, recommended for behavioral health.</td>
</tr>
<tr>
<td>Engagement Skills - Motivational Interviewing.</td>
<td>Participants use the theory and practice exercises from the online course to further develop skills. Participants demonstrate their ability to employ strategies for resolving ambivalence and dealing with resistance; identifying traps in helping; applying principles of motivational interviewing to avoid pitfalls; identifying change talk and how to operationalize individual goals. Motivational interviewing skills are applied in case studies and participants received feedback through peer and self-evaluation. It is highly recommended that Ohio START caseworkers and family peer mentors attend this training together.</td>
<td>Required course for family peer mentors, recommended for staff.</td>
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**OMHAS Peer Recovery Supporter Certification Training:**

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<tbody>
<tr>
<td>Ohio Mental Health Addiction Services (OhioMHAS)</td>
<td>Completion of this training package is required to be a certified peer supporter. It is coordinated with resources from OhioMHAS and scheduled in regions based on the number of recruits available. This training is for individuals with a lived experience of mental health and/or substance use disorders. Sixteen hours of pre-course work are a prerequisite to the 40-hour Integrated Peer Supporter Training needed for a certificate. The training is 40 hours of in-person training over the course of a 5-day period. Attendance for all training is mandatory to receive the certificate, there are no opportunities to make up work.</td>
<td>This training is required for family peer mentors and can be used to become certified in Ohio as a peer recovery supporter.</td>
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Ohio START Timeline

Initiation of a START Case– 38 Days

Note: All days listed are calendar days

*Written treatment recommendations given to PCSA within 5 days
## UNCOPE

**UNCOPE**  
*Norman G. Hoffmann, Ph.D.*

The UNCOPE consists of six questions found in existing instruments and assorted research reports. This excellent screen was first reported by Hoffmann and colleagues in 1999. Variations in wording are noted for several of the items. The first wording is the original for the “U” and “P” items. The more concrete wording of the revised versions were found to be slightly better as a generic screen. Either version of the six questions may be used free of charge for oral administration in any medical, psychosocial, or clinical interview. They provide a simple and quick means of identifying risk for abuse and dependence for alcohol and other drugs. Please maintain attribution.

**U**  
“In the past year, have you ever drank or **used** drugs more than you meant to?”

Or as **revised** “Have you spent more time drinking or using than you intended to?”

**N**  
“Have you ever **neglected** some of your usual responsibilities because of using alcohol or drugs?”

**C**  
“Have you felt you wanted or needed to **cut down** on your drinking or drug use in the last year?”

**O**  
“Has anyone **objected** to your drinking or drug use?”

Or, “Has your family, a friend, or anyone else ever told you they **objected** to your alcohol or drug use?”

**P**  
“Have you ever found yourself **preoccupied** with wanting to use alcohol or drugs?”

Or as **revised**, “Have you found yourself thinking a lot about drinking or using?”

**E**  
“Have you ever used alcohol or drugs to relieve **emotional discomfort**, such as sadness, anger, or boredom?”

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Citation for the UNCOPE: Hoffmann, N. G. (1999). UNCOPE. Smithfield, RI: Author.
A Caution Regarding All Screens

Screens merely provide an indication of whether an individual appears at risk for a given condition. Screens are inappropriate for use as treatment intake tools and insufficient for supporting diagnoses. The UNCOPE and other screens for substance use disorders are most appropriate for identifying risk for abuse or dependence when neither is clearly identified as a problem. Appropriate venues for screening would be mental health and medical clinics, employee assistance counseling, marital and family counseling. Screens are inappropriate for evaluating persons arrested for driving under the influence, those presenting for treatment, or those being evaluated for any issue associated with substances. These latter individuals are already identified as being at risk, so a screen would be redundant.

UNCOPE References:


Adverse Childhood Experience (ACE) Questionnaire: Finding your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often ...
   Swear at you, insult you, put you down, or humiliate you?
   or Act in a way that made you afraid that you might be physically hurt?
   Yes  No  If yes enter 1 ________

2. Did a parent or other adult in the household often ...
   Push, grab, slap, or throw something at you?
   or Ever hit you so hard that you had marks or were injured?
   Yes  No  If yes enter 1 ________

3. Did an adult or person at least 5 years older than you ever...
   Touch or fondle you or have you touch their body in a sexual way?
   or Try to or actually have oral, anal, or vaginal sex with you?
   Yes  No  If yes enter 1 ________

4. Did you often feel that ...
   No one in your family loved you or thought you were important or special?
   or Your family didn’t look out for each other, feel close to each other, or support each other?
   Yes  No  If yes enter 1 ________

5. Did you often feel that ...
   You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes  No  If yes enter 1 ________

6. Were your parents ever separated or divorced?
   Yes  No  If yes enter 1 ________

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes  No  If yes enter 1 ________

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes  No  If yes enter 1 ________

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes  No  If yes enter 1 ________

10. Did a household member go to prison?
    Yes  No  If yes enter 1 ________

   Now add up your “Yes” answers: _______ This is your ACE Score
Child Trauma Assessment Center Screen (CTAC)

Ages 0–5
CTAC Trauma Screening Checklist: Identifying Children at Risk

Please check each area where the item is known or suspected. The screen can help determine whether a comprehensive assessment may be helpful in understanding the child’s functioning and needs.

Note: Endorsing exposure items does not necessarily mean substantiation of the child’s experience; it is for screening purposes only.

1. Are you aware of or do you suspect the child has experienced any of the following:
   - Physical abuse
   - Neglectful home environment
   - Emotional abuse
   - Exposure to domestic violence
   - Exposure to other chronic violence
   - Sexual abuse or exposure
   - Parental substance abuse
   - Impaired parenting (mental illness)
   - Exposure to drug activity aside from parental use
   - Pre-natal exposure to alcohol/drugs or maternal stress during pregnancy
   - Lengthy or multiple separations from parent
   - Placement outside of the home (foster care, kinship care, residential)
   - Loss of significant people, places etc.
   - Frequent multiple moves, homelessness
   - Other

Even if no areas are checked above, but multiple concerns are present below, further assessment may still be indicated, as there is a strong relationship between the following areas and trauma exposure.

2. Does the child show any of these behaviors:
   - Aggression towards self, self-harm
   - Excessive aggression or violence towards others
   - Explosive behavior (Going from 0-100 instantly)
   - Hyperactivity, distractibility, inattention
   - Excessively shy
   - Oppositional and or defiant behavior
   - Sexual behaviors not typical for age
   - Difficulty with sleeping, eating, or toileting
   - Social/developmental delays in comparison to peers
   - Repetitive violent and/or sexual play (or maltreatment themes)
   - Unpredictable sudden changes in behavior (i.e., attention, play)
   - Other

3. Does the child exhibit any of the following emotions or moods:
   - Excessive mood swings
   - Frequent, intense anger
   - Chronic sadness, doesn’t seem to enjoy any activities, depressed mood
   - Flat affect, very withdrawn, seems emotionally numb or “zoned out”
   - Other

4. Does the child have any of the following relational/attachment difficulties:
   - Lack of eye contact, or avoids eye contact
   - Sad or empty eyed appearance
   - Overly friend with strangers (lack of appropriate stranger anxiety)
   - Vacillation between clinginess and disengagement and/or aggression
   - Doesn’t reciprocate when hugged, smiled at, spoken to
   - Doesn’t seek comfort when hurt or frightened; shakes it off, or doesn’t seem to feel it
   - Has difficulty in preschool or daycare
   - Other

Child’s Name or Identifier: ___________________________ County/Site: ___________________________

Age: ___________ Sex: _________ Race: ___________________________

Your name (who is filling out this form?): ___________________________ Date: ___________________________

Henry, Black-Pond, & Richardson (2010); rev. 3/15 Western Michigan University Southwest Michigan Children’s Trauma Assessment Center (CTAC)
Ages 6–18
CTAC Trauma Screening Checklist: Identifying Children at Risk

Please check each area where the item is known or suspected. The screen can help determine whether a comprehensive assessment may be helpful in understanding the child’s functioning and needs.

Note: Endorsing exposure items does not necessarily mean substantiation of the child’s experience; it is for screening purposes only.

1. Are you aware of or do you suspect the child has experienced any of the following:
   - Physical abuse
   - Neglectful home environment
   - Emotional abuse
   - Exposure to domestic violence
   - Exposure to other chronic violence
   - Sexual abuse or exposure
   - Parental substance abuse
   - Impaired parenting (mental illness)
   - Exposure to drug activity aside from parental use
   - Pre-natal exposure to alcohol/drugs or maternal stress during pregnancy
   - Lengthy or multiple separations from parent
   - Placement outside of the home (foster care, kinship care, residential)
   - Loss of significant people, places etc.
   - Frequent/multiple moves; homelessness
   - Other

Even if no areas are checked above, but multiple concerns are present below, further assessment may still be indicated, as there is a strong relationship between the following areas and trauma exposure.

2. Does the child show any of these behaviors:
   - Aggression towards self, self-harm
   - Excessive aggression or violence towards others
   - Explosive behavior (Going from 0-100 instantly)
   - Hyperactivity, distractibility, inattention
   - Excessively shy
   - Oppositional and/or defiant behavior
   - Sexual behaviors not typical for age
   - Difficulty with sleeping, eating, or toileting
   - Social/developmental delays in comparison to peers
   - Other

3. Does the child exhibit any of the following emotions or moods:
   - Excessive mood swings
   - Frequent, intense anger
   - Chronic sadness, doesn’t seem to enjoy any activities, depressed mood
   - Flat affect, very withdrawn, seems emotionally numb or “zoned out”
   - Other

4. Does the child have any of the following problems in school:
   - Low or failing grades
   - Attention and/or memory problems
   - Sudden change in performance
   - Difficulty with authority/frequent behavior referrals
   - Other

5. Does the child have any relational/attachment difficulties?
   - Lack of eye contact, or avoids eye contact
   - Lack of appropriate boundaries in relationships
   - Does not seek adult help when hurt or frightened

Child’s Name or Identifier: ___________________________ County/Site ___________________________

Age: ___________ Sex: ___________ Race ___________________________

Your name (who is filling out this form?) ___________________________ Date ___________________________

Henry, Black-Pond, & Richardson (2010), rev. 3/16 Western Michigan University Southwest Michigan Children’s Trauma Assessment Center (CTAC)
Ohio START Family Peer Mentor – Job Description

An Ohio START family peer mentor provides peer support to help families navigate through the child welfare and other systems while also providing hope and motivation to promote healing to keep children safe and families together. An Ohio START family peer mentor serves families referred to the PCSA due to child maltreatment with substance abuse being the primary risk factor. The Ohio START family peer mentor serves as a member of the local START team along with the child welfare caseworker, child welfare supervisor, and behavioral health service provider. The goal of the entire team is to keep children safe and families together. The Ohio START family peer mentor will have a caseload of no more than 10-12 families.

The Ohio START family peer mentor’s roles and responsibilities include:

- Participating as an active member of the Ohio START team;
- Working jointly with the Ohio START case worker and behavioral health provider to ensure seamless and efficient delivery of intensive wrap-around services to the START families on his or her caseload to assist with the safety of the child(ren);
- Participating in initial meetings, weekly status meetings and family team meetings to review families’ progress and child safety in their respective cases.
- Providing continual exploration of family’s needs to empower the family to take ownership over their long-term successes and the safety of the child(ren);
- Supporting the parent(s) in achieving personal independence;
- Connecting START families to community resources;
- Teaching families skills to effectively navigate to the child welfare system;
- Assisting families with identifying and accessing natural support systems in the community;
- Promoting coordination and linkage among providers within local community;
- Coordinating or providing assistance in crisis interventions and stabilization of families;
- Assisting families to develop of empowerment skills through promoting self-advocacy;
- Identify barriers (internal and external) to full participation in community resources and developing strategies to overcome those barriers;
- Providing input on court forms as needed; and
- Providing input on development of the case plan and child safety.
The START family peer mentor must:

- Demonstrate long term recovery (at least 2 years is required, three years is preferred) from a SUD;
- Have earned a minimum education level of GED;
- Demonstrate no ongoing criminal activity;
- Have lived experience with the child welfare system either as a parent or child, with the case closed at least one year or if do not have direct CPS experience, be able to describe how your substance use affected your children and family; and
- Maintain a current driver’s license.

The START family peer mentor should have knowledge or be able to attain knowledge of:

- Alcohol and drugs (pharmacology)
- Behaviors associated with addiction
- Court processes
- Diversity
- Ethics
- Family dynamics
- Family team meetings
- Health Insurance Portability and Accountability Act (HIPAA)
- Human behavior
- Local resources and services
- Maintain confidentiality
- Medically Assisted Treatment (MAT)
- Pathology of addiction
- Process of recovery
- Ohio START Program
- Self-help programs
- Signs of child abuse and neglect
- Trauma Informed Care
- Treatment options

The START family peer mentor should have skills in:

- Advocacy
- Coaching
- Communication (listening, verbal, nonverbal, written)
- Computers
- Coping
- Crisis intervention
- Cultural competency
- De-escalation
- Driving
- Motivational interviewing
- Multi-tasking
- Negotiation
- Networking
- Observation
- Organization
- Parenting
- Problem solving
- Professionalism
- Setting personal/professional boundaries
- Time management
The ideal candidate will possess the following traits:

- Common sense
- Compassion
- Creativity
- Empathy
- Honesty
- Integrity
- Non-judgmental
- Open mind
- Patience
- Personable
- Positivity
- Professional courage
- Reliability
- Self-motivation
- Sympathy
- Tolerance
Roles, Responsibilities, And Minimum Work Guidelines

This document provides a summary of the guidelines for activities for Ohio START staff designed primarily to keep children safe while facilitating the engagement of parents into services in a timely manner. The activities and timeframes are believed to represent best practice when working with families using an intensive wrap-around services approach. The guidelines allow for supervisory discretion and team input to meet the individual needs of families by matching the intensity of the service and contact to the intensity of the family's needs. Ohio START staff includes both the caseworker assigned to the family and the family peer mentor.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Team Member Responsibilities and Timeframes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First face-to-face contact with family</strong></td>
<td>• Within 2 working days of referral to Ohio START.</td>
</tr>
<tr>
<td><strong>Purpose of the meeting:</strong> START team explains the Ohio START program, introduces worker and mentor roles, completes a safety / prevention plan for the safe care of the child(ren), schedules behavioral health assessment and has parent(s) sign release forms.</td>
<td>• Both the caseworker and family peer mentor attend.</td>
</tr>
<tr>
<td></td>
<td>• START staff is introduced to family.</td>
</tr>
<tr>
<td><strong>Transportation</strong>*</td>
<td>• Family peer mentor may accompany and assist the parent with transportation to the initial behavioral health assessment.</td>
</tr>
<tr>
<td>*Transportation to a SUD treatment appointment CANNOT be paid for with VOCA funds. Transportation to other activities is encouraged, but VOCA may not be available to support such activities.</td>
<td>• May also transport parent or family to other appointments.</td>
</tr>
<tr>
<td></td>
<td>• Worker usually does not accompany mentor on transports.</td>
</tr>
<tr>
<td><strong>Contact Standards for In Home cases</strong></td>
<td><strong>Family Peer Mentor</strong></td>
</tr>
<tr>
<td><strong>Purpose of the meeting:</strong> Per the START model, families will receive intensive case management services with the case worker/family peer mentor dyad at least weekly contacts for the first 60 days of the case. These meetings will be used to discuss with the safe plan of care for the child(ren) with the family and the status of the case. How are things going? What do you need? What does “caseworker/FPM dyad” mean in context of practice and family visits? This can be</td>
<td>• Weekly face-to-face contact with parent(s), best practice states that 2 of the weekly contacts per month will occur in the home with the family.</td>
</tr>
<tr>
<td></td>
<td>• First home visit must be within one week of the initial family meeting.</td>
</tr>
<tr>
<td></td>
<td>• A minimum of one contact per month will include the child(ren).</td>
</tr>
<tr>
<td></td>
<td>• After 60 days, a minimum of twice per month (biweekly) face-to-face contact with parent(s), one of these biweekly contacts per month will</td>
</tr>
<tr>
<td>Activity</td>
<td>Team Member Responsibilities and Timeframes</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------------</td>
</tr>
</tbody>
</table>
| decided at each county and for each family how will work best but for purposes of fidelity to Ohio START:  
• minimum of first visit must be caseworker and FPM together  
• suggest that continue to visit together until roles and relationships established  
• caseworker and FPM will both be expected to each make weekly visits either together or separate  
• caseworkers and FPM will need to work together in terms of scheduling visits  
• it is important that this is a team approach whether visits or made together or separately | occur in the home with parent(s) and one will include the child.  
• Provide the family with informal supports.  
**Case Worker**  
• Weekly face-to-face with parent(s) for 60 days, best practice states that 2 of the weekly contacts per month will occur in the home with parent(s) and child(ren).  
• First home visit must be within one week of the initial family meeting.  
• After 60 days, a minimum of twice per month (biweekly) face-to-face contact with parent.  
• One of these biweekly contacts per month will occur in the home with parent(s) and one will include the child. |

**Contact Standards for Out of Home/Kinship Placement**  
**Purpose of the meeting:** Per the START model, families will receive intensive case management services with the case worker/family peer mentor dyad at least weekly contact for the first 60 days of the case. These meetings will be used to discuss with the safe plan of care for the child(ren) with the family and the status of the case. How are things going? What do you need?  
**Family Peer Mentor:**  
• Weekly face-to-face contact with parent(s), best practice states that 2 of the weekly contacts per month will occur in the home with the family.  
• First home visit with the parent must be within one week of the initial family meeting.  
• After 60 days, a minimum of twice per month (biweekly) face-to-face contact with parent, one of these biweekly contacts per month will occur in the home with the parent.  
• Family peer mentor to visit children in foster care or relative placement with the caseworker at least quarterly. Monthly is preferred when possible.  
**Case Worker:**  
• Face-to-face with parent minimum twice per month (biweekly), 1 of these contacts per month will occur in the home.  
• First home visit with the parent must be within one week of the initial family meeting.  
• Face-to-face contact with all children out of their parent’s custody (Kinship, relative, foster care) a minimum of once per month.  
• If parent resides with relative caregiver or joint custody between parent and relative, follow in-home standards.
<table>
<thead>
<tr>
<th>Activity</th>
<th>Team Member Responsibilities and Timeframes</th>
</tr>
</thead>
</table>
| **Contact Standards when Parent is in Residential SUD Treatment**  
 **Purpose of the meeting:** to discuss with the safe plan of care for the child(ren) with the family and the status of the case. How are things going? What do you need?  
 **Other:**  
 For parent(s) with short term jail sentences the same protocol will apply | **Case Worker and Family Peer Mentor:**  
 • Minimum of one face-to-face visit per month with parent and/or treatment facility staff  
 • Weekly phone contact with parent and/or treatment provider  
 • While the parent(s) is in residential treatment program, START team should engage with parent as much as is possible. This includes attending team meetings at residential facility, meeting or having phone calls with parent(s) and developing a plan for parent upon discharge including establishing local supports upon return to community for transition and a safety net.  
 • The required START activities, i.e. trauma screen, weekly visits for first 60 days, etc. will begin upon parent’s discharge from residential treatment program. |
| **Special Considerations** | **Contact Standards may change:**  
 • After a relapse-return to weekly contact  
 • At change in level of treatment  
 • Graduating or re-entering treatment  
 • Out of region treatment  
 • Reunification / trial home visit- return to weekly contact  
 • Re-engagement in treatment  
 • Supervisor and team consultation are required to decide on contact standards under all special circumstances. |
| **Parent-Child Visitation** | • Attempts will be made to provide weekly visitation between parents and children who have been removed from their birth family.  
 • The first visit should occur within 5 days of child’s removal from the birth family.  
 • It is recommended and encouraged that visits then occur once weekly at a minimum for children in out-of-home placements.  
 • All changes in visitation agreement to be discussed with supervisor.  
 • **Note:** Discussion of case plan objectives should not occur during parent-child visitation. |
<table>
<thead>
<tr>
<th>Activity</th>
<th>Team Member Responsibilities and Timeframes</th>
</tr>
</thead>
</table>
| **Family Team Meetings**  
Purpose of the meeting: This meeting includes family members and their informal support system, and all members of the local Ohio START team and offers collaborative planning for the safe plan of care for the children. These meetings engage the family in decision-making and empower the family to take ownership over their long-term successes and the safety of the child(ren). |  
- First family team meeting must be held within 30 days of case referral.  
- Also held at 6 months.  
- Also held as needed for any “crisis” (relapse, treatment change) and reunification, permanency change, and placement move, and within 30 days of case closure. |
| **Screening Tools/Assessment** | Caseworker will  
- Complete the UNCOPE screening during the initial meeting with the family.  
- Complete child trauma screening tool during the initial meeting with family and/or child. | Behavioral Health Partner will  
- Complete the ACEs screening tool with the parent(s) during their first meeting with the parent(s). |
| **START Evaluation Data** | All required data is to be entered into the SACWIS system on a weekly basis by the caseworker.  
- Data is to be entered into the Needs Portal on a weekly basis by the caseworker and FPM as appropriate  
- All payment and outcome measurement data required by VOCA must be documented in PCSA monthly report and submitted to PCSAO.  
- The child welfare supervisor to review monthly. |
| **Documentation of participation in services** |  
- Release of information form to be completed.  
- Weekly written updates on progress in substance use disorder treatment are to be requested; other service provider updates to be requested monthly.  
- Written reports from the family peer mentor. |
| **Drug Testing***  
*drug tests/screening are not an activity that can be paid for with VOCA funds. |  
- As recommended by the behavioral health provider.  
- In order to complete the Ohio START program, a parent must demonstrate sobriety, as proven through random drug screens. |
<table>
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<tr>
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</tr>
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</table>
| **Supervisory Consultations**                | • Each case must be formally consulted and documented monthly with Supervisor, Ohio START caseworker and family peer mentor.  
| These consultations are intended to check-in on the progress of the case as well as ensure there is safe plan of care for the child(ren) in place. | • Informal consults happen as needed.                                                                       |
| **Interaction with the Juvenile Court**       | • Ohio START Case Worker is responsible for all court filings, reports and contacts with CASA/GAL in the same manner as he or she would be in all other cases.  
|                                               | • Family peer mentor will provide input on court forms as needed.                                             |
| **Referrals**                                 | • Case Worker takes the lead on discussion with family regarding a formal case plan referral.  
|                                               | • Family peer mentor assists with identifying needed formal referrals by providing information to team and is very familiar with local resources that may be of assistance to family and provides information about those resources to the family as needed. These resources are all intended to empower the family to take ownership over their long-term successes and the safe plan of care for the child(ren). |
| **Prevention/Safety Planning**               | • The case worker takes the lead on developing the plan.  
|                                               | • Family peer mentor provides input on development of the plan, as needed.                                    |
Family Team Meeting Principles

Key Principles of the Child and Family Team

- **Child-centered and family-focused.** Services and informal supports should promote a child’s right to be safe, loved, and nurtured in a permanent family setting.

- **Respect.** Youth, families, and members of their support network are engaged as partners in the team environment.

- **Collaboration.** Team members work together on shared goals and a common understanding of the team’s plans to achieve them.

- **Empowerment.** Decision making is accomplished through a team process (except as required by legal obligations and agency mandates).

- **Accountability.** Each team member has a unique role and accompanying responsibilities. Individual team members are held accountable for their respective responsibilities. The team is accountable for ensuring access by the child and family to needed services, and follow-through toward the attainment of identified goals.

- **Cultural Humility.** Family culture and values are explored and respected, and services and meeting arrangements are harmonious with the family’s cultural orientation.

- **Self-Advocacy.** Parent support persons, youth advocates, and other team members encourage and assist youth and family to voice their opinions and advocate for themselves.

- **Support.** Team members assist the family to enhance their circle of support.

- **Creativity.** Team members should be creative in devising interventions and solutions that emphasize reliance on informal supports, peer services, and paraprofessionals.

- **Honesty.** Within the scope of confidentiality rights and informed consent, honesty is essential to the healthy functioning of the team.

- **Transparency.** The rationale, options, and actions related to planning, treatment, and service delivery should be fully explained in language that is comprehensible to families and their support network.

- **Evidence-based Expertise.** Based on extensive research concerning the effects of trauma on child development and later outcomes over the lifespan, trauma-informed practice provides the evidence-based approach that underlies Child and Family Teams. Trauma-informed practice facilitates and supports resiliency and recovery among
children and families who have experienced trauma. Physical and psychological safety for children and families should be maximized. When operationalized in the team process, knowledge and skills derived from trauma-informed practice direct team members to focus on services and informal interventions that will promote healing and health.

- **Permanency.** In addition to the legal definition of permanency, the Child and Family Team should identify for youth at least one individual who can provide a sustained relationship built on unconditional positive commitment and support.
MEMORANDUM OF UNDERSTANDING

BETWEEN

[NAME OF PCSA]

AND

[NAME OF SERVICE PROVIDER]

This Memorandum of Understanding (“MOU”) is entered into by and between the [Name of PCSA] (hereinafter “Agency”), [Street Address, City, State, Zip] and the [Name of Service Provider], [Street Address, City, State, Zip] (collectively referred to herein as the “Parties”).

WHEREAS, the Ohio Attorney General created a pilot program to serve families harmed by parental opioid abuse in Ohio, known as the Ohio Sobriety, Treatment, and Reducing Trauma (“Ohio START”) program; and

WHEREAS, the purpose of the Ohio START program is to address childhood trauma caused by parental drug abuse and adult trauma that may have led to drug dependency; and

WHEREAS, the Parties will work collaboratively as Family Teams to provide coordinated wrap-around services and intensive case management to achieve the purpose of the Ohio START program; and

WHEREAS, the Parties have entered into an agreement for the provision of specialized victim services for families participating in the Ohio START program; and

WHEREAS, the Parties understand that in the course of performing the responsibilities of the Ohio START program, Provider may have access to certain child welfare and other information from Agency which is considered confidential information (“Confidential Information”); and

WHEREAS, the Parties understand that in the course of performing the responsibilities of the Ohio START program, Agency may have access to certain healthcare, drug treatment, and other information from Provider which is considered (“Protected Health Information”); and

WHEREAS, the Parties wish to ensure the proper and confidential sharing of the Confidential Information and the Protected Health Information by setting forth the roles and responsibilities of the Parties; and
NOW, THEREFORE, the Parties, in consideration of the mutual promises, agreements and covenants herein contained, agree as follows:

I. PURPOSE
For the purpose of performing the Parties’ responsibilities under the Ohio START program as set forth in a separate agreement between the Parties (the “Purpose”), the Parties may have access to Confidential Information and/or Protected Health Information. This MOU establishes a process between the Parties to properly and confidentially transmit and share Confidential Information and Protected Health Information between themselves and to set forth the terms and conditions governing the information-sharing process. The Confidential Information and Protected Health Information will be transferred via an agreed upon method of transmission.

II. RESPONSIBILITIES OF THE PARTIES

A. Agency agrees to do the following:

1. Transfer Confidential Information to Provider in a secure manner as mutually agreed upon by the Parties, for example through an encrypted file sharing service.

2. Consult with Provider to ensure the Confidential Information is stored securely.

3. Use appropriate safeguards in storing Protected Health Information received from Provider. While Agency is not a Business Associate of Provider pursuant to the Health Information Portability and Accountability Act (“HIPAA”), Agency should undertake efforts to store information in compliance with Subpart C of 45 CFR Part 164, which includes:

   a. Ensuring confidentiality, integrity, and availability of Protected Health Information stored both in physical and electronic form;
   b. Protect against any reasonably anticipated threats to the security of the Protected Health Information;
   c. Protect against any impermissible disclosures of the Protected Health Information;
   d. Limit access to Protected Health Information to authorized employees of Agency and ensure that Protected Health Information is utilized only according to the Purpose and executed release;
   e. Track who has accessed Protected Health Information;
   f. Report to Provider any use or disclosure of Protected Health Information not permitted in the Purpose or executed release;
   g. Protect Protected Health Information from improper alteration or destruction; and
   h. Ensure that any subcontractors that create, receive, maintain, or transmit Protected Health Information on behalf of Agency agree to the same restrictions, conditions, and requirements.

4. Only use the Protected Health Information for the Purpose and for no other reason.
5. Immediately notify the Provider of any known or suspected unauthorized disclosure of the Protected Health Information.

6. Immediately notify the Provider of any requests for the Protected Health Information and refer the requestor of the Protected Health Information to the Provider.

7. **Return and/or destroy** any Protected Health Information transferred to Agency by Provider upon the termination or expiration of this MOU.

8. Obtain an executed release, in the form attached hereto as Exhibit A, from the clients who are eligible and selected to participate in the Ohio START program and store the executed releases in a secure manner.

9. Actively participate in the Ohio START program evaluation performed by The Ohio State University College of Social Work and the Ohio University Voinovich School of Leadership and Public Affairs.

B. The Agency point of contact shall be [contact name, title, phone number, e-mail address].

C. The Provider agrees to do the following:

1. Transfer Protected Health Information to Agency in a secure manner as mutually agreed upon by the Parties, for example through an encrypted file sharing service.

2. Consult with Agency to ensure the Protected Health Information is stored securely.

3. Use appropriate safeguards in storing Confidential Information received from Agency. Provider must ensure the access and protection of the Confidential Information is in compliance with all state and federal laws that govern the protection of child welfare data, including, but not limited to those set forth in Exhibit B attached hereto and updated as of March 2017, as may be amended or supplemented from time to time.

4. Only use the Confidential Information for the Purpose and for no other reason.

5. Protect the confidentiality of the Confidential Information in the same manner it protects the confidentiality of its own similar confidential information, but in no event using less than a reasonable standard of care.

6. Restrict access to the Confidential Information to its personnel engaged in a use permitted by this MOU, provided that such personnel are bound by obligations of confidentiality similar to the terms of this MOU.

7. Immediately notify the Agency of any known or suspected unauthorized disclosure of the Confidential Information.

8. **Return and/or destroy** any Confidential Information transferred to Provider by Agency upon the termination or expiration of this MOU.
9. Immediately notify the Agency of any requests for the Confidential Information and refer the requestor of the Confidential Information to the Agency.

D. The Provider point of contact shall be [contact name, title phone number, e-mail address].

III. OWNERSHIP OF CONFIDENTIAL INFORMATION AND LIABILITY

A. The Parties agree that the Confidential Information provided under this MOU is and will remain the property of the Agency.

B. The Parties agree that the Protected Health Information provided under this MOU is and will remain property of the Provider.

C. The Parties agree that the confidentiality obligations set forth in this MOU survive the termination or expiration of the MOU.

D. Provider understands that it may be held liable under the law for the unauthorized disclosure or dissemination of the Confidential Information.

E. Agency understands that it may be held liable under the law for the unauthorized disclosure or dissemination of the Protected Health Information.

IV. TIME OF PERFORMANCE

A. This MOU is effective as of the last date signed below and shall be effective for a period of one year. Thereafter, this MOU shall automatically renew for successive years unless terminated as set forth herein. If automatically renewed, this MOU shall not be effective past the date of the Ohio START pilot program, which terminates on October 1, 2019.

B. Upon the expiration of this MOU, all transferring of information provided for herein will cease, and the responsibilities of the Parties regarding use, storage and destruction of the information will survive the expiration of this MOU and continue in full force and effect.

V. GOVERNING LAW

This MOU is made pursuant to and shall be construed and interpreted in accordance with the laws of the state of Ohio.

VI. SUSPENSION AND TERMINATION

A. This MOU may be terminated by either party, without cause, by providing thirty (30) days written notice to the other Party.

B. If this MOU is breached, the non-breaching party may suspend or terminate this MOU immediately upon written notice to the breaching party. If the breach is of a nature that can be cured, the non-breaching party may provide the breaching party with written notice of the
breach and provide ten (10) days for the breaching party to cure its nonperformance or violation.

C. Upon termination of this MOU, for any reason, all transferring of information provided for herein will cease as of the effective date of the termination, and the responsibilities of the Parties regarding use, storage and destruction of the information will survive the termination of this MOU and continue in full force and effect.

VII. ASSIGNMENT AND WAIVER

A. Neither party may assign its rights or delegate its duties or obligations under this MOU without prior written consent of the other party.

B. A waiver of any provision of this MOU is not effective unless it is in writing and signed by the party against which the waiver is sought to be enforced. The delay or failure by either party to exercise or enforce any of its rights under this MOU will not constitute or be deemed a waiver of that party’s right to thereafter enforce those rights, nor will any single or partial exercise of any such right preclude any other or further exercise of these rights or any other right.

VIII. ENTIRE AGREEMENT/MODIFICATION

This MOU constitutes the entire agreement between the Parties, and any changes or modifications to this MOU shall be made and agreed to by the Parties in writing. Any prior agreements promises or representations not expressly set forth in this MOU shall have no force or effect.

IN WITNESS WHEREOF, the Parties hereto have caused this MOU to be executed as of the day and year last written below.

AGENCY

By: __________________________
Name: _______________________
Title: _________________________
Date: _________________________

PROVIDER

By: __________________________
Name: _______________________
Title: _________________________
Date: _________________________
Ohio START Program Release Form

Ohio START Authorization to Release Confidential Information

Name: ____________________________________  Date of Birth: ______________________
Address: ________________________________________________________________________
Phone: _______________________________
Child(ren)’s Names and Date(s) of Birth: ____________________________________________

I ______________________ hereby authorize [Treatment Provider] to disclose the following information (please initial next to all that apply):

(1) My name, my child(ren)’s name(s) and personal identifying information about me/my child(ren)
(2) Information regarding my status/my child(ren)’s status as a patient in alcohol and/or drug treatment
(3) Parenting evaluations
(4) Treatment and subsequent evaluations of my service needs by the Ohio START program
(5) Initial and subsequent evaluations of my service needs by the Ohio START program
(6) Any and all information related to any alcohol and drug treatment program(s) that have provided me services
(7) Drug screen results
(8) Summaries of alcohol, drug and/or mental health screening and assessment results and history
(9) Summaries of alcohol, drug and/or mental health treatment/service plan(s), progress and compliance
(10) Date of discharge from alcohol, drug, and/or mental health treatment/services and discharge status
(11) Home Study Records
(12) Other: ______________________________________________________

I authorize the disclosure of the above information to the following people (please initial next to all that apply):

(1) PCSA Case Worker, address
(2) Juvenile court official/Family Drug Dependency and Treatment Court official, address

I further authorize [PCSA] to disclose the following information (please initial next to all that apply):

(1) My name, my child(ren)’s name(s) and personal identifying information about me/my child(ren)
(2) Parenting evaluations
(3) Treatment and subsequent evaluations of my service needs by the Ohio START program
(4) Initial and subsequent evaluations of my service needs by the Ohio START program
(5) Drug screen results
(6) Home Study Records
(7) Other: ______________________________________________________
I authorize the disclosure of the above information to the following people (please initial next all that apply):

_____ (1) Family peer mentor, address;
_____ (2) Juvenile court official/Family Drug Dependency and Treatment Court official, address;

The above listed members of the Ohio START program will use this authorization for disclosure and re-disclosure to administer wrap-around services and intensive case management related to the Ohio START pilot program and to facilitate a cooperative approach through the exchange of disclosed information among the members of the Ohio START program.

This authorization will expire (please select one):

• 365 days after it is signed
• Less than 365 days (please give a specific date or event)

I understand that I may revoke this consent at any time with written notice or other practice in accordance with Provider’s Notice of Privacy Practices, except to the extent that the Ohio START Program acted in reliance on it. 45 CFR 164.508(b)(5)(i).

I understand that the members of Ohio START program may not condition treatment, payment, enrollment, or benefits eligibility on an individual granting an authorization, except in limited circumstances. 45 CFR 164.508(4). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient(s) to carry out their official duties. 42 CFR 2.35(d).

I understand that pursuant to federal regulations governing the confidentiality of alcohol and drug abuse patient records, 42 CFR, Part 2, and the Health Insurance Portability and Accountability Act, Public Law 104-191, information regarding individually identifiable health information and that of my child(ren), including any alcohol and/or drug treatment records and/or any other information relating to past, present, or future physical or mental health condition, is confidential and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This authorization is not sufficient for the purpose of the release of HIV test results or diagnoses.

My signature below indicates that I have received a signed copy of this authorization. 45 CFR 164.508(c)(4).

Date: _______ Signature of Client or other Responsible Party___________ Relationship_______

Date:_______ Witness Signature_____________________________ Witness Print Name:__________