The Sobriety Treatment and Recovery Teams (START) Model: Implementation Manual

Chapter 1: Basic Tenets and Essential Elements of START:

No More Business as Usual

Produced in a Partnership between the Kentucky Department for Community Based Services and Children and Family Futures.

2018

SOBRIETY TREATMENT AND RECOVERY TEAMS (START) MODEL: IMPLEMENTATION MANUAL

PREFACE

The *Sobriety Treatment and Recovery Teams* (START) model is a child welfare led intervention 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 (SUD). START is specifically designed to transform the system-of-care within and between child welfare agencies and SUD treatment providers; it also engages the judicial system and other family serving agencies. It includes a complex array of strategies such as peer mentor supports, quick access to intensive SUD treatment, cross-system collaboration, intensive case management, and a family-centered approach.

Children and Family Futures (CFF) is the only national resource for providing technical assistance, training and consultation on implementing START. CFF has extensive experience in providing technical assistance (TA) and capacity building to sites to implement programs and strategies designed to serve families affected by both child maltreatment and parental substance use disorders.

To be titled a START program, the practices of the model must be implemented with fidelity to the essential treatment components. The full *START Model Implementation Manual* is only available through formalized technical assistance and training. However, one chapter is included at https://www.cffutures.org/ for your information. This first chapter, entitled: *Basic Tenets and Essential Elements of START: No More Business as Usual,* covers the theoretical background of START, the essential implementation components, and a sample logic model. Please feel free to download chapter one of the implementation manual to learn more.

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- Parents and their children and extended families
- The University of Kentucky, Targeted Assessment Project
- Cuyahoga County Division of Children and Family Services

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CHAPTER 1: BASIC TENETS AND ESSENTIAL ELEMENTS OF START: NO MORE BUSINESS AS USUAL

Summary: This chapter introduces the elements that characterize the Sobriety Treatment and Recovery Team (START) Model and are essential in achieving program success. Included are the theories that explain the change mechanisms, a sample logic model, and a listing of core intervention components. Narrative quotes from an array of individuals involved in the START program are provided to illustrate these concepts.

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1.1 INTRODUCTION

1.1.1 Background and Rationale

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

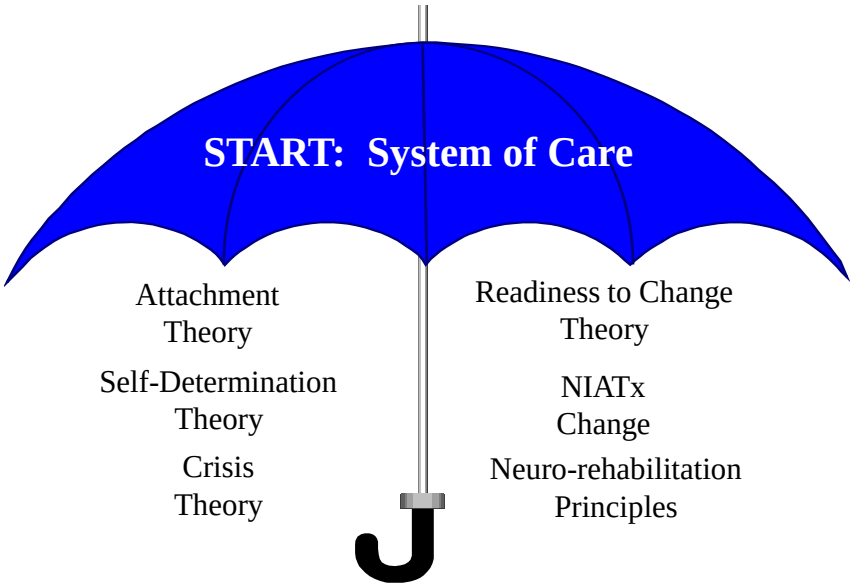
For families with both parental SUD and substantiated CA/N, family problems and child risks are further compounded by poverty, domestic violence, mental health issues, social isolation, head injuries, poor parental capacity, and criminality (Ellerbe et al., 2011; Scannapieco & Connell-Carrick, 2007). Neglected children with parental SUD experience more exposure to traumatic events (Sprang, Clark & Staton-Tindall, 2010). The time frames defined by ASFA (Adoption and Safe Family Act; Children's Bureau, 1998) allowing families 15 of 22 months to recover or face terminating parent rights (TPR) underestimate the strength of SUDs, the complexity of family needs, and the time needed for recovery and learning sober parenting (Herring, 2000). Maltreated children of parents with substance use disorders often remain in state custody longer and experience poorer outcomes than other children (GAO 2003).

The science of identifying and implementing treatment strategies for this population is still in its infancy. Ryan, Marsh, Testa, and Louderman (2006) found that recovery coaches helped parents with children in state custody access SUD treatment more often and more quickly, and reunify with their children. Integrated programs between CPS and SUD treatment providers that embed strategies with evidence of effectiveness such as motivational interviewing, recovery coaches, co-location of services, peer or family mentors, and family drug court practices are producing more potent service delivery models with improved outcomes (Boles, Young, Moore & DiPirro-Beard, 2007; Cohen & Canan, 2006; Coll, Stewart, Morse & Moe, 2010;

Green, Furrer, Worcel, Burrus, & Finigan, 2007; Gregoire & Schultz, 2001; Huebner, Willauer, Brock, & Coleman, 2010; Lee, Esaki, & Greene, 2009; Marsh, & Cao, 2005; Oliveros & Kaufman, 2011; Twomey, Miller-Loncar, Hinkley, & Lester, 2010).

For families affected by substance use disorder, the Sobriety Treatment and Recovery Team (START) Model provides the ground-breaking paradigm shift needed to improve child welfare outcomes for parents and children. START developed in Cuyahoga County (Cleveland), OH (Annie E. Casey Foundation, 2008; Young & Gardner, 2002) as an integration of best practices that recognized the tension between parent sobriety and child safety. The START model was designed to intervene rigorously to recruit, engage, and retain parents and caretakers in substance use disorder treatment while keeping children safe.

1.1.2 Theoretical Model



The concepts of evidence-based theories support the program strategies of START. Theories provide the rationale for the change mechanisms within a program; they are explanatory and naturally guide actions. Theories are broad statements that explain the interaction of events, people, or products and any change process. Theories guide program practices and the evaluation of the program; evaluation in turn tests and may refine the concepts of the theory.

The Sobriety Treatment and Recovery Team (START) Model operates using a System of Care approach as shown in Figure 1. The families served in START have complex needs. The parents, children and often relatives or other caregivers require services and supports across multiple providers, multiple agencies, and within several systems. The Systems of Care Approach is an organizing framework for such populations, served within multiple agencies (see for example, Pires, 2002; Lyons, 2004).

The hallmark of a system of care approach is collaboration between agencies and coordination of services toward shared outcomes. Every agency works together to achieve a common set of outcomes for the family at the center of the work; there is one intervention plan (Huebner, Young, Hall, Posze, & Willauer, 2017). Within the system of care approach, family members including children have a voice in the plan, understand the desired outcomes, and partner with providers to monitor progress and identify needs and solutions. Services are individualized for the adults and children in families using a "wrap-around" array of flexible supports, natural supports, formal services, and emergency adjustments. The system of care approach has become increasingly focused on achieving results through data-driven feedback that focuses on continuous quality improvement for all involved agencies.

Under the system of care 'umbrella' multiple theories and related best practices guide specific intervention strategies at different points in time. Recovery from substance use disorders requires a sustained behavioral change over a life-time; it is very hard. The START program is initiated with a report of child maltreatment to Child Protective Services (CPS) and the preliminary finding of evidence to support the report. Such a CPS investigation, often paired with court intervention and potential for loss of child custody usually sparks a crisis for parents and produces a readiness to change. Crisis theory (e.g., Borgman, Edmunds, & MacDicken, 1979) and Stages of Change Theory (Prochaska, DiClemente et al., 1992) explain the mechanism for change.

Crisis is a turning point in a person's life, a stressful life experience affecting the stability of an individual so that their ability to cope as usual may be seriously compromised. Crisis exists when the event will lead to considerable disruption, and the person is unable to resolve the disruption with their usual coping methods. Crisis is a temporary state of upset, disequilibrium, accompanied by disorganization that is time limited for approximately 4-6 weeks. Crisis theory posits that the best time to act, to activate change, is at the peak of the crisis. Parent with substance use disorders, may want to flee the situation, engage in more substance use, or try other maladaptive strategies. START capitalizes on the crisis by holding a family team meeting bringing all the supports to the table including the treatment provider and family mentor. They begin the assessment immediately and the mentor supports the parent through the change process. Ideally, this crisis and the immediate and intensive support engage the parent in treatment and provide a more acceptable and accessible alternative to flight. For other parents, the pull of SUDs is so strong that it may override their parental love for the child; they may flee or just go through the motions without necessary change. Sometimes a second or third crisis situation with their personal life or actual loss of their children sparks readiness to change.

Along with crisis theory, the stages of change theory (Prochaska, DiClemente et al., 1992) asserts that the behavioral change progresses through a cycle of five continuous but distinct stages. Movement between stages depends on a complex set of forces that alter an individual's thought processes and behavior. With SUDs, an individual may require a number of trials through all or several of the stages of change before a long-term behavioral change goal is achieved. The five stages are:

- Pre-contemplation, with no perceived need or intention to change.

- Contemplation, with awareness of a problem but no commitment to take action.
- Preparation for action that combines intention and initial behavior change.
- Recent change, with significant modification of behavior.
- Maintenance with sustained behavioral change.

The START program staff, including treatment providers, applies both the crisis and stages of change model to help parents initiate recovery. For example, motivational interviewing by the whole team is designed to improve readiness for change. Parents may enroll in treatment initially not really intending to change or even recognizing the need for change; they may only want to avoid the humiliation and pain of losing their child. CPS staff, family mentors, and treatment providers continually assess the readiness to change, use the crisis and motivational strategies including incentives to maintain progress toward change, and persist until the readiness is solidified. Relapse is viewed as another crisis with an opportunity for learning and a need to move through the readiness stages again, recognizing the difficulty of change and the strength of SUDs.

START also adheres to the principles of self-determination theory (Ryan & Deci, 2000) throughout the program. Even in the depth of the substance use cycle, it is important to treat the parent as they are capable of becoming. Self-determination theory proposes that humans have three basic psychological needs of autonomy, competence, and relatedness. The theory focuses on the processes by which a person acquires the motivation for initiating new behaviors and maintaining them over time. A sense of autonomy and competence is critical to the processes of internalization and integration so that the person comes to self-regulate and sustain behaviors. Autonomy is promoted by providing choice to the adult or child; they have control and can choose their own path. Competence comes from recognizing and building upon strengths, not only deficit reduction. Equally important is relatedness, people are more likely to adopt behaviors promoted by those they trust. Initially individuals in START may feel externally controlled by substances, people in their lives, CPS, the courts, or treatment providers. They may comply. But, if they are to be successful in the long-term, they need to understand their choice, how to regulate their choices and emotions and strengthen their personal assets, and they need long term relationship supports. START foster autonomy through group decision making and involving people in making choices, supports competence by focusing on strengths and progress, and builds immediate relationships with their CPS team, family mentor and providers while enhancing participation in community supports for long-term recovery.

START also adheres to the tenets of attachment theory (e.g., Baumeister & Leary, 1995; Bowlby, 1979; Kramer, 1992) that explain human interaction, loss due to separation, child neurological and psychological development, and prediction of resilience and social interaction over time. The good news is that the effects of attachment are somewhat malleable over time and many parents have had problematic attachment themselves; they need nurturance. For infants, secure attachment comes from predictable parenting that is nurturing, stable, and responsive to the infant and

young child. Without such parenting, child development including neurological development, cognition, response to stress and social relatedness will be impaired to varying degrees over the life span. START seeks child safety first and foremost. Children need a safe and nurturing environment to develop. Parenting also has benefits to the adult in reinforcing their own competence and bonding. When children are removed and placed in state custody or with relatives, the intent is to provide safe and permanent parenting. Because of this, separated parents involved with START have frequent visits with their children so that they bond, learn to parent, and are familiar and safe to the child.

Two other theories or ideas guide START. The NIATx (the Network for the Improvement of Addiction Treatment) model promotes small changes in substance use disorder treatment that will achieve its four aims of reducing wait times to get into treatment, reducing no-shows, increasing admission to treatment, and improving continuation at least through four appointments. The simple changes promoted by NIATx have been shown to improve outcomes and are consistent with the START expectations of quick and intensive treatment. These indicators are measured as part of the program evaluation and fed back to providers as measures of fidelity and ways to improve adherence to the program model.

Finally, substance use disorders compromise brain structure and function. People recovering from substance use disorders struggle with executive functions like planning and goal setting; a seemingly simple task may seem overwhelming. Their struggle with daily living tasks often looks similar to the struggles of people with traumatic brain injuries. Thus, the principles of neurological rehabilitation support START (e.g., Barnes, Ward, McMillian, & Greenwood, 2003). Large tasks may need to be broken down into small steps and reinforced with written notes or visual guides. Daily tasks may need to be structured by the treatment team with guidance such as a checklist on what needs to be done. The family mentor or other members of the treatment team may need to coach the parent on daily living tasks such as paying the electrical bill or cooking a meal. Because the adults served in START are young adults, they may also have had little prior experience with independence. Technical supports such as calendars, watches, lists, or notebooks may serve as functional aides. The parents may need modeling and practice to learn employment or other skills. Navigating the system of care can be overwhelming for people recovering from the haze of SUDs and they need guidance and supports to regain function.

1.1.3 Logic Model

Inputs	Activities	Proximal Outcomes	Distal Outcomes
Family Mentors (persons in successful long-term recovery)	Intensive recovery support for parent, Coaching on sober parenting and daily living skills.	Increase the parent's compliance with and completion of treatment. Empower the parent.	Improved parental protective capacity.
Specialized CPS workers and 1 supervisor per team.	Intensive CPS case management, service provision, team building.	Reduce the number of repeat referrals among families served. Prevent recurrent of child abuse and neglect (CA/N).	Reduced short and long-term recurrence of CA/N.
Training supports for CPS, SUD treatment providers, the courts, and others.	Cross-training between systems. Specialized skills training.	Adherence to best evidence supported practices in both agencies and the courts. Fidelity to the model.	Improved parental rates of sobriety.
Expanded Intensive out-patient Substance use treatment	Whenever possible, parents receive treatment in their community and stay at home.	Increased visitation with children if removed, bonding with child if at home with safety supports.	Reduce the amount of time to permanency for children.
Agreements with Substance Use Disorder Treatment Providers	Agreements for quick access, retention, intensive treatment.	Access, timely and intensive substance use disorder treatment. Level of care matches parent's needs.	Children remain at safely at home.
Supports from local, regional network and local and state steering committee	Community capacity building and targeted service development. FTM facilitation.	Enhanced resources and coordination of resources for families and children	Reduce children entering state custody.
Partnership with the Courts	Flexible yet focused work toward child permanency at critical decision points in cases.	Individualize decisions about out-of-home care.	Increase community supports for sobriety.
Individual and family mental health counseling.	Trauma and focused services to child, parent, and other family members.	Improve parent and child protective factors and resilience.	Reduce re-entry into foster care.

1.2 CORE INTERVENTION COMPONENTS

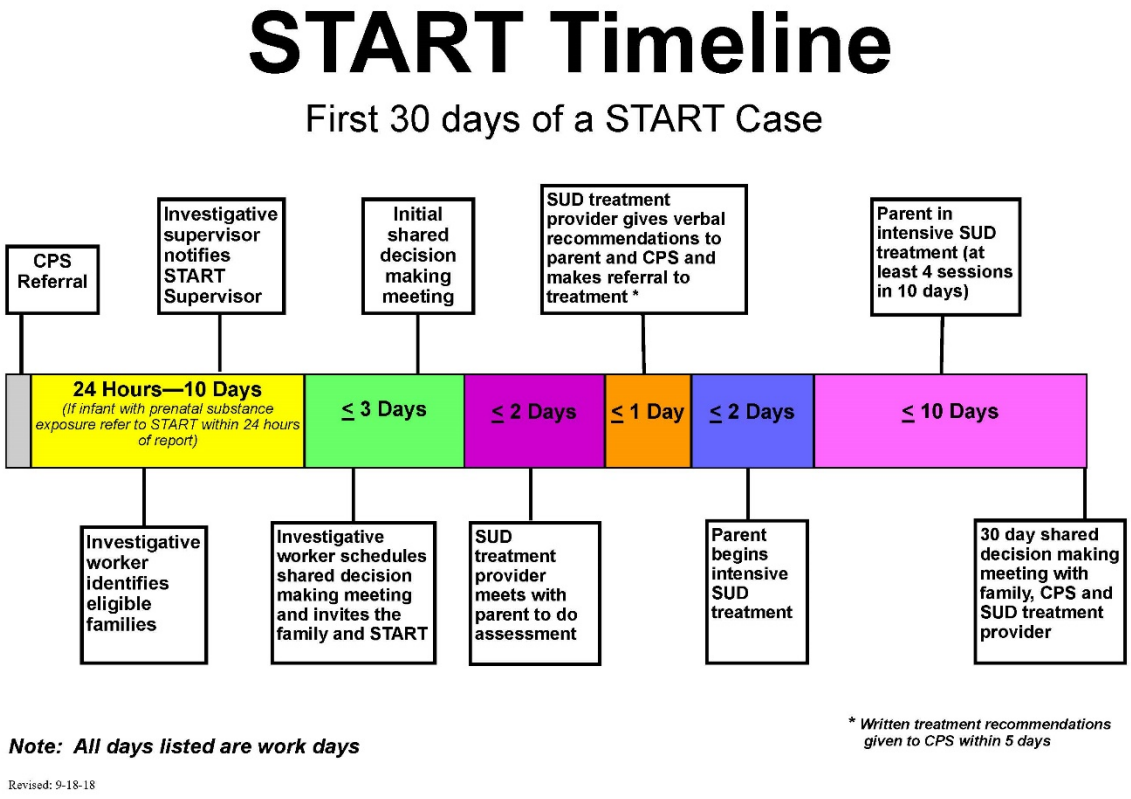
1.2.1 Essential Components

The following list includes the essential practices that must be included in a program in order to call it a START program. These core implementation components are mandatory: Each core implementation component must be included in a START program. The reader consents to abide by the agreement that any program labeled as START will adhere with reasonable fidelity to including these essential practices that are explained in detail in subsequent chapters.

1) First and foremost, START is a child welfare program initiated by child protective services (CPS) and driven by CPS for families with co-occurring child maltreatment and substance use.
2) A strong collaborative partnership with substance use disorder treatment provider(s) is required to coordinate treatment services to the client. The collaboration is supported by contracts and agreed upon START tenets.
3) The family is the client and the focus; family includes children, mothers, fathers, significant others, caregivers such as foster parents, and other relatives.
4) START must be based on principles implemented by decision making that is shared by families, CPS staff and service providers that may affect the child well-being.
5) START must be constantly evolving toward the use of best practices in CPS and substance use and co-occurring mental health disorder treatment, including trauma treatment.
6) START respects that children optimally belong with their family, seeks to promote parent/child bonding, and keeps children safely with family whenever possible.
7) Adherence to the START timeline that ensures quick access from CPS report to treatment. This timeline is included in the next section.
8) CPS practice and substance use disorder treatment must be intensive. CPS must adhere to the Minimum Work Guidelines included later in this manual.
9) Family mentors are essential to START. They must be people in long-term recovery from substance use disorders with drugs and/or alcohol with experiences that sensitize them to child maltreatment and family SUDs. They must be employed and housed and supervised by CPS.
10) One family mentor must be paired with one CPS worker.
11) Caseloads for the mentor/CPS pair must be no more than 12-15 families.
12) START must be engaged in continuous quality improvement guided by program evaluation data.

1.2.2 START Timeline

Provided as a guide for action implementation by workers, the following timeline (as shown in Figure 3.) illustrates appropriate progression of a START case over the first 30 to 45 days of the case. Following the timeline is essential to the model, but achieving adherence to the specific day limits may require time for problem solving and solidifying changes in practice.



1.2.3 Tenets

Throughout the development and early implementation of START, program developers agreed that all agencies involved in client recovery needed to agree upon and adopt certain beliefs to provide the best possible and most consistent service delivery solutions. Those beliefs are set forth in formally adopted tenets - agreed to be by the agencies - that clearly stated the principals that will guide the program.

The original tenets were based on a 12-step model and developed over the course of three years. To understand and modify the tenets for any site, administrators from each of the agencies – CPS, SUD treatment, and the office of the court (called the 'network') – may need to meet many times. The meetings should be highly participatory and may be lengthy and include general discussions, arduous exchanges, arguing and advocacy. The goal of the discussion is to explore the implications of each tenet for how the program serves families. Each agency brings to the discussions the sum of each agent's particular experiences, knowledge, beliefs

and agency doctrines and expectations. The end result will be a blending of beliefs into unified statements of guiding principles. The tenets will provide a foundation from which the network can be built and, in succeeding years, can grow. Building the network requires the steadfastness and stability of set principles that everyone can be guided by. Simultaneously, the tenets are meant to be fluid, in order to accommodate new knowledge, network growth and changes within the community and families served.

New sites implementing the START program should actively collaborate with CPS workers, family mentors and SUD treatment providers to modify the specific START tenets but should at all times rely upon the basic framework of the tenets. The framework serves as the underlying philosophy from which START operates. The specific START tenets are:

1) We acknowledge that SUDs can be a disease that requires abstinence. We support the recovery philosophy and understand that relapse may occur, requiring modified and/or intensified services.
2) We believe that the neglect and abuse of children is often associated with SUDs. The potential for losing custody of their child may often be the key to bringing the parent into treatment.
3) We understand that since the other needs of the parent are often rooted in the SUDs, the initial focus of services should be directed toward assessment and treatment of the SUDs and co-occurring disorders.
4) We believe that a sober, supportive living environment is critical to the recovery process, and optimal child development.
5) We are aware that no one partner contains all the resources and expertise to respond adequately to the needs of the parent who is addicted and who has abused or neglected their children.
6) We are committed to modifying agency policies or procedures which may impede the family's cooperation with all service providers and we are committed to engaging with both family members and other service providers in all significant decision making.
7) We commit ourselves to working cooperatively together, and to consulting on important decisions with each other and with the parents, to develop and implement plans to meet each family member's individual needs.
8) We believe that keeping parents and children closely connected is an essential factor to enhance or preserve their relationship.
9) We believe that when a child must be removed from his family for protection, the child has the right to frequent visits to family during the parent's treatment.
10) We agree to work cooperatively toward a goal of reunification of the family and child as quickly as the child's protection can be assured. If the parent is unable to provide the child a safe and permanent home, consideration will be given to other permanency options.

11) We believe that both the family and the child have the right to continuity of health care services.

12) We are committed to creative approaches to child care, improving parenting skills, building family support systems, etc. for those who are willing to enter treatment.

1.3 BASICS OF PROGRAM IMPLEMENTATION

1.3.1 Maintaining Fidelity

Implementation of a program such as START is a process with several stages from program adoption through long-term sustainability that will require up to four years of evolution to achieve full implementation (Fixsen, Naoom, Blasé, Friedman & Wallace, 2005). Each stage of implementation has unique challenges as described in Chapter 5, but an ongoing challenge is to attain and then maintain fidelity to the treatment model.

Fidelity is defined as implementing the strategies of the program so that the actual practices match the program description; program descriptions are the ideal desired practices. Program implementation of a program such as START requires enormous changes in policies, practices, partnerships, and processes that initially may create confusion and a general drift toward the previous familiar practices. Because implementation is a process that requires problem solving and learning to overcome barriers and achieve the desired practices, fidelity monitoring is essential to assist the program toward full implementation. For example, the START timelines specifies that providers must conduct an intake assessment for the referred START parent within 2 days. Fidelity monitoring tests the implementation of the program to determine how many referred parents are assessed within 2 days and overall how many are assessed in less than or more than 2 days. This information is used to drive program improvement.

Fidelity monitoring is the touchstone of program implementation that keeps practitioners focused on 'the prize.' The team receives regular feedback and access to data for their own monitoring as part of the empowerment evaluation; this regular feedback then stimulates problem solving sessions and opportunities for teaching by the START leadership. Of course, fidelity monitoring also documents when the target practice is attained and allows practitioners to celebrate success as well. Fidelity monitoring is critical to overall program evaluation as part of the formative evaluation and as a covariate in outcomes or results evaluation. Without full implementation of the program strategies, the program outcomes are likely to be diminished. Further explanation of fidelity monitoring is included in the Program Evaluation chapter.

1.4 CUSTOMER EXPERIENCES AND FEEDBACK

1.4.1 Narratives

The following statements illustrate the impact of the change in doing business inherent in the START program. Comments were taken from interviews with community partners, case workers/supervisors, and clients.

Community Partners:

"It is easy to miss how fundamentally and profoundly helpful — immediate access to treatment — is."

"START creates a vision of what can be and what is possible. This inspires all involved and sets a higher standard and expectation with changes in fundamental assumptions."

"When we first envisioned this, we assumed that we would primarily see single woman and that has not been true. In START we are seeing the men too. Mom and Dad – couples – we treat them separate in IOP and together."

"At first I was very skeptical of the idea of keeping children with their families. But, I have come to trust the START team that they will monitor the situation and keep children safe. I still am scared at times, but it does seem to work out and it makes my job as a judge easier since I have their support."

CPS Case Workers/Supervisors:

"Just knowing that families can access what they need changes the entire case planning process."

"Most of the time clients call us. We don't have to call them and track them down. They begin to like us and know that we are there to help and prevent removal or their children or help them reunite with their children."

"When it works, it works well together…We are all working together to find solutions and strengths… It would be nice if we could do all CPS cases this way."

"With START I have a much better grasp on the cases and I know the clients. In other cases, supervisors have less hands-on knowledge."

"My understanding of dependency and the ramifications of it have increased 10-fold since START. When I was a front-line social worker things were very different. The whole culture has changed from alcoholism to drug addiction."

"I have spent my entire life advocating for better treatment. Ten years ago no one cared; 15 years ago they denied addiction. Now, addiction is the new vogue thing. Generally there has been fatalistic thinking about addiction. I really feel that being involved with START has made me a better social worker and administrator. I am growing in my ability to serve families – a real big boost for me. I'm more receptive to my staff. It (START) has refreshed my spirit."

START Clients:

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

“I get help with mental health counseling that I have no money to pay for. I had a lot of trauma and need help. I get counseling, drug tests, and lots of support.”

“I never knew about addiction, but they taught me what addiction is, what it does to you in the long run, how it changes your brain and how to recover.”

“It’s hard to stay sober in a substance abusing community. The counselor helped me learn that addiction is a disease, and how to deal with the substance abusers (SIC) around me. We relapsed several times, but they keep working with us and help us to stay sober longer.” “As a drug abuser, I lost my maternal instinct… but now I am excited to see my children.” “I lost the ability to reason during my addiction. Even when I was clean my thinking was still like a drug addict. My days were chaotic and crazy. They (START team) structured my days to set goals of daily living.”

“I really liked the idea of have recovering addicts to help. They (mentors) know what it is like and make CPS more personal and credible; we have a better chance to make it with someone we can identify with. Others learn from books, but I am not a book learner. Mentors know what it is like. Now I see that it was a blessing from God that he sent CPS to my door. I was tired of using but didn’t know how to quit. I was told by the judge to cut out cocaine. I spoke to counselors saying that I was going to get and stay clean and sober and not go back to prison, but I didn’t know how. With this child, I knew that I do not want her to call anyone else ‘mommy’; I knew that I wanted to get it right. So, I asked for help, utilized the tools and group time, took feedback and suggestions. Although I felt like using during the process, my main motivation was to keep my child.”

“A lot of people could have used it (START) years ago when the idea was to get the addict out of the child’s life forever. I had all the excuses, but now I am proud of myself and living life clean and sober. I stay in touch with recovery supports and walk to the meetings. I contact my sponsor 3-4 times per week by phone and read my big book to help me stay on track. I am getting mental health counseling and this has helped me see why I used drugs to cope.”

“The contrast in my life is very stark. Before it was hell; I was lonely, desperate, afraid, just existing, and numb. Now, I am alive; I have feelings and they are good. I am loving life right now and so happy that I can’t find the words.”

“START provided me with the support to get into and stay in treatment. Having transportation lets me do the program. START helped me get a phone and a humidifier for my baby. They take me and the baby to appointments. We have gas cards to help with transportation. I get help with mental health counseling that I have no money to pay for. I had a lot of trauma and need help. I get counseling, drug tests, and lots of support.”

“START helped me become self-sufficient and more adult. I have to keep appointments and do things even when I don’t want to. I am becoming more reliable, responsible, and better able to take care of my kids. I never cared before but now I am working, staying sober, going to NA and providing for my family. I am doing things I never thought I could.”

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