2020 State Roundtable Report

Drug & Alcohol

Best Practices

D&A IDA

Luzerne County

Resource Guide

Benchcard

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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 the Honorable Jonathan Mark, Court of Common Pleas of Monroe County, and Wendy Hoverter, LCSW, Children and Youth Administrator of Cumberland County. In 2015 Kerry Browning, LSW, Deputy Director, Department of Human Services, Office of Youth and Family Services of Lackawanna County replaced Wendy Hoverter as co-chairperson upon her retirement. 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, the Workgroup met 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 discussion results 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 the Workgroup that collaboration is key when working with 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 and 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 substance use disorders.

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 assisted 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 provided direct assistance to eight diverse counties known as the "core counties" in the IDTA program. The Workgroup gained a deeper understanding of how substance abuse affects children and families. Now that the IDTA process is complete, issues that have been deferred will be comprehensively addressed, and research and evidence-based practice recommendations for Pennsylvania will be developed.

In addition to examining the issues counties are facing with the opiate addiction epidemic and the accessibility and quality of services, the Workgroup continued to refine the national IDTA program into a Pennsylvania specific process, the Pennsylvania Drug & Alcohol In-Depth Analysis that can be replicated in counties that could not be part of the national program.

PROGRESS AND UPDATES:

The Workgroup identified the following charges as their priorities for 2019-2020:

- Continue to test Pennsylvania's Drug & Alcohol In-Depth Analysis process in Luzerne County.
- Provide an informative WebEx on the importance of leadership, forming partnerships, and collaboration to create a culture change around Substance Use Disorder for counties interested in the Pennsylvania Drug & Alcohol In-Depth Analysis.
- Complete the Drug & Alcohol Resource Guide to serve as a reference for counties involved in the Pennsylvania Drug & Alcohol In-Depth Analysis.
- Finalize a benchcard for judges and hearing officers regarding things to consider when a parent is using substances, either because of a substance abuse disorder or as part of treatment.

❖ TEST PENNSYLVANIA'S DRUG & ALCOHOL IN-DEPTH ANALYSIS PROCESS:

Since February 2019, the Workgroup has been involved with Luzerne County as part of Pennsylvania's Drug & Alcohol In-Depth Analysis (D&A IDA). An overview of the D&A IDA process is attached as **APPENDIX I**. The leadership of each partner agency in Luzerne County formed the Executive Team for the D&A IDA. The Executive Team committed to participate in the process meaningfully, analyze their child welfare and substance abuse data closely, and participate in a systems walk-through. They also committed to developing a work plan to guide changes in practice and implement these changes to promote child safety, permanence, and well-being for families touched by substance use disorders.

Luzerne County Executive Team	
Jennifer L. Rogers	Dependency Judge
Romilda Crocamo	Chief County Solicitor
Joanne Van Saun	CYS Administrator
Ryan Hogan	D&A Administrator
Lynn Hill	DHS Administrator
John Alunni	DHS Program Director
Tara Vallet	MH & Developmental Administrator
Mary Roselle	Area Agency on Aging Director
Jim Spagnola	Veterans Affairs Director

The Executive Team then created a Core Team that would be responsible for completing the diagnostic tools, development, and completion of goals and activities, and preparing reports/presentations for the Executive Team as required. The Core Team is comprised of project leaders and managers from each partner agency with sufficient levels of responsibility to ensure activities and recommendations are carried out in a timely manner.

Luzerne County Core Team	
John Alunni	DHS Program Director (Lead)
Ryan Hogan	D&A Program Administrator
Deanna German	CYS Deputy Director
Ceil Bartolai	CYS Casework Supervisor
Lisa Fox	CYS Quality Assurance
Ranee Smith	MH/ID Program Specialist

On May 14, 2019, a Kick-Off Event was held in Luzerne County at their local Children's Roundtable. At this meeting, the State Roundtable's D&A Workgroup Co-Chairpersons informed the Luzerne County Children's Roundtable members of Pennsylvania's experience with the National Center on Substance Abuse and Child Welfare's In-Depth Technical Assistance, explained the purpose of the D&A IDA, reviewed the mission and goals, common barriers, and effective strategies, discussed the importance of the Collaborative Values Inventory (**APPENDIX II**), and the results of the 105 Luzerne County survey responses that had been received to date.

At the Kick-Off Event, the Honorable Jennifer L. Rogers asked that the county continue to distribute the Collaborative Values Inventory survey to gain a broader understanding of the stakeholders' values and beliefs on substance use and to facilitate the development of common principles. The county received a total of 392 survey responses. The below chart highlights some of their collective responses to the survey:

Collaborative Values Inventory Responses for Luzerne County		
Value Statement	**Agree**	**Disagree**
People with Substance Use Disorder (SUD) have a disease for which they need treatment.	94%	6%
People with SUD should be held fully responsible for their own actions.	90%	10%
Parents who use drugs cannot be effective parents.	67%	33%
I have adequate training, knowledge, and skills to work effectively with or on behalf of substance-abusing populations.	48%	52%
The standard for deciding when to remove or reunify children with substance abusing parents should be whether the parents are fully abstaining from alcohol or other drugs.	74%	26%
The court, substance abuse services, and child welfare should collaborate on behalf of the children and families they serve.	99%	1%

On June 25, 2019, a Systems Walk-Through was held in Luzerne County at their local Children's Roundtable to demonstrate how to use the Collaborative Values Inventory survey results. The Walk-Through also helped explain how to develop their cross-system baseline data using the Substance Abuse/Child Welfare Systems Data Profile Worksheet. Finally, the Walk-Through provided time to explain the purpose of doing a case file review for substance use disorder (**APPENDIX III**) and a drop-off analysis (**APPENDIX IV**).

In completing their cross-system baseline data (**APPENDIX V**), the Core Team reported they were surprised to learn the reporting and data collection methodology. Most surprising to them was how

the county child welfare agency reports the reason for a family's involvement, recognizing that drug abuse may be secondary to another issue. In reviewing their cross-system baseline data, the Core Team also believed they needed to assess better the parent and their families' drug and alcohol treatment needs and their families involved with child welfare and improve access, engagement, and retention to these services.

John Alunni, DHS Program Director and Lead for the Core Team, maintained contact with the Executive Team throughout the D&A IDA Work Plan development. On February 18, 2020, John Alunni and the Core Team presented their proposed work plan to the Executive Team and was approved to move forward with their plan. Following this meeting, the Core Team presented their findings and the formal written plan to their local Children's Roundtable (see **APPENDIX VI**). In addition to using the results from the Collaborative Values Inventory and the cross-system baseline data, the work plan included information the county had gained when they previously collaborated on the Plans of Safe Care implementation.

As of September 2020, the following has resulted from the efforts of Luzerne County through the D&A IDA process:

- Luzerne County has an integrated human services organization structure (Office of Human Services (OHS)), headed by a county Human Services Director responsible for all county human services. That structure supported and strengthened cross-system collaboration by:
    - Initiating a new employee onboarding process, which includes a quarterly cross-systems training for all new staff.
    - Requiring all OHS Department staff to attend a train-the-trainer series, "Trauma 101: An Overview of Trauma-Informed Care," through Lakeside Global Institute.
    - The OHS Program Director sits in on the four (4) departments' individual provider meetings, Executive Committee Boards, and Advisory Committees, which allows an opportunity to identify potential service area gaps or areas of overlap that have gone previously unaddressed. Also, it will enable opportunities for advanced learning opportunities between agencies.
    - Children and Youth is now invited to participate in monthly Drug and Alcohol Provider meetings to gain additional information on trends and updates within the Drug and Alcohol network.
    - The Drug and Alcohol Department has been invited to participate in Children and Youth's ACT 33 meetings to lend their voice and expertise in the increasing prevalence of substance abuse and misuse identified during these meetings.
- Luzerne County Drug and Alcohol Department created and filled a new SCA Case Manager position assigned to and co-located at the County Child Welfare Agency. This new position is specifically to work with families involved with child welfare.
- Luzerne County utilizes a new Electronic Monitoring Record (EMR) to track shared cases between child welfare and drug and alcohol more effectively. They will use EMR to identify trends and determine opportunities or areas to effectuate change.

Please see **APPENDIX VII** for Luzerne County's Progress Report summarizing all of their findings and work targeted/completed to date since their involvement in the D&A IDA process.

On September 4, 2020, Luzerne County started the case file review process for the D&A IDA. Based on Luzerne County having 3,709 abuse/neglect reports that resulted in investigations in 2018 (as per their Substance Abuse/Child Welfare Systems Data Profile Worksheet), the county will need to randomly pull 67 Children and Youth records for a 90% confidence interval of the sample. From this subset of case files, they will need 25 usable case files that meet the sample characteristics' requirements with at least eight (8) of the files being court-involved cases. Please see the Pennsylvania Counties Sample Size and Case File Review for Substance Use Disorder Instructions for additional details (**APPENDIX VIII**). Upon completing the case file review for substance use disorder, Luzerne County will need to complete their drop-off analysis. Please see the Pennsylvania Drug & Alcohol In-Depth Drop-Off Analysis Instructions for additional details (**APPENDIX IX**).

An update on Luzerne County's case file review for substance use disorder, drop-off analysis, and continued progress in the D&A IDA process will be provided at the 2021 Pennsylvania State Roundtable meeting.

As a reminder, the overall goal of Pennsylvania's D&A IDA process is two-fold:

1. to help Luzerne County make positive changes that impact the quality and/or accessibility of services to substance-abusing families involved with child welfare; and
2. to have a process available for counties to execute on their own that improves their practices for substance-abusing families involved with child welfare.

While Luzerne County was going through the D&A IDA process, John Alunni became a member of the Drug & Alcohol Workgroup. During the Workgroup meetings, Mr. Alunni was provided opportunities to share successes and challenges happening at the local level for the D&A IDA. Also, he provided input from the county perspective on how the Workgroup could improve the process.

Luzerne County's Perspective on the D&A IDA Process per John Alunni:

> "Luzerne County identified a direction to implement our D&A IDA early in the work plan development. This direction put our plan outside of the described D&A IDA process timelines, but the Workgroup consistently supported us in our planning. As we prepared our C&Y Quality Assurance (QA) team to complete the data requirements, we had staff turnover in leadership positions inside the QA department. Once the QA department transitions were complete, and a new lead was brought up to speed on the D&A IDA process, the COVID 19 pandemic started very soon after. This lead to another delay in preparing our data requirement; however, it never deterred us from putting the rest of the D&A IDA work-plan pieces in place. In order to build our plan, we recognized quickly that we needed to build something fluid and organic that could fit the agencies specific needs and requirements but could also be flexible to change when we identified potential service area gaps. Having autonomy to create such a plan, while also having support and

feedback throughout the process, can be identified as a contributing factor to the success of the plan."

Luzerne County worked hard on the D&A IDA process. Despite the interference caused by the COVID-19 pandemic, they were still able to make progress. They were able to begin changing the culture, improved communication between system partners, enhanced access for parents to be appropriately assessed for treatment needs, and can now collect additional data on shared cases to continually improve their system. Given the initial success and continued progress being made in Luzerne County from going through the D&A IDA, **the Workgroup recommends that the D&A IDA be made available for all counties in Pennsylvania.**

The Workgroup would like to specifically thank Luzerne County's Executive Team and Core Team for their leadership, extensive time, effort, and work they contributed to the D&A IDA process's success. Their efforts stand not only to benefit their own county but the larger system reform effort and, most importantly, children and families across the Commonwealth.

❖ INFORMATIVE WEBEX FOR THE PENNSYLVANIA DRUG & ALCOHOL IN-DEPTH ANALYSIS:

At the SRT D&A Workgroup's initiation, members were asked to contemplate the future of the children and families being served and to answer the following question, "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?" The Workgroup believes that the D&A IDA provides counties an opportunity to answer this very question for their community. **Therefore, the Workgroup recommends an informative D&A IDA WebEx be provided by the Office of Children and Families in the Courts and the D&A Workgroup Co-Chairpersons. The WebEx would explain the D&A IDA process, lessons learned throughout, and be available to all counties.**

The D&A IDA mission 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-system collaboration, and clinical integrity. Throughout the D&A IDA, the importance of leadership, forming partnerships, and collaboration to create a culture change around Substance Use Disorder was critical. This was true for Luzerne County and will be true for any county wishing to employ the D&A IDA process. Leaders will need to commit to the D&A IDA and provide oversight, direction, and charges for the process. Leaders will need to create and strengthen linkages and collaboration between partnering systems and the dependency court.

Collaboration is essential for the D&A IDA to successfully improve the lives and provision of services to children and families affected by substance abuse. Collaboration is more than networking or cooperation; it means forming an effective partnership to achieve common goals. In this partnership, each entity will need to address the barriers and challenges for the process. Some of these may include conflicting policies, segregated delivery of services, scarcity of

resources, differential treatment, different perceptions and loyalties, biases, and lack of engagement of children and families. It is critical that the appropriate individuals and agencies are brought into the planning process as early as possible. It is also crucial to create a clear plan toward attaining the intended goals of the process listed below:

- Develop cross-system values, principles, goals, and objectives for serving substance affected families.
- Increase timely access to services, including education, for substance-affected families.
- Maximize knowledge and use of existing best practice treatment and resources.
- Encourage awareness and utilization of sustainable supports for lifetime recovery.

Ultimately, leaders can make extraordinary contributions to improving the outcomes for families and children affected by substance use by having their county use the D&A IDA process. The D&A Workgroup Co-Chairpersons are in the initial development of the WebEx. Upon approval by the State Roundtable, the D&A IDA WebEx is targeted for Fall 2021.

❖ DRUG & ALCOHOL RESOURCE GUIDE FOR PENNSYLVANIA DRUG & ALCOHOL IN-DEPTH ANALYSIS:

Pennsylvania's Drug and Alcohol In-Depth Analysis (D&A IDA) was designed so counties that elect to utilize the process can work independently. Therefore the Workgroup created a D&A IDA Resource Guide to provide resources, information, and recommendations to assist counties through the process (See **APPENDIX X**). The Resource Guide includes many links to national and state webpages that will be continuously updated with the most recent research and findings. Given the D&A IDA Resource Guide is intended to be brief, the Workgroup wanted to take this opportunity to provide additional information on the following topics that are included in the guide:

Confidentiality and Information Sharing: I Can't Tell You That . . . Or Can I?

In the PA D&A IDA process, or in any other attempt to address substance use on a cross-system basis, confidentiality will inevitably be flagged as a barrier to inter-agency cooperation. While confidentiality must be respected and is a very real and important consideration, it is not and should not be an impediment to the type of teaming that is necessary to achieve the best outcomes for children, families, and persons with substance use disorders (SUD) who are impacted by the disease of addiction.

Why Confidentiality?

For Patients or Clients Seeking or Receiving Substance Use Treatment

Confidentiality is 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 the personal and professional lives of persons who seek or undergo treatment. The core of substance use treatment involves creating a safe space where a vulnerable individual can explore secrets, shame, and the isolation associated with SUDs. Confidentiality is the key to creating and protecting the safe space. Stigma and fear of retaliation or other adverse impacts remain among the top reasons why individuals do not seek the treatment they need. This is particularly true in the child welfare setting where treatment is avoided for fear of losing children. Proper sensitivity to confidentiality protections and safe spaces is critical, particularly at the early stages of treatment, so that the individual will engage in treatment and, over time, become more willing to collaborate across systems with his or her drug and alcohol counselor, child welfare worker, and other involved partners. Real or perceived violations of trust or invasions into the safe space can quickly lead to termination of needed therapeutic intervention.

For Drug and Alcohol Clinicians

Clinicians know they are treating a very vulnerable population and are acutely aware of the need of that population for a safe space and a therapeutic relationship based on trust. Thus, they are highly sensitive to the need for confidentiality that creates and safeguards the space and promotes trust.

In today's highly regulated and litigious society, clinicians (and their attorneys and insurance companies) are also sensitive to the legal consequences of violating confidentiality, which may include fines, adverse licensing consequences, and lawsuits.

For Other Partners and Providers

Clinicians are not the only persons with confidentiality rules. Children and youth caseworkers, mental health practitioners, educators, juvenile probation officers, medical providers, and other partners are subject to confidentiality rules of their own. These separate rules, like the substance use confidentiality rules, create safe spaces for specific types of relationships (i.e., attorney-client, doctor-patient), the violation or invasion of which can undermine the protected relationship, cause the individual to reject necessary services, and expose the professional to licensing or other consequences.

Confidentiality Laws

Confidentiality and information sharing are governed by both state and federal law. A full discussion of all laws is outside the scope of this report. What follows is a summary of the key confidentiality laws about which persons and entities providing services for children and families affected by SUDs should be aware. Citations to resources that provide a more in-depth analysis of these and other relevant laws are provided under the Resources heading.

Federal

The two key federal confidentiality laws that protect information pertaining to substance use treatment are the Health Insurance Portability and Accountability Act (HIPPA) Privacy Rule and 42 CFR Part 2.

The HIPPA Privacy Rule governs the confidentiality of individually-identifiable information held by a healthcare provider, plan, or clearinghouse and associated businesses. The Rule establishes the minimum confidentiality threshold for all healthcare providers and plans. State and other federal laws may be more protective. The most restrictive standard applies.

Part 2 regulations govern the confidentiality of patient records of substance use treatment providers who receive federal funding. The Part 2 regulations restrict disclosure and use of patient identifying information about individuals receiving, who received, or who have applied to receive substance use treatment. The regulations establish rules for disclosing information with patient consent, providing for disclosure without patient consent in specified circumstances, and permitting and setting disclosure requirements pursuant to a court order. State laws may be more restrictive, but may not authorize or compel disclosure of information prohibited by the Part 2 regulations.

In general, neither HIPPA nor Part 2 limits the purposes for which disclosure may be made with patient consent. However, re-disclosure requires consent.

Persons and entities who are subject to both the HIPPA Privacy Rule and the Part 2 regulations must follow both laws. Regarding substance use treatment information, the Part 2 regulations are more protective.

When state law provides greater protections than the federal laws, the more protective state law must be followed.

Pennsylvania

1. Statutes and Regulations

Pennsylvania's confidentiality laws are more restrictive than federal laws. Of significance, Pennsylvania limits the purposes for which substance use treatment information may be disclosed and the type of information that may be shared even with patient consent.

Section 108 of the Pennsylvania Drug and Alcohol Control Act governs confidentiality and disclosure of patient substance use treatment records.

Subsection (b) provides that records prepared or obtained under the Act are confidential and may be disclosed only with patient consent and only (1) to medical personnel exclusively for diagnosis and treatment, or (2) to government or other officials to obtain benefits relating to substance use dependence. Exceptions are allowed for life-threatening emergencies and disclosure pursuant to a court order issued upon a showing of good cause.

Subsection (c) further restricts disclosure of substance use treatment information prepared or obtained by any private healthcare provider or facility. Such information may only be disclosed with patient consent and only for the same two purposes allowed under Subsection (b) or to the parent or guardian of a minor, with the minor's consent. The life-threatening exception applies; however, there is no court order exception.

The Act also contains provisions governing substance use treatment for minors and disclosure of their treatment information. In a very broad overview, a child of any age may consent to treatment with or without parental consent. If a minor refuses to give consent, parents or legal guardians may provide consent. In addition, the Act provides a procedure by which parents or guardians may petition the court for involuntary treatment of a minor who is incapable of accepting or unwilling to accept voluntary treatment. There are strict requirements for requesting and issuing such orders. Under any treatment scenario, the minor, for the most part, retains control of the release or non-release of confidential information to the minor's parents or guardians. However, under some treatment scenarios, limited basic information may be given to parents or guardians.

Regulations are also significant. 4 Pa. Code §255.5 limits both the purposes for which substance use treatment information may be released and the type of information that may be released. In most child welfare and dependency matters, even with a valid consent, providers may release only the following information:

(1) Whether the client is or is not in treatment

(2) The prognosis of the client

(3) The nature of the project.

(4) A brief description of the progress of the client.

(5) A short statement as to whether the client has relapsed into drug, or alcohol abuse and the frequency of such relapse.

By itself, Section 255.5 applies to County SCAs and their programs. However, Section 255.5 is referenced and incorporated into a myriad of other regulations, binding and extending its limitations on the release of substance use treatment information to many other individuals, agencies, and organizations, including other drug and alcohol providers, mental health providers, and healthcare facilities. George Washington University's report on Pennsylvania's Confidentiality Laws, listed under the Resources heading, charts and discusses the administrative regulations which incorporate the Section 255.5 limitations and lists the other agencies and providers who, although not substance use providers, are bound by the limitations.

2. Exceptions to Confidentiality

Under both Pennsylvania and federal law, there are exceptions to the rules prohibiting disclosure of treatment information. The time-tested and honored exception, the one we all use every day, is a valid written consent signed by the person receiving, who received, or who has applied to receive substance use treatment. A valid patient consent permits providers and other holders to release Section 255.5 information.

There are other exceptions as well. Of significance to those providing services to children and families in the child welfare and dependency systems, there are exceptions for medical

emergencies, child abuse or neglect reporting, and court-ordered disclosures. In addition, information that is not protected under state and federal law may be disclosed.

The trainings and sources listed under the Resources heading include valuable information regarding the exceptions, including what is needed for a valid consent to release information, when other exceptions apply, and how and under what circumstances to obtain court-orders.

Information Sharing -- Act 126 and Information Sharing Agreements

Act 126 of 1998 amended the Juvenile Act to allow for the release to a court, a county children and youth agency, or a juvenile probation officer substance use treatment and other records of a child who is alleged to be or is adjudicated dependent or delinquent or of the child's parents in conformity with federal law. Treatment and other records may be released upon the consent of the child or the child's parent or legal guardian. If consent cannot be obtained, or if it is but a provider will not release the information, disclosure may be authorized by court order. The purpose of the amendment was to allow joint case planning and cross-systems sharing of information between the child welfare, juvenile justice, and drug and alcohol systems. While Act 126 effectively removed state law restrictions so that this purpose might be achieved in Juvenile Act matters, information sharing and court-ordered disclosure of treatment records remains subject to the less restrictive but nonetheless significant federal laws.

On June 1, 2002, the Department of Public Welfare (now DHS) (OCFC and OMHSAS), Department of Health (before DDAP, which was then a bureau in DOH, became a full department itself), and the Juvenile Court Judges' Commission jointly issued Bulletin 00-02-03 entitled "Protocol for Sharing Drug & Alcohol Information." Attached as **APPENDIX XI** is a copy of the Bulletin. The Bulletin describes the structure of Act 126; explains its purposes; outlines guidelines for obtaining client consent; summarizes the confidentiality provisions applicable to children and youth agencies and juvenile probation departments. It also establishes protocols for joint case planning, sharing substance use treatment information across systems, and obtaining a court order for disclosure. Finally, it includes a sample Consent to Release Confidential Information. Supplementing the Bulletin's protocols for obtaining a court order for disclosure, also included are examples from Dauphin County of a petition for a court order and a proposed order (**APPENDIX XII**).

Whether a county establishes a D&A IDA team or other collaborative or provides services in child welfare, dependency, and delinquency matters to children and families affected by substance use by other means, Act 126 is a valuable tool for information sharing.

More recently, the legislature added to the Juvenile Act a provision allowing agencies to enter into inter-agency information-sharing agreements. Specifically, under Section 6352.2 of the Act, subject to court approval:

> an interagency information-sharing agreement may be developed in each county among the county agency, juvenile probation department, local law enforcement agencies, mental health agencies, drug and alcohol agencies, local school districts, and other agencies and entities as deemed appropriate, to enhance the coordination of case management services to and the supervision of children who have been accepted for service by a county

> agency, who are being supervised under an informal adjustment or a consent decree, who have been found to have committed a delinquent act or who have been found to be dependent or delinquent, to enhance the coordination of efforts to identify children who may be at risk of child abuse, parental neglect or initial or additional delinquent behavior and to provide services to these children and their families.

Although this is not a drug and alcohol or substance use treatment record specific provision, and while information shared under this provision remains subject to federal and certain state confidentiality laws, Section 6352.2 is another tool that agencies have in their belts to assist children and families. It fits and dovetails nicely with the D&A IDA concept and other collaborative efforts.

3. System Partner Confidentiality Requirements

Although the focus of this section is the confidentiality of substance use treatment information, it bears mention that other systems and agency partners are subject to confidentiality requirements of their own. Partners outside the drug and alcohol system must comply with both their discipline's rules *and* the state and federal laws governing disclosure of substance use treatment information. In addition, under federal law, confidential substance use treatment information may not be re-disclosed without consent. Thus, there may be multiple layers of confidentiality requirements. While multiple layers of confidentiality might seem daunting, it is nothing that proper releases, inter-agency sharing agreements, and, perhaps most important of all, discussion and collaboration between system partners cannot resolve.

Changes in the Making?

HIPPA and the Part 2 Regulations have recently been amended and "modernized" to improve coordination of treatment. Amendments to the Part 2 regulations took effect as recently as August 14, 2020. It is expected that both sets of regulations may be amended again to reflect the CARES Act.

One of the criticisms of Pennsylvania's confidentiality laws is that they were promulgated a long time ago and need to be modernized. In addition, the laws are not centralized. George Washington University's report on Pennsylvania's Confidentiality Laws, listed under the Resource heading and linked on DDAP's website, identifies gaps, challenges, and conflicts, and outlines opportunities for change. In this regard, DDAP recently finished collecting stakeholder feedback about Pennsylvania's SUD confidentiality regulations – over 1,600 survey responses were received from stakeholders across the state. This stakeholder assessment aimed to better understand how Pennsylvania's unique regulations: (1) work well to protect people's privacy; (2) create barriers for clients and service providers; and (3) can be improved to make services better and more accessible. Findings from the survey and interviews will be summarized in a report expected to be released this fall.

All system partners should be on the lookout for potential changes in both state and federal laws and should provide input whenever the opportunity to do so arises.

Workgroup Recommendations

It is now almost universally accepted that to successfully achieve safety, permanency, and well-being for children and families, child welfare workers must team with others. Nowhere is this more obvious and critical than in assisting children and families who are impacted by substance use. The PA D&A IDA process is a beneficial way to achieve the inter-agency teaming that is essential. The process also lends itself to a cross-systems means by which to eliminate, or at least abate, the "barrier" of confidentiality.

For the reasons discussed, confidentiality is important to both the person receiving treatment and society. 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 SUDs. **The Workgroup 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, individual privacy, and the integrity of the therapeutic process, and to resolve virtually all concerns within existing regulations. Based on the applicable law, experiences and feedback from the seven core counties involved in the IDTA process with the National Center on Substance abuse and Child Welfare, and practices from a variety of jurisdictions, the Workgroup recommends or offers for consideration the following:**

General

- D&A IDA Process or Other Cross-Systems Discussion and Solutions – Through the PA D&A IDA process or otherwise, confidentiality should be discussed between all partners and stakeholders, and local protocols for information sharing should be developed. Local solutions can substantially enhance the ability to share information within existing legal restraints. Solutions that allow information sharing are a barometer of how much trust partners have in each other. The more trust, the easier it is to share information and the better the outcomes.

- Cross-Systems Education – Cross-systems discussions and problem-solving allow partners to educate each other on what is expected of patients/clients (i.e., for child welfare timely permanency for children and the time frames that apply). The process also provides opportunities for partners to educate each other on their discipline-specific confidentiality requirements, why certain information is needed, what will be done with the information, the persons and entities with whom the information will be shared. This type of inter-agency education builds trust and leads to better outcomes.

- Cross-Systems Training – Building on these considerations, the Workgroup recommends that all system partners undergo cross-systems confidentiality training so that all receive the same information and develop a full understanding of current confidentiality laws that apply. At a minimum, this should include the DDAP Drug and Alcohol Confidentiality training and the Child Welfare Resource Center (CWRC) Confidentiality in Child Welfare

training listed under the Resource Heading. DDAP also has a three-hour training on the Practical Application of Confidentiality, which addresses how to apply confidentiality principles effectively. Cross-systems education and training can dispel misconceptions and remove perceived barriers.

- Bulletin 00-02-03: Protocol for Sharing D&A Information – The Bulletin should be distributed to and discussed with children and youth agencies, juvenile probation departments, SCAs, drug and alcohol providers, other partner agencies, and the individuals who work within those systems. While ACT 126 and the Bulletin's information-sharing protocols specifically reference children and youth agencies, juvenile probation departments, and D&A providers, the protocols have application and are adaptable for broader cross-systems, inter-agency information sharing.

- Identify Information that is Not Protected and Other Legitimate Sources of Information – While a drug and alcohol system provider cannot release information or even confirm that a patient/client is in counseling without a valid consent or an exception that applies, there is no prohibition against the provider **receiving** information from system partners, or against system partners (with appropriate consents) giving information to the provider. Similarly, some information may be available through public databases or partner agencies that may not be prohibited from disclosing their knowledge. Finally, some information that does not disclose patient identifying information or is not otherwise protected may be shared.

- Patient/Client Self Release – Patients/clients may voluntarily provide information that providers may not be permitted or may refuse to disclose.

Voluntary Release of Information

- Consents - **All** necessary consents and releases should be obtained at the earliest possible stage. This will satisfy both state and federal law and obviate the "barrier." Practices relating to obtaining releases and using information implemented in other jurisdictions which the Workgroup recommends all system partners consider are:

    - Whenever a child or parent 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 moves through the levels of care, consents should be obtained for each provider. This may be achieved through policies, protocols, and even contract provisions in provider agreements.

- A request to sign a consent should include a discussion on how the protected information will be used and with whom the information will be shared. This discussion is an important component of the engagement and trust-building processes.

- 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 essential.

- Some providers wish to use their own form of release or want releases on their letterhead. Cross-systems discussion regarding releases can ferret this out and ensure that releases are sufficient and valid for their intended purpose. In one jurisdiction, the issue was resolved with the children and youth agency collecting releases from all contracted providers so that provider-specific releases could be signed regardless of where the child or parent sought or received treatment.

- Use Best Practice Multi-Discipline Team Meetings and Engagement Practices – Best practices such as Family Group Decision Making, Family Team Conferencing, and Plan of Safe Care Multi-Discipline Teams should be used whenever possible. Beyond the well-known substantive benefits, these types of meetings promote the broadest, most open form of information sharing, including information about substance use treatment, possible. Participants typically enter such meetings with consents already signed. If not, the person whose information is sought is there to give consent. Similarly, the D&A patient/client, as well as others who are not prohibited from doing so, can provide and discuss information that treating providers and others may not be permitted to release even with a signed consent. All will hear the same information, and treating providers will obtain information and perspectives they might not receive from the patient/client through self-reporting.

- Interagency Information Sharing Agreements – For Juvenile Act matters, consider entering into a Section 6352.2 Information Sharing Agreement or other similar agreement. Such agreements loop in other agencies, such as police departments, which are not always included in child welfare-based initiatives, but can have valuable information and input.

When Voluntary Release of Information is Not Obtained

There will be times when consent is refused or revoked, or providers will decline to release information even if consent has been given or an exception applies.

- Embrace the Purposes Behind Confidentiality – Understanding the reasons and need for confidentiality can ease the concern and frustration experienced when the information will not be voluntarily shared. It can also help agencies decide whether or not "involuntary" methods of obtaining information should be pursued.

- Focus on What Information Can be Obtained and Shared – A refusal or revocation of consent to release is not always fatal. An exception may apply. If not, focus on what information can be shared and not dwell on information that cannot be shared. Further, even if a county child welfare agency cannot obtain information through a release or other exception, the agency should continue to supply information to treating providers, especially about known or suspected substance use.

- Court Order – In Juvenile Act cases, if the child or parent refuses to consent, a court order permitting disclosure may be obtained. Bulletin 00-02-03 and other appendices attached to this report walk agencies through the process of obtaining such an order.

Drug Testing in Child Welfare

County Child Welfare Agencies are strongly encouraged to establish partnerships and collaborate with their Drug & Alcohol / Single County Authorities, Mental Health, and the Courts to develop and implement drug testing in the child welfare system. The US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) identified the following key action steps for developing comprehensive policies and protocols on drug testing:

- Understand value differences between partner agencies concerning approaches to families affected by substance use disorders.
    - The Collaborative Values Inventory for the D&A IDA can be used to complete this action step (**APPENDIX II**).
- Complete training on recognizing signs and symptoms of substance use disorders.
    - The PA Child Welfare Resource Center is revising their online course, Substance Use as a Risk Factor for Child Maltreatment, which is included in the Child Advocacy Studies Program (CAST II) series. This two-session module currently consists of information about the relationship between substance use disorder and child maltreatment, impacts of exposure to substance use disorder on children, substance use treatment options, definitions and examples of different types of substances, and working collaboratively with other professionals to support families affected by substance use disorder. The revised module will consist of both an online and in-person component. The in-person component will include Team-Based Learning™ and simulation-based training activities. To inform these revisions, the Resource Center has conducted a needs assessment with the Drug & Alcohol Workgroup members and representatives from county child welfare agencies.
    - Upon the cessation of quarantining restrictions, the Resource Center will continue to offer additional in-person courses on the topic of Substance Use, including Drug and Alcohol Issues: An Introduction for Child Welfare Professionals and Prescription Drug Abuse. Also available is an online course on Confidentiality in Child Welfare. Information regarding the Resource Center's courses and curriculum materials are located on its website at http://www.pacwrc.pitt.edu/.
- Identify a clear purpose for using drug testing.

- According to the Children's Justice State Council, appropriate uses for drug testing include:
  - As one component of a comprehensive family assessment to identify or treat substance abuse as a contributing factor to maltreatment when there are indicators of substance use.
  - To assist a parent in their readiness for treatment interventions.
  - When substance abuse is a contributing factor in maltreatment, and the parent does not participate in a substance abuse treatment program.
  - To provide positive reinforcement and to monitor parents, particularly in early recovery.
- Per Children's Justice State Council, inappropriate uses for drug testing include:
  - When a parent is already an active participant in a substance abuse treatment program in which frequent, random testing is a required component of the program.
  - When the parent admits to a relapse.
  - When used as a sole indicator of a parent's progress.
  - When used as a quantitative measure.
    - Drug tests are qualitative and designed to determine the presence of drugs in the body and not to measure or compare drug concentrations. Urine drug concentrations have little or no interpretative value. Interpretations based on urine drug test levels are generally inappropriate, factually unsupportable, and without scientific foundation.

- Determine how drug testing fits with the county child welfare agency's overall risk and safety assessment protocols.
- Decide which individuals to test.
- Select the type of specimen to collect and the testing methodology to use.
  - See **APPENDIX XIII** for the National Drug Court Institute's chart on drug-testing specimens' advantages and disadvantages.
- Determine when to use point-of-collection versus laboratory testing.
  - See **APPENDIX XIV** for the National Drug Court Institute's chart on the advantages and disadvantages of on-site virus laboratory-based drug testing.
- Establish the procedure for specimen collection and observation.
- Determine which drug(s) to include in the drug testing panel.
  - The National Institute on Drug Abuse provides a chart on commonly abused drugs: https://www.drugabuse.gov/sites/default/files/nida_commonlyuseddrugs_final_printready.pdf
- Consider the cost implications of the drug testing protocol and choice of a vendor.
- Determine what type of staff training to provide on drug testing and the qualifications needed to administer the test.
- Develop a parent engagement strategy.
- Establish the frequency of testing.
  - The National Drug Court Institute recommends that drug testing be performed at least twice a week in a random, unannounced manner.

    - See **APPENDIX XV** for the National Drug Court Institute's chart on drug detection windows for urine drug screens, which is most commonly used in child welfare systems.
- Decide how to address confirmed positive drug results, negative results, refusal to undergo testing, and adulterated specimens.
    - The Children's Justice State Council advises that a positive drug test serves as a means to talk about recovery needs and that positive tests should be viewed as an indicator of the need to adjust the parent's treatment planning. Some suggested responses to a positive test are:
        - Provide an opportunity for the parent to explain the results.
        - Consult with the treatment provider about the parent's relapse prevention plan.
        - Reassess the array of services offered to the parent.
        - Consider a modification of the frequency of the current drug test.
- Develop a procedure to notify county child welfare agencies and the courts of drug test results.
- Establish drug testing coordination and monitoring strategies with treatment agencies and the courts.
    - Coordinate with other agencies to ensure that information is shared so that individuals are not being tested simultaneously and possibly share costs.

Drug tests tell you whether a particular substance or panel of substances were present in a person's body at sufficient levels to register at a point in time. A positive drug test indicates that the drug or its metabolite is present at or above the test specimen's established concentration cutoff level. In contrast, a negative drug test only shows that the test did not detect the drug or its metabolite or that its concentration is below the established cutoff level in that particular specimen. It is also important to note that there are some limitations to drug testing:

- The drug test may not measure/detect the individual's drug of choice.
- The individual can engage in urine sample tampering strategies.
- Prescription drugs, over-the-counter products, and foods can trigger false-positive results in urine drug screens.
- If individuals are prescribed certain medications, they can use a substance that would show up as positive for the prescribed medicine.

The most effective way to evaluate if someone is not abusing drugs and/or alcohol is by using a combination of random drug tests, self-reports, and observations of indicators of substance abuse. According to SAMHSA, "a drug test alone cannot determine the existence or absence of a substance use disorder. In addition, drug tests do not provide sufficient information for substantiating allegations of child abuse or neglect or making decisions about the disposition of a case (including decisions regarding child removal, family reunification, or termination of parental rights). Child welfare workers, judges, and attorneys must make these decisions using information from the child abuse investigation, child safety and risk assessments, family assessments, and a comprehensive substance abuse assessment."

❖ BENCHCARD REGARDING THINGS TO CONSIDER WHEN A PARENT IS USING SUBSTANCES, EITHER BECAUSE OF SUBSTANCE ABUSE DISORDER OR AS PART OF TREATMENT:

At the Fall 2019 Leadership Roundtable meetings, the Workgroup asked, "What specific issues would you want the benchcard to address?" The following themes were identified from the responses that were received:

- Drug Testing in Child Welfare
- Dual Diagnosis of Substance Use and Mental Health
- Indicators of Substance Abuse
- Safety of the Child with Parent/Caregiver with Substance Use Disorder

Drug Testing in Child Welfare

Please see this report's section, "Drug & Alcohol Resource Guide for Pennsylvania's Drug & Alcohol In-Depth Analysis," for guidance on drug testing in the child welfare system.

Dual Diagnosis of Substance Use and Mental Health

In the 2019 State Roundtable Report, the Workgroup recommended that counties take an integrated approach in identifying, evaluating, and coordinating treatment for individuals with co-occurring disorders of substance use and mental health, rather than treating each disorder separately without consideration of the other disorder. According to Foundations Recovery Network, elements of an integrated treatment program include:

- Coordinated treatment for multiple disorders.
- Bundled interventions.
- No division between mental health and substance abuse treatments
- All health professionals collaborate in one setting.

The Workgroup was asked to identify what Co-Occurring Diagnosis providers are available in Pennsylvania. We reached out to the Department of Drug and Alcohol Programs (DDAP) and were provided with a list of Co-Occurring Substance Use and Mental Health Residential Programs licensed both by DDAP and the Department of Human Services (see **APPENDIX XVI**). **The Workgroup recommends that counties have their drug & alcohol / single county authority, mental health, and managed care organization included in their collaborative efforts in utilizing Dual Diagnosis & Co-Occurring Diagnosis Substance Use and Mental Health Treatment Programs.**

Indicators of Substance Abuse

The Workgroup was asked to identify what judges could look for in the courtroom regarding signs of misuse (of substances). Substance abuse can impact the way a person looks, acts, and feels. The symptoms of substance use disorders are linked to changes in the body, behavior, and emotions. Attached as **APPENDIX XVII** are indicators/signs of substance abuse in adults that can be observed.

Safety of the Child with Parent/Caregiver with Substance Use Disorder

Child safety is the cornerstone issue for all dependency proceedings. It underscores the decisions made by dependency judges and hearing officers, including decisions involving families impacted by substance use disorder. The Workgroup was asked:

- Is there a level of impairment that impacts the safety of the child?
- What criteria should we consider when removing a child from their home?
- At what point is the parent's recovery enough to safely return the child home?
- Is it safe to return the child when the parent is still using a substance? What is the line?

Judicial officers are required to make findings regarding safety and order services to mitigate or eliminate safety threats. According to the Pennsylvania Dependency Benchbook (Chapter 3.1.2.), decisions related to the child's removal and placement should be based upon an analysis of the child's safety. While the removal and placement of children may mitigate a safety threat, it is likely to simultaneously create emotional trauma for the child and their parents. This potentiality necessitates a methodical legal safety analysis be done by the judge and hearing officer. In the Pennsylvania Dependency Resource Companion – Chapter 10: Safety & Risk, a resource is provided to assist the court in making the ongoing assessment of a child's safety using a legal safety analysis, Child *Safety: A Guide for Judges and Attorneys* (Lund & Renne, 2009). In an attempt to answer the questions asked by Leadership Roundtables, the Workgroup will highlight some areas of the Child Safety Guide but strongly urge that this resource be reviewed in its entirety.

Information Drives Decisions about Safety:

It is critically vital that judicial officers understand the legal analysis, which concludes that a child is unsafe and must therefore be placed out of the home. In this legal analysis, child safety rests upon three critical factors:

1. the actual safety threat,
2. the child's level of vulnerability, and
3. the parent or guardian's protective capacity.

To accomplish the legal analysis of safety, the following information needs to be gathered about the family:

1. What is the nature and extent of the maltreatment?
2. What circumstances accompany the maltreatment?
3. How does the child function day-to-day?
4. How does the parent discipline the child?
5. What are overall parenting practices?
6. How does the parent manage his own life?

Threat of Danger?
+
Vulnerable Child?
-
Protective Capacity?
=
"Unsafe Child"

This information will help the judicial officer assess if threats of danger exist, if the child is vulnerable to the threats, and if sufficient protective capacities exist to manage the threats; and ultimately determine whether the child is safe.

Reasonable Efforts to Prevent Placement:

When a child is determined to be unsafe, a safety plan is necessary that includes actions and services to control the threats of danger. Judicial officers must decide if the agency made reasonable efforts to prevent removal by determining if the safety plan is sufficient, feasible, and sustainable. The court must question if an in-home or out-of-home safety plan, or some combination, will be the least intrusive approach to keep the child safe and still be sufficient?

Tasks and Responsibilities for an Out-of-Home Safety Plan:

When an in-home safety plan is not sufficient, feasible, or sustainable, an out-of-home safety plan becomes necessary. The judicial officer must decide:

1. What kind and amount of visitation will there be?

   Immediate and frequent contact between the child and parent(s) helps maintain their identity and reduces trauma.

2. What are the minimum expectations or conditions for the child to return home?

   The court can use the safety decision-making process as the logical foundation for identifying conditions for reunification. Conditions to return are based on what is needed for the child to be safe, with a sufficient, feasible, and sustainable in-home safety plan.

A Safety Decision on Reunification:

Deciding whether a child can be safely reunified with a parent with substance use disorder was most frequently asked by the Leadership Roundtables. The conditions for return are reunification benchmarks, not case plan goals and objectives. The fundamental issues are:

- Has there been enough change in threats, protective capacities, and the circumstances that the earlier reason an in-home safety plan was insufficient is no longer accurate?
- Does the analysis using the same criteria that required an out-of-home safety plan, now find that an in-home safety plan is sufficient to control the threats, is feasible, and can be sustained until the parent can protect without help?

The standard for deciding when to reunify a child with the parent with substance use disorder should not be based on whether the parent is fully abstaining from alcohol or other drugs or has fully completed all of their service objectives. The decision on reunification should be based solely on whether the child is currently safe.

An additional resource that is available on the legal safety analysis is a session that was provided at the 2013 Children's Roundtable Summit, "Protecting Children: What is safety?" by Jennifer Renne, Esq., National Resource Center on Legal and Judicial Issues, and Therese Roe Lund, MSSW, National Resource Center for Child Protective Services. Their presentation focused on understanding all safety elements, applying that knowledge to decision-making, and improving children and family outcomes. This recorded session is available to view at https://www.youtube.com/watch?v=alHp-FSIYTM&feature=youtu.be

Recovery and Recovery Supports

Although not requested by the Leadership Roundtables, the last task that the Workgroup was charged to address by the State Roundtable is on recovery and recovery supports. In 2010, the Substance Abuse and Mental Health Services Association (SAMHSA) collaborated with leaders in the behavioral health field to create a standard, unified working definition of recovery:

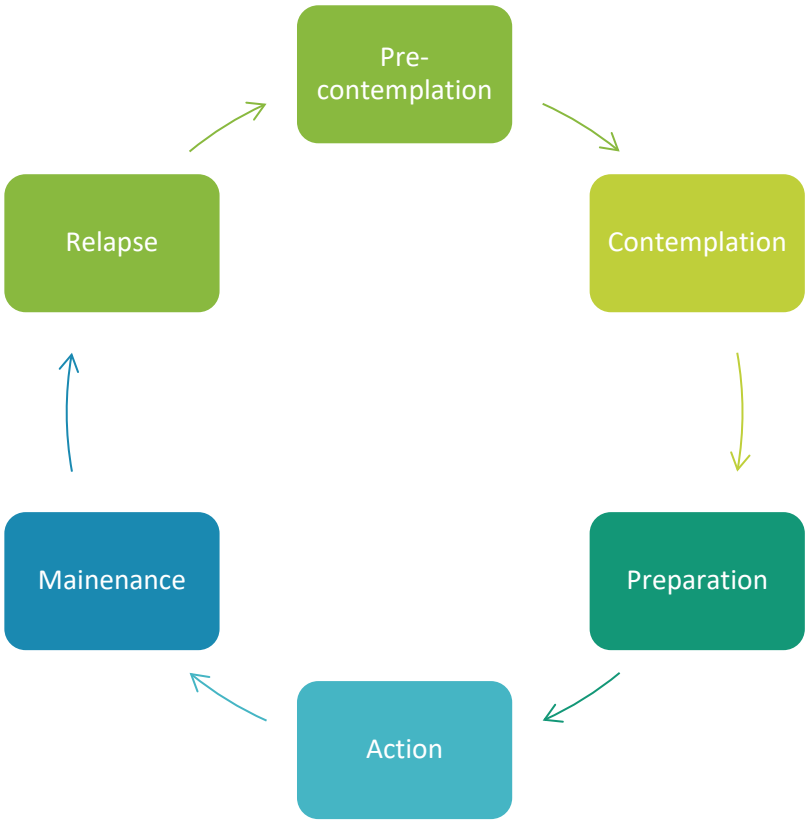
> "Recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential."

The process of recovery is highly personal and occurs via many pathways.

Stages of Change in the Recovery Process

Although recovery is an unpredictable process, many experts have noticed certain phases or stages every substance user goes through on their path to recovery. Having an understanding of the stages of change is a crucial aspect of understanding the recovery process. One of the best-known approaches to change is the *Stages of Change* or *Transtheoretical Model*, introduced in the late 1970s by psychologists James Prochaska and Carlo DiClemente. They created the model to offer insight into how recovery from addiction is achieved. Even after receiving an unprecedented amount of research attention, the Transtheoretical Model remains the dominant model for health

behavior change. There are six main stages of change in the recovery process (Prochaska & DiClemente, 1982):



S T A G E S

Pre-contemplation – Not seeing the need for change.

Contemplation – Considering a change but has not made the decision yet.

Preparation – Decided to make the change and considering steps to make this happen.

Action – Actively doing something to change.

Maintenance – Working on maintaining a change or new lifestyle.

Relapse – Reoccurrence of substance use or setback

It's normal for an individual to go around the cycle of change several times, sometimes moving forward or backward, before achieving stable change or sobriety. It is important to mention that relapse is preventable and recognized a normal occurrence or stage of change. Relapse does not mean that the individual has failed; it is common because recovery is a lifelong journey. Setbacks are a normal part of life, and building resiliency becomes a key component of recovery. Relapse provides an opportunity for the parent to recover from their setback, learn from the experience, and make appropriate changes to keep moving forward on their journey to sobriety.

Please see **APPENDIX XVIII** for additional considerations for the court based on the Stages of Change.

Support in Recovery

Another way for the parent to build resiliency is to have a support system to encourage them during challenging times in their recovery. Recovery support systems help individuals with substance use disorders manage their conditions successfully. According to SAMSHA, four major dimensions support a life in recovery, which will also support a safe environment for children:

- **Health**—overcoming or managing one's disease(s) or symptoms (for example, abstaining from the use of alcohol, illicit drugs, and non-prescribed medications) and making informed, healthy choices that support physical and emotional well-being.
- **Home**—having a stable and safe place to live.
- **Purpose**—conducting meaningful daily activities (such as a job, school, volunteerism, family, caretaking, or creative endeavors) and having the independence, income, and resources to participate in society.
- **Community**—having relationships and social networks that provide support, friendship, love, and hope.

Recovery support services are non-clinical services that help individuals and families recover from the impact and consequences of substance use disorder. These services complement the focus of treatment and help people heal by gaining the skills and resources needed to initiate, maintain, and sustain long-term recovery. These services refer to the collection of community services that can provide emotional and practical support for continued healing. Examples of recovery support services include mutual aid/support groups, alumni programs, ongoing counseling, coaching, sober living housing, employment support, recovery community centers, and support programs.

Peer Support and Recovery Specialists are more commonly offered as a support service for parents with substance use disorder involved in the child welfare system. The National Center on Substance Abuse and Child Welfare (NCSACW) has created a brief, *The Use of Peers or Recovery Specialist in Child Welfare Settings,* that provides an overview on these two types of models of support for families:

- **Peer Support**:
  Peer support is a person that has a lived experience of substance use disorder and child welfare involvement. This shared history provides the parent with a relatable ally to develop trust, get support in the engagement of services, and provide a successful role model for recovery and reunification.

- **Recovery Specialist**:
  Recovery specialists are professionals trained and/or certified in substance use treatment and recovery. Recovery specialists can enhance support by providing subject matter expertise. They may offer on-site substance use disorder consultation, substance use assessments, drug testing, and case management services to improve parents' access to and engagement in substance use treatment.

The importance of individuals in the recovery process having happy, connected lives cannot be understated! An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover, offer hope, support, and encouragement; and suggest strategies and resources for change. Family members, friends, peers, providers, faith groups, community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.

In a popular TED Talk, Johann Hari famously concludes that the opposite of addiction is not sobriety; it is human connection (TED, 2015). As human beings, we all need connection. When a meaningful connection is missing from our lives, an addiction may begin to fill the void. The good news, according to Johann Hari, is that this is something that can be overcome.

> *"The opposite of addiction is not sobriety… it is connection."*
>
> ~ Johann Hari

"When you view the war on drugs in this light, trying to eliminate the drugs—the addictive chemicals—will never end addiction completely because it avoids a deeper problem in society—a lack of connection. There is an alternative. You can build a system that is designed to help drug addicts to reconnect with the world—and so leave behind their addictions."

Interpersonal support through relationships and social networks are essential to the success of an individual's recovery. **The Workgroup recommends that the Courts ensure that individuals with substance use disorder have support in their recovery process.**

The Workgroup has created a "Stages of Change in the Recovery Process" benchcard. This benchcard provides judges and hearing officers with guidance on questions to ask parents/caregivers with substance use disorder depending on which stage of recovery they are currently in and support them on their journey (please see **Appendix XIX**).

Best Practices for Families Impacted by Substance Use Disorder

With the work that has been done from 2013 to 2020, the Workgroup wanted to highlight best practices for the dependency court system that have been identified for families impacted by substance use disorder (**APPENDIX XX**).

CELEBRATING SUCCESSES:

The Workgroup would like to acknowledge and celebrate their achievements since it was convened in 2013. The dedicated members of this Workgroup highlighted the issue of substance abuse as it intersects with the child welfare population and made recommendations that will improve practices

for families in child welfare and the dependency systems that are affected by substance use disorder.

Drug & Alcohol Workgroup's Achievements

Conducted Extensive Literature Review and Obtained Expert Presentations
Reviewed available Data in Pennsylvania to assess the ability to determine the Incidence of Parents Impacted by Substance Use Disorder in the Child Welfare System
Surveyed D&A Programs and Strategies used in other States
Explored available Federal Resources
Site Visited several Pennsylvania Drug & Alcohol Programs
Identified Current Practices that were being used in Pennsylvania
Partnered with the National Center on Substance Abuse and Child Welfare (NCSACW)
Circulated a Collaborative Values Inventory that was completed by more than 3,000 Respondents
Assisted Eight Core Counties that went through NCSACW's In-Depth Technical Assistance
Asked the Office of Children, Youth and Families (OCYF) to consider incorporating Substance Abuse Case Identification in their development of the CWIS System
Requested that the Children's Roundtable Summit Committee include a session on Substance Use Disorders. The 2015 Children's Roundtable Summit had a plenary session, "Effective Strategies for Working with Families with Substance Use Disorders."
Encouraged Counties to include someone from their local Single County Authority and/or primary Substance Abuse Treatment Provider on their local Children's Roundtable
Addressed funding by providing an outline of the most important features of the Mental Health Parity Act, the Affordable Care Act, and Pennsylvania's Medical Assistance Coverage
Presented at the 2017 Children's Roundtable Summit on "Current Trends in Substance Use Prevention, Intervention, and Treatment" by Workgroup Member and In-State Expert
Presented at a Pennsylvania Bar Institute Session, "Current Issues for Child Advocates," and "Addiction is a Family Disease" to a group of Drug Court Coordinators hosted by Administrative Office of Pennsylvania Courts (AOPC)
Modified NCSACW's IDTA to create a process more specific to Pennsylvania, the Drug & Alcohol In-Depth Analysis (D&A IDA)
Identified the need to take an Integrated Approach to Treatment for Individuals with Co-Occurring Substance Abuse and Mental Health Issues
Explored how Legalization of Marijuana may Impact Child Welfare
Tested One county with the D&A IDA process
Created a D&A IDA Resource Guide
Explored Confidentiality Issues for Cases with Substance Abuse
Created a D&A Benchcard on the Stages of Change in the Recovery Process
Provided Best Practices for Families Impacted by Substance Use Disorders

Special thanks to Allegheny, Clinton, Cumberland, Lackawanna, Lehigh, Lycoming, Luzerne, Monroe, and Venango! The D&A Workgroup could not have done our work without your involvement and efforts in improving practices for families impacted by Substance Abuse in Child Welfare and the Dependency Court System.

CONCLUSION:

The Workgroup believes that all charges have been accomplished, except for Luzerne County completing their case file review and drop-down analysis for the Drug & Alcohol In-Depth Analysis (D&A IDA). While it is anticipated that Luzerne County will complete these tasks soon, it does not require the Workgroup's oversight. As such, the Workgroup is recommending that the Workgroup come to an end. The Workgroup wants to be clear that its recommendation to end the Workgroup is because there is nothing further that can be done by this collective group and not because the drug epidemic is resolved or no longer impacting the children and families served by Pennsylvania's child welfare and dependency systems. While much effort and progress have been made over the past seven years, the drug epidemic remains.

Workgroup members strongly believe that while there is collective learning that can be gleaned from its work, it comes down to each county needing to assess and analyze its own needs surrounding substance use disorders. The Workgroup has done extensive research. The Workgroup has stressed the importance of building partnerships and collaborating cross-system. The Workgroup had eight counties go through the National Center on Substance Abuse and Child Welfare's In-Depth Technical Assistance (IDTA). Based on the experience of the IDTA, the Workgroup modified the process to be Pennsylvania specific and tested the new Drug & Alcohol In-Depth Analysis (D&A IDA) process in one county. The Workgroup has created various tools and identified resources to assist counties in going through the D&A IDA process. The process, if used with fidelity, has been proven to work.

Now the Workgroup needs counties in Pennsylvania to do their part. Counties need to commit to improving their system for families that are impacted by substance use disorder. Most importantly, counties need to utilize Pennsylvania's Drug & Alcohol In-Depth Analysis process to ensure that they are doing all they can as a system and as a society to give these families the best chance for success.

RECOMMENDATIONS:

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

1. The Office of Children & Families in the Courts, in collaboration with the co-chairpersons of the Drug and Alcohol Workgroup, provide an informative WebEx on the importance of leadership, forming partnerships and collaboration to create a culture change around Substance Use Disorder for counties interested in the Pennsylvania Drug & Alcohol In-Depth Analysis.
2. The State Roundtable strongly encourage the use of the Pennsylvania Drug & Alcohol In-Depth Analysis process for courts struggling with substance use disorder and child abuse.
3. The Drug & Alcohol Workgroup be permitted to sunset, as all SRT charges have been accomplished with the exception of Luzerne County completing the case file review and drop-down analysis for the D&A IDA

RESOURCES:

Foundations Recovery Network. *An introduction to Integrated Treatment.* https://dualdiagnosis.org/an-introduction-to-integrated-treatment/

Gateway Foundation (2020). *Signs and Symptoms of Drug Abuse in Adults*. https://www.gatewayfoundation.org/faqs/signs-and-symptoms-of-drug-abuse-in-adults/

Lund, J. & Renne (2009). *Child Safety: A Guide for Judges and Attorneys*

National Center on Substance Abuse and Child Welfare. *The Use of Peers or Recovery Specialist in Child Welfare Settings*. https://ncsacw.samhsa.gov/files/peer19_brief.pdf

Pennsylvania Dependency Benchbook, 3rd Edition. https://ocfcpacourts.us/judges-legal-professionals/benchbook-3rd-edition/

Pennsylvania Dependency Benchbook Resource Companion. https://ocfcpacourts.us/judges-legal-professionals/benchbook-resource-companion-2/

Prochaska, J. O., & DiClemente, C. C. (1982). *Transtheoretical therapy: Toward a more integrative model of change*. Psychotherapy: Theory, Research & Practice, 19(3), 276–288.

Substance Abuse and Mental Health Services Administration (SAMHSA). *Recovery and Recovery Supports*. https://www.samhsa.gov/find-help/recovery

TED (2015, June) Johann Hari: *Everything you think you know about addiction is wrong*. https://www.tedtalkbooks.com/johann-hari/#:~:text=Johann%20Hari%20is%20a%20Swiss-British%20writer%20and%20journalist.,Telegraph%20as%20one%20of%20the%20most%20influential%20

RESOURCES ON CONFIDENTIALITY:

Federal

42 CFR Part 2 (Confidentiality of Substance Use Treatment Records)

45 CFR Part 164, Subpart E (HIPPA Privacy Rule)

Federal Register, Vol. 85, No. 136, pp. 42986 – 43038. (https://www.govinfo.gov/content/pkg/FR-2020-07-15/pdf/2020-14675.pdf). (2020 Amendments to Part 2 Regulations. Provides a good overview of SAMHSA's position on confidentiality)

Substance Abuse Mental Health Services Administration (SAMHSA). (https://www.samhsa.gov/)

SAMHSA FAQs (samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs)

- Fact Sheet: Does Part 2 Apply to Me?
- Fact Sheet: How Do I Exchange Part 2 Data?
- FAQs: Applying the Substance Abuse Confidentiality Regulations

Webinar Training – "HIPPA and 42 CFR Part 2: Disclosure of Substance Use Disorder Records." Available through PA Train (https://www.train.org/pa/welcome) and on YouTube (youtu.be/JAq2wbnbq04)

Pennsylvania

Child Protective Services Law, 23 Pa. CSA §§6339-6340.1 (Confidentiality and Release or Exchange of Information) and 6386 (Plan of Safe Care)

Juvenile Act, 42 Pa. CSA §§6307 (Juvenile Court Records), 6352.1 (Act 126), 6352.2 (Inter-Agency Information Sharing Agreements)

Mental Health Procedures Act, 50 PS §7111(a) (Confidentiality of Mental Health Records; No Conflict with the Drug and Alcohol Control Act)

Pennsylvania Drug and Alcohol Control Act, 71 PS §§1690.108 (Confidentiality of Substance Use Treatment Records), 112 (Consent for Minors), and 112a (Commitment of Minors)

4 Pa. Code §255.5(b) (Restrictions on Disclosure of Client-Oriented Substance Use Treatment Information)

28 Pa. Code § 709.28 (Confidentiality; Requirements for a Valid Consent to Release Information)

55 Pa. Code §§3130.44, 3490.91-95, 3490.242 (Children and Youth Agency Confidentiality)

Bulletin 00-02-03 (Protocol for Sharing Drug & Alcohol Information)

Department of Drug & Alcohol Programs (DDAP). (https://www.ddap.pa.gov/)

Pennsylvania and Federal Law – Trainings and Other Resources

DDAP Training – "PA-DDAP: Drug and Alcohol Confidentiality." (Available in person (dates and locations on DDAP's website (ddap.pa.gov)) and online through PA Train (train.org/pa/welcome).

DDAP Overview Manual of Federal and State Confidentiality Regulations (Available at ddap.pa.gov/Documents/Agency%20Publications/Confidentiality_Federal_State_Regulations_Guide.pdf). (Current through 2017)

CWRC Online Course – Course 9000: Confidentiality in Child Welfare (http://www.pacwrc.pitt.edu/ELEARN.htm)

CWRC Handout: "Information D&A Professionals can Release to CYS." www.pacwrc.pitt.edu/Curriculum/309%20Drug%20and%20Alcohol%20Issues/Handouts/HO%2013%20Infrmtn%20D&A%20Prfssnls%20Cn%20Rls%20to%20CYS.pdf

Report: "Pennsylvania Law and Policy Governing the Confidentiality of Substance Use Treatment Information: Challenges and Opportunities," written by the George Washington University Health Information & the Law Project (Cartwright-Smith, Lara *et al*., November 20, 2019). (Link to the report through DDAP's website (ddap.pa.gov/Pages/SUD-Confidentiality.aspx) or view the report at healthinfolaw.org/PA_substance_use_information_confidentiality)

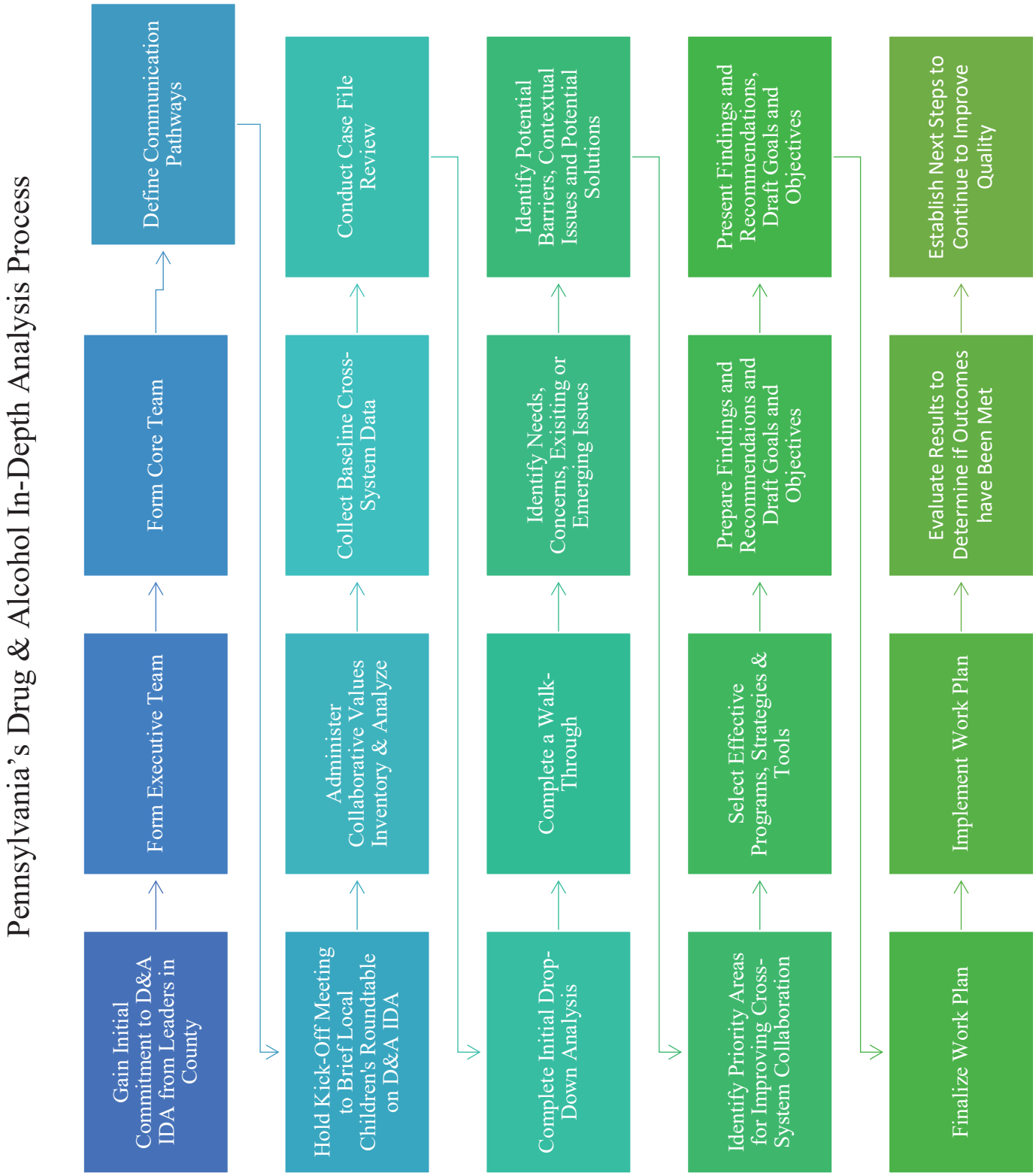
PA Plan of Safe Care Guidance (Jointly Issued by DOH, DHS, and DDAP) (http://keepkidssafe.pa.gov/cs/groups/webcontent/documents/document/c_287154.pdf)

RESOURCES ON DRUG TESTING IN CHILD WELFARE:

Center for Substance Abuse Treatment (2010). *Drug testing in child welfare: Practice and policy considerations*. HHS Pub. No. (SMA) 10-4556. Rockville, MD: Substance Abuse and Mental Health Services Administration. https://ncsacw.samhsa.gov/files/DrugTestinginChildWelfare.pdf

Children's Justice State Council (June 2011). *Drug-Testing Practice Guidelines*. https://ncsacw.samhsa.gov/files/IA_Drug_Testing_Bench_Card_508.pdf

National Drug Court Institute (2011). The Drug Court Judicial Benchbook.


Pennsylvania's Drug & Alcohol In-Depth Analysis Process
Gain Initial Commitment to D&A IDA from Leaders in County
Form Executive Team
Form Core Team
Define Communication Pathways
Hold Kick-Off Meeting to Brief Local Children's Roundtable on D&A IDA
Administer Collaborative Values Inventory & Analyze
Collect Baseline Cross-System Data
Conduct Case File Review
Complete Initial Drop-Down Analysis
Complete a Walk-Through
Identify Needs, Concerns, Exisiting or Emerging Issues
Identify Potential Barriers, Contextual Issues and Potential Solutions
Identify Priority Areas for Improving Cross-System Collaboration
Select Effective Programs, Strategies & Tools
Prepare Findings and Recommendaions and Draft Goals and Objectives
Present Findings and Recommendations, Draft Goals and Objectives
Finalize Work Plan
Implement Work Plan
Evaluate Results to Determine if Outcomes have Been Met
Establish Next Steps to Continue to Improve Quality

Collaborative Values Inventory for Drug & Alcohol In-Depth Analysis

Demographics:	
▪ Role ▪ Gender ▪ Area of Responsibility	▪ Jurisdiction of Agency or Court ▪ Years of Experience in Area of Responsibility ▪ County in which you Primarily Work

Questions:	Somewhat Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
People with Substance Use Disorder have a disease for which they need treatment.				
People with Substance Use Disorder should be held fully responsible for their own actions.				
Parents who use alcohol cannot be effective parents.				
Parents who have alcohol-related disorders cannot be effective parents.				
Parents who use drugs cannot be effective parents.				
Parents who have drug-related disorders cannot be effective parents.				
The standard for deciding when to remove or reunify children with their substance abusing parents should be whether the parents are fully abstaining from alcohol or other drugs.				
We should fund programs that serve children and families based on their outcomes, not on the number of people they serve.				
Judges should be involved with planning community-wide responses to problems associated with alcohol and other drugs for children and families involved in dependency court.				
Children and parents with Substance Use Disorders and involved in the child welfare system should be targeted as a high priority group for substance us prevention services.				
Substance abuse treatment programs should know whether their clients are involved in juvenile dependency proceedings.				
Substance abuse treatment programs should address the impact of parents' substance use disorders on the safety, permanency and well-being of their client's children.				
Child welfare service outcomes measures should include indicators regarding substance use disorder recovery status of parents and dependent children.				
Child welfare service outcomes measures should include indicators regarding substance use disorder recovery status of parents and dependent children.				

Questions:	Somewhat Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
Substance abuse services would be improved if agencies were more responsible to the differences between client groups.				
Court, substance abuse services and child welfare should collaborate on behalf of the children and families they are serving.				
Confidentiality is a significant barrier to allow greater cooperation among substance abuse services, child welfare and the courts.				
Publically funded alcohol and drug treatment providers should give a higher priority than they presently do to mothers referred from child welfare for available services.				
Publically funded alcohol and drug treatment providers should give a higher priority than they presently do to fathers referred from child welfare for available services.				
A person's relapse should lead to a collaborative intervention to reengage the person in treatment and re-assess child safety.				
Relapse is a normal part of the recovery process.				
Drug testing is an effective means of measuring abstinence.				
Abstinence is the best indicator of recovery.				
What a person does immediately following a relapse is a good indicator of where they are at currently in recovery.				
Parents who truly love their children would just stop using drugs.				
Most substance abusing people have experienced traumatic events in their lives.				
There is a link between substance abuse and trauma.				
Substance abuse treatment programs should include a trauma recovery component.				

The portion of parents who will succeed in treatment for alcohol and other drug problems is approximately	0-20%	21-40%	41-60%	61-80%	81-100%

I have adequate training, knowledge, and skills to work effectively with or on behalf of substance abusing populations.	Yes	No
There are adequate and effective series in our community to treat substance abusing parents.	Yes	No
There are adequate and effective recovery support services in our community.	Yes	No
My level of competence in working with or on behalf of the substance abusing population is high.	Yes	No
I can determine when someone needs a substance abuse assessment.	Yes	No

PENNSYLVANIA DRUG & ALCOHOL IN-DEPTH ANALYSIS
CASE FILE REVIEW FOR SUBSTANCE USE DISORDER

1. Reviewed by:	
2. Reviewed on:	Date:
Case Information	
3. Case Number	
4. Type of Case	GPS Case CPS Case
5. Case Opened	Date:
6. Case Closed	Date: N/A
7. Court Involved Case	Yes No
8. Docket Number (if applicable)	
9. Is substance abuse ever identified?	Yes No 9a. If yes, first date identified:
10. In allegation?	Yes No
11. In case notes?	Yes No
12. In the dependency petition?	Yes No N/A
13. In affidavit for removal?	Yes No N/A
14. Was the child or any sibling removed from the home?	Yes No
14a. If yes, was the removal due to substance abuse?	Yes No Unknown 14b. If unknown, provide explanation:

Custodial Parent and Family Characteristics		
	Parent 1	**Parent 2**
Gender	15. Female Male Other Unknown	18. Female Male Other Unknown
Date of Birth	16.	19.

	Parent 1	Parent 2
Race/Ethnicity (you may select more than one)	17a. African-American 17b. Caucasian 17c. Hispanic 17d. Asian/Pacific Islander 17e. Native American 17f. Unknown	20a. African-American 20b. Caucasian 20c. Hispanic 20d. Asian/Pacific Islander 20e. Native American 20f. Unknown
Number of children in case	21.	
Date of Birth for each child in case	22a. 1. 22b. 2. 22c. 3. 22.d 4.	22e. 5. 22f. 6. 22g. 7. 22h. 8.
Infant/Toddler (birth to 36 months)		
23. Does the case involve an infant or toddler?	Yes	No (Skip to next section)
23a. If yes, is there documentation of pre-natal or perinatal substance exposure?	Yes	No
23b. If yes, was the infant/toddler referred to Early Intervention?	Yes 23c. If yes, date of referral:	No
23d. If yes, was the infant/toddler assessed by Early Intervention?	Yes 23e. If yes, date assessed:	No
23f. If yes, was the infant/ toddler determined to be eligible for Early Intervention services and an Individualized Family Service Plan (IFSP) was developed?	Yes 23g. If yes, date of IFSP:	No
24. Was a Plan of Safe Care developed?	Yes 24a. If yes, date of plan:	No
24b. If yes, did the family accept or reject the Plan of Safe Care?	Accepted	Rejected

Drug Screening and Testing		
	Parent 1	**Parent 2**
Was any drug screening or drug testing undertaken?	25. Yes No	27. Yes No
Was drug screening or drug testing court ordered?	26. Yes No N/A 26a. If yes, date of court order:	28. Yes No N/A 28a. If yes, date of court order:
Screening and Assessment for Substance Use Disorder		
29. Does the County Children and Youth Agency have an identified substance use disorder screening instrument?	Yes 29a. If yes, what instrument is used:	No
	Parent 1	**Parent 2**
Was a screening done by the County Children and Youth Agency for substance use problems?	30. Yes No 30a. If yes, date of screening:	32. Yes No 32a. If yes, date of screening:
Did the screening result in a referral being made for a substance use assessment?	31. Yes No 31a. If yes, date of referral:	33. Yes No 33a. If yes, date of referral:
Assessment questions below must be answered regardless of whether screening occurred prior to the assessment or not at all.		
Was a referral for a substance use assessment made?	34. Yes No	43. Yes No
Was a referral for a substance use assessment ordered by the court?	35. Yes No N/A	44. Yes No N/A

	Parent 1	Parent 2
Was the substance use assessment completed?	36. Yes No 36a. If yes, date of assessment:	45. Yes No 45a. If yes, date of assessment:
Did the substance use assessment recommend treatment?	37. Yes No	46. Yes No
Were supports such as coaching/peer assistance provided?	38. Yes No	47. Yes No
Were other supportive services provided to the parent?	39. Yes No 39a. If yes, describe:	48. Yes No 48a. If yes, describe:
Were supportive services offered to the family?	40. Yes No 40a. If yes, describe:	49. Yes No 49a. If yes, describe:
Was the level of care determination available in County Children and Youth Agency record?	41. Yes No	50. Yes No
Comments/Notes	42.	51.
Treatment Referral for Substance Use Disorder		
	Parent 1	**Parent 2**
Was a referral made to substance use disorder treatment?	52. Yes No 52a. If yes, date of referral:	57. Yes No 57a. If yes, date of referral:

	Parent 1	Parent 2
Was parent admitted to substance use disorder treatment?	53. Yes No 53a. If yes, date of admission:	58. Yes No 58a. If yes, date of admission:
If no, why?	53b. Parent Already in Treatment Parent Refused Parent Incarcerated Other 53c. If other, describe:	58b. Parent Already in Treatment Parent Refused Parent incarcerated Other 58c. If other, describe:
Was the referral documented in the County Children and Youth Agency record?	54. Yes No	59. Yes No
Was a confidentiality release signed by the parent?	55. Yes No 55a. If no, why:	60. Yes No 60a. If no, why:
Comments/Notes	56.	61.
Treatment Services for Substance Use Disorder		
	Parent 1	**Parent 2**
Detox	62. Yes No 62a. If yes, length of stay:	71. Yes No 71a. If yes, length of stay:
If yes, completed?	62b. Yes No	71b. Yes No

Detox (continued)	**Parent 1**	**Parent 2**
If no, why?	62c. Funding Incarceration Transferred Left Against Advice Terminated by Facility Other 62d. If other, describe:	71c. Funding Incarceration Transferred Left Against Advice Terminated by Facility Other 71d. If other, describe:
Residential	63. Yes No 63a. If yes, length of stay:	72. Yes No 72a. If yes, length of stay:
If yes, completed?	63b. Yes No	72b. Yes No
If no, why?	63c. Funding Incarceration Transferred Left Against Advice Terminated by Facility Other 63d. If other, describe:	72c. Funding Incarceration Transferred Left Against Advice Terminated by Facility Other 72d. If other, describe :
Halfway House	64. Yes No 64a. If yes, length of stay:	73. Yes No 73a. If yes, length of stay:
If yes completed?	64b. Yes No	73b. Yes No

Halfway House (continued)	**Parent 1**	**Parent 2**
If no, why?	64c. Funding Incarceration Transferred Left Against Advice Terminated by Facility Other 64d. If other, describe:	73c. Funding Incarceration Transferred Left Against Advice Terminated by Facility Other 73d. If other, describe:
Partial Hospitalization	65. Yes No 65a. If yes, length of stay:	74. Yes No 74a. f yes, length of stay:
If yes, completed?	65b. Yes No	74b. Yes No
If no, why?	65c. Funding Incarceration Transferred Left Against Advice Terminated by Facility Other 65d. If other, describe:	74c. Funding Incarceration Transferred Left Against Advice Terminated by Facility Other 74d. If other, describe:
Intensive Outpatient	66. Yes No 66a. If yes, length of stay:	75. Yes No 75a. If yes, length of stay:
If yes, completed?	66b. Yes No	75b. Yes No

Intensive Outpatient (continued)	**Parent 1**	**Parent 2**
If no, why?	66c. Funding Incarceration Transferred Left Against Advice Terminated by Facility Other 66d. If other, describe:	75c. Funding Incarceration Transferred Left Against Advice Terminated by Facility Other 75d. If other, describe:
Outpatient	67. Yes No 67a. If yes, length of stay:	76. Yes No 76a. If yes, length of stay:
If yes, completed?	67b. Yes No	76b. Yes No
If no, why?	67c. Funding Incarceration Transferred Left Against Advice Terminated by Facility Other 67d. If other, describe:	76c. Funding Incarceration Transferred Left Against Advice Terminated by Facility Other 76d. If other, describe:
Was substance use disorder treatment information in the County Children and Youth Agency record?	68. Yes No	77. Yes No
What post-treatment services were provided?	69. Aftercare Recovery Support Other 69a. If other, describe:	78. Aftercare Recovery Support Other 78a. If other, describe:

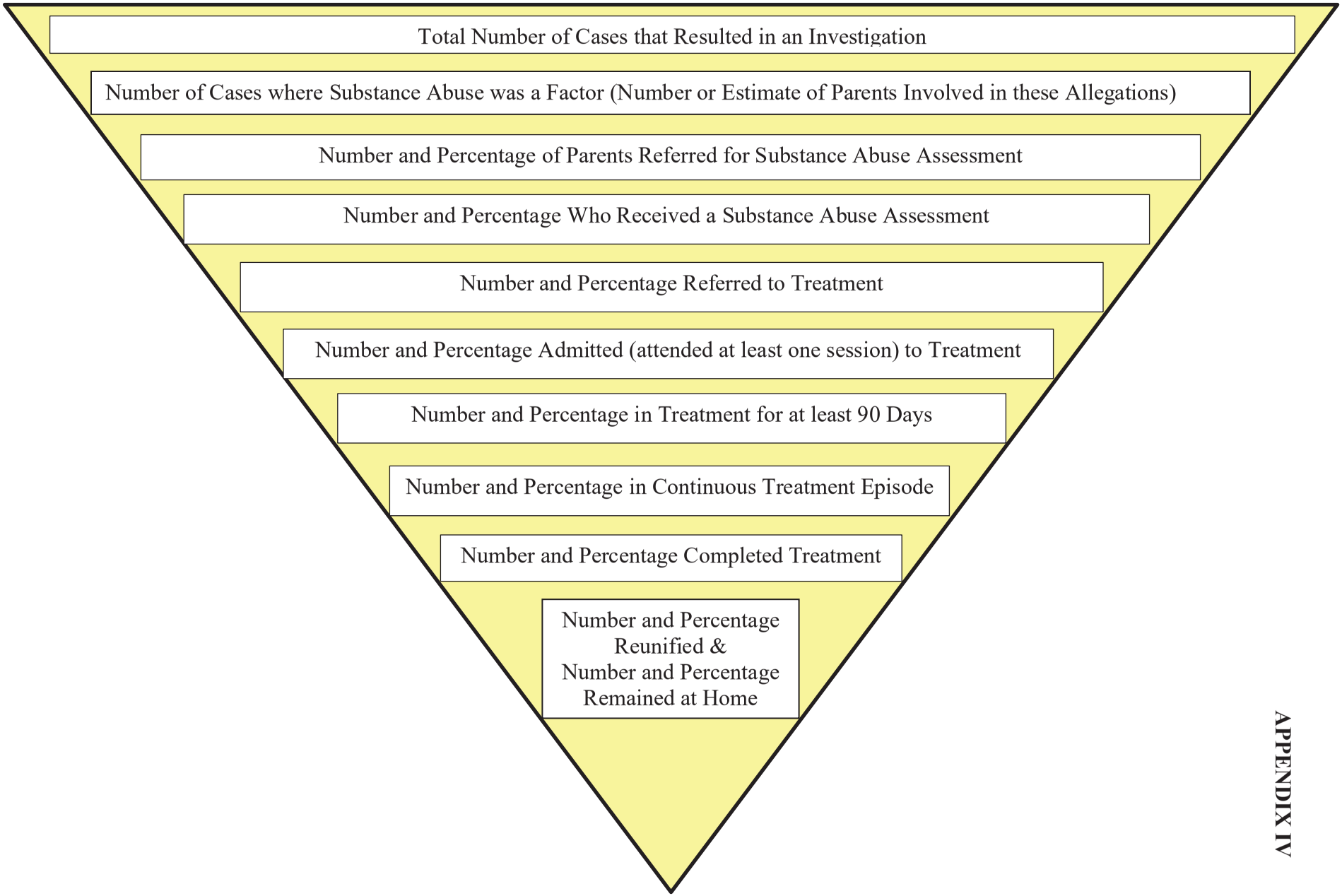
Comments/Notes	Parent 1	Parent 2
	70.	79.
Court Involved Cases *(If the child was never involved with court, skip to the next section)*		
Shelter Care Hearing (If applicable)		
80a. Date of court order		
80b. Was substance abuse mentioned?	Yes	No
80c. Other factors mentioned (i.e.: dirty house)		
Adjudication Hearing		
81a. Date of court order		
81b. Was substance abuse mentioned?	Yes	No
81c. Other factors mentioned (i.e.: dirty house)		
Disposition Hearing		
82a. Date of court order		
82b. Was substance abuse mentioned?	Yes	No
82c. Other factors mentioned (i.e.: dirty house)		
First/Initial Permanency Review Hearing		
83a. Date of court order		
83b. Was substance abuse mentioned?	Yes	No
83c. Other factors mentioned (i.e.: dirty house)		

First/Initial Permanency Review Hearing (continued)		
83d. What is the permanency goal?	Remain Home Reunification Adoption 83e. If APPLA, describe:	Permanent Legal Custodian Fit & Willing Relative APPLA
Last/Most Recent Permanency Review Hearing		
84a. Date of court order		
84b. Was substance abuse mentioned?	Yes	No
84c. Other factors mentioned (i.e.: dirty house)		
84d. What is the permanency goal?	Remain Home Reunification Adoption 84e. If APPLA, describe:	Permanent Legal Custodian Fit & Willing Relative APPLA
85. Was court supervision terminated?	Yes 85a. If yes, date of court order:	No

Comments - Please provide any addition clarification that may be needed:
86. 1. To understand what role parental/caregiver substance abuse had in this case and how it affected permanency planning and disposition.
87. 2. To understand what factors supported or impeded whether or not the parent/caregiver received substance use disorder assessment and/or treatment services if it was indicated.
88. 3. To understand what may have been done differently in the life of the case to improve outcomes for children of parents with substance use disorders.

This form has been modified from the Case File Review for Substance Abuse document that was used during the Drug & Alcohol In-Depth Technical Assistance with the National Center on Substance Abuse and Child Welfare.

Drop-Off Analysis Data Points



Substance Abuse / Child Welfare Systems Data Profile Worksheet

Luzerne County

Purpose

1. To determine the prevalence of families with substance use disorders in the child welfare system and its incidence in child welfare outcomes.
2. To identify the extent to which families in the child welfare system with substance use disorders are being referred and receive treatment services.

SUBSTANCE ABUSE DATA *	
Adult	
Number of Adult Treatment Admissions	299
• Number of Adults with at least one child *(Can you estimate how many children?)*	277
Number of Women Admitted to Treatment	188
• Number of Pregnant Women Admitted to Treatment	33
• Primary/Secondary Drugs of Choice at Admission	Heroin, Marijuana, Cocaine, Synthetic opioid, alcohol, methamphetamine
Number of Families Currently Involved in the Child Welfare System *(Establish a context for the penetration of families from child welfare compared to the overall number of adults receiving treatment services.)*	547
Number of Child Welfare System Referrals Who Were	
• Assessed	392
• Admitted to Treatment	278
• Completed Treatment	102
Overall Number of Adults Who Completed Treatment	104
Number of Substance Exposed Newborns	64
Children	
Number of Children Currently Involved in Child Welfare System	730
Number of Children	
• Assessed	77
• Admitted to treatment	52
• Completed treatment	14
• Diagnosed with Co-Occurring SA/MH Disorders	41

**Data source is most recent complete annual data set for all three systems.*

CHILD WELFARE DATA *	
Number of Abuse/Neglect Reports	5780
Number/Percentage of Reports that Resulted in Investigation	3709
Number/Percentage of Substantiated cases	1398
• Type of Maltreatment *(Emphasis on alcohol and drug as a factor)*	520 Drug and Alcohol
Caseload Profile (most recent snapshot available)	
• Number of children in out-of-home care	443
• Number of children remaining in-home (and under court jurisdiction)	228
• Number of case plans requiring substance abuse services	Our database does not capture this information.
• Number of families referred for substance abuse services	Our database does not capture this information.
• Number of children/families being served in family preservation cases	711 Children
CAPTA Referrals *1. Number of notifications (infants) made to child protective services by health care professionals due to prenatal drug exposure.* *2. Number of referrals of 0-2 substantiated cases to Part C agency for developmental referrals.*	There is no data available.
Reunification Rate	
• Number/percentage of children reunified. (Can SA cases be broken out separately? Can project staff be tracked with tagging or special codes in CW basic info system (SACWIS))	284 (64%)
• Median time to reunification	5.7 Months
Repeat Maltreatment Rate	
• Number/percentage of families with repeat maltreatment	56
• Type of maltreatment-to what extent is substance abuse a factor?	CPS
AFCARS data *Percent of child removals with alcohol or other drug abuse as reason for removal*	
• Alcohol abuse parent-%	5%
• Drug abuse parent-%	26%
• Both Alcohol and drug abuse parent - %	1%
Re-entry to Out-of-Home Care	
• Number and percentage who re-enter foster care within 12 months	38 (13.38%)
• How many involve parental substance abuse?	14

**Data source is most recent complete annual data set for all three systems.*

Family Drug Court Data*	
Overall Capacity	N/A
Number of Clients Enrolled	
Number of Graduates	
Total Number of Drop Out/Terminated Clients	
• Drop out Phase I	
• Drop out Phase II	
• Drop out Phase III	
• Drop out Phase IV	
Cost per Client	

**Data source is most recent complete annual data set for all three systems.*

Luzerne County 2019-2020
PA D&A IDA Work Plan

Key Issues	Key Action Steps	Target Date	Lead Parties
Mission, Underlying Values, Collaborative Relationships and Priorities			
Provide safe, timely permanency for children and their families with a focus on the families' substance use recovery by addressing the comprehensive needs of all family members. Increase community stakeholder's awareness of the prevalence of Substance Use Disorder (SUD) in child welfare involvement and the importance of providing integrated services to these families.	The Luzerne County Single County Authority (SCA), Case Management Department becomes the Centralized Intake Unit for MA recipients and all County funded Consumers. Utilizing resources through Luzerne County's STOP Coalition* to begin engaging local legislators, faith based organizations and institutes of higher education in our county to create a "town hall" forum in which the importance of prevention, education and community resources are discussed with the community. A panel discussion will include representation from child welfare to educate the community of the prevalence of SUD in child welfare. ** STOP Coalition was formed with a vision to create a healthier community by reducing the number of lives lost to overdoses.*	**Ongoing**	Judge Rogers, Hill, Alunni, Van Saun, German, Hogan, Kloss

Luzerne County 2019-2020
PA D&A IDA Work Plan

Key Issues	Key Action Steps	Target Date	Lead Parties
Increase communication and collaboration between systems (Child Welfare, Mental Health and Drug & Alcohol).	Continue placing an emphasis on collaboration utilizing relationships developed during our Plans of Safe Care implementation and roll out.		
Daily Practice: Screening and Assessment			
County Children and Youth Services (CYS) currently utilizes one drug and alcohol provider agency that is co-located within the County Child Welfare Agency for Screening and Assessment.	The Luzerne County Single County Authority (SCA), Case Management Department becomes the Centralized Intake Unit for all consumers who are referred through CYS.	**December, 2020**	Hogan, Van Saun, German, Alunni
Daily Practice: Engagement and Retention			
Majority of Drug & Alcohol referrals are currently made to one (1) provider who only provides two (2) levels of care.	A neutral party assessment from the County Case Management Unit will likely result in initial referrals to the most appropriate level of care. This will lead to increased access, engagement, and retention in Drug & Alcohol treatment and recovery services.	**December, 2020**	Hogan, Van Saun, German, Alunni
Daily Practice: Services to Children			
Human Services Department (HSD) staff do not receive regular training on Drug & Alcohol treatment services.	Luzerne County Office of Human Services developed a new employee on-boarding process which	**Ongoing**	Hill, Hogan, Van Saun, German, Alunni, Kloss, Vallet

Luzerne County 2019-2020
PA D&A IDA Work Plan

Key Issues	Key Action Steps	Target Date	Lead Parties
	includes a quarterly cross-training of all new staff. Staff receive a fifteen minute training specific to each of the five Human Service Departments. This is mandatory for all new staff. Existing staff are offered the opportunity to attend based on availability.		
A number of HSD staff have not received Trauma-Informed Care training.	Luzerne/Wyoming County System of Care sponsored a train-the-trainer series with support through Lakeside Trauma Workshop for Trauma Informed Care, Trauma 101. Seven HSD staff completed the training and will train staff within the HSD. This training provides education on the basic physical, mental and social outcomes of trauma. These workshops are topical and contextual to the issues that we encounter with children and adults impacted by trauma with necessary information and basic skills required to be trauma-sensitive.	**Ongoing**	
Working with Communities and Supporting Families			

Luzerne County 2019-2020
PA D&A IDA Work Plan

Key Issues	Key Action Steps	Target Date	Lead Parties
There is significant stigma against the Child Welfare Agency that exists within the community. There are misunderstandings of what the agency does in order to ensure safety and well-being of children and families.	Utilizing resources developed through Luzerne County's STOP Coalition begin outreach to local legislators, faith based organizations, and institutes of higher education in our county to create a "town hall" forum in which the importance of prevention, education and community resources are discussed with the community. A panel discussion will include representation from Child Welfare to educate the community of the prevalence of SUD in child welfare.	**Proposed Spring 2021**	Alunni, Van Saun, German, Hogan
Communication, Data Sharing and Information Systems			
Many of the private agencies (providers) that we contract with only recognize their Release of Information as consent for treatment. In some instances confidentiality and HIPAA laws have been manipulated creating barriers that affect access and engagement in treatment.	Human Service Program Director will work with County SCA to dialogue with D&A Provider network about release of information provided to the five Human Service Agencies.	**Ongoing**	Alunni, Roselle, Van Saun, Vallet, Hogan,
Budgeting and Sustainability			

Luzerne County 2019-2020
PA D&A IDA Work Plan

Key Issues	Key Action Steps	Target Date	Lead Parties
Adding additional county personnel can be challenging within the operating budget. Adding personnel has to occur within the parameters outlined by the County Charter and approved by our County Manager and County Council.	The County D&A office included additional Case Management staff in the 2020 county budget. The SCA included these positions in order to meet the need for additional staff to act as a fully functional Case Management Unit and assure compliance with the 2020-2025 Department of Drug and Alcohol Programs (DDAP) grant agreement.	**Completed, 2020**	Hill, Alunni, Hogan
Training and Staff Development			
OHS staff do not receive any form of cross-training to better understand services or resources available under the HSD umbrella. Staff training remains specific only to the hiring agency.	Training on the SCA role and function within the HSD through on-boarding and during quarterly cross-training of all new staff. Staff will receive a fifteen minute training specific to each of the five Human Service Departments. This is mandatory for all new staff. Existing staff are offered the opportunity to attend based on availability.	**Ongoing**	Alunni, Hogan, Van Saun, German
Evidence supports the significance of trauma on a significant portion of the population we serve, yet some staff in the HSD have not received formal Trauma training.	Luzerne/Wyoming County System of Care sponsored a train-the-trainer series with support through Lakeside Trauma Workshop for Trauma Informed Care, Trauma 101. Seven HSD	**Ongoing**	

Luzerne County 2019-2020
PA D&A IDA Work Plan

Key Issues	Key Action Steps	Target Date	Lead Parties
	staff completed the training and will train staff within the HSD.		
Working with Related Agencies			
As a result of a collaborative agreement, one specific Drug & Alcohol service provider is co-located within the CYS Agency. CYS staff may be unaware of the variety of service providers and levels of care available to consumers.	Human Service Program Director will coordinate with the County SCA and CYS to invite Drug & Alcohol service providers with an opportunity to provide educational outreach and distribute program literature on a monthly basis throughout calendar year 2021.	**December, 2020**	Hogan, Van Saun, German, Alunni, Meyers
Joint Accountability and Shared Outcomes			
Current reporting systems don't collect accurate data to record the number of families with SUD that become open cases with the Child Welfare Agency. Many cases are opened for reasons other than SUD as the primary concern; however, SUD is likely the cause of many on the issues of concern.	HSD Program Director and HSD Fiscal Director have begun research for developing a shared data system for all departments housed under the HSD. Utilizing the D&A IDA test group as a sample size we can begin tracking consumer's outcomes to establish trends and focus interventions.	**Ongoing**	Alunni, Hogan, Van Saun, German

DRUG & ALCOHOL IN-DEPTH ANALYSIS: PROGRESS REPORT FOR LUZERNE COUNTY

Complete a Progress Report from your involvement in the Pennsylvania Drug & Alcohol In-Depth Analysis and include the following:

1. **Partners:** Who were your key partners involved in this process?

2. **Advancing Practice**: Describe how you are, or plan to advance practice in your county to better address the needs of child welfare involved families with substance use disorders (e.g. improved knowledge, new methods or tools, improved collaboration…)

3. **Accomplishments**: List accomplishments to date and the key mechanisms that enable you to accomplish these goals/objectives.

4. **Challenges and Barriers**: Describe major challenges or barriers you have faced. Are they ongoing, or have they been addressed/resolved? If so, how?

5. **Outcomes**: What led to these changes and what outcomes to expect to achieve as a result?

6. **Sustainability**: What do you need to sustain what you are now doing?

7. **Lessons Learned**: What lessons did you learn from this process?

8. **Contact Information**: Name and contact information should any counties have questions about your experience in the PA D&A IDA process.

PARTNERS

- The Honorable Jennifer L. Rogers
- Luzerne County Children and Youth
- Luzerne County Drug and Alcohol Department
- Luzerne-Wyoming Counties System of Care
- Luzerne County Office of Human Service

ADVANCING PRACTICE

- The Luzerne County Drug and Alcohol Department will complete Drug and Alcohol, Level of Care assessments for families identified through the Children and Youth system. This provides families a non-biased, easier accessed, Level of Care assessment to better meet the needs of the family.
- The County Drug and Alcohol Department is in the process of exploring new Electronic Medical Record (EMR) technology for better tracking of clients served. This EMR will provide an enhanced mechanism for tracking consumers identified through the Children and Youth system.
- The Office of Human Services (OHS) initiated a new employee on-boarding process. This process includes a cross-training component which allows new employees an opportunity to get a fifteen (15) minute introduction to each of the four (4) departments housed in our physical location. Another component of the on-boarding process includes building tours. This allows new employees an opportunity to meet all Department Heads, meet department staff, and connect a face to a name.
- The OHS Program Director also sits in on the four (4) departments' individual provider meetings, Executive Committee Boards, and Advisory Committees. This allows an opportunity to identify potential service area gaps, or areas of overlap that have gone previously unaddressed. This has also allowed opportunities for advanced learning opportunities between agencies. This has led to increased collaboration between Children and Youth, and the Drug and Alcohol Department on issues pertaining to: Confidentiality, Release of Information, Harm Reduction Model, and streamlining questions that Children and Youth staff can ask of Substance Use Disorder (SUD) providers.

ACCOMPLISHMENTS

To date we have:

- The Department of Drug and Alcohol Programming (DDAP) 2020-2025 Grant agreement allowed for the expansion of the County Drug and Alcohol Programs Case Management program. As a result, the Luzerne County Drug and Alcohol Program was

able to take on an additional two (2) Case Managers. One (1) Case Manager is assigned to work specifically with Children and Youth families.

- The OHS on-boarding initiative provides a foundation for integration between the Children and Youth, and Drug and Alcohol Departments. Using this as an avenue to further that integration, Children and Youth is now invited to participate in monthly Drug and Alcohol Provider meetings to gain additional information on trends and updates within the Drug and Alcohol network. Additionally, the Drug and Alcohol Department has been invited to participate in Children and Youth ACT 33 meetings to lend their voice and expertise in the increasing prevalence of substance abuse and misuse identified during these meetings.

CHALLENGES AND BARRIERS

- A continued challenge is staff turnover within departments. Upon beginning the steps of the Drug & Alcohol In-Depth Analysis (D&A IDA), we have had turnover in the two key Departments involved. This caused minimal delay in our Drug and Alcohol program involvement, but had a more significant impact in the Children and Youth Agency. As our staff compliment evolves, the need to explain and re-explain our D&A IDA work plan exists.
- The COVID 19 pandemic started during the implementation of the D&A IDA and delayed the completion of some of the tasks.

OUTCOMES

- Prior to initiating the D&A IDA work plan, the County Children and Youth Department had an agreement in place with one (1) contracted Drug and Alcohol service provider to complete Level of Care (LOC) Assessments. This provider does not provide a full continuum of care and may not assess consumer's at the most appropriate level of care to meet their needs. The County Drug and Alcohol Department met with Children and Youth and proposed an alternative arrangement, but had little formal discussion in follow-up.
- After agreeing to participate in the D&A IDA the partners involved regrouped and discussed what it would look like with the County Drug and Alcohol, Case Management unit completing all LOC assessments. Children and Youth assessed an approximate number of referrals that could be expected by the Case Management department, and the County SCA determined that the number of referrals could be accommodated by one (1) Case Manager with assistance from the Case Management department as needed.
- It is expected that utilizing the County Drug and Alcohol Case Management unit to complete the LOC assessments, will create an easier transition; or 'one stop' source of referral for a family to access their services. With a Case Manager assigned to, and co-located in the Children and Youth office, LOC referrals can be completed in a more efficient and effective manner for the families that we serve.

- Utilizing a new Electronic Monitoring Record (EMR) purchased by our County Drug and Alcohol program, we can begin more effectively tracking our shared cases to identify trends and determine opportunities or areas to utilize our network of county partners to effect change.

SUSTAINABILITY

- The 2020-2025 DDAP Grant agreement allowed our Drug and Alcohol Department the opportunity to hire additional staff for co-location in our Children and Youth Department. The large majority of these families are funded through Medical Assistance. Our Drug and Alcohol Case Management Department is in the MA, Managed Care network of providers and can bill for assessments completed. Once we can identify an accurate number of referrals that are completed annually, this may help offset cost for adding an additional Case Manager if the need exists.
- The County Drug and Alcohol Department identified the need for an EMR to more effectively monitor consumer data. With the implementation of an EMR comes a variety of cost related to licensing and maintenance. Utilizing the Case Management department to complete LOC assessments, additional revenue realized can be utilized to continue funding the EMR system.

LESSONS LEARNED

- While the prevalence for Substance Use Disorders is high among many of CYS cases, the monitoring of cases originally identified, or opened as a result of substance misuse can be misrepresented.
- The day to day requirements of Children and Youth employees are very strenuous and it is difficult to remain up-to-date on the various changes amongst sister agencies. While many staff have indicated the need for a cross-training type of education, “silos” remain an issue within the day to day workforce. Using examples from our D&A IDA work plan we have improved on our delivery of training to educate staff across OHS agencies.

CONTACT INFORMATON

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Pennsylvania Counties Sample Size and

Case File Review for Substance Use Disorder Instructions

The State Roundtable's Drug & Alcohol Co-Chairpersons & Judicial Program Analyst will be working with Luzerne County to develop a drop-off analysis of child welfare cases involving substance abuse. In order to complete this analysis, the county will pull a random sample of County Children and Youth Agency records and review them with the Case File Review for Substance Use Disorder form. Instructions on sample size, sample requirements and how to complete the case file review follow.

As a reminder, the goals of the case file review and drop-off analysis process are to get a better understanding of:

1. Where and how earlier identification of families with substance use disorders can be undertaken;
2. How to better connect families with substance use disorders to assessments in a timely fashion;
3. How to connect families with substance use disorders to timely treatment, and the clinically indicated level of care (LOC);
4. What is needed to reach timely permanency outcomes for children and families with a goal of keeping children safely at home or reunifying them in a timely manner;
5. How to keep families with substance use disorders engaged so they can receive a sufficient dosage of treatment; and
6. The conditions that contribute to the best outcomes for parents and for children.

Sample Size

The chart below outlines how to determine the sample size to be randomly pulled, the sample size for the Quality Service Review (QSR) process based on your county's strata, the number of usable case file to review and how many cases must be court involved.

County Information		Sample Size		Number of Case Files to Review	
County	Number of investigations (1)	Number of case files to randomly pull with 90% confidence, 10% margin of error (2)	Number of case files reviewed during Quality Service Review (3)	Usable case files to review from Sample Size (4)	Case files that must be court involved (5) (subset of usable cases)
Luzerne	3709	67	15	25	8

1. Number of reports that resulted in investigations from the Systems Data Profile Worksheet.
2. Use https://www.calculator.net/sample-size-calculator.html to determine the sample size of case files to be randomly pulled based on the number of investigations.
3. Counties have been divided into eight strata for the Quality Service Review (QSR) based on the number of children served in each county during the federal fiscal year. (See QSR chart below.)
4. Multiply the number of cases pulled for the QSR for your Strata by the number provided in the below chart (QSR & County Strata). Then round to the nearest whole number.

QSR Strata	Multiply by Number
I	1.23
II	1.50
III	1.67
IV	1.83
V	2.00
VI	2.43
VII	2.54
VIII	2.76

5. Divide your usable case file review from sample size by 3

Strata I: 25 Cases	Strata II: 20 Cases	Strata III: 15 Cases	Strata IV: 12 Cases
Philadelphia	Allegheny	Berks Bucks Dauphin Delaware Erie Lackawanna Lancaster Luzerne Monroe Montgomery Northampton Washington York	Blair Bradford Butler Cambria Centre Chester Clearfield Crawford Cumberland Fayette Franklin Indiana Jefferson Lawrence Lebanon Lehigh McKean Mercer Northumberland Schuylkill Tioga Westmoreland
Strata V: 10 Cases	**Strata VI: 7 Cases**	**Strata VII: 5 Cases**	**Strata VIII: 3 Cases**
Adams Beaver Lycoming Somerset Susquehanna Wayne	Armstrong Bedford Carbon Clarion Clinton Columbia Greene Huntingdon Mifflin Pike Warren Venango	Elk Juniata Snyder Union Wyoming	Cameron Forest Fulton Montour Perry Potter Sullivan

Quality Service Review & County Strata

Sample Characteristics and Methodology

All randomly selected case files must include the following characteristics to be included in the final sample count:

1. All cases must be active in 2018. Counties have the choice to pull cases from ALL of 2018, or cases which were active only in the LAST TWO QUARTERS of 2018, depending on what is needed to reach the recommended sample size. Cases must have been opened in or before Quarter 3, of calendar year 2018 to be eligible.
2. From the final sample size, 1/3 of the cases must be court involved families.

Case File Review Form

Each file in the sample must be reviewed with the Case File Review for Substance Use Disorder form. The form gathers information on family characteristics, assessment and treatment needs, and court orders. The case file review form will inform the drop-off analysis, but will also give valuable information on the current processes occurring with child welfare involved families.

The full form should be completed for every County Children and Youth Agency record. For some cases, the information may not be available in the County Children and Youth Agency record. If information was sought outside of the record (i.e: by calling a treatment center for an update), please indicate that this was the case on the case file review form. If information is unavailable, please indicate this in the comments section.

The case file review form concludes with a comment box. Please use this box to indicate any barriers to assessment, treatment or ongoing participation in services that were not represented in the case file review form.

Next Steps

Once you have completed the review, proceed to aggregate the data. You can use the format in the case file review template to enter aggregated data. Briefly summarize the comments from the three closing questions in the template, adding your own analysis/interpretation of the comments to the summary. Once the data have been aggregated, the State Roundtable's Drug & Alcohol Co-Chairpersons and Judicial Program Analyst will work with you to complete the Drop-Off Analysis. Feel free to ask questions or seek assistance throughout this process. Good Luck!

Pennsylvania Drug & Alcohol In-Depth Analysis

Drop-Off Analysis Instructions

Purpose:

The Drop-off Analysis is a method used to assess linkages among child welfare, treatment agencies, and courts by identifying connections that families need to make between systems to obtain services and achieve their child welfare case goals. At each stage of the families' "hand-offs" between the systems, agencies using drop-off analysis collect data to determine how many families do not connect for services. By compiling the data for each of the data points in these guidelines, partnerships are able to identify the extent to which families in the child welfare system with substance use disorders are being identified, and referred for assessment and treatment services. Recognizing that all data may not be readily available in respective information systems, sampling methodologies are often employed. What is more important than gathering data on all possible families, is the extent of drop-off between the different processes in the drop-off analysis. The drop-off analysis can inform partnerships where engagement strategies need to be implemented to increase access to treatment to and successful completion of treatment, and subsequently, improved outcomes for children and families.

1. Total Number of Cases That Resulted in an Investigation.

2. Number of Cases (can the number of families be identified?) where Substance Abuse was a factor.
    - Can you identify the number of parents/caregivers involved in these allegations? If this link cannot be made, please estimate of the number of parents.

3. Of the number of parents identified in the number of cases, what number (percentage) were referred for a substance abuse assessment?

4. Of those parents who were referred for an assessment, what number (percentage) actually received an assessment?

5. Of those parents who received an assessment, what number (percentage) were referred to treatment?

6. Of those parents referred to treatment, what number (percentage) were admitted for treatment services?

    - This can be counted by showing up for the first session after the assessment or who were formally admitted for treatment services. We

define treatment as services provided in one of the following settings: short or long term residential rehabilitation (includes hospital based treatment); Outpatient or Intensive Outpatient; Interim Services; Continuing Care or Recovery Support Services. Do not count admissions only for detox, drug testing, education or prevention services.

7. Of those parents who were admitted to treatment, what number (percentage) remained in treatment for 90 days or longer?

8. Of those parents admitted to treatment, what number (percentage) were engaged for 90 days or longer in a continuous treatment episode, where a break in services does not exceed 30 days?

    - Per the Pennsylvania Department of Drug and Alcohol Programs, no more than one month can elapse between different levels of care or between encounters in a given level of care/type of service in which an individual was not discharged.

9. Of those parents admitted to treatment, what number (percentage) completed treatment?

Child Welfare Outcomes:

1. Of the parents/caregivers who completed treatment, what were their child welfare outcomes?
    a.) Number (percentage) of cases resulting in reunification. Can you identify the number of children reunified?
    b.) Number (percentage) of cases where children were able to remain at home. Can you identify the number of children who were able to remain at home?

    - You will not be able to do this for all of the treatment completers due to the timeframes of the sample.

Introduction & Purpose of Pennsylvania's D&A IDA Resource Guide

This resource guide provides resources, information, and recommendations that are intended to assist Dependency Judges, County Child Welfare Agencies, Drug & Alcohol Services, referred to as Single County Authorities (SCAs), and the Mental Health System that have elected to participate in the Pennsylvania Drug & Alcohol In-Depth Analysis (D&A IDA). This resource guide is intended to provide guidance on how to begin planning and implementing the D&A IDA process in your county. Many of the resources are provided via website links as the information is regularly updated, given ongoing research and new findings.

The D&A IDA mimics the Drug & Alcohol In-Depth Technical Assistance process used in Pennsylvania by the National Center on Substance Abuse and Child Welfare. The overall goal of the D&A IDA is to have a process available for counties to execute on their own that will improve their practices for substance-abusing families involved with the child welfare system.

The Pennsylvania Drug & Alcohol In-Depth Analysis (D&A IDA)

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-system collaboration, and clinical integrity.

Goals:

1. Develop cross-system 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.

At the very beginning of this process, it is recommended that the support and agreement to the mission and goals of the D&A IDA by the leadership of each discipline are memorialized (see Cross System Support of PA D&A IDA draft agreement). It is further recommended that the county establish a shared vision statement based on what the county has identified as their primary purpose(s) for electing to go through the D&A IDA and what the county wants to achieve with this process. It is essential to work collaboratively across systems, to engage stakeholders and community providers, and to be fully integrated into the process for the D&A IDA to be successful.

Measuring Outcomes

Counties will need to thoroughly assess their system response to families with substance use disorder and identify gaps and barriers to their practices/services. From the data and information gathered in their assessment, counties will need to develop priorities for practice and policy changes. Then counties will need to evaluate if these changes are effective and make necessary adjustments as needed.

In order to do so, counties will need to clearly articulate what outcomes they are expecting to achieve from the change. Then counties will need to specify what indicators/data they will use to measure, monitor, and track the outcome. Measuring outcomes will help determine whether the desired result has been achieved for improving the system.

Although each county is unique, many counties found similar concerns and implemented common practice changes through the National Center on Substance Abuse and Child Welfare's In-Depth Technical Assistance (IDTA). Some of the common outcomes included:

1. Strengthened collaboration among child welfare, local Substance Use Disorder (SUD) providers, and the courts; in some counties, this meant the development of special case review teams and meetings designated as joint case reviews;
2. Increased transparency within teams and across systems;
3. Earlier identification (screening and assessment); use of standardized screening tools and protocols for a referral to assessment and treatment;
4. Enhanced family engagement and family education; including use of motivational interviewing techniques and Recovery Coach/SUD Specialists; other recovery support services;
5. Implementation of specialized case management model;
6. Increased, consistent, and timely information sharing (assessments, progress reporting);
7. Staff training on disease model to promote culture change;
8. Increased collaboration with Early Intervention/Safe Start; and,
9. Tracking of child welfare referrals and outcomes across SUD services.

Different Roles in the D&A IDA

The Drug and Alcohol In-Depth Analysis (D&A IDA)is a powerful exercise that can easily occur within counties to identify strengths and concerns for current practices in supporting families impacted by substance abuse involved with the county child welfare agency, and possibly the courts. If a county elects to utilize the D&A IDA process, it is strongly recommended that the following participants collaborate to enhance the learning process and create a plan that will improve outcomes. Participants should also develop a Memorandum of Understanding (MOU) that very specifically outlines roles and holds them accountable for plan creation and follow through.

Participants from **Child Welfare** should include the Administrator and others from the administrative team, including Quality Assurance, supervisors, and caseworkers. It is important to

have participation from every level as workflow may differ from the perception of how a case enters the drug and alcohol system for treatment and the aftercare provided. It is the role of the County Child Welfare Agency to perform the case file review, which is the basis for the plan creation to improve outcomes.

Participants from the **Drug and Alcohol** field should include providers from the community that provide all levels of care to clients from psycho-educational groups to inpatient treatment. Some communities have an abundance of resources, and it would be impossible for all to participate. In that instance, it would be essential to be sure the full range of the service array is represented as well as the agencies most often used by clients involved in Child Welfare.

Also involved in the D&A IDA process should be members of the **Mental Health System**. Each county operates differently. Some have a provider network as the umbrella over the various services, and others have the county that functions as the umbrella. Regardless, individuals from the umbrella entity, along with an array of providers themselves, should participate in the D&A IDA process. The Managed Care provider in the county is also a significant partner in this process.

The **Single County Authority (SCA)** is another partner that must be considered in the D&A IDA process. The Administrator, supervisors, and line staff should all be engaged. In many counties, the SCA is responsible for performing Level of Care Assessments for clients and helping them enter treatment at the appropriate level. They can also help with temporary funding for treatment, while insurance options are explored. If the SCA in a particular county sub-contracts for the Level of Care Assessments, that provider should also participate in the D&A IDA.

Finally, the **Courts** play a significant role in the D&A IDA process. The President Judge and/or Lead Dependency Judge, and Family Treatment Court Judges should all be part of the D&A IDA to the extent possible. Through strong leadership, they will ensure that the plan is actively implemented and keep the local Children's Roundtable updated on the D&A IDA to connect all system partners to the process.

Substance Use Disorder

The Disease Model of Addiction:

Addiction is a complex disease of the brain and body that involves compulsive use of one or more substances despite serious health and social consequences. Addiction disrupts regions of the brain responsible for reward, motivation, learning, judgment, and memory. It damages various body systems as well as families, relationships, schools, workplaces, and neighborhoods.

https://www.centeronaddiction.org/what-addiction/addiction-disease

Additional resources:

Breshears, E.M., Yeh, S. & Young, N.K. (2009). Understanding Substance Abuse and Facilitating Recovery: A Guide for Child Welfare Workers. US Department of Health and Human Services. Rockville, MD: Substance Abuse and Mental Health Services Administration.
https://ncsacw.samhsa.gov/files/Understanding-Substance-Abuse.pdf

Addiction is a Family Disease - Effects on the Child and Family/Kin:

An addicted family member significantly disturbs normal family functioning. Family members need treatment and support that parallels treatment for the addict. Counties need to become familiar with programs, services, and resources available for the children of substance users and for family and kin currently caring for these children. Counties should address the needs of the children and families/kin by holding a Family Group Decision Making Conference or identify the services in the Family Service Plan and/or Child Permanency Plan.

Resources:

- KinConnector Helpline assists in identifying available resources for grandparents raising their grandchildren and other kinship care families. Contact the KinConnector Helpline at 1-866-KIN-2111. Later this year, a website of resources is to be launched at www.kinconnector.org.
- Kinship Navigator in Penn State Extension's online database of programs, services, and resources available for kinship care families.
https://aese.psu.edu/extension/intergenerational/program-areas/kinship/programs
- Additional information and resources are available on Penn State's Intergenerational Program, Support for Kinship Care Families.
https://aese.psu.edu/extension/intergenerational/program-areas/kinship

Confidentiality and Consent

In the Pennsylvania D&A IDA process, confidentiality will inevitably be flagged as a barrier to inter-agency cooperation. While confidentiality must be respected and is a very real and important consideration, it is not and should not be an impediment to the type of teaming necessary to achieve the best outcomes for children, families, and persons with Substance Use Disorders (SUD) who are impacted by the disease of addiction.

Confidentiality and information sharing are governed by both state and federal law. Under the HIPPA Privacy Rule, 42 CFR Part 2, the Pennsylvania Drug and Alcohol Control Act, and 4 Pa. Code §255.5, strict client information confidentiality is required. One exception is that treatment information may be disclosed with patient consent. However, Section 255.5 limits both the purposes for which information may be released and the type of information released. In most

child welfare and dependency matters, even with a valid consent, providers may release only the following information:

(1) Whether the client is or is not in treatment.

(2) The prognosis of the client.

(3) The nature of the project.

(4) A brief description of the progress of the client.

(5) A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.

The Drug & Alcohol Workgroup's 2020 State Roundtable Report expands on the consent exception, explains what is needed for a valid consent, identifies other exceptions, discusses special rules that apply in Juvenile Act matters, and walks agencies through the process of obtaining a court order for disclosure of substance use treatment information in appropriate cases. Also, included in the 2020 State Roundtable Report as an appendix are sample consents.

Confidentiality is important to both the person receiving treatment and society. 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 SUDs. The PA D&A IDA process lends itself to a cross-systems means to eliminate, or at least abate, the "barrier" of confidentiality. With informed cross-systems training, discussion, education, and collaboration, it is possible to properly balance issues of child safety, family, individual privacy, and the integrity of the therapeutic process and resolve virtually all concerns within existing regulations. D&A IDA teams addressing confidentiality should consider the following, presented here in bullet-summary form and expanded upon in the Drug & Alcohol Workgroup's 2020 State Roundtable Report:

General

- Cross-systems discussion enhances and leads to local solutions regarding substance use treatment information sharing that have the added benefit of trust-building among partner agencies
- All partner agencies should engage in cross-system education and training, including confidentiality training. At a minimum, this should include the DDAP and CWRC Confidentiality trainings listed under the Resource Heading. Cross-systems education and training can dispel misconceptions and remove perceived barriers
- The Drug and Alcohol Protocol for Sharing Information Bulletin cited under the Resource Heading should be distributed to and discussed with children and youth agencies, juvenile probation departments, SCAs, drug and alcohol providers, other partner agencies, and the individuals who work within those systems
- Identify information that is not protected and other legitimate sources of information. This may include the patient/client, who is not restricted to the information that he or she may disclose, and information available through public databases or partner agencies that may not be prohibited from disclosing their knowledge.

Voluntary Release of Information

- **All** necessary consents and releases should be obtained at the earliest possible stage. Strategies and practices used in various jurisdictions are discussed in the DAWG report.
- Use best-practice multi-discipline team meetings and engagement practices such as Family Group Decision Making, Family Team Conferencing, and Plan of Safe Care Multi-Discipline Teams.
- Consider entering into inter-agency information-sharing agreements.

When Voluntary Release of Information is Not Obtained

- Embracing the purposes behind confidentiality can ease the concern and frustration experienced when the information will not be voluntarily shared. It can also help agencies decide whether or not "involuntary" methods of obtaining information should be pursued.
- Focus on what information can be obtained and shared and do not dwell on information that cannot be shared. Further, even if a county children and youth agency cannot obtain information through a release or other exception, the agency should continue to supply information to treatment providers, especially about known or suspected substance use.
- In Juvenile Act cases, if the child or parent refuses to consent, a court order permitting disclosure may be obtained. Bulletin 00-02-03 walks agencies through the process of obtaining such an order.

Confidentiality and consent to release substance use treatment information are comprehensively addressed in the Drug & Alcohol Workgroup's 2020 State Roundtable Report. Counties collaboratively discussing confidentiality as part of the PA D&A IDA process are referred to pages 10 - 18 of the report.

Drug & Alcohol Workgroup's 2020 State Roundtable Report. http://ocfcpacourts.us/childrens-roundtable-initiative/state-roundtable-workgroupscommittees/drug-and-alcohol/state-roundtable-reports/

Drug Testing in Child Welfare

According to the Substance Abuse and Mental Health Administration (SAMSHA), a drug test alone cannot determine the existence or absence of a substance use disorder, nor can it be used as a sole indicator of recovery. County Child Welfare Agencies are strongly encouraged to establish partnerships and collaborate with their Single County Authorities and the Courts to develop and implement drug testing policies and practices. Additional guidance on drug testing development within the child welfare system is provided in the Drug & Alcohol Workgroup's 2020 State Roundtable Report on pages 18-21.

Drug & Alcohol Workgroup's 2020 State Roundtable Report. http://ocfcpacourts.us/childrens-roundtable-initiative/state-roundtable-workgroupscommittees/drug-and-alcohol/state-roundtable-reports/

Additional resources:

Center for Substance Abuse Treatment (2010). Drug testing in child welfare: Practice and policy considerations. HHS Pub. No. (SMA) 10-4556. Rockville, MD: Substance Abuse and Mental Health Services Administration. https://ncsacw.samhsa.gov/files/DrugTestinginChildWelfare.pdf

National Center on Substance Abuse and Child Welfare: Drug Testing Practice Guidelines. (Adopted by the Children's Justice State Council, 6/10/2011). https://ncsacw.samhsa.gov/files/IA_Drug_Testing_Bench_Card_508.pdf

Screening, Assessment, and Treatment

Screening:

Screening is a set of questions that determine if an individual has concerns regarding substance abuse in order to help to determine what their needs are and if an assessment should be conducted. Screening is usually the first step when seeking D&A treatment and is often completed via initial phone contact.

https://www.integration.samhsa.gov/clinical-practice/sbirt/screening

Assessment:

An assessment gathers more in-depth information about an individual, ranging from their past experiences to their present situation. It gauges a person's readiness for change, as well as any diagnosis, disabilities, and/or strengths they possess. An assessment is a lengthier process than screening and is done in person. The American Society of Addiction Medicine (ASAM) is then used to determine the next step.

ASAM is the set of guidelines used by clinicians to standardize treatment planning and provide levels of care recommendations for adults and adolescents with substance abuse concerns, to determine in which level of treatment they should be engaged. This criterion is how the treatment provider will determine what level of treatment a person needs to enter or continue.

https://www.asam.org/resources/the-asam-criteria/about

There are differences in ASAM criteria for adolescents and adults.

https://www.americanhealthholding.com/Content/Pdfs/asam%20criteria.pdf

Additional resources:

American Society of Addictive Medicine (ASAM) Screening and Assessment Tools.

https://www.asam.org/education/live-online-cme/fundamentals-program/additional-resources/screening-assessment-for-substance-use-disorders/screening-assessment-tools

Pennsylvania Department of Drug and Alcohol Programs (Revised August 2019). Pennsylvania Guidance for Applying *The ASAM Criteria, 2013* https://www.ddap.pa.gov/Documents/ASAM/ASAM%20Application%20Guidance%20Final.pdf

Treatment:

"Level of care" is what treatment the individual needs to participate in to address the substance abuse issue adequately to provide their greatest chance of success. This continuum of care may range from withdrawal management (previously known as detox) to residential (inpatient rehabilitation) to outpatient services (Intensive outpatient, Outpatient, Partial Hospitalization Programs), which each differ in levels of intensity. See link below for an outline of what each level of care means and what each program offers.

https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/

Sometimes, circumstances will result in a change in the level of care, such as child care issues, employment time constraints, etc. The clinician involved will determine whether an adjustment is appropriate or necessary to accommodate the individual. While there will be barriers, it will be the goal to stay connected with the client to ensure treatment success. The clinician will tailor the treatment to meet the person's needs when deemed appropriate. See below to read more about clinical issues and challenges when serving this population and the strategies to handle them: https://www.ncbi.nlm.nih.gov/books/NBK64101/

Additional resources:

National Center on Substance Abuse and Child Welfare (2018). Understanding substance use disorder treatment: A resource guide for professionals referring to treatment. https://www.cffutures.org/files/nccan2019/web/usud/Understanding_Treatment_for_CW_and_Court_Professionals.pdf

National Institute on Drug Abuse (2018). Principles of drug addiction treatment: A research-based guide (3rd ed.). Bethesda, MD: National Institutes of Health; US Department of Health and Human Services. https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition

Medication Assisted Treatment (MAT)

Kinds of MAT & How Used:

- Methadone – clinic-based opioid agonist that *does not block* other narcotics while preventing withdrawal while taking it; daily liquid dispensed only in specialty regulated clinics. Methadone is a medication used to treat Opioid Use Disorder (OUD). Methadone is a long-acting full opioid agonist and a schedule II controlled medication.

- Naltrexone – office-based non-addictive opioid antagonist *that blocks* the effects of other narcotics; daily pill or a monthly injection. Naltrexone is a medication used in medication-assisted treatment to treat both opioid and alcohol use disorders.
- Buprenorphine – office-based opioid agonist/ antagonist *that blocks* other narcotics while reducing withdrawal risk; daily dissolving tablet, cheek film, or 6-month implant under the skin. Buprenorphine is used in medication-assisted treatment to treat Opioid Use Disorder (OUD).

https://www.samhsa.gov/medication-assisted-treatment

Dosage of Medication:

- Methadone- Doses of methadone vary depending on the client's history/tolerance and the doctor's decision on what would work best for the client. It may take a few weeks to find a stable dosage that works best for the client. The standard dosage ranges between 80–120 mg per day.
  https://www.healthline.com/health/methadone-oral-tablet#dosage
- Naltrexone- It comes in a pill form or as an injectable. The pill form of naltrexone (ReVia, Depade) can be taken at 50 mg once per day. The injectable extended-release form of the drug (Vivitrol) is administered at 380 mg intramuscular once a month. https://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone
- Buprenorphine-containing transmucosal products for opioid dependency, Bunavail (buprenorphine and naloxone) buccal film, Suboxone (buprenorphine and naloxone) film, Zubsolv (buprenorphine and naloxone) sublingual tablets. Dosing varies depending on the medication and what mg stabilizes the client.
  https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine

Effects of MAT on User:

- Methadone is safe and effective when taken as prescribed. Methadone reduces opioid craving and withdrawal and blunts or blocks the effects of opioids. https://www.samhsa.gov/medication-assisted-treatment/treatment/methadone
- Naltrexone blocks the euphoric and sedative effects of drugs such as heroin, morphine, and codeine. It works differently in the body than buprenorphine and methadone, which activate opioid receptors that suppress cravings. Naltrexone binds and blocks opioid receptors and is reported to reduce opioid cravings. There is no abuse and diversion potential with naltrexone. If a person relapses and uses the problem drug, naltrexone prevents the feeling of getting high.
  https://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone
- Buprenorphine has unique pharmacological properties that help lower the potential for misuse and diminish the effects of physical dependency on opioids, such as withdrawal symptoms and cravings and increase safety in overdose cases. Buprenorphine is an opioid partial agonist. This means that, like opioids, it produces effects such as euphoria or respiratory depression at low to moderate doses. With buprenorphine, however, these

effects are weaker than full opioid agonists such as heroin and methadone. https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine

MAT is Most Effective in Conjunction with Counseling:

- When appropriately prescribed, medication assisted treatment is an effective form of harm reduction to help prevent overdoses and continued drug use. Research shows that prescribed medication in conjunction with forms of counseling is most effective. As shown below, all forms of medicated assisted treatments are paired with counseling to achieve the best results.
- Methadone is prescribed as part of a comprehensive treatment plan that includes counseling and participation in social support programs. https://www.samhsa.gov/medication-assisted-treatment/treatment/methadone
- As with all medications used in medication-assisted treatment, naltrexone is to be prescribed as part of a comprehensive treatment plan that includes counseling and participation in social support programs. https://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone
- Medications such as buprenorphine, combined with counseling and behavioral therapies, provide a whole-patient approach to treating opioid dependency. When taken as prescribed, buprenorphine is safe and effective. https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine

Ability to Care for Child when on MAT:

- Medication Assisted Treatment does not hinder a parent from caring for their child as long as they are stable on their medication. Being stable on any form of Medicated Assisted Treatment will allow a client to get their life back together and be a productive part of society; this includes not being under the influence while caring for their children.
- Methadone: Women who are pregnant or breastfeeding can safely take methadone. Comprehensive methadone maintenance treatment should include prenatal care to reduce the risks of complications during pregnancy and at birth. Research has shown that breastfeeding benefits outweigh the effect of the small amount of methadone that enters through breast milk. https://www.samhsa.gov/medication-assisted-treatment/treatment/methadone
- Limited data indicate that naltrexone is minimally excreted into breastmilk. If the mother requires naltrexone, it is not a reason to discontinue breastfeeding. https://www.ncbi.nlm.nih.gov/books/NBK501239/
- Buprenorphine may be prescribed to women who are pregnant and have an opioid use disorder. Buprenorphine and methadone are considered the treatments of choice for OUD in pregnant and breastfeeding women. https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine https://www.samhsa.gov/find-help/recovery

Recovery Support Services

"Recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential."
https://www.samhsa.gov/find-help/recovery

Stages of change in the recovery process:

Having an understanding of the stages of change is a crucial aspect of recovery.

S Pre-contemplation – Not seeing the need for change.
T Contemplation – Considering a change but has not made the decision yet.
A Preparation – Decided to make the change and considering steps to make this happen.
G Action – Actively doing something to change.
E Maintenance – Working on maintaining a change or a new lifestyle.
S Relapse – Reoccurrence of substance use, or setback.

- It is imperative to have a prevention plan developed to support recovery and deter relapse in the maintenance stage. It is important to mention that relapse is preventable. Relapse does not mean that the individual has failed; it is common because recovery is a lifelong journey.
- There are considerations and steps to assess when creating a relapse prevention plan. Identifying emotional, mental, and physical triggers are vital to a relapse prevention plan. It is also important to distinguish personal barriers that may impede on the follow-through of the relapse plan.
- Relapse prevention and recovery center around forming new coping mechanisms, building support systems, changing social networks, and avoiding triggers.
  https://www.healthline.com/health/opioid-withdrawal/relapse-prevention-plan

Additional resource:

Substance Abuse and Mental Health Services Administration (SAMHSA). Working Definition of Recovery. https://store.samhsa.gov/system/files/pep12-recdef.pdf

Certified Recovery Specialist (Peer Support):

A Certified Recovery Specialist is an individual in long-term recovery that utilizes their personal experience with addiction and the recovery process to provide hope and inspiration to clients and the community.

https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers

Additional resource:

Kaplan, L., (2008) The Role of Recovery Support Services in Recovery-Oriented Systems of Care. DHHS Publication No. (SMA) 08-4315. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. http://www.pacdaa.org/SiteCollectionDocuments/SAMHSA%20White%20Paper%20on%20The%20Role%20of%20Recovery%20Support%20Services.pdf

Self Help Groups:

Self-Help Groups are not treatment in a formal sense, but rather are continuing-care, peer-support groups. These groups offer huge advantages because they are free, available in the large majority of communities, and held several days per week and at various times of the day.

- Alcoholics Anonymous – for individuals with a drinking problem
- Al-Anon - for family members of alcoholics
- Alateen - for teens with a family member who is an alcoholic
- CoDA – for co-dependent individuals
- Nar-Anon - for family members of addicts
- Narateen - for teens with a family member who is an addict
- Narcotics Anonymous - for individuals whom drugs had become a major problem
- Recovering Couples Anonymous – for recovering couples

General Resources and Websites

American Society of Addictive Medicine (ASAM)
https://www.asam.org/

Office of Children & Families in the Courts (OCFC)
http://www.ocfcpacourts.us/

Pennsylvania Department of Drug and Alcohol Programs (DDAP)
https://www.ddap.pa.gov

National Center on Substance Abuse and Child Welfare (NCSACW)
https://www.ncsacw.samhsa.gov/technical/idta.aspx

National Institute on Drug Abuse (NIDA)
https://www.drugabuse.gov

Substance Abuse and Mental Health Services Administration (SAMHSA)
https://www.samhsa.gov

Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Locator
https://findtreatment.samhsa.gov/locator

Cross-System Support and Agreement to the Pennsylvania Drug & Alcohol In-Depth Analysis

The Pennsylvania Drug & Alcohol In-Depth Analysis (PA D&A IDA) requires collaboration and cooperation amongst system partners. This partnership is needed to ensure that efforts are coordinated, and information is shared across systems. A collaborative partnership is necessary to enhance and integrate service delivery, and ultimately improve the quality and/or accessibility of services for the substance abuse affected families involved in the child welfare system.

Pennsylvania Drug & Alcohol In-Depth Analysis

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-system collaboration, and clinical integrity.

Goals:

1. Develop cross-system 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.

The undersigned hereby support and agree to the mission and goals of the PA D&A IDA, will commit to being a member of the PA D&A IDA Executive Team for the duration of this process, as well as will assign a member from your system with sufficient levels of responsibility to the PA D&A IDA Core Team to ensure activities and recommendations are carried out in a timely manner.

The PA D&A IDA process requires the support and agreement of the county's Lead Dependency Judge, County Child Welfare Administrator, Drug & Alcohol Services Administrator, and the Mental Health System Administrator at a minimum.

Cross-System Support and Agreement to the Pennsylvania Drug & Alcohol In-Depth Analysis

Signature _____

Title _____

Organization _____

Date _____

Signature _____

Title _____

Organization _____

Date _____

Signature _____

Title _____

Organization _____

Date _____

Signature _____

Title _____

Organization _____

Date _____

Signature _____

Title _____

Organization _____

Date _____

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

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

APPENDIX XII

IN THE MATTER OF	: IN THE COURT OF COMMON PLEAS OF
	: DAUPHIN COUNTY, PENNSYLVANIA
	:
	:
	: NOS. ___-AD-____ / ORPHANS' COURT &
MINOR	: CP-22-DP-____-2015 / JUVENILE COURT

ORDER OF COURT

AND NOW, this _____ day of _____, 2017, upon request of Dauphin County Social Services for Children and Youth, it is HEREBY ORDERED AND DECREED that _____, its agents and employees, including but not limited to _____, are hereby directed to release all Drug and Alcohol evaluations, medication management records, progress reports, attendance list, treatment summaries, and the results of all drug screens and all confidential or privileged information obtained by them as a result of any confidential relationship established with _____, mother of the above-referenced minor child, _____.

_____ is FURTHER ORDERED to appear and testify at the upcoming joint Permanency Review hearing and Goal Change to Adoption and Termination of Parental Rights hearing scheduled for _____ at 1:30 p.m.

This Order directing the release of all privileged information and testimony, applies to all records or memoranda in possession of _____ to Dauphin County Social Services Children and Youth Services for case-planning purposes. The release of this information is made pursuant to 42 Pa. C.S. Section 6352.1 of the Pennsylvania Juvenile Act.

BY THE COURT:

_____
John F. Cherry, Judge

DISTRIBUTION:

IN THE MATTER OF	: IN THE COURT OF COMMON PLEAS OF
	: DAUPHIN COUNTY, PENNSYLVANIA
	:
:	
	: NOS. -AD-2017 / ORPHANS' COURT &
MINOR	: CP-22-DP-____-2015 / JUVENILE COURT

TO THE HONORABLE JUDGE JOHN F. CHERRY, JUDGE OF SAID COURT:

MOTION TO COMPEL RECORDS AND TESTIMONY

Dauphin County Social Services for Children and Youth, by and through its Assistant Solicitor, Natalie Burston, Esquire, respectfully represents:

1. Dauphin County Social Services for Children and Youth is a public agency which receives and provides for the care of children under the supervision of the Pennsylvania Department of Human Services and provides adoption services in accordance with standards established by said Department.

2. A joint Permanency Review hearing and Goal Change to Adoption and Involuntary Termination of Parental Rights hearing for the minor child, _____ is scheduled for _____ at 1:30 p.m. before the Honorable John F. Cherry.

3. The mother, _____, has been Court-ordered to obtain a Drug and Alcohol evaluation, follow all recommendations for treatment based off of the evaluation she obtained and submit to random urine screens three times a week.

4. Ms. _____ informed her Dauphin County Children and Youth Supervisor that she was currently receiving intensive outpatient drug treatment through _____. She has indicated that she is receiving _____ treatment, has a recovery specialist and is attending drug and alcohol meetings; however, it is unknown whether she receives these additional services through _____.

5. It is believed that Ms. _____ has been evaluated and admitted to treatment at _____. While attending treatment at _____, Ms. _____ has allegedly

received a drug and alcohol evaluations, medication management records, progress reports, attendance list, treatment summaries, and submitted to drug screens.

6. _____ is a vital witness to both Dauphin County Social Services for Children and Youth and Ms. _____ on the grounds that Ms. _____ has been involved with drug and alcohol treatment at this facility and may have received a drug and alcohol evaluation, provide drug screens and participated in treatment.

7. On April 10, 2017, Ms. _____, counselor at _____, informed the Agency Supervisor that she cannot come to the upcoming hearing unless there is a Court Order attached to the Subpoena. She is willing to provide documentation, but requires a Court Order for testimony at the April 18, 2017 hearing.

8. It is believed and therefore averred, that _____ requires a Court Order to release the records and to testify regarding evaluations and reports for the mother.

9. The records, evaluations and reports are necessary to Dauphin County Social Services for Children and Youth for case-planning purposes for the subject minor child and to evaluate _____ compliance with Court-ordered objectives.

10. The records, evaluations and reports and testimony by Ms. _____ are also necessary for the Court to make a determination with regard to the requested involuntary termination of parental rights and goal change to adoption.

11. It is believed and therefore averred that the requested information must be released to the Agency pursuant to the Pennsylvania Juvenile Act, 42 Pa. C.S. §6352.1.

12. On April 10, 2017, the Agency Legal unit contacted _____ Guardian Ad Litem, by email concerning the Agency's request. Attorney _____ has no objection to this request.

13. On April 10, 2017, the Agency Legal unit contacted _____ counsel for Ms. _____, by email concerning the Agency's request. Attorney _____ has no objection to this request.

WHEREFORE, Dauphin County Social Services for Children and Youth prays that This Honorable Court enter a Court Order directing that _____ release the records, evaluations and reports for _____ to Dauphin County Social Services for Children and Youth and that _____ appear and testify at the upcoming joint Permanency Review hearing and Goal Change to Adoption and Termination of Parental Rights hearing scheduled for April 18, 2017.

Respectfully submitted,

DATE: April _____, 2017

_____

Natalie Burston, Esquire, Asst. Solicitor,
Dauphin County Social Services for Children and Youth
1001 N. Sixth Street
Harrisburg, PA 17102
(717) 780-7200

IN THE MATTER OF	: IN THE COURT OF COMMON PLEAS OF
	: DAUPHIN COUNTY, PENNSYLVANIA
	:
	:
	: NOS. __-AD-2017 / ORPHANS' COURT &
MINOR	: CP-22-DP-____-2015 / JUVENILE COURT

CERTIFICATE OF SERVICE

AND NOW, this _____ day of April, 2017, I, Jennifer Risser, SWAN LSI Paralegal, hereby certify that I did serve a true and correct copy of the foregoing Motion to Compel Records and Testimony by hand delivery or by depositing, or causing to be deposited, same in the U.S. Mail, postage prepaid, at Harrisburg, Pennsylvania, addressed as follows:

BY U.S. MAIL

_____
Jennifer Risser, SWAN LSI Paralegal

APPENDIX XIII

National Drug Court Institute: Advantages and Disadvantages of Drug-Testing Specimens

Specimen	Detection Period	Advantages	Disadvantages
Urine	Provides a profile of both current and recent past substance usage. Detection time generally calculated in days for most drugs (excluding alcohol).	Provides detection for both recent and past usage. Sample is generally available in large quantities for testing. Drug and metabolites are highly concentrated; therefore easily detectable using both laboratory-based and on-site testing devices. Numerous inexpensive testing options including on-site testing. Uniform forensic criteria supported by years of court/legal case law and adjudication. Established cutoffs.	Invasive "witnessed" collection procedures required – necessitates same gender observed collections. Specimen is susceptible to tampering via dilution or adulteration. Drug concentration influenced by fluid intake; savvy clients may consume copious fluids to alter testing results. Sample collection process can be time consuming. Urine drug levels provide no interpretive data (no dose/ concentration relationship).
Sweat (Patch)	Measure current (ongoing) drug use following patch application; past exposure not detected. Patch is FDA approved to be worn for up to 7 days.	Ability to monitor 24/7 for extended periods, which provides a significant adjunct to the therapeutic process. Relatively client tamper-proof. Use has participant acceptability due to noninvasive approach. Increased deterrent to drug use. Cross-gender collections.	Cannot detect prior drug exposure. Limited collection devises and testing laboratories. Potential risk of contamination during patch use. Can be removed. Limited number of drugs detected. No on-site testing.
Oral Fluid (Saliva)	Provides recent usage detection. Many drugs cannot be detected beyond 24 hours after use.	Noninvasive, cross-gender collections. Specimen tampering reduced. Data may relate to behavior/performance. On-site testing available (but not recommended).	Short detection window. Specimen collection can be time consuming. Limited collection devices and testing facilities. Cutoffs not well established. Limited number of drugs detected. On-site testing devices pose forensic concerns regarding accuracy and reliability.

Specimen	Detection Period	Advantages	Disadvantages
Hair	Provides past drug usage only; detection period up to 90 days. Does not provide recent drug use information (hair required to grow out of scalp prior to sample acquisition).	Extended detection period. Noninvasive, cross gender sample collection. Reduced specimen tampering. No biohazard issues. No poppy seed interference.	Increased cost per sample tested. Inability to detect recent drug usage. Limited number of testing facilities. No on-site testing. Continuing concerns regarding ethnic, hair-color bias. Use of body hair forensically controversial. Testing may not detect single use drug use event. Date of drug use cannot be assessed.
Blood	Detects very recent usage of abused substances; detection time often measured in hours following use.	Results both qualitative and quantitative may provide behavior/performance data in select circumstances such as driving while impaired (DWI). Specimen tampering eliminated.	Invasive sample collection – venipuncture required by medical staff. No on-site testing. Traditional urine testing methods not applicable to blood analysis. Limited sample volume can be obtained. Detection of abused drugs in blood difficult for many laboratories due to low level of drugs. High potential for false negative results. Specimen not recommended for drug abstinence monitoring.
Eye Scanning / Pupilometer Instruments	Designed to determine impairment, recent use monitoring client only. Detection time measured in hours.	No specimen collection. On-site devices, immediate results. Ease of operation.	Monitors impairment rather than abstinence. Short detection window. May require additional specimen collections to confirm positives. Not peer reviewed. Devices may detect client fatigue as “positive.”

National Drug Court Institute: Onsite versus Laboratory-Based Drug Testing

Type	Advantages	Disadvantages
On-Site Drug Testing	Rapid results turn-around time (quick reward for drug free behavior or quick justification for sanctions). Ease of use technology. Potential for reduced testing costs. No capital equipment expenditures. Reduced training costs. Elimination of specimen transport and storage issues.	Increased cross-reactivity and interference (potential false positive results). On-site testing often does not include quality control. On-site testing does not include testing for diluted samples (creatinine) and adulteration testing. Testing personnel competency is often not assessed. Reduced flexibility in testing panels (limited number of drugs tested). Potential privacy or conflict-of-interest concerns.
Laboratory-Based Drug Testing	Testing often provided by professional trained technologists. Use of approved scientific methods. Integrated quality assurance. Confirmation testing more readily available. Creatinine and adulteration testing more readily available. Toxicology expertise/forensic competency. Established custody and control procedures.	Increased results turn-around time (compared to on-site testing). Additional sample handling and shipment required. Potential increased cost per test. Difficulty in accessing data and information from large corporate laboratories.

National Drug Court Institute: Drug Detection Windows

Drug	Approximate Drug Times in Urine
Amphetamines	1-4 days
Barbiturates	1-7 days
Benzodiazepines	1-7 days
Cannabinoids	At 50ng/mL cutoff: • Up to 3 days for single event/occasional use • Up to 10 days for heavy chronic use At 20ng/mL cutoff: • Up to 7 days for single event/occasional use • Up to 21 days for heavy chronic use
Cocaine Metabolite	1-3 days
Opiates	1-4 days
Phencyclidine (PCP)	1-6 days
Alcohol **-as ethyl alcohol** **-as alcohol metabolites EtG/EtS**	 Variable, usually measured in hours At the 500/100 ng/mL cutoff: 24-48 hours

Co-Occurring Residential Substance Use and Mental Health Programs

(As of September 2020)

Bowling Green Brandywine
1375 Newark Rd.
Kennett Square, PA 19348
(610) 347-5608
(*Chester County*)

Cove Forge
202 Cove Rd.
Williamsburg, PA 16693
(814) 554-0149
(*Blair County*)

Crisis Management Services
2401 Penrose Ave.
Philadelphia, PA 19145
(215) 755-6112
(*Philadelphia County*)

Eagleville Hospital
100 Eagleville Rd.
Eagleville, PA 19403
(800) 255-2019
(*Montgomery County*)

Gage House
1813 Holland St.
Erie, PA 16504
(814) 878-2100
(*Erie County*)

Gaudenzia Broad Street
3025-31 N. Broad St.
Philadelphia, PA 19132
(215) 223-9460
(*Philadelphia County*)

Gaudenzia Common Ground
3740 Chambers Hill Rd.
Harrisburg, PA 17111
(717) 238-5553
(*Dauphin County*)

Gaudenzia Crossroads
414 W. 5th St.
Erie, PA 16507
(814) 459-4775
(*Erie County*)

Gaudenzia Winner Program
1832-34 W. Tioga St.
Philadelphia, PA
(215) 225-1192
(*Philadelphia County*)

Girard Medical Center
801 W. Girard Ave.
Philadelphia, PA 19122
(620) 724-8291
(*Philadelphia County*)

Lehigh County Center for Recovery
1620 Riverside Dr.
Bethlehem, PA 18016
(866) 769-6822
(*Lehigh County*)

Malvern Treatment Center
240 Fitzwatertown Rd.
Willow Grove, PA 19355
(610) 625-8376
(*Montgomery County*)

New Perspectives at White Deer Run
3030 Chestnut St.
Lebanon, PA 17042
(717) 454-2486
(*Lebanon County*)

Penn Foundation
807 Lawn Ave.
Sellersville, PA 18960
(215) 257-6551
(*Bucks County*)

Pyramid Healthcare Hillside
420 Supreme Court
East Stroudsburg, PA 18302
(570) 213-3300
(*Monroe County*)

Pyramid Healthcare
1894 Plank Rd.
Duncansville, PA 16635
(814) 940-0407
(*Blair County*)

Pyramid Healthcare Pittsburgh
306 Penn Ave.
Pittsburgh, PA 15221
(215) 536-9070
(*Allegheny County*)

Retreat at Lancaster County
1170 S. State St.
Ephrata, PA 17522
717) 859-8000
(*Lancaster County*)

Roxbury Treatment Center
601 Roxbury Rd.
Shippensburg, PA 17257
(800) 648-4673
(*Franklin County*)

The Ranch Pennsylvania
1166 Hilts Rd.
Wrightsville, PA 17368
(717) 969-9126
(*York County*)

UHS Recovery Foundation-Keystone Center
2001 Providence Ave.
Chester, PA 19013
(610) 876-9000
(*Delaware County*)

White Deer Run
360 White Deer Run Rd.
Allenwood, PA 17810
(570) 980-2475
(*Union County*)

White Deer Run of Lancaster
53-55 North West End Ave.
Lancaster, PA 17603
(717) 869-0408
(*Lancaster County*)

White Deer Run of York
1600 Mount Zion Rd.
York, PA 17042
(717) 802-8181
(*York County*)

Indicators of Substance Abuse in Adults

PHYSICAL SYMPTOMS

Common physical signs of drug or alcohol addiction are:

- **Bloodshot eyes:** Anyone who is addicted to heroin usually has constricted pupils, also known as miosis. They may also have bloodshot eyes.
- **Sudden weight loss:** People who are addicted to cocaine, ecstasy or methamphetamine may lose their appetite and subsequently lose weight quickly.
- **Interrupted sleep patterns:** Common signs of substance abuse include insomnia (difficulty sleeping at night) or hypersomnia (sleeping for too long).
- **Change in complexion:** Repeated drug use can lead to acne, paleness and jaundice. There may also be scabs, scars, bruises and track marks on the body.
- **Poor personal hygiene:** Bathing, brushing teeth and physical cleanliness may decline in anyone who is drug dependent.

CHANGES IN BEHAVIOR

In addition to physical changes, a person who is misusing alcohol or drugs may act abnormally. Some of the significant behavioral signs of drug abuse in adults include:

- **Secretive behavior:** The person withdraws from friends and family and constantly looks for a private place to use drugs.
- **Ignoring responsibilities:** Becoming addicted to drugs or alcohol can make a person avoid their daily responsibilities such as work, school or taking care of the home.
- **Financial distress:** Most illicit drugs are very expensive, so a person using drugs may need to keep borrowing money without a reason. They may also sell their belongings to get money for drugs.

PSYCHOLOGICAL SYMPTOMS

When someone misuses drugs, they may experience changes in their feelings, which will also affect their behavior. Some common psychological signs include:

- **Depression and anxiety:** You may notice signs of depression and anxiety where they never existed before, including your loved one losing interest in things they used to love, sleeping too little or too much or gaining or losing dramatic amounts of weight, to name a few.
- **Low self-esteem:** Individuals with drug addictions may demonstrate a marked lack of confidence in their abilities, intelligence, looks or other aspects of their life.
- **Poor motivation:** You may notice that people demonstrating substance misuse symptoms set extravagant goals, but have no motivation to achieve them.
- **Irritability and mood swings:** Another symptom of drug use can manifest as sudden agitation and unpredictable temperament.

Gateway Foundation (2020). Signs and Symptoms of Drug Abuse in Adults.
https://www.gatewayfoundation.org/faqs/signs-and-symptoms-of-drug-abuse-in-adults/

Considerations for the Court on Stages of Change

Progress and Compliance

When a family involved in the Child Welfare system is before the Court for a Dependency matter the Court must consider the progress and compliance that family is making toward the goals on the plan that has been adopted. Compliance is the easiest to assess when managing child welfare & drug and alcohol cases however progress is most helpful when determining child safety. Determining where the parent is on the change process while engaging and partnering during planning will result in a comprehensive safe plan.

Pre-contemplation - This parent sees no need to change. At this stage, the person has not even contemplated having a problem or needing to make a change. This is the stage where denial, minimization, blaming, and resistance are most commonly present. A parent struggling with addiction in this stage poses the most risk in their parental role. Caution is needed when engaging with the parent to develop a plan to keep their child safe. Constant and consistent outside people are always needed at this stage to ensure a safe plan.

Contemplation - This parent considers change, but also rejects it. At this stage, there is some awareness that a problem exists. This stage is characterized by ambivalence; the person wants to change, but also does not want to. They will go back and forth between reasons for concern and justification for unconcern. This is the stage where persons feel stuck. Decision making is often compromised in this stage and partnering and modeling within the planning process is needed to ensure the plan is safe. Outside supports are a must to ensure a plan is comprehensive and safe.

Determination - This parent wants to do something about the problem. At this stage, there is a window of opportunity for change: the person has decided to change and needs realistic and achievable steps to change. Safety planning in this stage sees a partnership in the parent however follow though is still difficult. Enough external supports are needed to assist the parent is planning tasks and follow through with each task.

Action - This parent takes steps to change. At this stage, the person engages in specific actions to bring about change. The goal during this stage is to produce change in a particular area or areas. This stage sees and active, engaged and independent partner in planning and task completion. This stage also is the stage when independent responsibility of their plan can begin.

Maintenance – This parent maintains goal achievement. Making the change does not guarantee that the change will be maintained. The challenge during this stage is to sustain change accomplished by previous action and to prevent relapse. Maintaining change often may require a different set of skills than making the change. This stage is where coaching, feedback and self-evaluation is occurs. Increased skill development is also focused on and plans in this stage are self-guided and internally motivated.

Relapse - This parent slips or returns to the pre-change state. At times, the person might "slip" and not regard the setback as serious enough to be concerned, yet someone may be at risk. Relapse is

a normal and expected part of the change cycle. This stage needs to be planned for throughout the life of a case. A good comprehensive child safety plan will incorporate this stage of recovery. When planning during this stage there needs to be a level of clear understanding, honesty, responsibility taken by the parent to ensure ongoing safety.

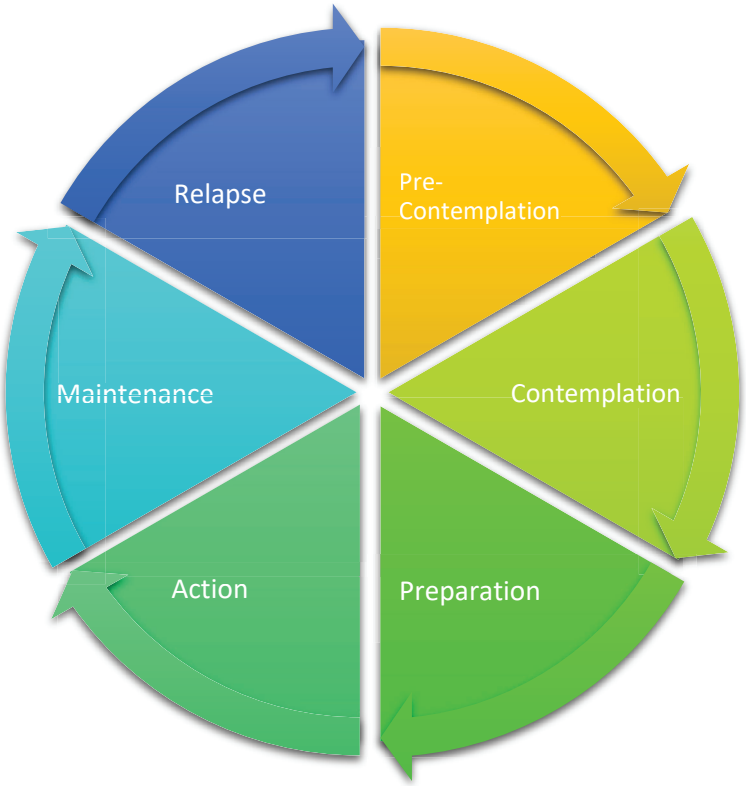
It is very important for the agency and the court to consider the interplay of progress and compliance when making a safety determination. A parent might be very compliant about attending the intervention or providing a sample for a drug screen but may not be making any progress on the behavioral changes necessary to safely parent a child as outlined above in the stages of change. There should be observable and tangible actions a parent is displaying based on the examples described above to achieve the designation of making progress on a goal.

Treatment & ASFA Timeframes

Children have rights of protection and care. They have the right to live free from abuse and neglect in their homes. Child welfare is tasked with ensuring safety, permanency & well-being of children by empowering families. When validated child welfare cases of abuse or neglect result in placement, regardless of the precipitating factors, timelines are established to ensure permanency for children. The Adoption & Safe Families Act (ASFA) timeframes are twelve consecutive months in care or fifteen out of twenty-two months. This timeframe often does not coincide with a parent's recovery from addiction. Children need permanency and stability for their optimal development and emotional safety. When a parent is struggling with addiction and recovery and exceeds the ASFA timeframes, there needs to be a shift from reunification planning to concurrent planning of adoption. When this shift occurs, focus must clearly fall on identifying the child's need for permanency, outweighing the parent's desire to reunify. However, consideration can be given to parents who are clearly in the maintenance phase of recovery that experiences a slip and whose relationship with the child is clearly in the best interest for the child's well-being to be maintained. Any additional time awarded to a parent needs to be clearly negotiated and with measurable tasks and goals outlined.

There has been considerable debate regarding balancing of the ASFA Timeframe and the disease model of Addiction. It can be argued that this disease won't be cured within the timeframe as it is a life -long process. That said, children also have a right to permanency. Child Welfare agencies and the Court should once again rely on where a parent is in the change process and the observable behaviors that are allowing them to reach their goals. An example of this is a parent whose child has been in placement for 11 months yet they are only in the contemplation stage of change. They have not taken any tangible action steps toward safely parenting. The notion that this might be achieved within the ASFA timeframe is questionable and an agency would most likely choose to file TPR paperwork. Conversely, a parent whose child has been in placement for 11 months and is in the action stage of change might have a better prognosis of a safe return. An agency and Court may want to consider a compelling reason that the parent is still involved in a course of treatment and extend the ASFA timeframe that better aligns with the intervention. This should not be an indefinite timeframe though as the child does deserve permanency.

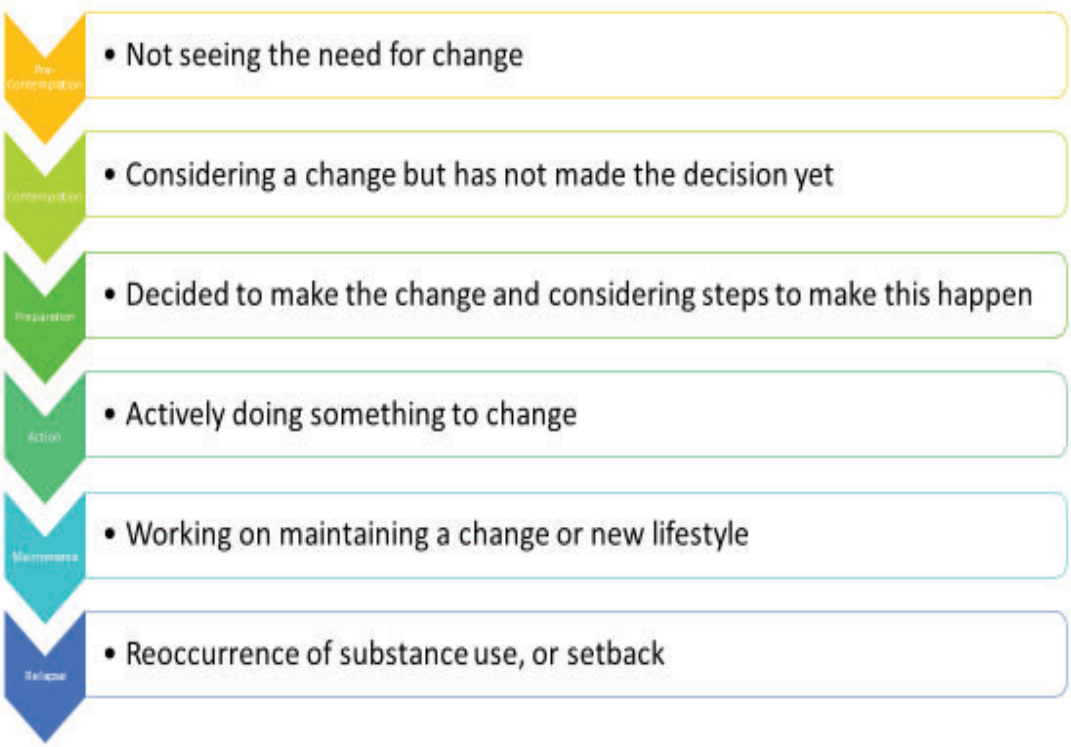
Stages of Change in the Recovery Process & Recovery Supports



Does he or she have the following to support them in recovery?

- Health
- Home
- Purpose
- Community

Who are his or her supports in recovery?



Questions for Each Stage of Change in the Recovery Process

Pre-Contemplation – not seeing the need for change

- People use drugs because they see benefits in some way. What are the good things about your drug use? What do you like about it?
- What may happen if things continue as they are?
- What would be different if you went into treatment?

Contemplation – considering a change but has not made the decision yet

- What makes you think that you need change?
- What could you do to reduce any barriers while you're deciding what to do?
- Can you tell me about any downsides of drug use? What are some a things that you wouldn't miss about your drug use?
- What are the worst things that may happen if you continue using? What are the best things that might happen if you stop using?

Preparation – decided to make the change and considering steps to make this happen

- You were saying that you were trying to decide to continue or go to treatment. If you decide to change, what would you have to do to make that happen?
- It shows a lot of strength/courage/determination to think about change. How can I support you?
- I understand some of the barriers/difficulties that you have discussed. How can I help you get past some of these? Is there something else that could help you?

Action – actively doing something to change

- I hear you have considered goals/plans/values, how can we work together to make them happen?
- What are some short term goals that you have for yourself in recovery?
- Have you ever done any of these things before? What has worked/not worked in the past?

Maintenance – working on maintaining a change or new lifestyle

- What sorts of things are important to you?
- Give me some characteristics in yourself that we can use to maintain recovery?
- What are a few long term goals you have for yourself in recovery?
- What importance has your support network had in your recovery? Whose support network are you part of?
- Do you have a prevention plan developed to support your recovery and deter relapse?

Relapse – reoccurrence of substance use, or setback

- I understand that you may see relapse as a failure, it takes a lot of courage to admit you made a mistake. How can we use this experience as a way to empower your continued journey in recovery?
- It shows a lot of strength/courage/determination to think about change. How can I support you?
- You have found recovery in the past and I know that you can again. What can we do to support you in your journey of recovery?

Best Practices for Families Impacted by Substance Use Disorder

- **Understand that addiction is a disease** for which diagnosis and treatment are essential to restore family functioning.

- **Create a trauma-informed courtroom** by making the experience more welcoming and supportive, and by interacting with people before you in a way that fosters safety, empowerment, and trustworthiness.

- **Use motivational interviewing to empower the people before you in the courtroom to make meaningful changes.** This evidence-based approach helps people living with addictions and mental illness make positive behavioral changes to support their overall health and well-being. Motivational interviewing techniques are important to learn and use within the basic knowledge set of stages of change related to addiction and recovery.

- **Provide an intensive courtroom experience** by holding more frequent court hearings to ensure reasonable efforts are being met and for greater court oversight in the monitoring of timely and effective substance use disorder treatment and other services being provided to the family, and closely monitor case plan compliance and progress in recovery.

- **Use an interdisciplinary team approach in court** and have the county child welfare agency, drug and alcohol / single county authority, and mental health systems all present and involved at the proceedings.

- **Integrated focus on the well-being and safety of the whole family** by addressing the substance use disorder treatment needs of the affected parent, the child and other family members. Addiction is a family disease.

- **Ensure the individual with substance use disorder have supports in the recovery process.** Interpersonal support through relationships and social networks is essential to recovery.

- **Keep the parent affected by substance use disorder involved in their role and responsibilities as a parent.** This might include kinship care with appropriate contingencies, foster care with increased visitation, or in-patient substance use disorder treatment facilities for mothers and their children.

- **Reunify the child with his or her parent with substance use disorder when it is determined the child is safe using the legal safety analysis.** Establish the conditions for reunification based on what is needed for the child to be safe, with a sufficient, feasible and sustainable in-home safety plan.

- **Understand that relapse is normal in the recovery process**, especially in the early stages of recovery. This is an opportunity for them to recover from the setback, and to learn from their relapse by making the appropriate changes.