



THE OHIO STATE UNIVERSITY



Linking Systems to Implement Substance Use Treatment in Child Welfare

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- Public Children Services Association of Ohio (US Department of Justice/OH Attorney General 2019-VOCA-132234677) (Freisthler)

Substance Misuse Affects Families

Ohio & Opiates...

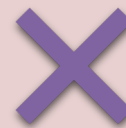
- **1st** in absolute numbers of heroin- and synthetic opioid-related deaths
- **1st** in heroin-related, age-adjusted death rates;
- **5th** in synthetic opioid-related, age-adjusted death rates
- Ohio overdose death rate >3x national rate



Rising numbers of children entering foster care in Ohio due to caregiver substance misuse (PCSAO, 2016; Radel, Baldwin, Crouse, Ghertner, & Waters, 2018).



Caregivers' SUD treatment needs often go unmet (GAO, 2018)



High likelihood of substantiated allegations, foster care placement, and failure to reunify (Freisthler et al, 2017; Wulczyn, et al, 2019; Lloyd, Akin, & Brook, 2017)

Sobriety Treatment & Recovery Teams (START)

Key Components	
1	Early identification of families affected by substance use disorders (screening)
2	Quick access to quality treatment
3	Increasing parent recovery services and engagement in treatment through peer support
4	Focusing on family-centered services and parent-child relationships
5	Increasing oversight for parents and children
6	Sharing responsibility for parent accountability and program outcomes across service systems
7	Collaborating across service systems and with the courts

Child welfare intervention for families affected by child maltreatment & parental substance use disorder (SUD)

- ✓ Expedites parents' access to treatment
- ✓ Improves treatment retention
- ✓ Increases level of sobriety
- ✓ Keeps families together during and after the intervention

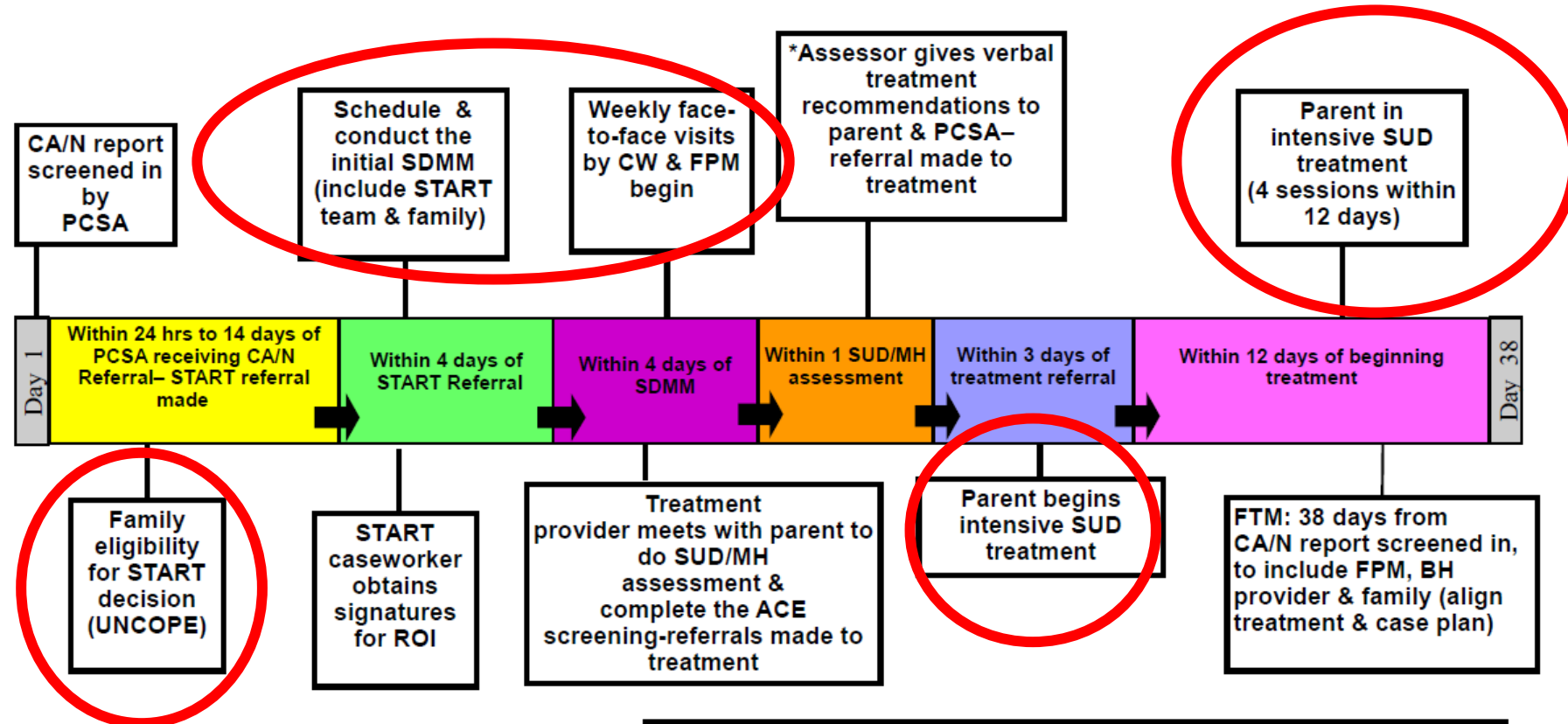
Hall, Wilfong, Huebner, Posze, & Willauer, 2016

Huebner, Posze, Willauer, & Hall, 2015

Huebner, Willauer, & Posze, 2012.

Initiation of a START Case– 38 Days

- Ohio START is adapted from the national model to also address trauma exposure
- Began implementation in April 2017 with 17 counties

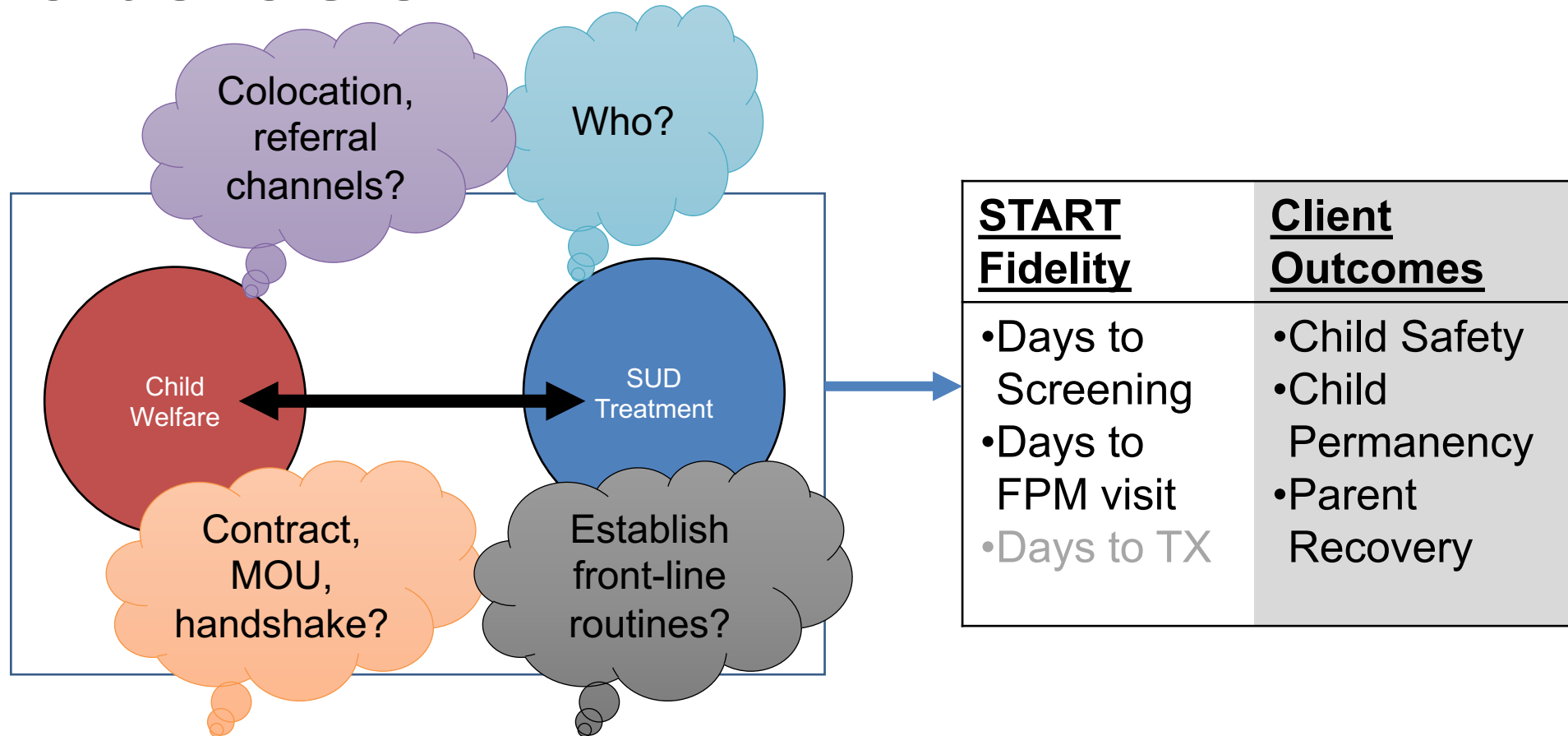


Note: All days listed are calendar days

*Written treatment recommendations given to PCSA within 5 days

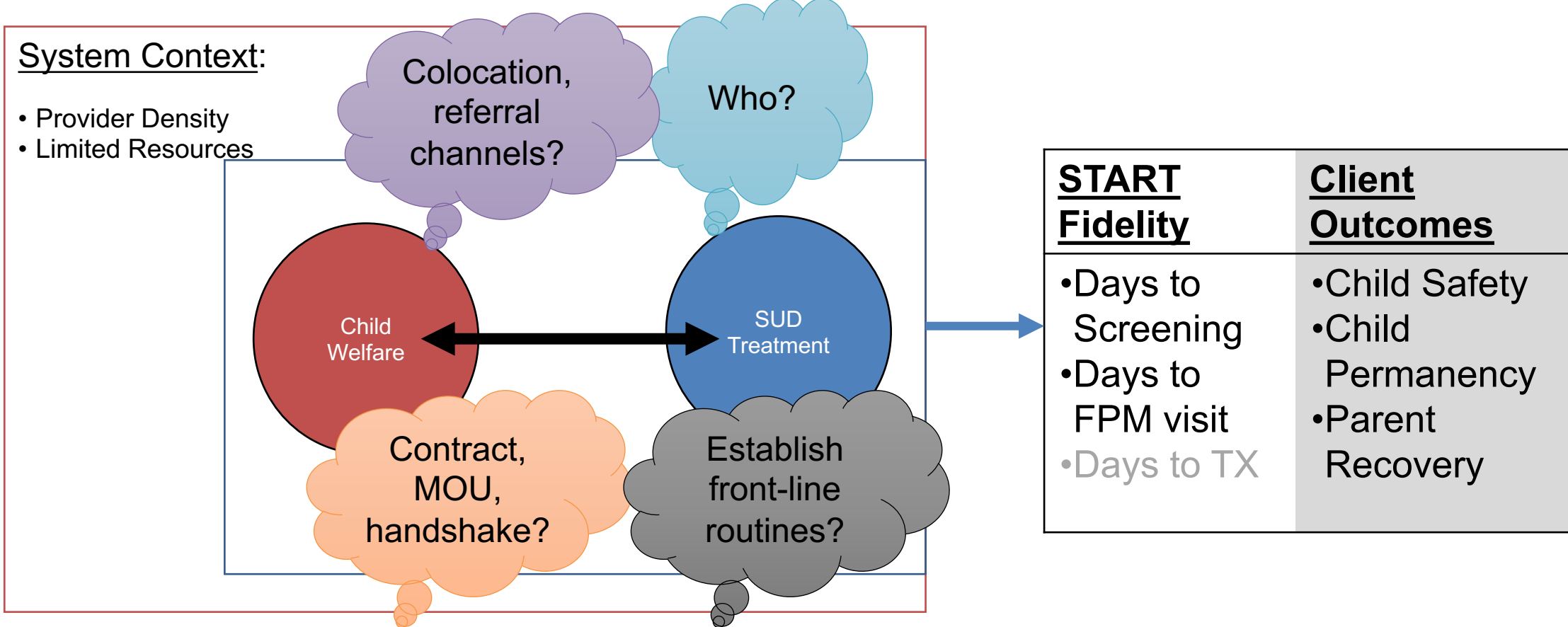
Child Trauma Screening (CTAC) & referral for further assessment completed within 30 days of START referral.

Implementation Depends on Collaboration...



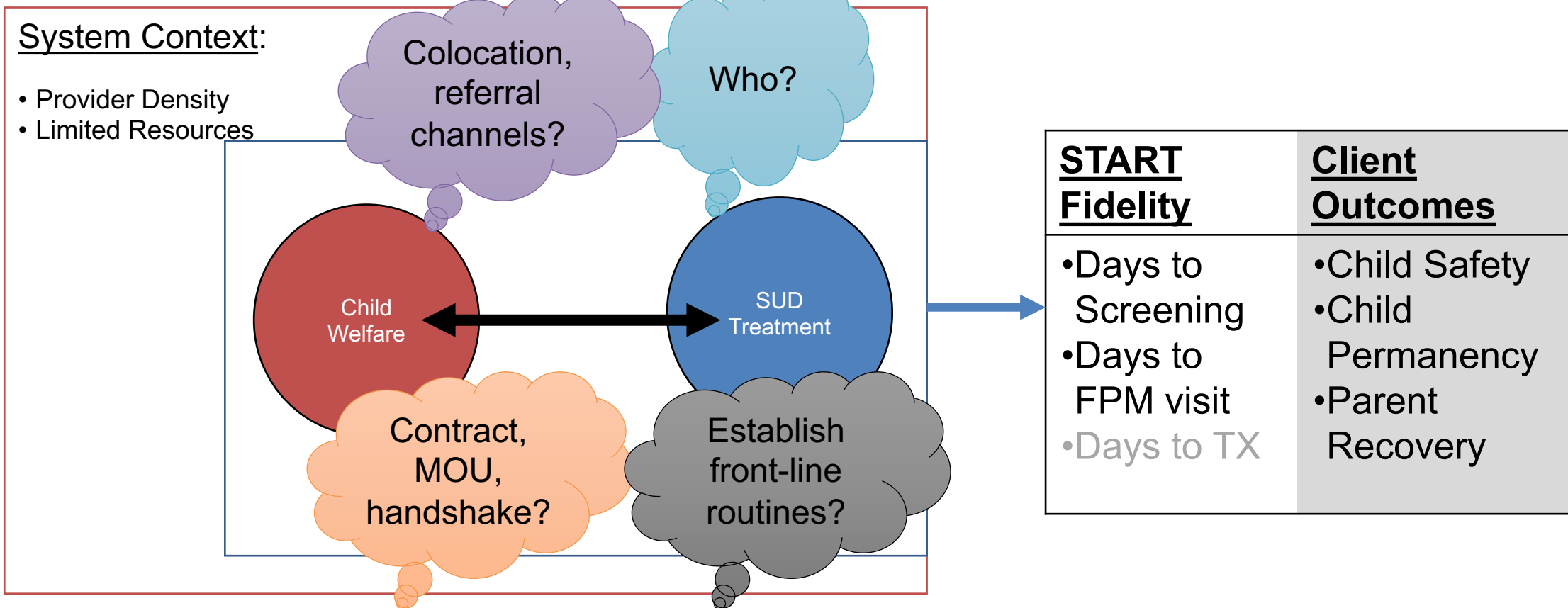
...& Collaboration Challenges Delay Implementation

Implementation Depends on Collaboration...



...& Collaboration Challenges Delay Implementation

How does the county context shape collaboration & implementation?



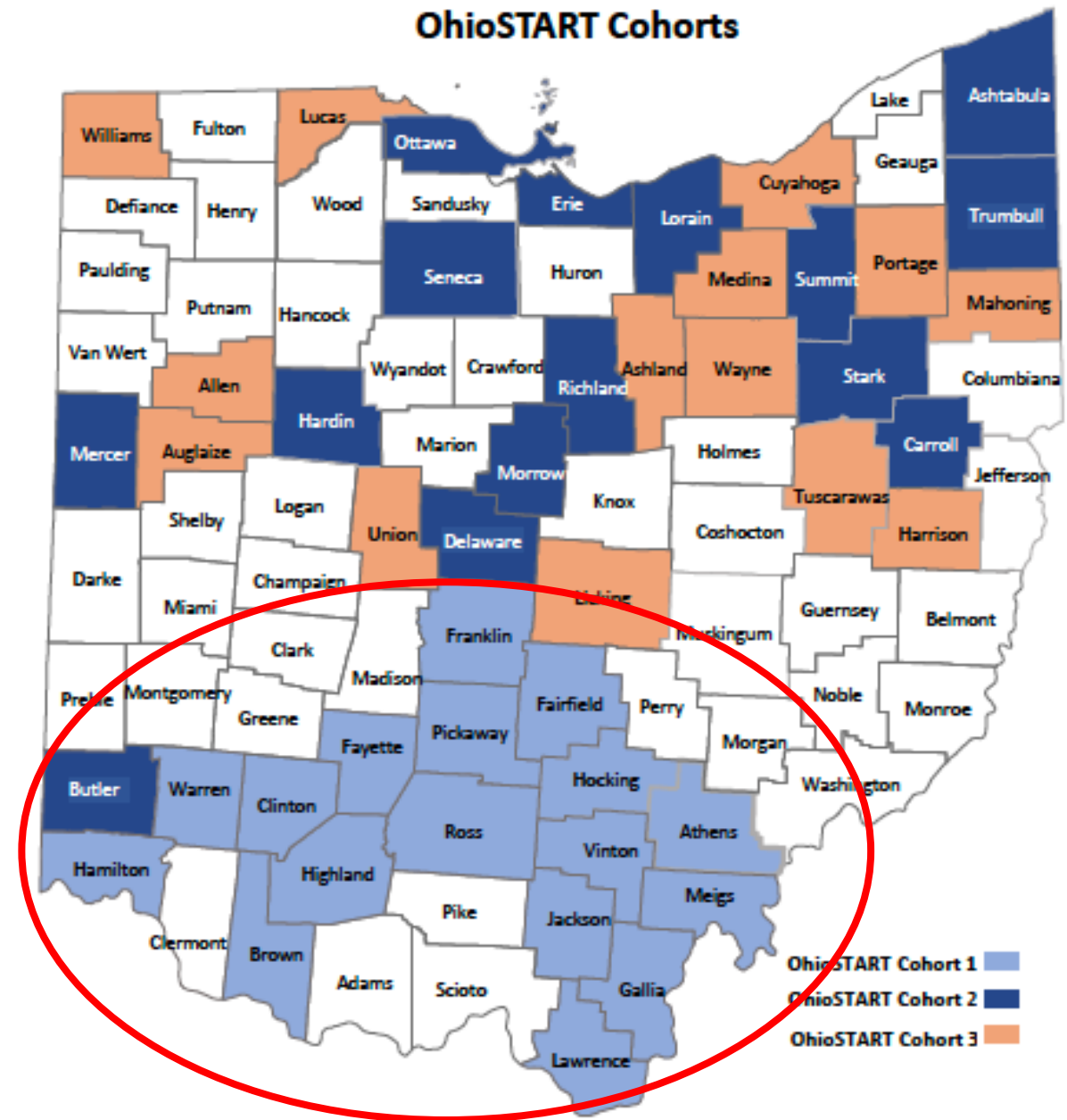
****We expect stronger START fidelity in counties with more providers and stronger partnerships.**

Design & Context

Cohort 1 = 17 Counties

- Small/Medium sized (76%)
- Rural (53%)
- Appalachian (59%)
- 271 families as of Sept. 2019

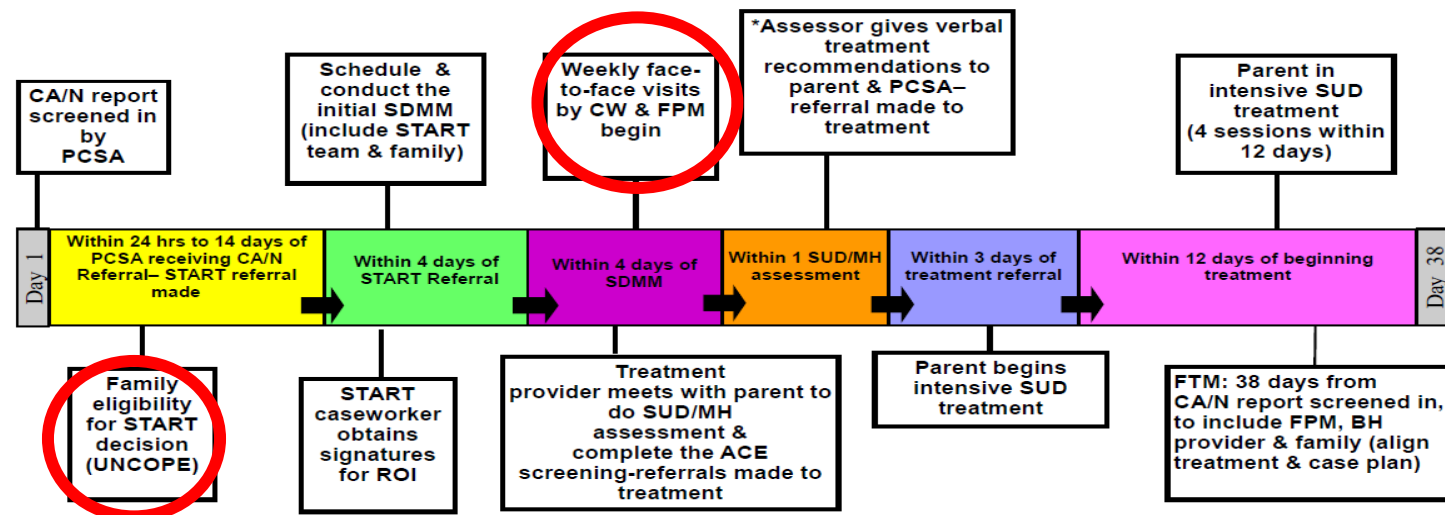
*Multiple holistic case study



Data - Fidelity

Variable/Indicator	Data Source	Notes
Fidelity		
Days to UNCOPE	Needs Portal	Avg. for caregivers in county
Days to 1 st FPM mtg	Needs Portal	Avg. for cases in county

Initiation of a START Case– 38 Days



Note: All days listed are calendar days

*Written treatment recommendations given to PCSA within 5 days

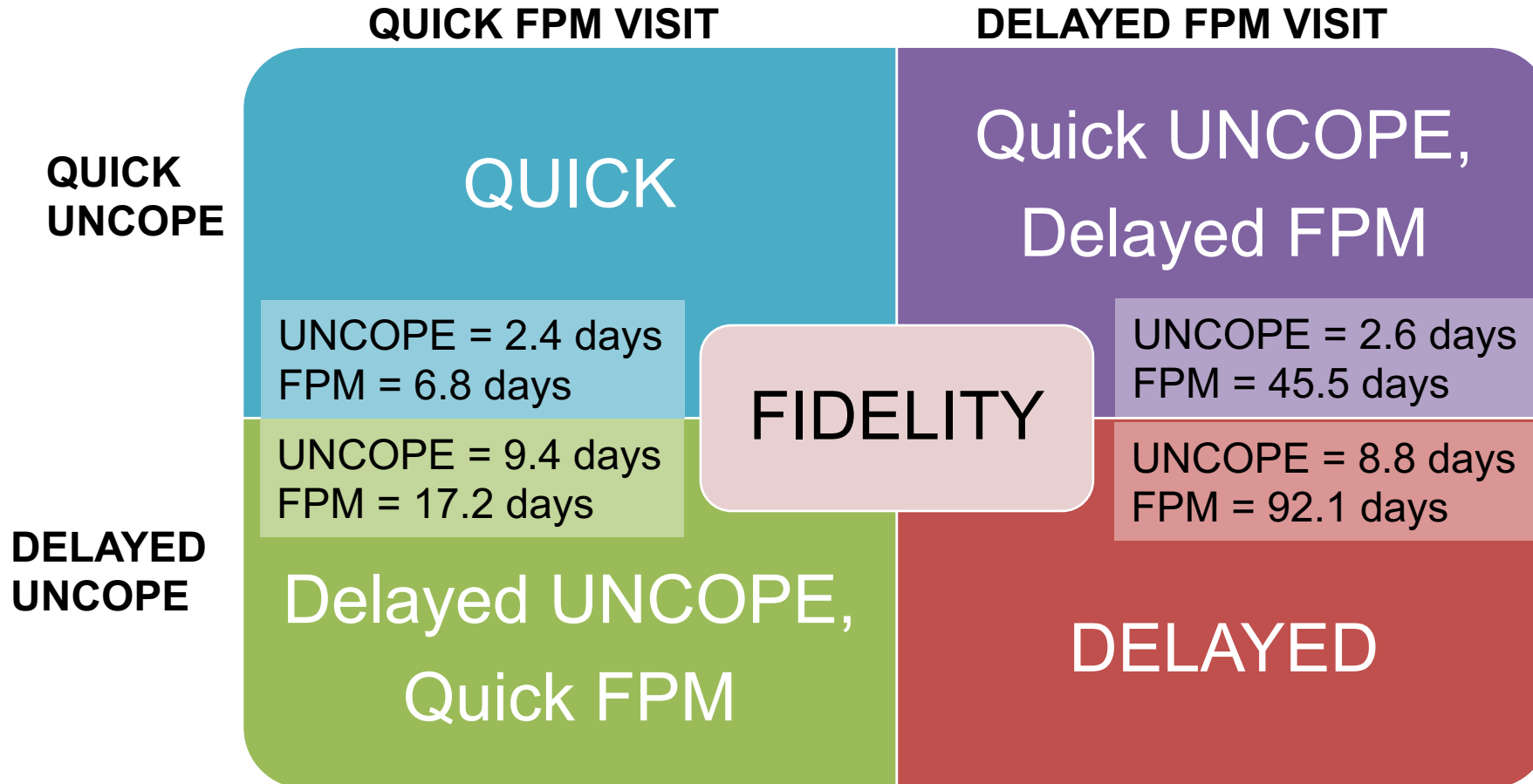
Child Trauma Screening (CTAC) & referral for further assessment completed within 30 days of START referral.

Data - Conditions

Variable/Indicator	Data Source	County Aggregation
<i>Cross-System Partnerships</i>		
Formal Partnership (yes/no)	Contracts, MOUs, other agency documents	Presence/absence of a formal partnership w/BH org
# of SUD referral partners	Follow-up worker surveys (between 1 - 2 years post imp.)	Avg. for workers in county
Frequency of SUD referrals	Follow-up worker surveys (between 1 - 2 years post imp.)	Avg. for workers in county
<i>Treatment Availability - Provider Density</i>		
# of SUD treatment orgs	SAMHSA Behavioral Health Treatment Locator	Total for each county

Results

	M	Mdn	Range
Days to UNCOPE	5.4	5	0-16
Days to 1 st FPM	30.9	24	1-156



Results

	All (n=17)	Quick Both (n=4)	Quick UNCOPE (n=5)	Quick FPM (n=5)	Delayed Both (n=3)
<i>Fidelity</i>					
Days to UNCOPE	5.4	2.4	2.6	9.4	8.8
Days to FPM	30.9	6.8	45.5	17.2	92.1

Results

	All (n=17)	Quick Both (n=4)	Quick UNCOPE (n=5)	Quick FPM (n=5)	Delayed Both (n=3)
<i>Fidelity</i>					
Days to UNCOPE	5.4	2.4	2.6	9.4	8.8
Days to FPM	30.9	6.8	45.5	17.2	92.1
<i>Cross-System Partnerships</i>					
Formal Partnerships	65%				
SUD Referral Partners	2.9				
SUD Referral Freq.	2.7				
<i>SUD Availability</i>					
# of Treatment Providers (range, outliers)	7.4 (0-11, 26, 46)				
<i>County Context</i>					
% Small/Medium	76%				
% Rural	53%				
% Appalachian	59%				
Avg. # of Cases	15.9				

Results

	All (n=17)	Quick Both (n=4)	Quick UNCOPE (n=5)	Quick FPM (n=5)	Delayed Both (n=3)
Fidelity					
Days to UNCOPE	5.4	2.4	2.6	9.4	8.8
Days to FPM	30.9	6.8	45.5	17.2	92.1
Cross-System Partnerships					
★ Formal Partnerships	65%	50%			
SUD Referral Partners	2.9	2.4			
★ SUD Referral Freq.	2.7	3.3			
SUD Availability					
★ # of Treatment Providers (range, outliers)	7.4 (0-11, 26, 46)	4.5 (1-4, 11)			
County Context					
★ % Small/Medium	76%	100%			
% Rural	53%	75%			
% Appalachian	59%	100%			
Avg. # of Cases	15.9	16.3			

Results

	All (n=17)	Quick Both (n=4)	Quick UNCOPE (n=5)	Quick FPM (n=5)	Delayed Both (n=3)
Fidelity					
Days to UNCOPE	5.4	2.4	2.6	9.4	8.8
Days to FPM	30.9	6.8	45.5	17.2	92.1
Cross-System Partnerships					
★ Formal Partnerships	65%	50%	60%	80%	
★ SUD Referral Partners	2.9	2.4	1.9	2.9	
★ SUD Referral Freq.	2.7	3.3	2.7	2.8	
SUD Availability					
★ # of Treatment Providers (range, outliers)	7.4 (0-11, 26, 46)	4.5 (1-4, 11)	7.6 (0-7, 26)	12 (1-7, 46)	
County Context					
★ % Small/Medium	76%	100%	60%	60%	
% Rural	53%	75%	60%	20%	
% Appalachian	59%	100%	40%	40%	
Avg. # of Cases	15.9	16.3	18.2	18.2	

Results

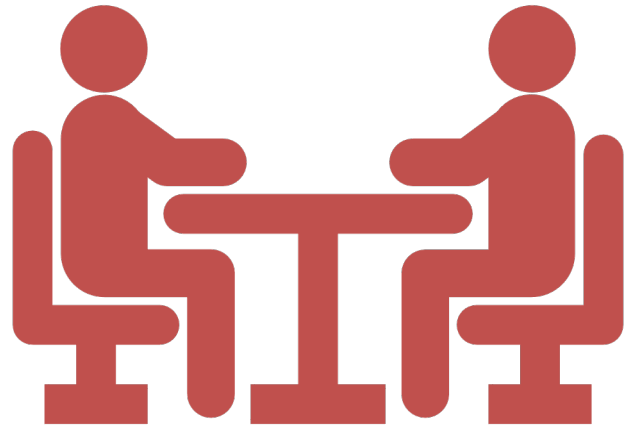
	All (n=17)	Quick Both (n=4)	Quick UNCOPE (n=5)	Quick FPM (n=5)	Delayed Both (n=3)
Fidelity					
Days to UNCOPE	5.4	2.4	2.6	9.4	8.8
Days to FPM	30.9	6.8	45.5	17.2	92.1
Cross-System Partnerships					
★ Formal Partnerships	65%	50%	60%	80%	67%
★ SUD Referral Partners	2.9	2.4	1.9	2.9	2.8
★ SUD Referral Freq.	2.7	3.3	2.7	2.8	2.6
SUD Availability					
★ # of Treatment Providers (range, outliers)	7.4 (0-11, 26, 46)	4.5 (1-4, 11)	7.6 (0-7, 26)	12 (1-7, 46)	3.3 (2-5)
County Context					
★ % Small/Medium	76%	100%	60%	60%	100%
% Rural	53%	75%	60%	20%	67%
% Appalachian	59%	100%	40%	40%	67%
Avg. # of Cases	15.9	16.3	18.2	18.2	8

Summary

- Strongest Fidelity
 - Small, rural/Appalachian counties with limited Tx availability
 - Less likely to have formal partnerships, but frequent referrals (contrary to hypothesis)
 - Informal partnerships might be especially important in small/rural counties.
- Delayed Counties
 - Look similar to strong counties, but have low START case volume.
 - Why??

Discussion

The way counties collaborate for implementation
may vary based on context



- **Informal Partnerships** (front-line referrals) might be important ...
 - When there are resource constraints.
 - To overcome system and organizational challenges
 - And formal partnerships might be redundant?
- **Formal Partnerships** (contracts, MOUs, etc) might be important ...
 - In larger counties with more resources..
 - When there are many partners to choose from
 - To remove roadblocks to front-line collaboration?
- Does this hold when we look at access to treatment?

Our Next Steps



Additional fidelity indicators (days to SUD tx)



Expand contextual conditions (e.g. leadership, climate, community need)



More robust analysis (QCA)



Understand why!



Develop/test a cross-system collaboration decision support guide to expedite partnership development for implementation

Questions?

Please email us:

STARTCollaborating@osu.edu

Research Website
<https://u.osu.edu/collaborateforchange/>



Ohio START Website
<https://Ohiostart.org>

