2014 Pennslvania State Roundtable Report

Drug & Alcohol Workgroup

Drug and Alcohol Workgroup Members

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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 Dependency 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 (DAWG) 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. In addition to the monthly meetings, the Workgroup traveled to various treatment sites and heard from treatment professionals and recovering substance abusers to become better informed of the concerns and successes of those struggling with substance use disorders (SUD).

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 those of its "parent" for 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.

From the beginning the Workgroup realized that it would take several years to fully analyze all of the complex issues it has been tasked with addressing. As a result, in this first year of existence, the Workgroup strategically focused its time and energy on understanding how substance abuse intersects with the child welfare population. In doing so, the Workgroup concentrated on substance abusing parents. Substance abuse by children and co-occurring disorders were, for a time, deferred.

The Workgroup also came to the realization that it would have to “chunk out’ the issues and tackle them a few at a time. Keying in on the SRT’s top issue of changing culture and value, the Workgroup let its research into that issue guide it to other issues. While this report will directly or indirectly touch on all topics, in-depth research into several of the issues prioritized by the SRT, including effective treatments, relapse protocols, and dual diagnoses, is just beginning. As a result, substantive recommendations pertaining to those subjects will also be deferred.

Adopting a multi-faceted approach to exploring the issues allowed the Workgroup to: 1) widely circulate a Collaborative Values Survey that was completed by more than 3,000 respondents; 2) review existing literature; 3) survey programs and strategies being used in other states; 4) explore available federal resources; 5) visit several Pennsylvania drug and alcohol programs; 6) bring in expert speakers to educate its members about a variety of issues; 7) begin the process of identifying practices that are being used in the Commonwealth; and 8) conduct internal discussions and debate between its diverse membership.

Following this approach led the Workgroup to discover and, as discussed in more detail below, partner with the National Center on Substance Abuse and Child Welfare (NCSACW). The partnership will assist 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). At the same time, the IDTA process will provide direct assistance to at least seven diverse counties throughout the Commonwealth who will be the core counties in the IDTA program. As the Workgroup gains a deeper understanding of how substance abuse affects children and families in the child welfare system and the IDTA process moves forward, the issues which have been deferred will be comprehensively addressed and research and evidence-based practice recommendations for Pennsylvania will be developed.

National Center on Substance Abuse in Child Welfare

IDTA through the NCSACW is provided in a systematic, phased approach accomplished in five steps. Pennsylvania is beginning the first phase, known as Pre-IDTA. During this timeframe, activities will focus around the assessment of need and readiness for change. As this will be done at the county level, supported by the Workgroup and state offices, selected core counties will work with a senior level technical assistant to determine the individual county's needs and practices. Time will be spent developing a deeper understanding of the child welfare, mental health, drug & alcohol and court systems and the needs as they relate to those with SUDs.

Following this initial phase, core counties will work to develop a strategic plan to address concerns and need areas and to build capacity to begin the next phase. The third phase is actual implementation and evaluation at the county level. Phase four will bring the elements of practice and lessons learned to the state as well as local level participants for dissemination, evaluation, and sustainability planning. The process ends with monitoring and aftercare during the fifth phase. Each county will develop a core team who will be responsible for the actual work with the NCSACW. One person from that group will join the DAWG which will ensure a communication loop providing shared information. Each county's local children's roundtable will provide oversight to the core team just as the SRT provides oversight to the DAWG. The Workgroup itself will function as steering committee to the core counties. Leaders from the Office of Children, Youth and Families, Office of Children and Families in the Courts, Department of Drug and Alcohol Programs and the Office of Mental Health and Substance Abuse Services will serve as the Executive Committee to work on state level systemic issues. A working model of the communication structure and the draft work plan/timeline for the IDTA process is attached.

Information Gathered to Date

The Workgroup has gathered substantial information and identified numerous resources in a relatively short period of time. This section will provide the results of the Collaborative Values Survey, impart some of the knowledge the Workgroup has gained, and summarize the research it has conducted, literature it has reviewed, and information it has collected to date. In doing so, several suggestions and key points will be advanced. While the Workgroup is not yet ready to cite the suggestions and key points as formal recommendations, the urgency surrounding substance abuse in child welfare would not allow it to wait until next year for formal recommendations. It is hoped that sharing the information will prompt spirited discussion at local, regional, and the state roundtable that will advance the goal of improving outcomes for children and families who are affected by substance use disorders.

Development of the Department of Drug and Alcohol Programs

The state signaled a culture change when it created a cabinet level department to address drug and alcohol issues. Historically, substance abuse treatment was

managed and monitored by the Bureau of Drug and Alcohol Programs located in the Department of Health. Act 50 of 2010, which was implemented in 2012, elevated the Bureau to the Department of Drug and Alcohol Programs (DDAP). It was charged with the coordination of the efforts of all state agencies in the control, prevention, intervention, treatment, rehabilitation, research, education and training aspects of drug and alcohol abuse and dependence problems. Prior to this, there was a culture of programs working in "silos". This change has increased collaboration between related systems of care, which allows for better outcomes. This, in turn, allows related systems to increase awareness of current trends and best practices in the treatment of SUD.

Another associated cultural change found within DDAP relates to an increasing awareness of the effects of drug and alcohol use across systems such as child welfare, and criminal justice. This awareness highlights the aspect of addiction as a developmental disease with some parallels to diabetes and heart disease, in that it can be progressive and best managed with a chronic care model of treatment. Historically, lengths of stay for residential treatment were much longer and have become shortened to the point of hindering effectiveness in the 1990's and 2000's. However, recent understanding of growing substance use problems and proper evidence-based treatment protocols emphasizes treatment with clinical fidelity for intensity and effective length of stay.

Collaborative Values Inventory

To aid its inquiry into how to change the culture and beliefs surrounding addiction, it was first necessary to gauge what the current culture is around substance use and abuse. In order to do this, the Workgroup used a modified version of the Collaborative Values Inventory created by the NCSACW. The modified version brought Pennsylvania specific information into an otherwise generic survey. A wide distribution of the survey to state and county level workers in Children & Youth, Drug & Alcohol, Mental Health and Court and Legal System allowed for a diverse and robust response rate. Responses were anonymous with the exception of identifying role, system, gender and county by Leadership Roundtable. The number of responses totaled over 3,300. Most completed every question.

Results from the survey showed that Pennsylvania is poised to engage in best practices for children and families touched by SUD. Highlights from the survey show that:

- 75% strongly agree that SUD is a disease.
- 68% strongly agree that children of parents with SUDs involved in the child welfare system should be targeted as a high priority group for prevention services.
- 70% strongly agree that treatment programs should know if their clients are involved with CYS and 83% that those programs should address the impact of parent's SUDs on safety, permanency, and well-being of their client's children.
- 85% strongly agree that court, substance abuse services, and child welfare should collaborate on behalf of the children and families they are serving.

In regards to the person struggling with a substance use disorder:

- 76% strongly agree that a relapse should lead to a collaborative intervention to re-engage the person in treatment and reassess child safety.
- 85% strongly agree or somewhat agree that relapse is a normal part of the recovery process.
- 88% strongly agree or somewhat agree that what a person does immediately following a relapse is a good indicator of where they are at in recovery.
- 88% strongly agree or somewhat agree that there is a link between substance abuse and trauma.
- 94% strongly agree or somewhat agree substance abuse programs should include a trauma recovery component.

Overall, it was found that most believe that less than half of the SUD parents will succeed in treatment. This could be related to the finding that more than half of the responders believed that there were not adequate and effective treatment and recovery support services in their communities. Approximately half of the respondents thought their training, knowledge and skills were adequate to work effectively with or on behalf of substance abusing population and that they were competent in working with this population. When the substance abuse professionals were screened out of responses, more than half of the respondents *did not believe* that their training, knowledge and skills were adequate to work effectively with or on behalf of substance abusing population and that they were competent in working with this population. However, even in this population, it is noted that 70% believed they knew when someone needed a substance abuse assessment.

Full results of the Collaborative Values Inventory can be found on the Office of Children and Families in the Courts website at www.ocfcpacourts.us/childrens-roundtable-initiative/state-roundtable-workgroups/drug-and-alcohol .

Pennsylvania Data on Substance Abuse and Child Welfare

In addition to understanding the culture around substance abusers, it was necessary to ascertain the scope of the problem in Pennsylvania. A data subcommittee was created and tasked with reviewing the data available in both the children and youth system (CYS) and the drug and alcohol system (D&A) in Pennsylvania to assess the ability to determine the incidence of parents impacted by SUDs in the children and youth system. The reported incidence varies nationally but studies suggest that parental SUDs are seen as a factor for one- to two-thirds of children involved in the children and youth system.

Children and Youth System data sources reviewed include:

Federal Adoption and Foster Care Analysis and Reporting (AFCAR) Data

This data is collected at the county level for every child who is removed from the care of their parent/guardian. The data is then submitted to DPW/OCYF for

submission to the federal government. One of the data elements is “removal reason”.

The limitations of this data include:

1. All children served by CYS are not included in this data.
2. Non-dependent children are not included.
3. Only dependent children who are “removed from their homes” are included.
4. Inconsistent documentation of removal reasons across the Commonwealth with variability in the percentage of cases reporting parental drug & alcohol as a removal reason.

Data from County Case Management Systems

Pennsylvania is in the process of developing a way to capture CYS case data statewide. Over the past several years counties were required to select a case management system that would meet specifications outlined by DPW/OCYF. There are a total of eight different systems in use across the Commonwealth. One of the eight systems, CAPS, is in use in 54 counties. Counties currently report AFCAR data to DPW/OCYF via these systems.

The limitations of this data include:

1. The limitations described above regarding AFCARS data.
2. Statewide data will not be fully available until CWIS is in place.
3. Child Protective Services (CPS) cases do not have a category that would indicate the impact of substance use in a general way.
4. There is no tracking of substance exposed newborns.

As a result of the limitations of the data, the incidence of involvement with CYS on either the General Protective Service level or the Child Protective Service level due to substance abuse cannot be adequately ascertained. That being said, one attempt to analyze the data available within the AFCAR system statewide for the period of April 1, 2012 to March 30, 2013 found that of the 9,543 removals from the home, 49% were removals due to substance abuse. Over a shorter time frame of July 1, 2013 to September 30, 2013, of the 1,278 removals 52% were removals due to substance abuse.

These numbers are believed to provide only a fraction of the picture of the intersection of substance abuse with child welfare. Even with the limitations of the data, Pennsylvania’s incidence of substance abuse as cause for removal is consistent with national incidence of parental substance use disorders as a factor for children involved in the children and youth system. Hand counts of data on the county level have shown to be consistent with national averages as well. Please see attachment, Data Request 13Q4-03, for information on individual counties.

There is a data opportunity that presents itself. The next stage of the development of a statewide system is currently underway. DPW/OCYF is developing the Child Welfare

Information Solution (CWIS) to upload information from the eight different systems. CWIS will ultimately have the ability to access information about all cases but is only in the beginning phases of development. Since it is currently in development, there is an opportunity to include fields that would gather information concerning the impact of parental substance use on families and children in the child welfare system.

Drug and Alcohol System data sources reviewed include:

Department of Drug and Alcohol Programs – Strengthening Treatment and Recovery Data System (STAR)

STAR is able to report adolescent and adult treatment admissions and completions with an additional category for pregnant women admissions. There is also a category for child welfare admissions and completions.

The limitations of this data include:

1. Only licensed drug and alcohol providers who receive federal, state or local funds are required to report via STAR.
2. Child Welfare System referrals include not only child welfare but any federal, state, or local agency that provides aid in the areas of poverty relief, unemployment, shelter, or social welfare.
3. There is no tracking of substance exposed newborns.

There was no information available specific to substance abuse or substance exposed newborns in the court's data management system, CPCMS. As our work moves forward with the NCSACW, multiple counties will be working on these issues within cross-systems teams. These teams could be tasked with exploring and making recommendations in regards to additions to data management systems.

Literature Review

The Workgroup also created a committee to conduct a review of existing literature; they did a phenomenal job with their tasks. The literature review subcommittee was charged with conducting a comprehensive review of journal articles that examined the field of substance abuse treatment with a focus on those individuals in the child welfare system and corresponding best practices. It became apparent early on there is a scarcity of information related to treatment issues of the child welfare population. The literature reviewed considered risk factors, treatment implications, and the impact substance use has on families and adolescents in particular. The most salient conclusions and/or findings are reported below.

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. Relatedly, a community risk factor for perpetration includes high densities of alcohol outlets in a given neighborhood. 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.

Reportedly, substance abuse treatment professionals with superior knowledge of addiction theory and treatment may harbor perceptions regarding the child welfare professional that can interfere with effective communication and collaboration. Some substance treatment providers report the perception that child welfare professionals view substance abusing parents as never being capable of caring properly for their children by virtue of their addiction, loyal to the child at the expense of the family relationship, judging parents or caretakers too harshly, and failing to recognize substance abuse as a disease and the corresponding challenges associated with addiction and treatment (Lee, Esaki, and Greene, 2009). Similarly, the child welfare professional reports concerns that the substance abuse treatment providers are loyal to the parent at the expense of the safety of the child, unwilling to share critical information that would protect the child, and fail to recognize the trauma children experience by chronic exposure to substance abusing parents or caretakers (Lee, Esaki, and Greene, 2009). Child welfare professionals and drug and alcohol treatment providers can ultimately have the same goal: keeping families together while making sure that children are safe. An enhanced partnership and shared understanding is imperative if parents are to recover and children are to remain with their families (McAlpine, Marshall, and Doran, 2001).

Interventions for women with addiction issues are considered women-centered treatments. Women-centered treatment is holistic towards the unique needs of women including high unemployment, poverty, incarceration, domestic violence, physical and mental health issues and being involved in the child welfare system. Often, women-centered treatments allow children to remain with their mothers during treatment and would include child care and recovery coaches. In one study, “several positive emotional and developmental effects were noted on children with mothers involved in integrated programs. The information underscores the importance of integrated programs given the risks for child maltreatment and poor outcomes in children of women with substance abuse issues. Findings suggest that the risk could be minimized with interventions addressing parental substance abuse and child-related services.” (Niccols, Milligan, Smith, Sword, Thabane, and Henderson, 2012).

Drug court also has been identified as an effective treatment intervention for substance affected offenders. As opposed to traditional judicial intervention, drug courts take the time to work with the defendant, uphold due process rights, and have better outcomes of remanding a productive member of society back to the community at the conclusion of the program when compared to the traditional court process at one tenth the cost of incarceration (Hora and Stalcup, 2008).

The incidence of adolescent substance use was noted by Keller, Catalano, Haggerty, and Fleming (2002). In their study, they demonstrate how the transitional nature of child welfare involvement may contribute to adolescent substance use. Controlling for baseline behaviors and risks, they sought to determine whether parent figure transitions were associated with delinquency and drug use. In their sample, they found that the likelihood of engaging in delinquent activity increased with the number of parent figure transitions. Their findings suggest that prevention and intervention with children in drug-affected families should address issues of family stability.

Pamela Hyde considered the general deleterious impact of substance abuse on families in the Substance Abuse and Mental Health Services Administration's Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues (2013). According to Hyde, there is a workforce crisis in the addictions field due to high turnover, worker shortages, an aging workforce, inadequate compensation, recruitment, retention, and distribution of the workforce, as well as misperception and prejudice about addiction. Meanwhile, there is an anticipated increase in need in the field of substance abuse due to eligibility for health care coverage by Medicaid through the Affordable Care Act. In response, SAMHSA is focusing on four areas: capacity building, data collection, evidence-based and cross-systems training, and utilization and support of the non-traditional workforce, including funding of innovations and services that include peers and family members.

Conclusions of the research of the literature review subcommittee confirmed the work of the full Drug and Alcohol Workgroup. In its simplest form the literature shows:

- ✓ 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.

Due to the dearth of articles examining the intersection of child welfare and substance use, a second level review was conducted by the University of Pennsylvania, Field Center for Children's Policy, Practice, and Research. Findings by the Field Center were similar to those of the subcommittee. The Field Center also convened their interdisciplinary team of experts to delve further into the themes that emerged from the group's work. An important recognition was the lack of research focusing on the co-occurrence between child welfare and substance abuse; despite the fact that it is a strong variable in such a large number of the cases that come to the attention of child welfare.

Five national reports have been issued on alcohol and other drug problems in child welfare. Although now somewhat dated, the reports generally provide the framework, foundation, and data for national policy on problems in the child welfare system that are caused by substance abuse. In addition, they are cited or referenced in more recent studies, analyses, articles, and government publications. In one way or another, the reports point to the need for cross-systems collaboration and training to address and

alleviate the adverse impacts of substance abuse on children and families in the child welfare system – a need and strategy that is now almost universally accepted.

The reports are large. However, Children and Family Futures, the parent organization of the NCSACW, has prepared a one-page annotated bibliography that cites the five reports (attached to this report), as well as a seven-page summary, in chart form, of the relevant findings and recommendations made in the reports. The bibliography and summary are available on-line at www.ncsacw.samhsa.gov/files/Summary5NationaReports.pdf. Along similar lines, the NCSACW has prepared an annotated bibliography that identifies the major literature between January 2000 and August 2009 covering cross-systems issues involving child welfare, substance abuse services, and dependency courts. It is available at http://www.ncsacw.samhsa.gov/resources/annotatedbiblio.aspx.

Other States and Evidence-Based Practices

Another subcommittee created was one charged with the research and review of what is being done in other states and to identify evidence and strength-based programs that are in use in other jurisdictions. Supplementing this component of its exploration of the issues, staff from the Office of Children and Families in the Courts had contact with Court Improvement Program staff from Iowa, Connecticut, and Nebraska. Much interest has been expressed from the court in the area of substance abuse and dependency. Judges ask for help in guiding them in their decision making for families and children affected by SUDs. Many resources are consumed with drug testing, screenings, evaluations and assessments. States are looking at the development of resources to assist judges and to provide training and opportunities for collaboration with other system partners.

When the Workgroup began discussions with the NCSACW, independent research into practices being used in other states was supplanted by and put on hold until discussions with NCSACW were solidified and the partnership was created. This was due, in part, to the fact that many of the major initiatives, practices, and programs in other states had been or were being developed through the IDTA process with NCSACW. The Workgroup's separate research into practices from other jurisdictions will resume in year two and be supplemented through its partnership with NCSACW.

Before suspending its formal research into this area, several trends and practices were identified and preliminarily analyzed. In broad summary, the findings were:

- Cross-systems collaboration is the foundation of programs and practices in most, if not all other states, cities, and judicial districts that have tackled the task of improving systems and practices for children and families who are affected by SUDs.
- Several other states have entered into the IDTA process with NCSACW.
- Several jurisdictions have created drug courts, including family drug courts.
- Many jurisdictions have keyed on screenings and early identification of substance abuse. Of note, several jurisdictions that started out creating a

universal screening tool have quickly expanded their screenings to add components ensuring timely assessment, referral, and engagement in treatment services.

- Some jurisdictions have created Benchbooks or practice guides. For example, in Maryland, a Benchbook on Substance Abuse and Addiction for Family Courts was published as a result of a statewide inter-agency conference on the subject. Similarly, in New York, an IDTA process resulted in creation of a Collaborative Practice Guide for Managers and Supervisors in Child Welfare, Chemical Dependency Services, and Court Systems.
- Rhode Island and some other states have developed an in-home social work model to address substance abuse issues.
- Others, such as Connecticut, employ "parent mentors" who are often recovering individuals who have been successful in moving through the child welfare system. These mentors provide parents with an opportunity to connect with someone who has "been there" as well as have accountability and support for tasks such as finding and completing treatment and working on service plan goals and maintaining contact with children who have been removed from the home.

While the Workgroup has not yet endorsed or recommended best practices, several federal agencies have compiled lists of practices that are or may be considered evidence based or promising practices. In this regard, the Child Welfare Information Gateway (CWIG) surveyed numerous programs, several of which are in use in some variation in Pennsylvania and most if not all of which involve inter-agency collaboration. The following are listed as Promising Practices:

Prevention and Treatment

- Focusing on early identification of at-risk families in substance abuse treatment programs so that prevention services can be provided to ensure children's safety and well-being in the home.
- Providing coaching or mentoring to parents for their treatment, recovery, and parenting.
- Offering shared family care in which a family experiencing parental substance use and resulting child maltreatment is placed with a host family for support and mentoring.
- Giving mothers involved in the child welfare system priority access to substance abuse treatment slots.
- Providing inpatient treatment for mothers in facilities where they can have their children with them.
- Motivating parents to enter and complete treatment by offering such incentives as support groups or housing.

Systems Change

- Stationing addiction counselors in child welfare offices or forming ongoing teams of child welfare and substance abuse workers.
- Developing or modifying dependency drug courts to ensure treatment access and therapeutic monitoring of compliance with court orders.
- Developing cross-system partnerships to ensure coordinated services (e.g., formal linkages between child welfare and other community agencies to address each family's individual needs).
- Providing wraparound services that streamline the recovery and reunification processes.
- Conducting cross-system training.
- Recruiting and training a diverse workforce, including training in cultural competence.
- Exploring various funding streams to support these efforts (e.g., using state or local funds to maximize child welfare funding for substance abuse-related services or using Temporary Assistance to Needy Families [TANF] funds to support substance abuse treatment for families also involved with the child welfare system).
- Family services for grandparents and other relatives providing care for children affected by substance abuse.

Source: CWIG. "Parental Substance Use and the Child Welfare System." U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. Washington, DC. January 2009. Available online at https://www.childwelfare.gov/pubs/factsheets/parentalsubabuse.pdf.

Along similar lines, the Substance Abuse Mental Health Services Administration (SAMHSA) has established a National Registry of Evidence-Based Programs and Practices (NREPP). According to SAMHSA's website, the NREPP is a searchable online registry of more than 330 interventions supporting mental health promotion, substance abuse prevention, and mental health and substance abuse treatment. The NREPP may be found at http://www.nrepp.samhsa.gov.

Despite its name, the NREPP is not a listing of programs that are evidence-based, but of programs that have been reviewed. The listing includes a scoring system describing the quality of the program in certain areas. Other national registries, each with its own evaluation process, include:

- Office of Juvenile Justice and Delinquency Prevention, Model Programs Guide found at: http://www.ojjdp.gov/mpg/
- Exemplary and Promising Safe, Disciplined and Drug-Free Schools Programs, sponsored by the U.S. Department of Education, found at: http://www2.ed.gov/admins/lead/safety/exemplary01/exemplary01.pdf
- Center for the Study and Prevention of Violence Blueprints for Healthy Youth Development found at: http://www.blueprintsprograms.com/

Site Visits and Presentations

As additional aids to its work, the Workgroup visited several drug and alcohol rehabilitation programs, obtained expert presentations on a range of topics related to substance abuse, and heard from two parents who are involved in the child welfare system. This included:

- State Intermediate Punishment (SIP) program, a post-conviction sentencing alternative consisting of an intensive twenty-four month drug and alcohol rehabilitation program that begins in prison at the State Correctional Institution at Camp Hill and ends in the community with a transitional half-way house.
  NOTE: Information about the SIP program and its effectiveness is available online at: www.cor.state.pa.us/portal/server.pt/community/major_initiatives/21262/state_intermediate_punishment/1354887

- Salvation Army Adult Rehabilitation Center, a free six month faith and work therapy-based inpatient drug and alcohol treatment program located in Harrisburg, Pennsylvania
  NOTE: The web address for the Salvation Army Adult Rehabilitation Center is http://satruck.org/national-rehabilitation. There are more than thirty Salvation Army Rehabilitation Centers in Pennsylvania and its neighboring states.

- Vantage House, a long-term inpatient drug and alcohol treatment center for women with children located in Lancaster, Pennsylvania and operated by Gaudenzia, Inc.

- Family Drug Court in Lackawanna County with Judge Michael Barrasse and his team.

- A presentation on problem solving courts, including drug courts, by P. Karen Blackburn, Program Administrator, Problem Solving Courts Program, Administrative Office of Pennsylvania Courts.

  NOTE: Information about drug courts in Pennsylvania and the AOPC's Problem Solving Court Program is available on-line at www.pacourts.us/judicial-administration/court-programs. For information on drug courts in general, refer to the National Drug Court Institute/National Association of Drug Court Professionals website at http://www.ndci.org and the Office of Justice Programs Drug Court Clearinghouse and Technical Assistance Project publication, Juvenile and Family Drug Courts: An Overview, available at http://www.ncjrs.org/html/bja/jfdcoview/welcome.html.

- A presentation on the "Nature and Treatment of Addiction," by Kimberly C. Kirby, Ph.D, Director of the Parents' Transitional Research Center at the Treatment Research Institute.

- A presentation on "Parents with Drug Addiction," by Mary Louise E. Kerwin, Chair of the Psychology Department at Rowan University.

- A presentation on "Effective Substance Abuse Treatment for the Criminal Justice Population," by Ken Martz, Psy.D., workgroup member and the Director of the Bureau of Treatment, Prevention, and Intervention, Pennsylvania Department of Drug and Alcohol Programs (D-DAP).

NOTE: PowerPoint versions of Ms. Blackburn's presentation, including a current listing of drug courts and other problem solving courts in Pennsylvania, and the presentations given by Drs. Kirby, Kerwin, and Martz, are available online at the Office of Children and Families in the Courts website at www.ocfcpacourts.us/childrens-roundtable-initiative/state-roundtable-workgroups/drug-and-alcohol

- Nicholas Colangelo, Ph.D., the CEO of Clearbrook, an inpatient drug and alcohol facility located in Luzerne County, gave a presentation on the importance of educating family members about their loved ones' substance abuse and, when necessary, treating the whole family.

- Finally, the Workgroup heard from two parent presenters - one of whom was a dependent child and is now a parent ambassador; the other a recovering addict whose children are in care but who is working hard on her recovery and reunification. These women provided invaluable testimonials about their experiences in the system, parenting while actively consuming drugs, their time in rehabilitation, their feelings about their children, and "what they know now that they wished they knew then."

The site visits, expert presentations, parent testimonials, and internal workgroup discussions yielded a wealth of information. A full description of each is outside the scope of this report. What follows is a synthesized summary of the key points:

Substance use disorder (SUD) is considered to be a disease since it is chronic, progressive, and fatal if untreated. It is a brain disease. It is also a family disease. While adults can and do become addicted, substance use disorder is generally a developmental disease that typically begins sometime between early adolescence and the mid-twenties. The disorder occurs over a continuum from use to abuse to addiction.

Understanding the neurobiology of addiction is critical to both proper treatment and proper analysis of a substance abusing parent's progress or lack of progress in the child welfare and dependency systems. It is also the starting point for changing the culture, beliefs, and approaches to addiction.

Drug abuse changes both the structure of the brain *and* its functioning. In the non-addicted brain, control mechanisms are developed and inhibitory control can be applied as needed. In the addicted brain, this control circuit becomes impaired because of drug use and loses much of its inhibitory power over the circuits that drive responses. The result: once a person is addicted, he acts in a way that does not seem logical to those who are not addicted, but internally, there is an intense drive to continue to act that way.

While the disease is treatable, there is unfortunately no "cure." The good news is that treatment can work! The brain - and the person - *can* recover. Recovery takes time and is a long-term process that may require multiple treatments. Relapse is common (but not inevitable) and often signals either a need for reinstatement or restructuring of treatment, typically indicating that the prior treatment did not meet the

necessary intensity, duration and maintenance. Statistically, half of the individuals with SUD will relapse within 6 months. For those who reach five years of abstinence, 90% of individuals will remain drug free for the rest of their lives.

Treatment best practices call for quick, effective screening, assessment, and treatment, when necessary, of substance use disorders.

Screening for and early identification of SUDs is important in all cases. Therapeutically, the earlier a person suffering from a substance use disorder enters treatment the better. In fact, early detection can prevent a SUD from progressing. In or outside of the child welfare system, this helps both the addict and the addict's family, including minor children who themselves might be genetically predisposed to addiction.

Considerations Around Treatment

In dependency cases with a substance abusing parent, early identification of SUDs is important due to timing considerations. In this regard, child welfare workers, treatment providers, parents, parent attorneys, and others involved in the dependency system consistently report conflicting pressures that arise from trying to meet, concurrently, the relatively short timeframes required by the Adoption and Safe Families Act (ASFA) and corresponding Pennsylvania law to promote permanency for children; the time required to access open treatment slots; the time necessary for successful treatment participation; and the developmental needs of children.

Screening for SUDs should be a routine part of child welfare investigations, risk and safety assessments, and case planning and monitoring. Evidence of substance abuse may not be noticeable upon initial investigation, but may emerge over time as caseworkers develop relationships with a family or notice that family members are unable to participate in program activities. Given the prevalence of substance use and abuse in families involved in the child welfare system, child welfare caseworkers should consider screening during all stages of the case. Using a brief screening instrument takes little time and often yields beneficial results. A prior inter-agency task force convened by the Department of Public Welfare, Office of Children, Youth and Families in conjunction with the NCSACW worked towards the identification and implementation of a standardized screening tool called the UNCOPE, a quick six question tool in which two or more positive answers suggest the need for further assessment. A copy of the UNCOPE can be found attached to this report. It should be noted that screening is not always accurate. As a result, child welfare workers should supplement screenings with additional techniques, such as observation, review of medical histories, reports from family members or friends, or arrest records.

After screening, treatment best practice includes the need for timely assessment to determine whether a person suffering from a SUD needs treatment and, if so, the level of treatment he or she needs. For publicly funded treatment, the Pennsylvania Client Placement Criteria (PCPC) defines the level of care. For adolescents and coverage determinations under some insurance policies, the American Society of Addiction

Medicine (ASAM) guidelines are sometimes used. Too often, substance abusers are not treated at the proper level of care. Treatment at an insufficient level of care may occur due to a variety of reasons, including the substance abuser's refusal to participate in the appropriate level of care or leaving treatment prematurely, funding issues, an improper assessment, an assessment based on an inadequate history, lack of treatment resources in a community, lack of sufficient engagement efforts, and other reasons.

Best practice treatment further requires that substance abusers be treated for the appropriate duration. Treatment must be long enough as well as strong enough to provide for the best chance of recovery. This will vary based on the needs of the individual. There is a significant risk of under treatment, which can lead to relapse and subsequent loss of motivation in the individual, their families, child welfare workers, and the court system. Similar to giving half a dose of antibiotic, in order to get the desired results, a complete course of treatment is necessary. Another element of treatment best practice is that recovering substance abusers should "step down" in an appropriate continuum of care. So, for example, once an individual completes a residential program, he/she is referred to outpatient aftercare so that the length of treatment is extended as the individual slowly increases responsibility in their new sober world. After a period of time, the individual may "step down" again, discharging from outpatient and maintaining in community supports such as 12-step groups. As discussed above, the risk of relapse goes down the longer someone has been abstinent, so ongoing supports are important to help extend the length of abstinence.

When considering entry to treatment, studies have shown that it is not necessary for an individual to volunteer or be internally motivated. Part of the treatment process is to engage and motivate a client. However, attendance and participation is necessary, and this can be supported and even required by the court system. Arrests and child welfare investigations provide effective points of intervention to convince parents to enter and engage in substance abuse treatment programs. Compulsory treatment ordered by a court is effective in improving treatment retention so that parents remain in treatment long enough for programs to have desired effects. In this regard, alternative sentencing strategies such as the SIP program, other alternative sentencing strategies, and criminal and family drug courts can complement standard voluntary treatment opportunities in order to maximize participation and encourage recovery for parents involved with child welfare. As one recovery saying goes, "by nudge, by grudge, or by judge."

Similarly, it is not necessary for an individual to "hit rock bottom." Since this is defined by the individual, and as addiction is a progressive disease, there is always another bottom until one reaches death. This highlights the need for child welfare workers, family members, and other support persons to develop and continually use skills to engage and motivate individuals to treatment. These skills are also important for continual engagement of those who voluntarily enter treatment as their motivation often diminishes during treatment if steps are not taken to maintain motivation. Motivational

Interviewing has proven to be an invaluable skill for professionals to use in doing this and training in this technique is encouraged for caseworkers, attorneys, and judges.

There is no single treatment that is appropriate for everyone. As noted, multiple treatments are often necessary. As another recovery saying goes, the "longer and stronger the treatment, the better." While the Workgroup is just beginning to explore best practices in treatment and will recommend those to the State Roundtable in the 2015 report, some that appear promising and are considered evidence-based modalities, such as Cognitive Behavioral Therapy, Motivational Enhancement Therapy, and Therapeutic Community might be considered.

In the context of the intersection of the child welfare system with SUD, Family Systems Therapy could be effective. When the addict is a parent, evidence-based programs such as Parent-Child Interactive Therapy and Multi-Systemic Therapy could be used. As always, an evidence-based intervention should be considered in light of the outcome it is evidenced to achieve. The continuum of treatment should include transition and after-care counseling that assists the recovering addict with obtaining housing, education, or employment, and training and skills that are necessary to overcome barriers to sobriety. Similarly, if the individual is returning to the community from prison, the continuum of care should include appropriate transition and re-entry counseling and supports. In this case, specialty treatment should also address other risk factors of recidivism such as criminal thinking errors, and antisocial peers.

When a substance abusing parent involved in the child welfare or dependency system is actively participating in recovery, the parent's participation may minimize the amount of time, energy, and focus the parent has for parenting at any given point in the reunification process. For example, early on, the parent may need to put 80% of his/her efforts into recovery, leaving only 20% for parenting/visitation. Properly focused treatment, or treatment that includes the children, can reverse that deficit. While there are few studies about fathers with drug addiction and their children, there is an established and growing body of research on mothers and on interventions for mothers with SUDs. Research shows that treatment should be comprehensive, multidisciplinary, gender-specific, accessible, and tailored to the mother's needs. It should also involve substantial parent-child interaction. In this regard, treatment programs are available that accept both the mother and child. In such programs, the child remains in daycare at the facility where the mother is in treatment to lessen the trauma to the child and provide increased opportunities to teach mothers effective sober parenting skills. Mother-child treatment programs are a focus of DDAP and mothers a targeted population.

When a parent involved in the child welfare system has a SUD, drug and alcohol services often focus resources primarily or exclusively on the parent. However, addiction is a family disease and children of addicts and alcoholics frequently have medical, emotional, behavioral, and social problems, and sometimes cognitive limitations, that stem from the addiction. Accordingly, systems should treat the entire family, including children, *and* educate the family about the parent's disease.

Children are impacted by their parents' substance abuse in many ways. As a result, children should be evaluated and, if necessary, treated for the impacts. In addition, foster parents should receive specialized training in working with children from families in which parents abuse alcohol or drugs. Importantly, child welfare workers, parents, foster parents, and relatives must help children understand that their parents' SUD is not their fault. One way to do this is by teaching children the "7 Cs of Addiction" developed by the National Association for Children of Alcoholics:

The 7 Cs of Addiction

I didn't Cause it.
I can't Cure it.
I can't Control it.

I *can* Care for myself by
Communicating my feelings,
Making healthy Choices, and
Celebrating myself!

Source: National Association for Children of Alcoholics, on-line at http://www.nacoa.org

Substance Abuse and the Risk to Safety Continuum

Co-Chair Wendy Hoverter led the Workgroup through a discussion of Pennsylvania's Safety Assessment process as it relates to allegations of parental substance use, an issue that has arisen regularly during the work of the group. This resulted in the outlining and walk-through of a case example to develop an understanding of what happens when a threat is identified by a child welfare worker. The information was new to many workgroup members and it became apparent that it is important for all system members to have at least a working knowledge of the safety analysis process. The exercise was helpful in pointing out that parental substance use may not always constitute a child safety threat and subsequent removal of the child from the home. For example, an appropriate adult family member with adequate protective capacities may be present in the home or in-home interventions by the child welfare agency may provide a sufficient level of safety. This discussion would be of value to all local children's roundtables to develop a shared understanding as they explore issues of providing services to children in families who are affected by substance abuse. Cross-systems training on children's emotional needs for safety also remains to be addressed.

Funding

During its April 2014 meeting, the Workgroup began its examination of the complex issue of funding. By next year, the Workgroup hopes to produce a funding resource guide but wanted to share some very good preliminary information that it received about funding, insurance laws, and Drug & Alcohol Single County Authorities (SCA).

> ***When private insurance is available***: Act 106 of 1989, 40 P.S. Section 908-1 *et. seq.*, requires all commercial group health plans, HMOs, some self-insured plans, and the Children's Health Insurance Program (CHIP) to

provide comprehensive treatment for alcohol and other drug addictions based on a physician or psychologist's certification, not "medical necessity" or placement criteria. This certification in all instances controls both the nature and duration of treatment. This statutory benefit guarantees *at least* 30 inpatient days per year (90 lifetime), *at least* 30 outpatient/partial hospitalization sessions per year (90 lifetime), and additional treatment of 30 days of outpatient/partial hospitalization services that could be converted to an additional 15 days of inpatient. Family counseling services are also protected and available. Act 106 should be utilized whenever possible.

When insurance is through Medicaid: Act 152 of 1988, 71 P.S. Section 611.14, would apply. In this situation, the only criterion for determination for level of care is determined by DDAP. This is the PCPC for adults and ASAM for children. The PCPC identifies the level of care needed and the appropriate review times for each level of care. For example, if a client is in level 3C long term residential, utilization reviews should occur no more than once a month. For level 3B, short term residential, authorizations should occur no more than every 7 days.

***Mental Health Parity and Addiction Equity Act* (MHPAEA)**: MHPAEA requires group health plans that offer coverage for mental health or substance use disorders to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. In other words, the plans must provide the same level of benefits for mental health and substance abuse that they do for general medical treatment. The MHPAEA applies to plans sponsored by private and public sector employers with more than 50 employees, including self-insured as well as fully insured arrangements. Significantly, the MHPAEA also applies to Medicaid managed-care programs, CHIP, and Medicaid Alternative Benefit Plans and benchmark equivalent plans. Plans are not required to offer mental health and substance abuse benefits; however, if they do, there must be parity with physical health coverage. The MHPAEA should be invoked whenever the law applies.

Drug & Alcohol Single County Authorities

In order to more fully understand how a client can access drug and alcohol treatment at the county level, child welfare and court partners should have an understanding of the SCA structure and how the SCA identifies and prioritizes drug and alcohol services (prevention, intervention, and treatment). There are four basic SCA structures in Pennsylvania: 1) Planning Councils, in which a full-time administrator operates the SCA under the county MH/DS program; 2) Public Executive Commissions, in which a full-

time administrator oversees a separate but equal program on par with other agencies; 3) Private Executive Commissions, in which the county contracts SCA responsibilities to a non-profit organization with a governing board of directors; and 4) Public Executive Commissions, in which the county relinquishes responsibility for oversight of drug and alcohol programs so that DDAP directly contracts drug and alcohol responsibilities to a non-profit organization with a governing board of directors. No matter how an SCA functions, each is able to provide a "point of access" for a client to access services.

In general, SCAs are funding sources of last resort. In other words, other funding sources such as private pay, private or public insurance, and medical assistance must, for the most part, be exhausted before SCA funds are used. Understanding the SCA's goals, needs, and objectives will provide a framework for treatment services. Key reports to consider include the SCA's Treatment & Prevention Needs Assessment, Prevention Profile Part III, and Annual Report. These public information reports, obtained through the local county SCA office, will emphasize the SCA's treatment and service priorities based upon the identified needs of the county.

No matter the structure, each SCA has the ability to re-define priorities and collaborations based on the needs of their county and the availability or continued availability of funds. Whether the SCA is part of the Human Services Block Grant pilot or not, all SCAs have the same funding streams to utilize (though each stream has its own allowances and restrictions). Therefore, SCAs are able to work collaboratively with child welfare to determine access and treatment needs for families. In this regard, in its 2013-2014 Annual Plan and Report, DDAP states that, "SCAs are contractually required to provide access to a full continuum of care and provide preferential services for pregnant women and women with dependent children." A list of programs for women and women with children is included in Chapter 2 of the DDAP report which is available on-line at www.ddap.pa.gov.

While all SCAs are the "funders of last resort," their approaches to treatment may differ from county to county. In some counties, such as Lehigh, the decision has been made that the SCA will assist a client (or department referral) in navigating the drug and alcohol continuum of treatment regardless of the funding source. The idea is to allow the SCA to "do what it does best" and allow child welfare, probation, or other collaborative partners to "do what they do best," thereby increasing the client's access to clinically appropriate levels of service. In other counties SCAs do not enter the continuum until later in the process. When a SCA begins to run out of money and is therefore forced to either stop funding treatment other than detoxification or fund services below needed levels or duration of care, it is required to report its election to DDAP. In some counties where cross-systems collaboration has been established, the SCA will also provide this information to its system partners.

Conclusion

There is an urgency to address the issue of substance abuse in child welfare. As communities see incidence of substance abuse increase in the overall population, the

child welfare system, among others, finds itself moving toward a crisis point. Substance abusing parents, especially those whose children have been removed, need to be a priority in receiving effective treatment that is strong enough and long enough to begin a process of healing and recovery, not just for themselves, or for their children, but also for the generations of their families to come. System partners need to develop mutual values based on understanding the disease of addiction and come together, collaboratively, to create a system that supports the process of recovery to give addicts and their families the best possible chance of success. Children can't wait; their lives need to be free of the effects and consequences of substance abuse on their bodies, minds and souls. Once affected, remediation needs to be swift and comprehensive. Their lives might depend on it. The one thing everyone can do starting tomorrow is to ask the question, early on and often, "Is there D & A involvement with this family?"

Recommendations

The Workgroup respectfully submits to the State Roundtable the following recommendations:

1. Continue work on the issue of substance abuse in child welfare.
2. Move forward in working with the National Center on Substance Abuse in Child Welfare.
3. Make a request to the Office of Children, Youth and Families to consider ways to incorporate the identification of cases involving substance abuse in their development of a CWIS system.
4. Make a request to the summit planning committee to consider including a presentation on Substance Use Disorders including the neurobiology of addiction as part of addressing a cultural change.
5. In the spirit of promoting cross-systems collaboration, courts consider becoming leaders in a culture change by inviting a representative from the Drug & Alcohol system to join the local children's roundtable if one is not already present.

A Call for Collaboration: Addressing the Issue of Substance Abuse in Child Welfare, a Report to the State Roundtable
2014

Summary of Key Points

Intersection of Substance Abuse and Child Welfare

- The relationship between substance use disorders and child maltreatment and neglect is compelling and undeniable.
- Children of parents who have substance use disorders and who are also in the child welfare system are more likely to experience emotional, physical, intellectual, and social problems than children whose parents do not abuse drugs or alcohol. Additionally, abused and neglected children from families affected by substance abuse are more likely to be placed in foster care and to remain there longer than maltreated children from families not affected by substance abuse.
- In dependency cases involving parental substance abuse, the amount of time that a parent must remain in treatment before the child may be safely returned often exceeds the ASFA - based time periods for child permanency.
- Building collaborative relationships is the key to improving services and the lives of children and families in our systems. Collaboration builds on the individual strengths of each agency and family member, forging shared approaches that are more effective than an individual response.
- Collaboration is best established through a multidisciplinary team approach that brings together as many sectors of the community as possible.

Changing Cultures, Beliefs, and Approaches to Addiction

- Substance Use Disorder is a chronic, progressive disease which, left untreated, is fatal.
- Specifically, addiction is a brain disease. It creates changes to the brain and physiology, leading to some habitual behaviors which must be avoided long term.
- There is no cure. However, treatment is effective and brain functioning and processing abilities can be restored with a period of abstinence.
- Understanding the “disease model” and the neurobiology of addiction is critical to both proper treatment and proper analysis of a substance abusing parent’s progress or lack of progress in the child welfare and dependency systems.
- Understanding the disease of addiction is also the first key to changing the culture, beliefs, and approaches to addiction.
- In the Collaborative Values Survey, 75% of respondents strongly agreed with the statement that, “People with substance use disorders have a disease for which they need treatment.”

- Holding substance abusers accountable for their actions is consistent with the disease model of addiction. The SIP program is a clear medical-legal example of how the disease model and accountability are neither mutually exclusive nor inconsistent.
- In the Collaborative Values Survey, 52.6% of respondents strongly agreed and 40.8% somewhat agreed with the statement that, "People with substance use disorders should be held fully responsible for their own actions."
- Externally motivated treatment, including court-mandated treatment, is effective. In this regard, arrests and child welfare investigations can provide effective points of intervention to convince parents to enter and engage in substance abuse treatment programs. Compulsory treatment is effective in improving treatment retention so that clients remain in treatment long enough for programs to have desired effects.

Effective Treatment, Recovery and Relapse Supports, Overcoming Barriers, Screening and Assessments, and Evidence-Based Practices

- Early detection of substance abuse is critical. Early detection can prevent a substance use disorder from developing. It also enhances treatment prospects.
- Given the high rates of substance use disorders in the child welfare system, most if not all individuals should be screened for substance use and misuse. Screenings should be used throughout the case.
- Assuring timely access to comprehensive substance abuse treatment services is equally important.
- Once access is assured, elements of effective treatment with integrity include: intensity, duration, and continuum of care.
- Child welfare workers must develop and use skills to engage and retain clients in treatment and support ongoing recovery.
- Addiction is a family disease. Accordingly, the whole family should be involved in treatment when appropriate..
- Treatment should treat the whole person physically, mentally, emotionally, and spiritually. Evidence-based practices should be used.
- When the substance abuser is a parent, treatment should include comprehensive treatment services with a strong family/parenting component in addition to services that address substance use disorders and co-occurring mental health problems, including the effects of trauma.
- When the substance abuser is a mother with children, treatment should involve women-centered and need-specific programming for women and children. In proper situations, this may include mother-child rehabilitation centers.
- Both voluntary and mandated treatments are effective.
- Alternative sentencing strategies such as the State Intermediate Punishment program, other alternative sentencing strategies, and criminal and family drug courts can complement standard voluntary treatment opportunities in order to maximize participation and encourage recovery for parents involved with the child welfare system.

Funding

- County SCAs should be invited to participate in local children's roundtables.
- County HealthChoices Behavioral Health Managed Care Organizations (BHMCO) should be invited to participate in local children's roundtables.
- Cross-systems training, education, coordination, and collaboration between county SCAs, BHMCOs, and child welfare agencies should provide the foundation for reducing funding barriers and enhancing and expediting delivery of treatment services to children and families who are affected by substance abuse.
- SCA's should work collaboratively with County Assistance Offices to facilitate timely enrollment in Medicaid for eligible individuals.
- SCAs are required to provide preferential services to pregnant women and women with dependent children.
- Courts and child welfare agencies should request that SCAs inform them if and when the SCA begins to run out of money and is therefore forced to either stop funding treatment other than detoxification or fund services below needed levels or duration.
- No cost programs such as the Salvation Army Adult Rehabilitation Center program should be considered when inpatient treatment is needed, funding is unavailable, and the parent is either not being treated or is being under treated.
- Leverage Act 106 insurance benefits whenever necessary for the commercially insured.
- Leverage Act 152 insurance guidelines whenever necessary for Medicaid clients.
- Invoke the Mental Health Parity and Addiction Equity Act requirements whenever necessary.

DPW Data Request 13Q4-03

Original Request:

For the periods April 1, 2012 – March 30, 2013 and July 1, 2013 – September 30, 2013 provide the following:

- the total number of children removed from the home and
- the total number of children removed due to parent or child drug or alcohol abuse.

Results:

During the twelve months from April 1, 2012 to March 30, 2013, 9,543 total children were removed from the home. Of those, 4,672 (49%) were removed due to parental or child substance abuse.

During the three months from July 1, 2013 to September 30, 2013, 2,457 total children were removed from the home. Of those, 1,278 (52%) were removed due to parental or child substance abuse.

A breakdown of the above data points by county follows.

County	April 2012 - March 2013			July 2013 - September 2013		
	Total Removals	Removals due to Substance Abuse		Total Removals	Removals due to Substance Abuse	
		#	%		#	%
Statewide Total	**9,543**	**4,672**	**49%**	**2,457**	**1,278**	**52%**
Adams County	36	6	17%	6	2	33%
Allegheny County	1,118	271	24%	223	52	23%
Armstrong County	24	7	29%	10	0	0%
Beaver County	58	20	34%	9	5	56%
Bedford County	45	12	27%	10	4	40%
Berks County	380	146	38%	125	44	35%
Blair County	98	21	21%	13	4	31%
Bradford County	54	10	19%	13	1	8%
Bucks County	228	92	40%	46	23	50%

County	April 2012 - March 2013			July 2013 - September 2013		
	Total Removals	Removals due to Substance Abuse		Total Removals	Removals due to Substance Abuse	
		#	%		#	%
Butler County	93	39	42%	28	9	32%
Cambria County	73	29	40%	21	3	14%
Cameron County	9	0	0%	2	0	0%
Carbon County	18	3	17%	4	1	25%
Centre County	36	4	11%	11	6	55%
Chester County	60	12	20%	23	1	4%
Clarion County	23	5	22%	10	1	10%
Clearfield County	50	9	18%	16	8	50%
Clinton County	56	29	52%	15	7	47%
Columbia County	28	10	36%	7	0	0%
Crawford County	78	19	24%	20	5	25%
Cumberland County	113	31	27%	49	23	47%
Dauphin County	226	32	14%	48	17	35%
Delaware County	246	99	40%	79	33	42%
Elk County	9	2	22%	1	0	0%
Erie County	193	58	30%	57	16	28%
Fayette County	110	40	36%	53	26	49%
Forest County	2	0	0%	0	0	-
Franklin County	107	18	17%	33	5	15%
Fulton County	13	3	23%	1	0	0%
Greene County	58	16	28%	4	2	50%

County	April 2012 - March 2013			July 2013 - September 2013		
	Total Removals	Removals due to Substance Abuse		Total Removals	Removals due to Substance Abuse	
		#	%		#	%
Huntingdon County	26	10	38%	9	6	67%
Indiana County	34	16	47%	9	3	33%
Jefferson County	34	1	3%	11	4	36%
Juniata County	17	4	24%	2	1	50%
Lackawanna County	184	57	31%	30	12	40%
Lancaster County	214	38	18%	58	20	34%
Lawrence County	141	28	20%	39	9	23%
Lebanon County	44	0	0%	9	2	22%
Lehigh County	160	35	22%	32	9	28%
Luzerne County	337	107	32%	69	18	26%
Lycoming County	63	3	5%	6	0	0%
McKean County	44	10	23%	16	5	31%
Mercer County	83	8	10%	13	6	46%
Mifflin County	33	7	21%	5	0	0%
Monroe County	104	17	16%	40	5	13%
Montgomery County	153	64	42%	46	23	50%
Montour County	8	3	38%	0	0	-
Northampton County	120	49	41%	51	16	31%
Northumberland County	79	19	24%	19	9	47%
Perry County	24	13	54%	3	0	0%
Philadelphia County	2,894	2,793	97%	728	704	97%

County	April 2012 - March 2013			July 2013 - September 2013		
	Total Removals	Removals due to Substance Abuse		Total Removals	Removals due to Substance Abuse	
		#	%		#	%
Pike County	44	12	27%	4	0	0%
Potter County	13	4	31%	0	0	-
Schuylkill County	124	48	39%	41	20	49%
Snyder County	9	4	44%	7	4	57%
Somerset County	37	13	35%	16	7	44%
Sullivan County	4	3	75%	0	0	-
Susquehanna County	20	5	25%	6	3	50%
Tioga County	51	24	47%	8	2	25%
Union County	5	2	40%	3	1	33%
Venango County	29	3	10%	13	1	8%
Warren County	39	13	33%	7	1	14%
Washington County	284	90	32%	69	40	58%
Wayne County	15	2	13%	17	6	35%
Westmoreland County	147	39	27%	52	24	46%
Wyoming County	17	4	24%	6	1	17%
York County	267	81	30%	76	18	24%

Data Source:

Records were identified from the AFCARS six-month files via a "date of latest removal" (element #21) falling during the specified time period. Records were unduplicated by record number.

Pennsylvanian-Depth Technical Assistance (IDTA) Project

Scope of Work and Detailed Work Plan

Linda Carpenter, Lead Consultant Liaison
Ken DeCerchio, Pam Baston, Jill Gresham

Work Plan and Timeline for Completion

Phase I:Assessment of Need and Readiness for Change			
Major Action Steps	**Projected Timeline**	**Completion Date**	**Lead**
1. Gain initial commitment from agency leaders to participate in Pre-IDTA	February 2014	February 2014	DAWG, Linda Carpenter, Ken DeCerchio
2. Finalize Oversight Committee Membership	March 2014	March 2014	State Roundtable
3. Finalize Executive Committee Membership	March 2014	March 2014	Executive Committee
4. Finalize Steering Committee Membership	March 2014	March 2014	DAWG
5. Identify primary liaison between Steering Committee; Implementation Sites and NCSACW Consultant Liaison	February 2014	February 2014	DAWG
6. Develop Mission statement and anticipated project outcomes; review with Oversight Committee	March-April 2014	March 2014	DAWG
7. Define the communication pathways between the Oversight Committee, DAWG, the State Liaison, the IDTA Consultants, the County Core Teams and the Local Children's Roundtable Teams	March-April 2014		State Liaison, Linda C. and Ken D.
8. Define criteria for county selection; one Implementation County within each of the seven Leadership Roundtable Regions	March-April 2014	March 2014	DAWG
9. Identify one Implementation Site in each of the seven Leadership Roundtables.	May 2014		DAWG
10. Convene one-day meeting of county teams to discuss mission, project goals, tasks and timelines and expectations for	May 28, 2014		DAWG, NCSACW team

Phase I:Assessment of Need and Readiness for Change			
Major Action Steps	**Projected Timeline**	**Completion Date**	**Lead**
June 25 meeting.			
11. Brief Local Children's Roundtable to discuss IDTA purpose, frequency of meetings, Communication Pathways, local needs and concerns	June-July 2014		Core Teams, Local Children's Roundtable
12. Conduct first onsite meeting with County Core Teams and Steering Committee; demonstrate how to use CVI results and initial base-line data	June 25, 2014		NCSACW team (Linda, Ken, Pam & Jill) and State Liaison
13. Utilize all or a combination of the following diagnostic tools to identify cross-system challenges, barriers and gaps for each implementation site	July- September 2014		NCSACW team (Linda, Ken, Pam & Jill) , State Liaison and Core Teams
a. Collect baseline cross-system data	May-June Cumberland County		
b. Complete initial Drop-Off Analysis	May-June Cumberland County		
c. Conduct initial Walk-Through			
d. Analyze existing Collaborative Values Instrument data ; missing partners to complete CVI	June 28 (?)		
e. Complete Collaborative Capacity Inventory (CCI) as needed			
14. Use baseline data and diagnostic results to identify needs, concerns, existing and emerging issues, initial target populations (e.g. 0-3 cases, all substantiated cases)	July-October - 2014		NCSACW team (Linda, Ken, Pam & Jill) , State Liaison and Core Teams
15. Identify potential barriers, contextual issues and potential solutions. Review recommendations, brainstorming from August 2013 State Roundtable and DAWG meetings. Identify priority areas for improving cross-system collaboration.	June 25 meeting, July-September Implementation Sites 2014		NCSACW team (Linda, Ken, Pam & Jill) , State Liaison and Core Teams
16. Prepare findings and recommendations and draft goals and objectives	September-October 2014		NCSACW team (Linda, Ken, Pam & Jill) , State Liaison and Core

Phase I:Assessment of Need and Readiness for Change			
Major Action Steps	**Projected Timeline**	**Completion Date**	**Lead**
			Teams
17. Present findings, recommendations, goals and objectives to Steering and Executive Committees; 2nd on-site	October 2014		NCSACW team (Linda, Ken, Pam & Jill) , State Liaison and Core Teams
18. Prepare IDTA Application with Statewide Mission and anticipated outcomes and Implementation Sites' goals, objectives and outcomes	October 2014		NCSACW team (Linda, Ken, Pam & Jill) , State Liaison, DAWG, Executive Committee and Core Teams
19. Steering and Executive Committees review and approve Application; Letter of Commitment from Executive Committee Members	October 2014		State Liaison, DAWG
20. Submit Report on Phase I activities and IDTA Application for Phase II-IV to NCSACW and CORs	November 2014		Linda Carpenter
21. Approve IDTA application	December 2014		CORs

Mission:

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.

IDTA Project Goals:

1. Develop cross-systems values, principles, goals, and objectives for serving substance affected families.

2. Increase timely access to services, including education, for substance affected families.

3. Maximize knowledge and use of existing best practice treatment and resources.

4. Encourage awareness and utilization of sustainable supports for lifetime recovery.

State Roundtable

Executive Committee

DAWG

1 2 3 4 5 6 7

LCRT LCRT LCRT LCRT LCRT LCRT LCRT

Core Team | Core Team | Core Team | Core Team | Core Team | Core Team | Core Team

Core Team Leaders Join DAWG

Literature Review Subcommittee

Works Cited

Austin, M. and Osterling, K.L. (2006). Substance abuse interventions for parents involved in the child welfare system: Evidence and implications. Journal of Evidence-Based Social Work, 5 (1-2), 157-189.

Child maltreatment: Risk and protective factors, (2014). The Center for Disease Control and Prevention, National center for Injury Prevention and Control. Retrieved from: http://www.cdc.gov/violenceprevention/childmaltreatment/riskprotectivefactors.html

Douglas-Siegel, J.A. and Ryan, J.P. (2013). The effect of recovery coaches for substance-involved mothers in child welfare: Impact on juvenile delinquency. Journal of Substance Abuse Treatment, 45 (4), 381-387.

Hora, P.F. and Stalcup, T. (2008). Drug treatment courts in the twenty-first century: The evolution of the revolution in problem solving courts. Georgia Law Review, 42 (717), 719-808.

Hyde, P.S., (2013). Report to congress on the nation's substance abuse and mental health workforce issues. Substance Abuse and Mental Health Services Administration. Retrieved from: http://store.samhsa.gov/product/Report-to-Congress-on-the-Nation-s-Substance-Abuse- and-Mental-Health-Workforce-Issues/PEP13-RTC-BHWORK

Keller, T.E., Catalano, R.F., Haggerty, K.P., and Fleming, C.B. (2002). Parent figure transitions and delinquency and drug use among early adolescent children of substance abusers. The American Journal of Drug and Alcohol Abuse, 28 (3), 399-427.

Lee, E., Esaki, N., and Greene, R. (2009). Collocation: Integrating child welfare and substance abuse services. Journal of Social Work Practice in the Addictions, 9 (1), 55-70.

McAlpine, C., Marshall, C.C., and Doran, N.H. (2001). Combining child welfare and substance abuse services: A blended model of intervention. Child Welfare, 80 (2), 129-149.

Niccols, A., Milligan, K., Smith, A., Sword, W., Thabane, L., and Henderson, J. (2012). Integrated programs for mothers with substance abuse issues and their children: A systematic review of studies reporting on child outcomes. Child Abuse and Neglect, 36 (4), 308-322.

Weber, E. (2007). Child welfare interventions for drug-dependent pregnant women: Limitations of a non-public health response. University of Missouri-Kansas City Law Review, 75 (3), 789-845.

FIVE NATIONAL REPORTS ISSUED ON ALCOHOL AND OTHER DRUG PROBLEMS IN CHILD WELFARE

Responding to Alcohol and Other Drug Problems in Child Welfare: Weaving Together Practice and Policy. Washington, DC: Child Welfare League of America. 1998. [CWLA]

> Sets forth a policy framework of innovative ways to address the overlapping problems of substance abuse and child abuse. The guidebook describes a number of effective models for linking child welfare services and alcohol and other drug treatment. Copies may be ordered by calling the Juvenile Justice Clearinghouse at 800-638-8736 and asking form publication #ncj 171669.

Foster Care: Agencies Face Challenges Securing Stable Homes for Children of Substance Abusers. Washington, DC: U.S. General Accounting Office. September 1998. [GAO]

> Discusses the extent and characteristics of parental substance abuse among foster care cases and the difficulties agencies face in making timely permanency decisions for such children. Offers model initiative to achieve timely permanency outcomes. Copies may be ordered on-line at www.gao.gov or by calling (202) 512-6000 and asking for GAO/HEHS-98-182.

No Safe Haven: Children of Substance-Abusing Parents. New York: The National Center on Addiction and Substance Abuse at Columbia University. January 1999. [CASA]

> Illustrates the impact substance abuse has had on the child welfare system and its failed ability to respond. Calls for an emphasis on prevention, new training and protocols for child welfare, court and other professionals, increased funding for comprehensive treatment and greater attention to evaluation outcomes. The report is available on-line at www.casacolumbia.org and may be ordered by calling CASA at 212-841-5227.

Healing the Whole Family: A Look at Family Care Programs. Washington, DC: Children's Defense Fund. 1998. [CDF]

> Profiles 50 residential treatment programs from across the country which provide comprehensive services to mothers and children. The report focuses on the importance of family care and describes the unique characteristics that make it work for children and families in crisis. The Executive Summary is available on-line at www.childrensdefense.org. Copies may be ordered by calling CDF Publications at 202-662-3652.

Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Protection. Washington, DC: Department of Health and Human Services. 1999. [DHHS]

The report was developed jointly by the Administration for Children and Families, the Substance Abuse and Mental Health Services Administration, and the Office of the Assistant Secretary for Planning and Evaluation. It provides background information on understanding addiction, substance abuse and recovery, the nature of child maltreatment, the extent and scope of the problems as well as current efforts and further directions to address the problem. The report can be accessed on-line at www.aspe.os.dhhs.gov or www.acf.dhhs.gov/programs/cb/

Attached Summary Provided by Children and Family Futures, Irvine, CA

The UNCOPE

U – Have you continued to use alcohol or drugs longer than you intended?

N – Have you ever neglected some of your usual responsibilities because of alcohol or drug use?

C – Have you ever wanted to cut down or stop using alcohol or drugs but couldn't?

O – Has your family, a friend or anyone else ever told you they objected to your alcohol or drug use?

P – Have you ever found yourself preoccupied with wanting to use alcohol or drugs?

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

Scoring: Two or more positive responses indicate possible abuse or dependence and a need for further assessment.

Hoffman, N. G. *UNCOPE.* Smithfield, RI: Evince Clinical Assessments. Retrieved July 28, 2006 from http://www.evinceassessment.com/UNCOPE_for_web.pdf