2015 Pennsylvania State Roundtable Report

Drug & Alcohol Workgroup

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A Call for Collaboration: Addressing the Issue of Substance Abuse in Child Welfare

The mission of the Drug and Alcohol Workgroup is to promote child safety, permanence, and well-being for families touched by substance use disorders by providing access to a continuum of services that include early engagement, cross-systems collaboration, and clinical integrity.

BACKGROUND:

During its 2013 meeting, the Pennsylvania State Roundtable (SRT) spent several hours discussing the subject of substance abuse in the context of child welfare. As was heard clearly in all of the Leadership Roundtables, and as common knowledge within the field, substance abuse is an ever-increasing problem in communities across the Commonwealth. It was decided that a workgroup be created to explore the issue of substance abuse as it intersects with the child welfare population. Ultimately charged with making recommendations that will improve practices for families in the child welfare and the dependency system that are affected by substance use disorders, areas of focus for the workgroup were as follows, in priority order:

- Changing the culture, beliefs, and approaches to addiction, including the manner in which addiction is treated
- Finding effective treatment for substance abusers and their families
- Recovery/relapse supports
- Funding issues
- Identifying and overcoming barriers to successful treatment
- Drug & alcohol assessments
- Research, investigate, review, and visit successful programs and evidence-based practices and report positive outcomes
- Dual diagnosis, co-occurring disorders
- Collaboration

The Drug and Alcohol Workgroup (Workgroup) was convened in August, 2013 led by Honorable Jonathan Mark, Court of Common Pleas of Monroe County and Wendy Hoverter, LCSW, Children and Youth Administrator of Cumberland County. The Workgroup, with a membership that covers a broad spectrum of state and local level positions within the courts, child welfare, substance abuse and mental health fields, meets monthly to explore the issue of substance abuse in Pennsylvania.

Brainstorming at its first full meeting, the Workgroup discussed issues, barriers to service, and the individual and collective strengths and weaknesses of our systems. Even with a more diverse group of participants than the SRT, the results of the discussion mirrored the SRT for its concerns and priority areas of focus: changing beliefs and cultures surrounding substance abuse, effective treatment at objectively

proper levels of care, cross-systems education and training, and funding. At the end of the meeting, one member remarked, "Wow! We are people in systems who work side-by-side every day but who don't know each other." That prescient in-the-moment statement foreshadowed a common theme that the Workgroup has heard, loud and clear, from numerous sources: collaboration between child welfare, treatment providers, and the courts is essential to improving the lives of and the provision of services to children and families affected by substance abuse.

Research validates the position of both the SRT and Workgroup that collaboration is key when working the substance abusing child welfare population. The Center for Disease Control and Prevention's National Center for Injury Prevention and Control (2014), identified risk and protective factors associated with child maltreatment. Included on its list of individual risk factors for perpetration of child maltreatment is substance use. The connection between child maltreatment and substance use necessitates collaborative and coordinated delivery of services by two interveners, the child welfare professional and the substance abuse treatment provider. However, barriers exist. According to Lee, Esaki, and Greene (2009), several factors can serve as barriers to genuine and effective collaboration between these two primary interveners including but not limited to different perceptions and loyalties, segregated delivery of services, conflicting policies and biases and differential treatment which inhibit communication, and consequently collaboration.

An extensive literature review confirmed the beliefs of the SRT and the Workgroup. In its simplest form the literature showed:

- ✓ The importance of treatment interventions including the whole family.
- ✓ The need for collaboration and cross-training between the courts, child welfare, mental health and drug and alcohol.
- ✓ The need to recognize addiction as a disease in order to move forward with helping individuals and families affected by SUDs.

To assist with the priority charge given by the SRT, culture change regarding substance using people and facilitate change at the local level, the Workgroup sought the assistance of the National Center on Substance Abuse and Child Welfare (NCSACW). The partnership is assisting the Workgroup in identifying, fleshing out, and better understanding the unique features of the issues in Pennsylvania through an established program known as In-Depth Technical Assistance (IDTA). Simultaneously, the IDTA process is providing direct assistance to eight diverse counties who are the core counties in the IDTA program. As the Workgroup gains a deeper understanding of how substance abuse affects children and families and the IDTA process moves forward, issues which have been deferred will be comprehensively addressed and research and evidence-based practice recommendations for Pennsylvania will be developed.

2014 PENNSYLVANIA STATE ROUNDTABLE:

The Workgroup made several recommendations to the SRT in May 2014. Recommendations included:

- Moving forward in working with the National Center on Substance Abuse and Child Welfare.

  ✓ *Work has progressed forward in eight counties, each doing an intensive case review process, a walk through and gap analysis, and creating a plan of action to address their priority areas. Implementation of strategies to enhance substance abuser services is ongoing.*

- Requesting that the Office of Children, Youth and Families consider incorporating substance use case identification in their development of a CWIS system.

  ✓*A request was made at a Pennsylvania Children and Youth Administrators meeting by co-chair Wendy Hoverter. This was followed up by a written request to the Office of Children, Youth, and Familes for consideration in their second level CWIS release.*

- Requesting that the Summit Committee include a session on Substance Use Disorders including the neurobiology of addiction to address a cultural change.

  ✓*A request was made to the Summit Committee to include a session on Substance Use Disorders during the bi-annual summit. The summit was held April 20-22, 2015 and included a plenary session, Effective Strategies for Working with Families with Substance Use Disorders, presented by Pam Baston, one of the consultants for the National Center on Substance Abuse and Child Welfare.*

- Urging Local Children's Roundtables to invite a representative from the Drug & Alcohol system and join them if one is not already present.

  ✓*Counties have been encouraged to include someone from the local Single County Authority and/or a primary substance abuse treatment provider on their local Children's Roundtable. Many counties reported extending this invitation.*

Continuing to prioritize the issue of culture change, the SRT approved all Workgroup recommendations. Additionally, it tasked the Workgroup with developing a cross systems training providing for a shared understanding of substance abuse and the needs of substance using people involved with the child welfare system. Additionally, the SRT requested that the issue of confidentiality, as it relates to the release of treatment information, be explored.

PROGRESS AND UPDATES:

During the past year, the Workgroup continued its work on culture change by facilitating the IDTA process and addressing topics that will provide a common understanding of areas touching the lives of those with substance abuse disorders. In doing this, the Workgroup divided into separate committees enabling the group to maximize the amount of work completed. Committees met during the monthly Workgroup meetings and as needed by phone and email. Additionally, the Workgroup provided a discussion forum for the county core team leaders of the IDTA process as they became members of the Workgroup. This provided a communication loop for the Workgroup and counties enabling peer support and accountability.

Funding Committee

The Funding Committee set out to capture the important elements of funding for drug and alcohol services. While understood by treatment providers and Single County Authorities (SCA), funding can be a challenge for others to understand. Several issues were at play during this time that complicated the work on this topic, the largest being the change to the multi-tiered Healthy PA program and then the subsequent announcement that Healthy PA would be transitioning to the traditional Medicaid expansion offered by the federal government.

The committee kept the Workgroup apprised of changes as they were occurring. In several instances the Funding Committee was able to provide assistance to counties represented at the workgroup to gain a clear understanding of factors in eligibility for coverage. Additionally, the committee created a document that outlines the most important features of the Mental Health Parity Act and the Affordable Care Act. Also included in the document is the spectrum of treatment services that are featured in the Pennsylvania Client Placement Criteria (PCPC), and the standardized tool that points to the level of care a substance abuser needs. In ascending order of dosage, these are:

- Outpatient
- Intensive Outpatient
- Partial Hospitalization
- Halfway House
- Medically Monitored Inpatient Detoxification
- Medically Monitored Short-Term Residential
- Medically Monitored Long-Term Residential
- Medically Managed Inpatient Detoxification
- Medically Managed Inpatient Residential

Priority populations for allocation of resources as identified by the federal government and adopted by the Department of Drug and Alcohol Programs (DDAP) are: pregnant women who inject drugs, pregnant women who are substance abusers, and injections drug users. A Benefit Flow Chart is included and it is recommended by the committee

that this chart be shared with child welfare staff, judges and attorneys to assist them in understanding funding.

In the spirit of cross systems collaboration, the document also includes a section regarding Childen and Youth Services funding and some of the essential laws and regulations that provide governance. These may be particularly helpful to substance abuse staff, judges and attorneys as they interact with substance abusing clients who are involved with the child welfare system.

Cross-Systems Training Committee

As requested by the 2014 State Roundtable, the Workgroup began the development of a cross-systems training intended for an audience of judges, attorneys, child welfare professionals, and substance abuse professionals. With an overarching goal of developing a shared understanding of systems, terminology and responsibilities toward substance abusers, the training committee worked tirelessly to develop a list of training topics that represents the foundational points of a collaborative and shared value system. Among the topics are:

- Disease of Addiction
- Family Systems Approach: addiction is a disease that includes the whole family
- Indicators of Addiction
- Information on Level of Treatment
- The Process of Accessing Treatment
- Funding Overview
- Substance Abuse Effects on Parenting
- Impact of Drug & Alcohol Treatment on Parenting
- Dependency Court and CYS Timelines
- Relapse and Recovery Process
- Best Practices for Treatment
- Confidentiality
- Systemic Barriers to Collaboration
- Acronyms & Terms of Art: Making Sense of Alphabet Soup
- Legal Standard for Dependency
- Decision-Making within Systems

The Workgroup believes that the best way to deliver this training is a one-day in person training with a cross systems audience. It has been suggested that there be a plenary session in the morning and then breakout sessions by disciplines for a closer look at the issues in the afternoon.

The committee is planning an interactive day including a common scenario that each system (legal, child welfare, and substance abuse) will approach from their own perspective and illustrate to the other systems critical points in decision-making and reasoning. Futher training opportunities may be identified for those that need more information.

Confidentiality Committee

Prompted by the 2014 State Roundtable, the Workgroup created a committee to research the confidentiality of substance abuse treatment records, an issue that the State Roundtable, the Workgroup, and all eight of the IDTA core counties identified as a an issue affecting cross-systems treatment of children and families who are affected by substance abuse. The committee was tasked with making recommendations that would allow collaborative sharing of drug and alcohol information and reduce or lower the confidentiality concerns in a manner consistent with existing laws.

The committee researched and began compiling a bibliography of applicable laws, rules, and regulations as well as identifying best and promising practices. It quickly became clear that this issue involves a number of nuances which require careful analysis in order to understand the relationship between the varied regulations. It also became clear that understanding and resolving issues surrounding confidentiality and the sharing of information involves a delicate balancing of established interests.

Specifically, confidentiality protections are rooted in a fundamental value of creating a safe space for an individual to examine and explore very vulnerable beliefs and shame in the therapy situation. Stigma and fear of retaliation remain among the top reasons why individuals do not seek the substance abuse treatment they need, and this is particularly true in the child welfare setting where treatment is avoided for fear of losing children. Proper sensitivity to this protection is critical, particularly at early stages of treatment so that an individual can become more willing to collaborate across systems with their drug and alcohol counselor, child welfare worker, and criminal justice partners. At the same time, the reciprocal sharing of information among involved agencies is often critical to promote the best outcome for children and families affected by substance abuse.

The committee is of the firm belief that, with proper cross-systems training, discussion, education, and collaboration, it is possible to properly balance issues of child safety, family and individual privacy, and the integrity of the therapeutic process and to resolve virtually all concerns within existing regulations. However, the committee is not yet ready to make definitive, final recommendations. The complexity of the issues and the need for further discussions with DDAP require additional time and analysis. In addition, most if not all of the IDTA core counties are currently working through confidentiality and information-sharing concerns raised by local providers. It is expected that the IDTA process, as well as the individual and collective experiences of the core counties, will result in the identification of effective procedures on the local level that can be shared. The committee believes it is important to factor the core counties' experiences and solutions into its final recommendations.

As a result, the committee will continue its work over the next year before making the final recommendations. The committee will meet with DDAP, conduct additional research, work with the NCSACW, and synthesize the combined experience and solutions of all IDTA core counties into its 2016 State Roundtable recommendation.

In the meantime, the committee offers the following practices as guidance to currently working through confidentiality issues:

- All necessary consents and releases should be obtained at the earliest possible stage. In this regard, whenever a child, parent, or guardian is referred for an assessment or treatment, the referring agency should properly request that the person referred execute consents and releases in favor of all agencies involved in the case. As the person receiving treatment moves through the levels of care, consents should be obtained for each provider.

- Consents and releases merely authorize the release of specified information. They do not guarantee the sharing of information. Continual, consistent communication between involved agencies and all providers is critical.

- Expanding on one of last year's recommendations, counties should consider inviting their Single County Authorities (SCA) and their drug and alcohol providers to join local roundtables.

- CYS personnel should become familiar with the 2002 Bulletin entitled "Protocol for Sharing Drug and Alcohol Information," jointly issued by the Department of Public Welfare (now Department of Human Services), Department of Health, and Juvenile Court Judges' Commission (Bulletin 00-02-03, issued June 1, 2002). The Bulletin should be distributed to and discussed with partner agencies, SCAs, and drug and alcohol providers. A copy of the Bulletin is included as Appendix 2.

- CYS Agencies and SCAs should meet with local and regional drug and alcohol providers and other system partners (i.e., Juvenile Probation Offices, County MH/DS agencies, etc.) to discuss confidentiality and develop protocols for information sharing. Until more in-depth recommendations are made or statewide practices are implemented, local solutions can be extremely helpful and can exponentially enhance the ability to share information.

- DDAP has a one-day training on confidentiality that is mandatory for drug and alcohol counselors and is open to CYS personnel, probation officers,

and others. Agencies should strongly consider sending key representatives to the training. These trainings occur on a regular basis around the Commonwealth. A current listing may be found at www.ddap.pa.gov. The booklet (Confidentiality Training Handouts) used in the training is available at:
http://www.ocfcpacourts.us/childrens-roundtable-initiative/state-roundtable-workgroups/drug-and-alcohol. Additionally, there is a 3 hour training on Practical Applications of Confidentiality which addresses how to apply the principles effectively.

- The committee is primarily focusing on practices and protocols for obtaining consents and releases and, through such devices, the voluntary sharing of information across systems. However there may be cases in which CYS personnel are not able to obtain proper consents or where the provider refuses to disclose information. In such situations, if established criteria are met, disclosure may be authorized by court order. The 2002 Bulletin and the DDAP confidentiality training handout provide steps and protocols for obtaining such court orders.

- Focus on information that *can* be shared and do not dwell on information that cannot be shared. In this regard, even with a consent or release, there may be limitations on what information can be shared. However, an agency armed with a signed release can (and should) communicate to drug and alcohol providers relevant information about clients referred for assessments or service, especially about known and suspected alcohol or other drug use. In addition, there are exceptions to confidentiality laws other than the release of information pursuant to a proper consent. The exceptions include communications that *do not* disclose patient identifying information, court-ordered disclosures, and child abuse or neglect reporting. Further, clients may voluntarily provide information that providers may not be permitted or may refuse to disclose. Finally, relevant information may be available in public data bases or through partner agencies that may not be prohibited from disclosing their knowledge.

In-Depth Technical Assistance (IDTA) Project

Since June of 2014 the Workgroup has been actively involved with the National Center on Substance Abuse and Child Welfare (NCSACW) as part of their in-depth technical assistance project. Through their federal contract, the NCSACW provides Pennsylvania with four consultants that work individually with eight counties: Allegheny, Clinton, Cumberland, Lackawanna, Lehigh, Lycoming, Monroe, and Venango. These counties

were selected via a competitive process and chosen as a reflection of the state's county size diversity. Each agreed to closely analyze their child welfare and substance abuse data, participate in a systems walk-through with their consultant, plan, and implement changes to a priority area of their choice.

The overall goal of the IDTA process in Pennsylvania is two-fold: to help counties make positive changes that impact the quality or accessibility of services to substance abusing families involved with child welfare and to define a process that non-IDTA counties can replicate and do their own analysis of cases at the intersection of child welfare and substance abuse. To capture this process, each county was asked to elect a "core team" leader and the leader joined the Workgroup. At each Workgroup meeting the core team leaders have an opportunity to share success and challenges happening at the local level and suggest ways to efficiently complete tasks.

Following the system's walk-through and gap analysis done during November 2014, the NCSACW prepared a summary of information collected in the implementing counties. Common themes were found across Pennsylvania. Themes related to the following issues:

- Consistency and timeliness of screening, identification, and assessment
- Consistency of interpretation of Informed Consent and Release of Information
- Training on Substance Use Disorders for child welfare workers
- Need for more appropriate levels of treatment

As defined by the NCSACW's Framework for Analysis, a ten-point matrix of key areas to examine in planning for positive outcomes for familes involved with child welfare and the substance abuse system, Pennsylvania continues to do well in the following areas:

- Cross systems collaboration
- Working with related agencies
- Working with community
- Supporting families
- Services to children

Counties have expressed enthusiasm and satisfaction with the IDTA process. Each has found their assigned consultant helpful and instrumental in identifying areas where change could make a maximum impact and planning strategies around those. Counties were asked to develop a formal written plan that would guide their work. In reviewing the plans, most counties developed goals in similar areas: identification and implementation of a standardized screening tool for use by child welfare caseworkers, increasing the use of recovery supports to engage and retain parents in treatment, building pathways for the sharing of information across systems, and providing staff with information and better skills to identify substance use earlier and engaging the substance abusing parent(s).

Counties will highlight their findings, goals, and accomplishments at a site visit meeting with the consultants from the NCSACW and key stakeholders from the court, child welfare and substance abuse systems on June 18, 2015. It is anticipated that following this event, the NCSACW consultants will begin their wrap-up work with the counties with an end to the IDTA process expected in late September. Counties will continue to work toward their goals with the support of the Workgroup. Each county will develop a two page summary of their findings and work targeted/completed for inclusion in the 2016 Workgroup report to the State Roundtable.

CONCLUSION:

Child welfare data (AFCARS) shows that 52% of the cases in Pennsylvania where children were removed from the home during the reporting period (October 1, 2013-September 30, 2014) were placed because of substance abuse. In-depth reviews of cases in IDTA counties predominately mirror this data. In the wake of an ever increasing heroin epidemic, child welfare and substance abuse systems are bursting at the seams; courts are packed with cases that are either driven by or impacted by the use and abuse of drugs and alcohol. Looking toward the futures of the children and families that are being served, it is necessary to ask, “Are we doing all that we can do, as a system and a society to provide substance abusing individuals the access, the treatment and the recovery support that will give them the best chance for success?” While it is likely resources will remain finite, how can the resources currently available be used to the best advantage and what non-monetary measures can be taken to identify those with substance use disorders early on and provide supports to them on their journey to recovery?

RECOMMENDATIONS:

The Drug and Alcohol Workgroup respectfully submits to the Pennsylania State Roundtable the following recommendations:

1. Develop a resource to serve as a quick reference guide for substance use disorders.
2. Develop the training content for a cross systems training addressing substance use disorders and a training delivery plan.
3. Continue with the In-Depth Technical Assistance process and develop a plan to disseminate findings and process for replication to counties.
4. Submit a written request to the Department of Human Services to consider adding a component on Substance Use to the Quality Service Review Process.

APPENDIX 1

The Parity Act and the Affordable Care Act

Pennsylvania's Medical Assistance Coverage

Drug and Alcohol

The Department of Drug and Alcohol Programs (DDAP) mission is to engage, coordinate and lead the Commonwealth of Pennsylvania's effort to prevent and reduce drug, alcohol and gambling addiction and abuse; and to promote recovery, thereby reducing the human and economic impact of the disease. This mission is carried out through a grant agreement between DDAP and its county-level grantees called Single County Authorities. The grant agreement is a multi-year legal document that binds the SCA to the requirements of the Commonwealth and serves as the mechanism by which the SCAs can obtain Federal and State funds. These funds are to be used for the provision of drug, alcohol and gambling prevention; intervention; treatment; and treatment-related services. DDAP shall not fund any services where there is a third party, including another Government or State agency, obligation to pay for services rendered. DDAP is payer of last resort.

The SCA is responsible for planning, administering, funding and evaluating substance abuse and gambling services in their geographic area. DDAP's grant agreement identifies minimum administrative, program and fiscal requirements, however, each SCA will determine the needs of their community; manage and allocate resources to meet needs; evaluate the effectiveness of how needs are being addressed; adjust allocation of resources, if necessary; and, advocate for services, to include coordination with other stakeholders. For SCAs that is a part of, or contracted by, county government, the County's Department of Human Services may have different funding categories.

Substance Abuse Prevention and Treatment Block Grant (SAPT BG) Funds – Federal funds issued by DDAP for the provision of prevention, intervention, treatment and treatment related services. Specific amounts of these funds are allocated between prevention and intervention/treatment and must be spent within those categories.

DDAP State Program Funds - General Assistance State dollars are the primary state funding source relative to the SCA's agreement with DDAP. All SCA's receive funding from this source. These State funds are issued for the administrative functions and provision of prevention, intervention, treatment and treatment related services.

Other DDAP Funding – This may include federally or state-funded special initiatives not included in the categories above.

Behavioral Health Services Initiative (BHSI) Funds – State funds issued by the Department of Human Services (DHS), Office of Mental Health and Substance Abuse Services (OMHSAS) to provide treatment services to clients impacted by Act 35 of 1996. Funding may cover

administration, case and care management and treatment activities for persons who have lost eligibility for medical assistance due to welfare reform.

Act 152 Funds – State funds issued by the DHS, OMHSAS to provide inpatient non-hospital (medically monitored) treatment services for MA eligible clients.

HealthChoices - Income received from the provision of administration and clinical care services related to the HealthChoices Program, such as case management and administrative and clinical oversight of the MCO.

Human Service Development Fund (HSDF) - State funds issued by DHS/Office of Social Programs (OSP), to provide various human service initiatives. The allocation of funds to the SCA is at the discretion of the county and must be included in the annual plan submitted by the county through their designated agency to DPW/OSP. Funding may cover all intervention, treatment and treatment-related activities. Prevention activities may be funded on a case-by-case basis, and must be specifically approved by DHS/OSP.

Children, Youth and Family Funds – Funds received from the local children and youth office and utilized by the SCA for the provision of substance abuse services to clients involved in the Children and Youth System.

Driving Under the Influence (DUI) Funds – Funds issued by the county for the purpose of aiding programs promoting alcoholism prevention, education, treatment and research. Distribution of these funds is at the discretion of the county executives.

PA Commission on Crime and Delinquency (PCCD) Funds – Grant funds, such as intermediate punishment programs or juvenile incentive initiatives, received directly from PCCD for the provision of substance abuse services.

County Funds – Funds provided by the county which meet or exceed the county's required financial commitment to the SCA for the delivery of D&A services.

Pregnant Women and Women With Children (PWWWC) Funds - Funding for programs designed for the PWWWC population. The objective of the funds is to improve and expand D&A abuse treatment and case management services to the client, either directly, or through arrangements with other public or non-profit entities. PWWWC services stress the family as a unit. The client must have custody or be in the process of regaining custody of their children in order for the SCA to utilize PWWWC dollars. SCAs are required to provide treatment through a continuum of care (to include methadone maintenance), as well as to provide or facilitate ancillary services (such as shelter, health services, case management services, day-care, etc.) to assure the holistic wellness for this vulnerable population. The SCAs shall take into consideration the prevention needs of the children as part of the Performance Based Prevention community-wide needs/risk assessment process when providing services to the

PWWWC population. If selected as a targeted population, prevention funds awarded under this program may be used to fund the services.

Compulsive and Problem Gambling Treatment Fund – funds solely for problem gambling as it relates to : needs assessment, prevention services, outreach services, education services and other DDAP approved services.

Impact of Act 106 of 1989 and The Affordable Care Act

Act 106 of 1989 requires all commercial group health plans, HMOs, some self-insured plans, the Children's Health Insurance Program, Health Exchanges and Private Coverage Option (PCOs) plans to provide comprehensive treatment for alcohol and other drug addiction. All treatment must be provided in a program licensed by the Pennsylvania Department of Drug and Alcohol Programs specifically to provide alcohol and other drug treatment.

The Affordable Care Act builds on the Mental Health Parity and Addiction Equity Act of 2008 to extend federal parity protections to 62 million Americans. The parity law aims to ensure that when coverage for mental health and substance use conditions is provided, it is generally comparable to coverage for medical and surgical care. The Affordable Care Act builds on the parity law by requiring coverage of mental health and substance use disorder benefits for millions of Americans in the individual and small group markets who currently lack these benefits, and expanding parity requirements to apply to millions of Americans whose coverage did not previously comply with those requirements.

The Affordable Care Act and its implementing regulations, building on the Mental Health Parity and Addiction Equity Act, will expand coverage of mental health and substance use disorder benefits and federal parity protections in three distinct ways: (1) by including mental health and substance use disorder benefits in the Essential Health Benefits; (2) by applying federal parity protections to mental health and substance use disorder benefits in the individual and small group markets; and (3) by providing more Americans with access to quality health care that includes coverage for mental health and substance use disorder services (ASPE ISSUE BRIEF, Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for 62 Million Americans, February 20, 2013, Kirsten Beronio, Rosa Po, Laura Skopec, Sherry Glied).

Treatment through Act 106 of 1989 is accessed simply by means of a physician's or psychologist's certification and referral. County SCA and HealthChoices/MA treatment is accessed through the 2014 Pennsylvania Client Placement Criteria for Adults, 3rd Edition, as follows:

Drug and Alcohol Levels of Care for Treatment

1A	**Outpatient**	Outpatient treatment is an organized, non-residential treatment service providing psychotherapy in which the client resides outside the facility. Treatment sessions cannot total more than 5 hrs/week.
1B	**Intensive Outpatient**	Intensive Outpatient is an organized, non-residential treatment service in which the client resides outside the facility. It provides structured psychotherapy and client stability through increased periods of staff intervention. Services are provided through a planned regimen consisting of regularly scheduled treatment sessions at least 3 days per week for at least 5 hours (but less than 10)/week.
2A	**Partial Hospitalization**	Partial Hospitalization treatment consists of the provision of psychiatric, psychological and other types of therapies on a planned and regularly scheduled basis in which the client resides outside the facility. This service is designed for those clients who do not require 24-hour residential care, but who would nonetheless benefit for more intensive treatments than are offered in outpatient treatment projects. Services consist of regularly scheduled treatment sessions at least 3 days per week, with a minimum of 10 hours/week.
2B	**Halfway House**	A Halfway House is a treatment facility located in the community that is state licensed, regulated, and professionally staffed. Programs focus on developing self-sufficiency through counseling, employment and other services. Some of these programs staff medical and psychiatric personnel on site to assist individuals with their medical and/or co-occurring needs. This is a live in/work out environment. The setting is usually an independent physical structure containing no more than 25 beds. This type of facility is meant to provide a “home-like” atmosphere within the local community, be accessible to public transportation, and give no indication of being an institutional setting. Normal housekeeping and food preparation are done on the premises by the residents.

3A	**Medically Monitored Inpatient Detoxification**	Medically Monitored Inpatient Detoxification is a treatment conducted in a residential facility that provides a 24-hour professionally directed evaluation and detoxification of addicted individuals. Detoxification is the process whereby a drug- or alcohol-intoxicated or dependent individual is assisted through the period of time required to eliminate the presence of the intoxicating substance (by metabolic or other means) and any other dependency factors while keeping the physiological and psychological risk to the individual at a minimum. This process should also include efforts to motivate and support the individual to seek formal treatment after the detoxification process. This type of care utilizes multi-disciplinary personnel for individuals whose withdrawal problems (with or without biomedical and/or emotional problems) are severe enough to require inpatient services, 24-hour observation, monitoring, and, usually, medication. However, the full resources of an acute care general hospital or a medically managed intensive inpatient treatment system are not necessary. The multi-disciplinary team and the availability of support services allows detoxification and a level of treatment consistent with the individual's mental state and required level of care, as well as the conjoint treatment of any coexisting sub-acute biomedical or emotional conditions which could jeopardize recovery.
3B	**Medically Monitored Short Term Residential**	Medically Monitored Short Term Residential treatment is a type of service that includes 24-hour professionally directed evaluation, care, and treatment for addicted individuals in acute distress. These individual's substance use disorder symptomatology is demonstrated by moderate impairment of social, occupational, or school functioning. Rehabilitation is a key treatment goal. This treatment is conducted at a DDAP-licensed drug and alcohol residential non-hospital treatment and rehabilitation facility located in a freestanding or a health care-specific environment.

3C	**Medically Monitored Long Term Residential**	Medically Monitored Long Term Residential treatment is a type of service that includes 24-hour professionally directed evaluation, care, and treatment for addicted individuals in chronic distress, whose substance use disorder symptomatology is demonstrated by severe impairment of social, occupational, or school functioning. Habilitation is the treatment goal. These programs serve individuals with chronic deficits in social, educational, and economic skills, impaired personality and interpersonal skills, and significant drug-abusing histories that often include criminal lifestyles and subcultures. These individuals need a model more accurately described as habilitation, as opposed to the rehabilitation model. This service often requires global changes in lifestyle, such as abstinence from mood-altering drugs (other than those needed to treat illnesses), elimination of antisocial activity, a new outlook regarding employment, and the development, display, and integration of positive social attitudes and values. This treatment is conducted in a DDAP-licensed drug and alcohol residential non-hospital treatment and rehabilitation facility located in a freestanding or health care-specific environment.

4A	**Medically Managed Inpatient Detoxification**	Medically Managed Inpatient Detoxification is a type of treatment that provides 24-hour medically directed evaluation and detoxification of individuals with substance use disorders in an acute care setting. Detoxification is the process whereby a drug- or alcohol-intoxicated or dependent individual is assisted through the period of time needed to eliminate (by metabolic or other means) the presence of the intoxicating substance or the dependency factors, while keeping the physiological or psychological risk to the individual at a minimum. Ideally, this process should also include efforts to motivate and support the individual to seek formal treatment after the detoxification process. The individuals who utilize this type of care have acute withdrawal problems (with or without biomedical and/or emotional/behavioral problems) that are severe enough to require primary medical and nursing care facilities. 24-hour medical service is provided, and the full resources of the hospital facility are available. Although this treatment is specific to SUD, the multi-disciplinary team and the availability of support services allows for the conjoint treatment of coexisting acute biomedical and/or emotional/behavioral conditions which could jeopardize recovery and need to be addressed. This type of treatment is conducted at a PA Department of Health-licensed acute care setting, with intensive biomedical and/or psychiatric services and a DDAP-licensed treatment unit. Three examples of such settings are: an acute care general hospital, an acute care psychiatric hospital or a psychiatric unit in an acute care general hospital, or an appropriately licensed drug dependency specialty hospital with an acute care medical and nursing staff and emergency and life-support equipment. Such settings must be capable of providing medically directed acute detoxification and related treatments aimed at alleviating acute emotional, behavioral, and/or biomedical stress resulting from the individual's use of alcohol or other drugs. If needed, life support care and treatment is available on-site, or through an effective arrangement, for the timely and responsive provision of such care. This may be accomplished through the transfer of the individual to another service within the facility or to another medical facility.

4B	**Medically Managed Inpatient Residential**	Medically Managed Inpatient Residential treatment provides 24-hour medically directed evaluation, care, and treatment for addicted individuals with coexisting biomedical, psychiatric, and/or behavioral conditions that require frequent care. Facilities for such services need to have, at a minimum, 24-hour nursing care, 24-hour access to specialized medical care and intensive medical care, and 24-hour access to physician care. The setting for this type of care is a PA Department of Health-licensed acute care facility, with an intensive biomedical and/or psychiatric service contained in a DDAP-licensed treatment unit.

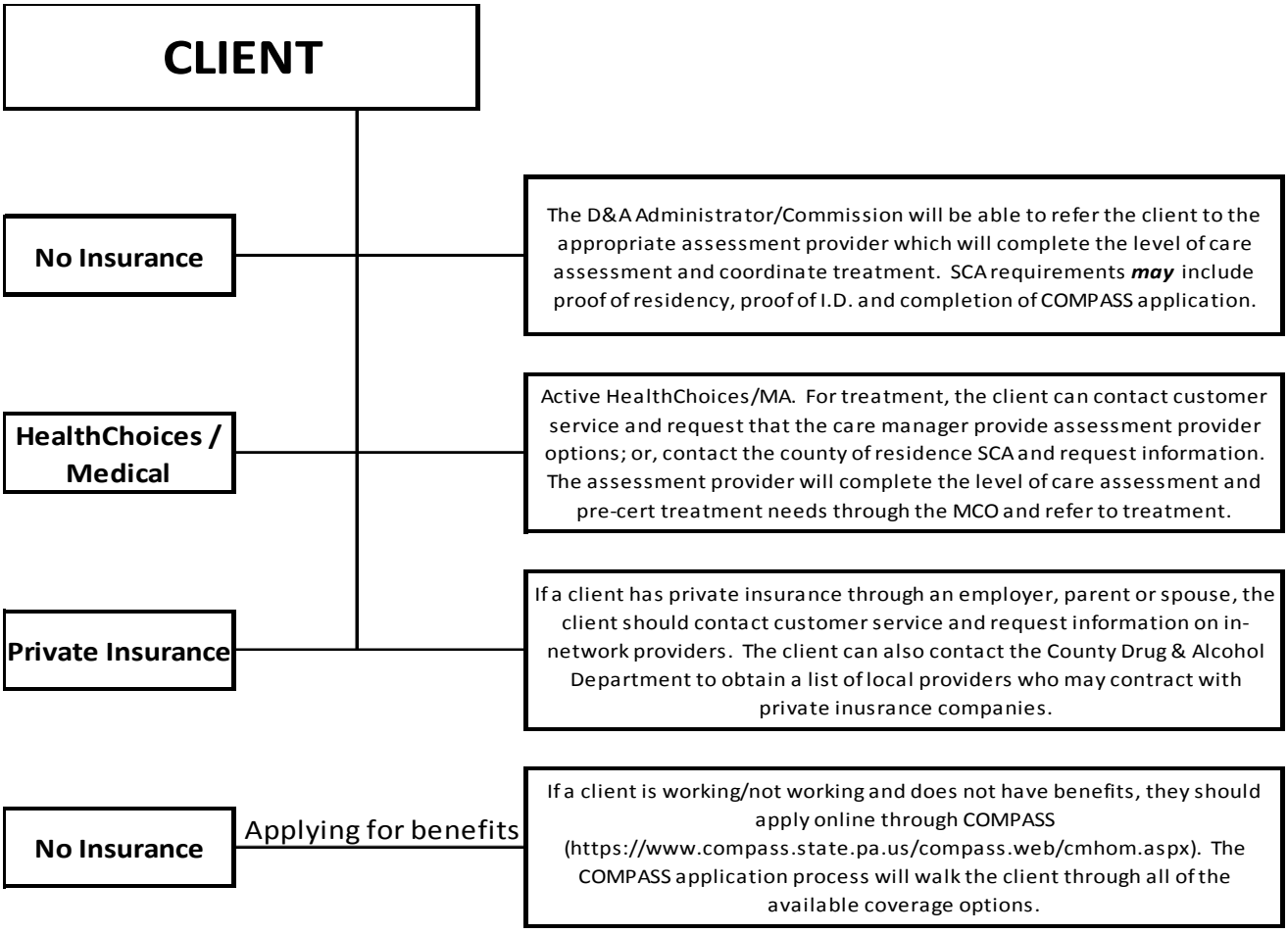
PRIORITY POPULATIONS*

1-Pregnant Injecting Drug User (IDU)
2-Pregnant Substance Abusers*
3-Other Injecting Drug Users
****Recent Overdose**

***If the SCA chooses to restrict access to assessment and/or treatment, such restrictions shall not apply to pregnant women.**

****Most SCAs have voluntarily added Recent Overdose to their Priority population list.**

BENEFIT FLOW CHART:



Child Welfare

Overview:

- Pennsylvania's child welfare system is state administered and county operated which means that state law prescribes the minimum standards for the child welfare system and the child welfare and juvenile justice services are delivered by County Children and Youth Agencies and County Juvenile Probation Offices.
- Child welfare funds cover adoption services, permanency services, in-home services, family services, placement costs, juvenile delinquency placement and services, and child welfare staff and administrative costs.
- County agencies choose and contract with the services their county population needs. The state does not contract with any community providers for services to children and families involved in the child welfare system.

- OCYF reviews the services received by Pennsylvania's children and families to ensure the quality of services provided and purchased.
- OCYF monitors the financial commitment and spending of the counties with regard to the children and youth services they deliver. The financial review focuses on the reasonableness and necessity of the county request and whether the county plan and budget focuses on the state's goals of increasing safety; improving permanency; safely reducing reliance on out-of-home care, particularly residential institutional programs; and decreasing re-entry into placement.
- Substance abuse services for parents can be funded when the parent does not have insurance or medical assistance and when there are no drug and alcohol funds available. If a person isn't eligible for MA, the local Single County Authority (SCA) can assist with payments. Title 55 Pa. Code §3140.21 states that medical services are not reimbursable when the client is eligible for healthcare benefits. Per Title 55 Pa. Code §3140.46, counties are required to pursue all other funding streams first.
- Act 148 funds can be utilized when the agency makes a determination that D&A services are needed, contracts with a provider and has assured that no other funding, including health care benefits, is available.
- Currently, when a child/youth is involved in child welfare and in need of inpatient drug and alcohol services, child welfare is able to fund the residential costs if the placement facility is dually licensed by both DDAP and DHS. Drug and alcohol would fund the treatment component of the placement costs for the child/youth.

Federal:

- Title IV-E Foster Care - foster care maintenance costs for eligible children; administrative costs related to management of the child welfare program, and training for staff, foster parents and certain private agency staff.
- Title IV-E Adoption Assistance program - provide ongoing financial assistance to meet the needs of children who are adopted with special needs; administrative costs related to management of the adoption assistance program, and training for staff and adoptive parents. These funds may only be used to provide services for children who meet Title IV-E Adoption Assistance eligibility criteria.
- Title IV-E Guardianship Assistance Program - known as Subsidized Permanent Legal Custodianship (SPLC) in Pennsylvania, is used to provide ongoing financial assistance to meet the needs of children who enter into SPLC arrangements. These funds may only be used to provide services for children who meet Title IV-E SPLC eligibility criteria. These funds also are used to aid in the administration of the SPLC program and training for staff and adoptive parents.
- The Child Welfare Demonstration Project (CWDP) - was implemented July 1, 2013. The CWDP allows participating counties the flexibility to use funds for children's maintenance costs for foster family and non-secure residential facilities that are licensed by the Office of Children, Youth and Families. The restriction regarding the child being eligible for Title IV-E funds is waived. These funds may also be used for administrative costs related to management of the child welfare program, and training

for staff, foster parents and certain private agency staff. CWDP funds may also be used for in-home services (prevention, intervention, reunification, etc.), with the exception of investigation services.

- Temporary Assistance to Needy Families (TANF) - used to support the delivery of child welfare services. These funds may be used to provide family preservation, reunification, support services and emergency shelter placement services that are designed to promote the TANF purposes. These funds may only be used to provide services for children who meet TANF eligibility criteria.
- Title IV-B grants – funding allocated to states based upon population. Subpart 1 pays for in-home services, (excluding investigation services) and community-based and institutional services (excluding secure facilities) that are not funded with other federal funds. Subpart 2 funding pays for preventive intervention, including family centers, time-limited family reunification services, fatherhood initiatives, integrated children's services planning, the Safe Haven program, the Pennsylvania Child Welfare Training Program, and the Statewide Adoption and Permanency Network (SWAN). Title IV-B is also used to pay for training.
- Title XX - also known as the Social Services Block Grant (SSBG), funds are available to reimburse counties for social service expenditures, which include preventing child abuse. These funds cannot be used for maintenance (clothing, room and board, etc.) costs for foster family and non-secure residential facilities.
- Medical Assistance - funds are available to reimburse counties for allowable administrative costs related to providing Medical Assistance services to children. (Medical Assistance costs to pay for services are shown in the Office of Medical Assistance Programs' budget.)
- Chafee Foster Care Independence Program - funds are allocated to states to provide Independent Living services for youth most likely to remain in foster care until age 18, re-enter foster care after age 18 and those discharged from foster care until age 21. Chafee Education and Training Grant Program funds are allocated to states to provide financial awards or grants of up to $5,000 per year to students to attend post-secondary education.

State: State funds are allocated to each county based upon need as certified through the needs-based plan and budget process. These funds are used to support the delivery of child welfare services to all children and families served by the county agency. State funds may be used to reimburse the following services:

- Adoption services;
- Adoption Assistance;
- Subsidized Permanent Legal Custodianship;
- Emergency shelter service;
- Community residential service and group home service;
- Foster family service;
- Supervised independent living service;

- Alternative treatment programs – service in a non-secure setting, designed to return the child to the child's home or another legally assured permanent home; and minimizes the duration of out-of-home placement;
- Child protective services—child abuse;
- Counseling/intervention services;
- Day care service;
- Day treatment service;
- Child protective service—general;
- Homemaker/caretaker service;
- Intake and referral service;
- Life skills education;
- Service planning;
- Residential service;
- Secure residential service;
- Juvenile detention service;
- Youth Detention Centers/Youth Forestry Camps;
- Juvenile Act Proceedings.

Special Grants: State funds are also allocated and certified through the needs-based plan and budget process to promote the use of evidenced-based programs and services:

- Evidence-Based Programs
- Pennsylvania Promising Practices
- Alternatives to Truancy Programs
- Housing Programs
- Information Technology
- SWAN (services allocated, not funds)

Needs Based Plan and Budget: Requests and approvals are based on need, how needs are justified, the trends of abuse/neglect in that county, spending trends and how outcomes will be measured.

Children and Youth Social Services:

- Services designed to prevent dependency and delinquency of children and that help overcome problems that result in dependency and delinquency;
- Services designed to first and foremost protect children from abuse and neglect and that enable children to remain safely in their own homes and communities;
- Services designed to provide permanency and stability for children in their own homes or in placement and to preserve relationships and connections for children with their families and communities of origin;
- Services designed to meet the needs of children and families and to enhance the family's capacity to provide for their children's needs including services to meet the educational, physical and behavioral health needs of children;

- Services designed for youth alleged and adjudicated delinquent, which are consistent with the protection of public interest and which provide balanced attention to the protection of the community, the imposition of accountability for offenses committed and the development of competencies to enable youth to become responsible and productive members of the community; and
- Services and care ordered by the court for children who have been alleged and adjudicated dependent or delinquent.

3130.39: Services and facilities which may be used: a service or facility used by the county agency to serve children shall be licensed or approved by the appropriate state agency if that service or facility is subject to licensure or approval. Facilities used by the county agency for the residential care of children shall meet basic state and local requirements for the health and safety of children. Children who are dependent and not also adjudicated delinquent may not be placed in a facility operated for the benefit of delinquent children.

3130.40 Delivery of services through other service providers:
(a) When the county agency arranges for the provision of children and youth services through the County Mental Health/Mental Retardation Agency, the Drug and Alcohol Abuse Agency or the County Assistance Office, it shall have a written service agreement with the provider agency which describes the responsibilities of the agency providing the service.
(b) If the county agency provides children and youth services for which State reimbursement will be claimed, the county agency shall comply with Chapters 3140 and 3170 (relating to planning and financial reimbursement requirements for county children and youth social service programs; and allowable costs and procedures for county children and youth).
(c) The county agency shall make available to a service provider diagnostic, service plan and case information that is necessary to carry out the terms of a service plan as required by § § 3130.61 and 3130.67 (relating to family service plans; and placement planning).

3140.21: There are limits to what is reimbursable to a county under the Needs Based Budget. Specifically, state funds may not be used to reimburse the following costs:

- Mental health or mental retardation treatment;
- Medical or dental services for children who are eligible for other health care benefits;
- Education;
- Services for children placed outside the Commonwealth when the placement is not made in accordance with the Interstate Compact on the Placement of Children;
- Care, maintenance and treatment of children when placed in facilities that:
  - Are not licensed or approved when the facility is subject to approval or licensure; or
  - Do not meet basic state and local health and safety requirements;
- Care, maintenance and treatment of dependent children when they are placed in a facility operated for the benefit of delinquent children.
- County probation office staff;
- Juvenile court staff; or
- County social service staff, not part of the county children and youth agency.

Local: County general funds are used to provide the necessary local match for both federal and state funds. The local match ranges from 0 to 40 percent.

Committee Recommendations

1. Single County Authorities should be the point of contact in counties to coordinate drug and alcohol services. They can assess and/or refer for assessment so the appropriate level of service is provided, refer to services deemed necessary, and assist individuals with applying for medical assistance.
2. There should be an engrained coordination process for system partners so that families involved in child welfare and in need of drug and alcohol services are effectively served. This could be operationalized by regularly scheduled coordination meetings between the two agencies or a dual-funded position that is assigned to these specific families.
3. The detailed system and funding descriptions documented should be provided to Single County Authorities, child welfare agencies and judges so that funding and eligibility criteria are understood, as well as the process for accessing services.
4. The benefit flow map can be provided to Single County Authorities, child welfare agencies and judges to understand the hierarchy and process of drug and alcohol funding.

APPENDIX 2

JUN 2 4 2002

BULLETIN

COMMONWEALTH OF PENNSYLVANIA

Department of Public Welfare --- Office of Children, Youth and Families

Department of Public Welfare --- Office of Mental Health and Substance Abuse Services

Department of Health --- Health Promotion and Disease Prevention

Department of Health --- Quality Assurance

Juvenile Court Judges' Commission

ISSUE DATE:	EFFECTIVE DATE:	NUMBER:
JUN 0 1 2002	Immediately	00-02-03

SUBJECT:

PROTOCOL FOR SHARING DRUG & ALCOHOL INFORMATION

BY:

Wayne Stevenson
Deputy Secretary for Children, Youth and Families

Gerald Radke
Deputy Secretary for Mental Health and Substance Abuse Services

Stephen H. Suroviec
Deputy Secretary for Health Promotion and Disease Prevention

Richard Lee
Deputy Secretary for Quality Assurance

James E. Anderson
Executive Director, Juvenile Court Judges' Commission

SCOPE:

CHIEF JUVENILE PROBATION OFFICERS
COUNTY CHILDREN AND YOUTH SOCIAL SERVICE AGENCIES
COUNTY CHILDREN AND YOUTH ADVISORY COMMITTEES
COUNTY COMMISSIONERS AND EXECUTIVES
JUVENILE COURT JUDGES
JUVENILE COURT JUDGES' COMMISSION
JUVENILE DETENTION CENTERS
LICENSED DRUG AND ALCOHOL TREATMENT PROVIDERS
PRIVATE CHILDREN AND YOUTH SOCIAL SERVICE AGENCIES
SINGLE COUNTY AUTHORITIES

REFER COMMENTS AND QUESTIONS REGARDING THIS BULLETIN TO:

APPROPRIATE REGIONAL OFFICE

ORIGIN: Ms. Cindi Manuel, Telephone: (717) 783-7372

JUN 20 AM 11:01

PURPOSE:

To provide information and procedures to Single County Authorities (SCAs); licensed drug and alcohol treatment providers; juvenile probation offices; and County Children and Youth Agencies (CCYAs) for the sharing of drug and alcohol information in compliance with federal and state law, consistent with best practice standards related to issues of child safety and family and individual privacy. The bulletin is intended to provide direction and set forth operational protocols and is not intended to be and should not be considered legal advice.

BACKGROUND:

Act 126 of 1998, effective January 1, 1999, amended the Juvenile Act, 42 Pa. C.S. §§ 6301 - 6365, to allow for the release of drug and alcohol treatment information to a court, a CCYA or a juvenile probation officer (JPO) in conformance with federal regulations. As permitted by federal regulation state law generally imposes greater restrictions on the release of drug and alcohol information than found in federal law, see 42 C.F.R. §2,20; 71 P.S. § 1690.108; 4 Pa. Code § 255.5(b). By eliminating the restrictions imposed by other provisions of state law, Act 126 allows for the release of drug and alcohol treatment and other records regarding a child who is alleged to be or adjudicated dependent or delinquent, or the child's parents, to an extent not permitted in other proceedings or anywhere else in Pennsylvania law. The purpose of the amendment was to allow for joint case planning between the child welfare, juvenile justice and drug and alcohol systems; it affects each of these systems as they provide services to children and their families while continuing to meet their respective mandates.

This bulletin addresses one very essential component of the collaboration needed for successful joint case planning - the sharing of drug and alcohol information. Prepared by a workgroup of professionals from across the disciplines, it provides direction to all of those who come in contact with families whose children are in a situation of risk or who are in substitute care. The bulletin establishes protocols to share drug and alcohol information in compliance with federal and state law, consistent with best practice and respectful of the need to balance the issues of child safety, family and individual privacy and the integrity of the therapeutic process. It also encourages professionals to reach across their traditional service delivery boundaries in order to achieve better outcomes for the entire family, not just for the individual receiving services. While the individual case circumstances will shape the way that the protocols in this bulletin are applied, the essential framework for information sharing and case planning should remain consistent.

DISCUSSION

Historically, state confidentiality regulations have limited the ability of drug and alcohol treatment providers to share treatment information. Confidentiality protections

are important to encourage people to seek treatment; to protect the client-counselor therapeutic relationship; and to guard against the release of information that may be adversely used in people's personal and professional lives. Yet the reciprocal sharing of information among the child welfare, juvenile justice, drug and alcohol and judicial systems is often critical to promote the best outcome for the client and his or her family. Act 126 balances these competing interests by removing state law restrictions and requiring compliance only with federal confidentiality provisions, thereby expanding the degree to which systems are allowed to share confidential information.

CONFIDENTIALITY REQUIREMENTS

Even with the enactment of Act 126, drug and alcohol providers may release information to a CCYA or JPO only as permitted by federal law. Federal requirements are found at 42 U.S.C. §§ 290dd-2 and 42 C.F.R. Chapter I, Part 2 (§§2.1-2.67).

Under federal law, records of the identity, diagnosis, prognosis, or treatment of any client maintained in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research are confidential. In general, disclosure of information contained in such records is permitted only with the client's written consent, or by a court order authorizing disclosure, or to medical personnel in a medical emergency or other specified personnel for research, audit, or program evaluations. Disclosure must be limited to the information that is necessary to carry out the purpose of the disclosure. Information may not otherwise be disclosed or used in any civil, criminal, administrative or legislative proceedings conducted by any federal, state or local authority. Finally, information received with the written consent of the client may not be used to initiate a criminal investigation or to prosecute the client.

Once an agency receives information, it may disclose that information, either verbally or in writing, only to such entities as authorized by the client's written consent or by court order. Disclosure to any other person or entity constitutes an illegal redisclosure of information.

Violation of any of these confidentiality requirements is subject to criminal penalties, but claimed violations are construed in favor of the potential violator.

Although federal confidentiality provisions are very broad, they are not absolute. Federal law does not, for example, protect any information relating to suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. Nor does federal law prohibit drug and alcohol providers from communicating information to law enforcement officials about a client relating to a crime committed or threatened to be committed at the provider's facility or against any person who works for the provider.

The child welfare and the juvenile justice systems are bound by different confidentiality requirements, which are less restrictive than the federal drug and alcohol

confidentiality provisions. In order for the child welfare system or the juvenile justice system to release information to drug and alcohol treatment providers, the child welfare worker (CWW) or JPO must adhere to the restrictions and follow the procedures in the following statutes and regulations:

- Child Protective Services Cases, 23 Pa. C.S. § 6339, 55 Pa. Code §§ 3490.91 - .95; 55 Pa. Code § 3130.44
- General Protective Services Cases, 55 Pa. Code § 3130.44; 55 Pa. Code § 3490.242
- Juvenile Court Records, 42 Pa. C.S. § 6307

JOINT CASE PLANNING

The child welfare and juvenile justice systems often need to rely on the expertise of the drug and alcohol treatment provider to help make informed decisions about how to best plan for children and their families. At the same time, both the child welfare and the juvenile justice systems have a responsibility to share information with those drug and alcohol providers who are either completing assessments or providing treatment to the children and families served by all three systems. Most of the decision making and planning needs of all three systems can be met through joint case planning or case consultation. This kind of planning allows for the full and active participation of child welfare and juvenile probation in identifying those issues especially related to the disposition of the child. Once identified, these issues may be included, if appropriate, in the specific drug and alcohol treatment plan.

Joint case planning is also essential to appropriate court dispositions. In a delinquency case, the court is required to make a disposition that provides balanced attention to the protection of the community, the imposition of accountability for offenses committed and the development of competencies to enable the child to become a responsible and productive member of the community. In a case where a referral for a drug and alcohol assessment or treatment is made, it is essential that the juvenile court judge obtain case information regarding a delinquent child and the child's parent(s) with such specificity as to allow the judge to make well-informed and appropriate decisions concerning the child's future.

In a dependency case, the court is required to make a disposition that is best suited to the protection and physical, mental and moral welfare of the child. Effective January 1, 1999, the Juvenile Act was amended, consistent with the federal Adoption and Safe Families Act of 1997 (ASFA), Pub. L. 105-89, to place new emphasis on time-limited attempts to reunify families when children have been adjudicated dependent and placed out of their homes. Parents of these children face new time frames in which to resolve their problems and become active parents. When a dependent child has been in out-of home placement for 15 of the most recent 22 months, the CCYA must file a petition to terminate parental rights, unless certain statutory exceptions are met. See 42 Pa. C.S. § 6351(f)(9). One of these exceptions is when the child's family has not been provided with necessary services (including drug and alcohol treatment) within the time

frames set forth and listed in the permanency plan. See 42 Pa. C.S. § 6351(f)(9)(iii). It is the child welfare system's responsibility to balance a child's safety and right to permanency with a parent's right to parent his or her child and to provide services to achieve those goals. In order for the CWW to make an appropriate recommendation and ultimately for the judge to make the best-informed decision, it is essential that information regarding a child's or parent's substance abuse problem and treatment be available to the court.

Joint case planning and case consultation clearly constitute best practice when clients are involved in multiple systems. As such, joint case planning should be viewed as the expectation rather than the exception. An open dialogue and sharing of information can only improve the planning and development of services and enhance the appropriateness of delinquency and dependency dispositions under the Juvenile Act.

Examples of Information Which May Be Requested and Exchanged

County Children and Youth Agencies	Drug and Alcohol Providers and SCAs
Court Order	Treatment Plan
Court Report	Aftercare Plan
Permanency Plan	Service Plan (Intensive Case Management)
Risk Assessment	Discharge Summary
Social Summary	Progress Report (verbal and written)

With the client's consent, a CWW or JPO may participate with drug and alcohol professionals in joint case planning without a court order. Obtaining client consent may eliminate the need in most cases for court-ordered participation of the CCYA or JPO in the development of the actual drug and alcohol treatment plan. However, recognizing the importance of joint case planning, in the absence of consent Act 126 allows the court to "order the participation of the county agency or juvenile probation officer in the development of a treatment plan for the child as necessary to protect the health, safety or welfare of the child, to include discussions with the individual, facility or program providing treatment and the child or the child's parent in furtherance of a disposition" of a dependent or delinquent child. See 42 Pa. C.S. § 6352.1.

The following protocols describe procedures that agencies should follow to facilitate joint case planning. As a first resort, every agency working with children and their families should seek the client's consent to release and exchange drug and alcohol information. Only after the client has refused to give such consent should agencies seek to obtain a court order. Regardless of whether the release of drug and alcohol information is authorized by consent or by other available means, the same protocol for sharing such information applies. **Questions regarding disclosure of confidential drug and alcohol treatment information in particular cases should be referred to an attorney for advice.**

PROTOCOL FOR INFORMATION SHARING AMONG THE DRUG AND ALCOHOL, JUVENILE JUSTICE AND CHILD WELFARE SYSTEMS

1. When a CWW or JPO suspects that a client or, as applicable, a client's parent or guardian, has a substance abuse problem, a referral should be made to the SCA, or other qualified assessment site, for an alcohol and other drug assessment. The assessment should include: a determination as to whether a substance use disorder exists, a description of the severity of the problem, a determination of the appropriate level of care (treatment), if treatment is warranted, and a recommendation for a facility in which the client may be most appropriately treated.

   The treatment funding source, e.g:, managed care organizations or commercial insurance plans, may dictate who is responsible for conducting the assessment. The referring CWW or JPO should attempt to ascertain insurance information prior to making a referral for an assessment. If the SCA is to complete the assessment, the SCA will establish what funding may be available to pay for the recommended treatment services and advise the CWW or JPO of possible resources.

2. At the time the CWW or JPO makes the referral for an assessment, all information that is known about the client's suspected use and related issues should be provided for the drug and alcohol assessor. This information may include worker observations, police reports, any known legal involvement, specific concerns around parenting and supervision issues, and specific client behaviors. The information is helpful to the assessor who can then use the information to probe specific areas related to addiction symptomatology. Referral information from the CWW or JPO should also address specific concerns or issues that he or she would like to see the treatment provider address and specify the time frame in which the results of the assessment are needed, e.g., date of upcoming court hearing, and allow ample time for the assessment to be completed. (There are a variety of time frames and access standards related to a face-to-face assessment.) In the event the SCA is not involved in the assessment or referral process, the same referral information should be forwarded to the treatment provider.

3. If requested, and with appropriate authorization, the provider will forward the assessment and any recommendations to the referring CWW or JPO.

4. After a recommended course of action has been determined, the CWW or JPO will forward the Permanency Plan, including the Family Service Plan, Social Summary, Drug and Alcohol Assessment and all other available relevant information to the treatment provider.

5. Once the client is admitted to treatment, the treatment provider and the referring CWW or JPO should discuss what information would be needed, e.g., progress reports, and the frequency of information sharing (see Examples of Information That May Be Exchanged). This process will allow for clear expectations by each of the systems involved in the coordination of care.

6. At the earliest possible stage, the treatment facility should discuss aftercare recommendations and plans with the CWW or JPO in order to allow for appropriate follow up by the CWW or JPO.

GUIDELINES FOR OBTAINING CLIENT CONSENT

The first thing that any entity seeking to obtain consent for the release or disclosure of drug and alcohol information should consider is the purpose and need for the communication of information. Once these have been identified, it is easier to determine how much and what kind of information needs to be released.

It is important that any entity seeking to obtain consent for the release or disclosure of drug and alcohol information confirm that the client understands the nature of the information that is being requested or exchanged. The client should understand exactly what information will be released, why it is being released, how it will be used and the possible consequences of refusing to consent.

Regardless of the age of the client, unless the client lacks mental capacity, only the person referred for or receiving the alcohol or other drug treatment may consent to the release of his or her drug and alcohol information. In order for a consent to be valid, a client must consent in writing to the specific treatment information, e.g., the treatment plan, discharge summaries, progress reports, or aftercare plans that is to be released; the specified purpose for which the released information will be used; and the individual(s) or agency(cies) which is to receive the information.

The length of time for which a consent may be valid is not defined in federal or state law. The consent should generally remain in effect until the client has completed treatment at the facility specified on the consent form.

In most cases, a separate consent form should be used for each type of disclosure and for each different recipient of information. However, a single consent form may suffice for a series of disclosures of the same type of information to the same recipient as long as the type and amount of information, the identity of the recipient, the purpose of the disclosure and the duration of the consent are specified on the form.

The client may revoke his or her consent at any time except to the extent that action has already been taken in reliance on the consent. Revocation of consent does not require the facility to retrieve information that has already been disclosed; nor does it negate actions or determinations based on information already disclosed.

A sample consent form that conforms to federal requirements is reproduced at Attachment A. Agencies are strongly encouraged to use this sample form, as any deviation could render the consent invalid. The drug and alcohol provider has an obligation to refuse to honor a consent that does not comply with federal regulations, has expired, or is known to be revoked, false or invalid. See 42 C.F.R. § 2.31(c).

PROTOCOL FOR OBTAINING A COURT ORDER TO ALLOW INFORMATION SHARING AMONG THE DRUG AND ALCOHOL, JUVENILE JUSTICE AND CHILD WELFARE SYSTEMS

The following protocol is based on federal requirements at 42 C.F.R. §§ 2.61 – 2.67.

1. If the CWW or JPO is not able to obtain the proper consent, or if consent is obtained but the treatment facility refuses to disclose the information, disclosure may be authorized by court order. Although a court order will authorize the facility to disclose information, it will not compel an unwilling facility to disclose the information. In such cases, the party seeking disclosure must obtain and serve a subpoena along with the court order authorizing disclosure.

2. The party seeking disclosure must file an application with the court. If the facility has refused to disclose the information even though the client gave consent, the client may apply for a court order, or the parties may apply jointly. In those delinquency proceedings that are not closed to the public, in accordance with 42 Pa. C.S. § 6336(e), the party seeking the court order must request that the application and order, as well as all associated proceedings, be filed under seal. If there is any doubt whether the court will grant the request in its entirety, then the application must refer to the client using a fictitious name (such as John or Jane Doe), and may not contain information identifying the client. A similar request need not be made explicitly in other delinquency or in dependency proceedings because such proceedings are mandated to be closed to the public and the records are by law protected from public scrutiny.

3. The court must give the client and the record custodian adequate notice and afford them the opportunity to respond, in writing or in person, to the application for a court order.

4. If either the client or the record custodian requests to respond to the application in person so that the court holds a hearing on the application, the hearing must be conducted in chambers.

5. The court may issue an order only if it determines that good cause exists. To determine whether such good cause exists, the court must consider whether other effective ways of obtaining the information are available, and whether the public interest and need for disclosure outweigh potential injury to the patient, the physician-patient relationship, and the treatment services.

6. A court order authorizing disclosure must limit disclosure to the parts of the record necessary to fulfill the order's objective, restricting the recipients of the information to those persons whose need for information is the basis for the order, and must include such other measures as are necessary to limit disclosure for the protection of the client.

7. If the court order is sought for disclosure of drug and alcohol treatment information that is or may be related to a criminal investigation or prosecution, the procedures are similar, but the applicant must meet additional, heightened requirements to establish good cause.

NOTE: The CCYA or JPO does not need to wait to apply for a court order until it wants a drug and alcohol treatment provider to testify or provide records in court. Application for a court order may be made at any point in a delinquency or dependency proceeding, as necessary to, for example, monitor the child's or parent's progress in treatment.

DEFINITIONS:

Aftercare Plan - A continuing care plan for clients to follow after they leave formal treatment in the Drug and Alcohol system. It is the client's individualized plan for the future, including an identification of the client's personal goals and objectives.

Child in Substitute Care – A child living outside his or her home in the legal custody of a CCYA or under the jurisdiction of the juvenile probation department in any of the following settings: shelter home, foster home, group home, supervised independent living, residential treatment facility and secure and non-secure residential placement.

Dependent Child – As defined in the Juvenile Act, 42 Pa. C.S. § 6302.

Delinquent Child – A child ten years of age or older whom the court has found to have committed a delinquent act and to be in need of treatment, supervision or rehabilitation.

Discharge Summary - A clinical summary used in the drug and alcohol system, completed within one week of discharge, describing the reasons for treatment, services offered, response to treatment and client's status or condition upon discharge.

Disposition – An outcome of a juvenile court case, as ordered by the Court.

Joint Case Planning – A process coordinating the services that will be provided by the agencies directly involved in the client's case, providing an opportunity for each agency to identify specific client concerns and program mandates. The planning meeting should discuss general strategies to be utilized by each agency in addressing

the client's issues as well as identifying the areas of responsibility of each involved agency.

Permanency Plan – The document that is presented to the court at a Permanency Hearing on behalf of a dependent or delinquent child or youth. It consists of two parts:

(a) **Family Service Plan** – The document prepared when a family has been accepted for services through the CCYA or is under the jurisdiction of the juvenile probation department. It contains:

- identifying information about the family;
- a description of the circumstances under which the case was accepted;
- the service objectives for the family;
- changes needed to protect the children from abuse, neglect or exploitation and to prevent placement;
- child safety issues;
- the services to be provided;
- the actions to be taken by the parties;
- the date the actions will be completed; and
- the results of reviews and permanency hearings.

(b) **Child's Permanency Plan** (formerly known as the placement amendment) – The document prepared when a child enters substitute care. It contains:

- a description of the circumstances that make placement necessary;
- to the extent available and accessible, health and education information on the child as detailed in Title 55. Pa. Code, Chapter 3130 (Administration of County Children and Youth Social Service Programs);
- a description of efforts that have been made and the services that have been provided to prevent placement (required only at initial placement);
- an identification of the type of home or facility in which the child will be placed and a discussion of the appropriateness of the placement;
- the anticipated duration of the placement, stated in months;
- an identification of the appropriate permanency goal;
- a description of the service objectives that shall be achieved by the parents or child to attain the identified goal for the child;
- an identification of services to be provided to the family, the child and if applicable, the foster family;
- the schedule for visits between the child and parents; and
- the results of permanency hearings and administrative reviews.

Progress Report - A tool utilized by the drug and alcohol system to summarize the client's status with regard to meeting treatment goals, which may include comments related to the client's understanding of the goals, progress in achieving goals, and degree e of cooperation with program rules.

Protective Services – Protective services for children includes two categories – child protective services and general protective services.

> **(a) Child Protective Services (CPS)** – Those services and activities provided by the Department of Public Welfare and each CCYA for child abuse cases. Reports of child abuse include non-accidental serious physical injury, serious mental injury, serious physical neglect, sexual abuse and imminent risk of serious physical injury or imminent risk of sexual abuse. 23 Pa. C.S. §§ 6301-6385 (relating to the Child Protective Services Law)
>
> **(b) General Protective Services (GPS)** – Those services to prevent the potential for harm to a child who is without proper parental care or control, subsistence, education as required by law, or other care or control necessary for his physical, mental or emotional health or morals as well as those additional conditions enumerated in Title 55 Pa. Code § 3490.223 (ii) through (ix).

Service Plan - An individualized, strengths based, specific plan developed jointly by a client and his/her Drug and Alcohol Intensive Case Manager, which includes specific action steps required to achieve goals related to the acquisition and maintenance of needed ancillary or support services. Support services might include housing, transportation, medical, family/social, mental health, legal counseling, education, employment, life skills, childcare or basic needs.

Treatment Plan - A time limited, individualized, specific plan detailing the treatment services to be provided within the confines of the drug and alcohol treatment program. The treatment plan includes short and long-term goals for treatment, the type and frequency of treatment and rehabilitation services, and the proposed type of support service.

ATTACHMENT A

SAMPLE

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, *John Doe* give my consent and authorize *ABC Assessment/Treatment Program* to release to *County Juvenile Probation Officer or Child Welfare Worker* information for the sole purpose(s) of: [specify in detail the purpose of the release - e.g., *enabling the agency worker to make responsible decisions concerning treatment and continuing care needs.*

I understand that information will be disclosed only for the purpose(s) noted above, and the release of information will be limited to the following information:

Progress Reports	_____	Comprehensive Treatment Plan	_____
Service Plan	_____	Discharge Summary	_____
Aftercare Plan	_____		

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R., Chapter I, Part 2, and cannot be disclosed without my written consent unless otherwise permitted by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event, this consent expires automatically as follows: *after 180 days [or] the completion of treatment at this facility.*

_____ _____

Client signature Date

_____ _____

Witness signature Date

NOTICE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Chapter I, Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Chapter I, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I _____ have been offered a copy of this form and I have:
Signature of Client

_____ Accepted ____ Refused

DEPARTMENT OF HEALTH
... in pursuit of good health

Act 126 - Department of Health, Department of Public Welfare (OCYF), Juvenile Probation

Examples of Information Which May be Requested

- Treatment Plan
- Aftercare Plan
- Service Plan (Intensive Case Management)
- Discharge Summary (treatment)
- Progress Report (verbal and written)

Definitions

- **Treatment Plan** - A time limited, individualized, specific plan detailing the treatment services to be provided within the confines of the drug and alcohol treatment program. The treatment plan includes short and long term goals for treatment, the type and frequency of treatment and rehabilitation services, and the proposed type of support service.

- **Aftercare Plan** - A continuing care plan for clients to follow after they leave formal treatment. It is the client's individualized plan for the future, including an identification of the client's personal goals and objectives.

- **Service Plan** - An individualized, strengths based, specific plan developed jointly by a client and his/her Drug and Alcohol Intensive Case Manager, which includes specific action steps required to achieve goals related to the acquisition and maintenance of needed ancillary or support services. Support services might include: housing, transportation, medical, family/social, mental health, legal counseling, education, employment, life skills, child care or basic needs.

- **Discharge Summary** - A clinical summary describing the reasons for treatment, services offered, response to treatment and client's status or condition upon discharge. This summary is completed within one week of discharge.

- **Progress Report** - A summary of the client's status with regard to meeting treatment goals. The report may include comments related to the client's understanding of the goals, progress in achieving goals, and degree of cooperation with program rules.