Substance Use Services Guide

A Resource for Juvenile Probation Officers and Other Youth Service Professionals

Developed by

The Behavioral Health Subcommittee
of
The PA Council of Chief Juvenile Probation Officers

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PCCJPO Substance Use Services Guide

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1. Introduction

The Behavioral Health (BH) Subcommittee of the PA Council of Chief Juvenile Probation Officers (PCCJPO) is pleased to offer this online *Substance Use Services Guide* for juvenile probation officers and other youth service professionals. It was developed in a similar manner and purpose as the *Behavioral Health Services Guide.* While the Subcommittee attempted to identify substance use information it thought would be useful, the Guide is far from a comprehensive source of substance use information. It is designed to provide basic information and then offer links to the websites of official and recognized agencies and organizations related to substance use that provide more comprehensive and detailed information. Users of this guide are encouraged to frequently visit these websites for the most updated information. These websites include, but are not limited to:

National Institute of Mental Health (NIMH)
Office of Substance Abuse and Mental Health Services Administration (SAMHSA)
National Institute on Alcohol and Abuse and Alcoholism (NIAAA)
Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS)
Pennsylvania Department of Drug and Alcohol Programs (DDAP)
Pennsylvania Association of County Drug & Alcohol Administrators (PACDAA)
American Society of Addiction Medicine (ASAM)
Pennsylvania Commission on Crime and Delinquency (PCCD)
Pennsylvania Youth Survey (PAYS data)

It is essential for juvenile probation officers to engage with their respective county Drug and Alcohol offices as processes, practices and resources can vary from county-to-county. Again, this Guide is designed to provide basic information. County Drug and Alcohol offices can provide more detailed information and explanations on requirements and processes to access substance use services for youth involved with the juvenile justice system.

Finally, but very importantly, the PCCJPO BH Subcommittee is comprised of representatives from the behavioral health, drug and alcohol, and juvenile justice systems and recognizes that cross-system collaboration and cooperation is crucial to effectively access and deliver the services and interventions that may be required for youth. Professionals of all youth serving systems are encouraged to identify and participate in local structures that promote and permit cross-systems collaboration and planning. Wherever possible, juvenile probation and other juvenile justice professionals are encouraged to participate in these structures and processes for individual cases, but also to promote better cross system understanding and collaborative development.

Users of the Substance Use Resource Handbook are reminded to consult with your county Drug and Alcohol agency and county solicitor for interpretation, application, and clarification regarding law, regulation, and policy. It is strongly recommended that that you routinely review information and updates issued by the Commonwealth of Pennsylvania's Department of Drug and Alcohol Programs (DDAP).

2. Definitions & Diagnostic Criteria

The following definitions and diagnostic criteria were obtained from the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services. Readers are encouraged to visit SAMHSA's website for additional or updated information.

The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), no longer uses the terms substance abuse and substance dependence, rather it refers to substance use disorders, which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

The following is a list with descriptions of the most common substance use disorders in the United States.

2.1 Alcohol Use Disorder (AUD)

Excessive alcohol use can increase a person's risk of developing serious health problems in addition to those issues associated with intoxication behaviors and alcohol withdrawal symptoms. According to the Centers for Disease Control and Prevention (CDC), excessive alcohol use causes 88,000 deaths a year.

Many Americans begin drinking at an early age. In 2021, about 22% of eighth graders and 27% of twelfth graders used alcohol in the past year.

The definitions for the different levels of drinking include the following:

- Moderate Drinking—According to the Dietary Guidelines for Americans, moderate drinking is up to 1 drink per day for women and up to 2 drinks per day for men.
- Binge Drinking—SAMHSA defines binge drinking as drinking 5 or more alcoholic drinks on the same occasion on at least 1 day in the past 30 days. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines binge drinking as a pattern of drinking that produces blood alcohol concentrations (BAC) of greater than 0.08 g/dL. This usually occurs after 4 drinks for women and 5 drinks for men over a two-hour period.
- Heavy Drinking—SAMHSA defines heavy drinking as drinking 5 or more drinks on the same occasion on each of 5 or more days in the past 30 days.

Excessive drinking can put you at risk of developing an alcohol use disorder in addition to other health and safety problems. Genetics have also been shown to be a risk factor for the development of an AUD.

To be diagnosed with an AUD, individuals must meet certain diagnostic criteria. Some of these criteria include problems controlling intake of alcohol, continued use of alcohol despite problems resulting from drinking, development of a tolerance, drinking that leads to risky situations, or the development of withdrawal symptoms. The severity of an AUD—mild, moderate, or severe—is based on the number of criteria met.

Learn more about alcohol from the Alcohol, Tobacco, and Other Drugs topic. Learn more about the treatments for AUD. Find more information at the NIAAA website.

2.1.1 Alcohol and Adolescent Brain Development

Adolescence is a time of transition, physically, socially, and emotionally. The adolescent brain is in transition as well. Although important structural and functional changes take place in the brain from childhood to adulthood (Giedd et al., 1999), during adolescence such changes are widespread. During adolescence, the brain undergoes a major remodeling involving the formation of new connections between nerve cells, as well as the pruning of existing synaptic connections. These changes affect the processes involved in planning and decision making, impulse control, voluntary movement, memory, and speech production, among others (Rubia et al., 2000). Similar changes occur in those parts of the brain that seem to affect how a person responds to alcohol and other drugs (Spear, 2000; Teicher et al., 1995). As a result, alcohol appears to have different effects on adolescents than adults (Spear, 2000).

Animal studies suggest that alcohol may have a greater impact on adolescent than adult memory (Markweise et al., 1998; Pyapali et al., 1999) and that these effects may be long lasting. Preliminary studies suggest that rats exposed to high levels of alcohol during adolescence may be more sensitive to alcohol-induced memory impairments later in life (White et al., 2000). Human studies have detected cognitive impairments in adolescent alcohol abusers weeks after they stopped drinking (Brown et al., 2000).

Although the causes of these long-lasting changes are unclear, they may in some cases involve alcohol-induced injury to the nervous system. In rats, exposure to high amounts of alcohol produces more extensive brain damage in adolescents than adults (Crews et al., 2000). In humans, adolescent-onset alcohol abuse has been associated with a reduction in the size of the hippocampus (DeBellis et al., 2000). Research also suggests that adolescents are less sensitive than adults to some of alcohol's effects. For example, adolescent rats, on their first exposure to alcohol, are less susceptible than adult rats to alcohol's sedative effects, as well as its effects on balance and motor coordination (Little et al., 1996; White et al., 2001). It is not known whether these differences occur in humans. However, the findings suggest that adolescents might be able to stay awake and mobile at higher blood alcohol levels than adults with an equivalent history of alcohol exposure while, at the same time, experiencing greater alcohol induced cognitive impairments and, possibly, more injury to the brain following high alcohol exposure levels.

Data from the 2023 Pennsylvania Youth Survey shows that 21.5% of 8th graders report using alcohol in their lifetime and by 10th grade this number climbs to 32.5%%.

Drinking alcohol use before the age of 15 significantly increases risk of a young person developing a substance use disorder in adulthood. [1]

2.1.2 Fetal Alcohol Spectrum Disorders

Fetal Alcohol Spectrum Disorders (FASD) is an umbrella term describing the range of effects that can occur in an individual who is exposed to alcohol during the nine-month prenatal period before birth.

1. [1]https://www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide

These effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications.

Individuals with Fetal Alcohol Spectrum Disorders, FASD, have trouble with assessment, judgment, and reasoning. Many will never socially mature beyond the level of a 6-year old. This makes it more difficult for them to make "smart" long-term goals and makes them vulnerable to manipulation and coercion into false confessions. Many individuals also suffer from poor memory, misunderstanding cause and effect, and an inability to understand and interpret concepts. These behavioral impairments make people with FASD more likely to get into trouble with the law. Due to their disabilities, people with FASD often repeat the same mistakes.

Individuals with an FASD are involved with the criminal justice system at an alarming rate. Youth and adults with an FASD have a form of brain damage that may make it difficult for them to stay out of trouble with the law. They do not know how to deal with police, attorneys, judges, social workers, psychiatrists, corrections and probation officers, and others they may encounter.

Additional information on Fetal Alcohol Spectrum Disorders can be found at the National Institute on Alcohol Abuse and Alcoholism website. Information on Fetal Alcohol Spectrum Disorders specific for the criminal and juvenile justice systems is also provided by National Organization on Fetal Alcohol Syndrome.

2.2 Tobacco Use Disorder

According to the CDC, more than 480,000 deaths each year are caused by cigarette smoking. Tobacco use and smoking do damage to nearly every organ in the human body, often leading to lung cancer, respiratory disorders, heart disease, stroke, and other illnesses.

For information and strategies to help you or a loved one stop smoking or using tobacco, visit SAMHSA's Treatments for Substance Use Disorders page.

Additional resources and information can be found at the Pennsylvania's Department of Health website: Tobacco Prevention and Control (pa.gov) and Quitline 1-800-QUIT-NOW (1-800-784-8669)

2.3 Cannabis Use Disorder

According to SAMSHA, marijuana use comes with real risks that can impact a person's health and life.

Marijuana is the most commonly used illegal substance in the U.S. and its use is growing. Marijuana use among all adult age groups, both sexes, and pregnant women is going up. At the same time, the perception of how harmful marijuana use can be is declining. Increasingly, young people today do not consider marijuana use a risky behavior.

But there are real risks for people who use marijuana, especially youth and young adults, and women who are pregnant or nursing. Today's marijuana is stronger than ever before. People can and do become addicted to marijuana.

Approximately 1 in 10 people who use marijuana will become addicted. When they start before age 18, the rate of addiction rises to 1 in 6.

Over the past few decades, the amount of THC in marijuana has steadily climbed; today's marijuana has three times the concentration of THC compared to 25 years ago. The higher the THC amount, the stronger the effects on the brain—likely contributing to increased rates of marijuana-related emergency room visits. While there is no research yet on how higher potency affects the long-term risks of marijuana use, more THC is likely to lead to higher rates of dependency and addiction.

As of the 2021 administration of the Pennsylvania Youth Survey, lifetime and past month use rates for the Commonwealth of Pennsylvania continue to drop. See the chart below for more detail about prevalence by grade level.

Grade	Marijuana Use Lifetime		Marijuana Use in past 30 days	
	2021	2023	Pennsylvania 2021	National 2023
8th	5.7%	5.6%	2.7%	2.7%
10th	14.8%	12.4%	8.0%	6.8%
12th	30.4%	26.2%	16.8%	14.6%

See Highlights from the 2023 PAYS Report.

Marijuana's immediate effects include distorted perception, difficulty with thinking and problem solving, and loss of motor coordination. Long-term use of the drug can contribute to respiratory infection, impaired memory, and exposure to cancer-causing compounds. Heavy marijuana use in youth has also been linked to increased risk for developing mental illness and poorer cognitive functioning.

Some symptoms of cannabis use disorder include disruptions in functioning due to cannabis use, the development of tolerance, cravings for cannabis, and the development of withdrawal symptoms, such as the inability to sleep, restlessness, nervousness, anger, or depression within a week of ceasing heavy use.

For information about the treatment of cannabis use disorder, visit SAMHSA's Treatments for Substance Use Disorders page.

2.4 Stimulant Use Disorder

Stimulants increase alertness, attention, and energy, as well as elevate blood pressure, heart rate, and respiration. They include a wide range of drugs that have historically been used to treat conditions, such as obesity, attention deficit hyperactivity disorder and, occasionally, depression. Like other prescription medications, stimulants can be diverted for illegal use. The most commonly abused stimulants are amphetamines, methamphetamine, and cocaine. Stimulants can be synthetic (such as amphetamines) or can be plant-derived (such as cocaine). They are usually taken orally, snorted, or intravenously.

According to the 2023 Pennsylvania Youth Survey lifetime use of prescription drugs by 12th graders continues to decrease, was 2.9%.

Symptoms of stimulant use disorders include craving for stimulants, failure to control use when attempted, continued use despite interference with major obligations or social functioning, use of larger amounts over time, development of tolerance, spending a great deal of time to obtain and use stimulants, and withdrawal symptoms that occur after stopping or reducing use, including fatigue, vivid and unpleasant dreams, sleep problems, increased appetite, or irregular problems in controlling movement.

Learn more about stimulants from the Alcohol, Tobacco, and Other Drugs topic. For information about the treatment of stimulant use disorder, visit SAMHSA's Treatments for Substance Use Disorders page.

2.5 Hallucinogen Use Disorder

Hallucinogens can be chemically synthesized (as with lysergic acid diethylamide or LSD) or may occur naturally (as with psilocybin mushrooms, peyote). These drugs can produce visual and auditory hallucinations, feelings of detachment from one's environment and oneself, and distortions in time and perception.

In 2014, approximately 246,000 Americans had a hallucinogen use disorder. Symptoms of hallucinogen use disorder include craving for hallucinogens, failure to control use when attempted, continued use despite interference with major obligations or social functioning, use of larger amounts over time, use in risky situations like driving, development of tolerance, and spending a great deal of time to obtain and use hallucinogens.

Learn more about hallucinogens from the Alcohol, Tobacco, and Other Drugs topic.

2.6 Opioid Use Disorder

Opioids reduce the perception of pain but can also produce drowsiness, mental confusion, euphoria, nausea, constipation, and, depending upon the amount of drug taken, can depress respiration. Illegal opioid drugs, such as heroin and legally available pain relievers such as oxycodone and hydrocodone can cause serious health effects in those who misuse them. Some people experience a euphoric response to opioid medications and it is common that people misusing opioids try to intensify their experience by snorting or injecting them. These methods increase their risk for serious medical complications, including overdose. Other users have switched from prescription opiates to heroin as a result of availability and lower price. Because of variable purity and other chemicals and drugs mixed with heroin on the black market, this also increases risk of overdose..

Substance use disorders (SUDs) impact the lives of millions of Americans. More than 100,000 people died from drug overdoses from April 2020 to 2021, an increase of 28.5% from the prior year, according to a report by the **Centers for Disease Control and Prevention (CDC)**.

Symptoms of opioid use disorders include strong desire for opioids, inability to control or reduce use, continued use despite interference with major obligations or social functioning, use of larger amounts over time, development of tolerance, spending a great deal of time to obtain and use opioids, and withdrawal symptoms that occur after stopping or reducing use, such as negative mood, nausea or vomiting, muscle aches, diarrhea, fever, and insomnia.

Learn more about opioids from the Alcohol, Tobacco, and Other Drugs topic. For information about the treatment of opioid use disorder, visit SAMHSA's Treatments for Substance Use Disorders page.

Opioid addiction is a national crisis that affects individuals and families from all walks and circumstances of life. The Pennsylvania Department of Health has developed information and resources for treating heroin and opioid addiction. User of this Guide are strongly encouraged to visit this website for the most up to date and comprehensive information to combat this national crisis.

What is Fentanyl?

Fentanyl is a powerful synthetic opioid that is similar to morphine but is 50 to 100 times more potent.[1,2]

It is a prescription drug that is also made and used illegally. Like morphine, it is a medicine that is typically used to treat patients with severe pain, especially after surgery.[3] It is also sometimes used to treat patients with chronic pain who are physically tolerant to other opioids.[4] Tolerance occurs when you need a higher and/or more frequent amount of a drug to get the desired effects.

In its prescription form, fentanyl is known by such names as Actiq®, Duragesic®, and Sublimaze®.[4,5]

Synthetic opioids, including fentanyl, are now the most common drugs involved in drug overdose deaths in the United States.

(Retrieved from National Institute of Drug Abuse Website May 22, 2024)

Xylazine

Xylazine, a non-opioid veterinary tranquilizer not approved for human use, has been linked to an increasing number of overdose deaths nationwide in the evolving drug addiction and overdose crisis.[1] Studies show people exposed to xylazine often knowingly or unknowingly used it in combination with other drugs, particularly illicit fentanyl.[1–4]

While the full national scope of overdose deaths involving xylazine is unknown, research shows overdose deaths linked to xylazine have spread westward across the United States, with the largest impact in the Northeast. From 2015 to 2020, the percentage of all drug overdose deaths involving xylazine increased from 2% to 26% in Philadelphia. Xylazine was involved in 19% of all drug overdose deaths in Maryland in 2021 and 10% in Connecticut in 2020.[1]

Research has shown xylazine is often added to illicit opioids, including fentanyl,[3] and people report using xylazine-containing fentanyl to lengthen its euphoric effects.[1] Most overdose deaths linked to both xylazine and fentanyl also involved additional substances, including cocaine, heroin, benzodiazepines, alcohol, gabapentin,[3] methadone, and prescription opioids.[7]

Also known as "tranq,"[5] xylazine is a central nervous system depressant that can cause drowsiness and amnesia and slow breathing, heart rate, and blood pressure to dangerously low levels.[6,7] Taking opioids in combination with xylazine and other central nervous system depressants—like alcohol

or benzodiazepines—increases the risk of life-threatening overdose.[1,8] Learn more about the effects of taking more than one type of drug (polysubstance use) from the U.S. Centers for Disease Control and Prevention (CDC).

In the event of a suspected xylazine overdose, experts recommend giving the opioid overdose reversal medication naloxone because xylazine is frequently combined with opioids.[9] However, because xylazine is not an opioid, naloxone does not address the impact of xylazine on breathing.[1,3,8] Because of this, experts are concerned that a growing prevalence of xylazine in the illicit opioid supply may render naloxone less effective for some overdoses.[1,2,10] Emergency medical services should always be alerted to a suspected overdose. Learn more about stopping overdose from the CDC.

Repeated xylazine use is also associated with skin ulcers, abscesses, and related complications.[1,4,11] People report using xylazine or xylazine-containing drugs by injecting, snorting, swallowing, or inhaling.[3,4]

(Retrieved from National Institute of Drug Abuse Website May 22, 2024)

3. Co-occurring Disorders

The coexistence of both a mental health and a substance use disorder is referred to as co-occurring disorders. Information on the relationship between Substance Use and mental Health can be found in the CDC publication: *Behavioral Health Equity Report 2021*.

People with mental health disorders are more likely than people without mental health disorders to experience an alcohol or substance use disorder. As both may vary in severity, co-occurring disorders can be difficult to diagnose due to the complexity of symptoms. In many cases, people receive treatment for one disorder while the other disorder remains untreated. This may occur because both mental and substance use disorders can have biological, psychological, and social components. Other reasons may be inadequate provider training or screening, an overlap of symptoms, or that other health issues need to be addressed first. In any case, the consequences of undiagnosed, untreated, or undertreated co-occurring disorders can lead to a higher likelihood of experiencing homelessness, incarceration, medical illnesses, suicide, or even early death.

People with co-occurring disorders are best served through integrated treatment. With integrated treatment, practitioners can address mental and substance use disorders at the same time, often lowering costs and creating better outcomes. Increasing awareness and building capacity in service systems are important in helping identify and treat co-occurring disorders. Early detection and treatment can improve treatment outcomes and the quality of life for those who need these services.

Learn more about treatment for co-occurring mental and substance use disorders.

4. Common Drugs of Abuse within Juvenile Justice Population

4.1 Youth and Young Adults

Many people wrongly assume that the national opioid epidemic is manifesting in greater youth misuse of prescription opioids. The data for Pennsylvania shows a decline in rates of youth who report abusing prescription opioids in all grades. Furthermore, the prevalence of youth use of opioids is much less than youth use of Alcohol, Marijuana, and Tobacco. In light of these facts, prevention and intervention efforts for the Juvenile Justice Population must maintain a broad focus across all substances.

People are most likely to begin abusing drugs*—including tobacco, alcohol, and illegal and prescription drugs—during adolescence and young adulthood.

By the time they are seniors, almost 70 percent of high school students will have tried alcohol, half will have taken an illegal drug, nearly 40 percent will have smoked a cigarette, and more than 20 percent will have used a prescription drug for a nonmedical purpose. There are many reasons adolescents use these substances, including the desire for new experiences, an attempt to deal with problems or perform better in school, and simple peer pressure. Adolescents are "biologically wired" to seek new experiences and take risks, as well as to carve out their own identity. Trying drugs may fulfill all of these normal developmental drives, but in an unhealthy way that can have very serious long-term consequences.
Many factors influence whether an adolescent tries drugs, including the availability of drugs within the neighborhood, community, and school and whether the adolescent's friends are using them. The family environment is also important: Violence, physical or emotional abuse, mental illness, or drug use in the household increase the likelihood an adolescent will use drugs. Finally, an adolescent's inherited genetic vulnerability; personality traits like poor impulse control or a high need for excitement; mental health conditions such as depression, anxiety, or ADHD; and beliefs such as that drugs are "cool" or harmless make it more likely that an adolescent will use drugs.

4.1.1 Reported Substance Use by Pennsylvania Youth Survey (PAYS)

Since 1989, the Commonwealth has conducted a survey of school students in the 6th, 8th, 10th and 12th grades to learn about their behavior, attitudes and knowledge concerning alcohol, tobacco, other drugs and violence. The 'Pennsylvania Youth Survey,' or PAYS, is sponsored and conducted every two years by the Pennsylvania Commission on Crime and Delinquency. Detailed state-wide and county-specific information can be found at PCCD's PAYS website.

4.2 Role of the Juvenile Justice System in Addressing Adolescent Substance Use

Involvement in the juvenile justice system is unfortunately a reality for many substance-abusing adolescents, but it presents a valuable opportunity for intervention. Substance use treatment can be incorporated into the juvenile justice system in several ways. These include:

- screening and assessment for substance abuse upon arrest
- initiation of treatment while awaiting trial

- access to treatment programs in the community in lieu of detention or out of home placement (e.g., juvenile treatment drug courts)
- treatment during out of home placement followed by community-based treatment after release

Coordination and collaboration between juvenile justice professionals, Substance abuse treatment providers, and other social service agencies are essential in getting needed treatment to adolescent offenders, about one half of whom have substance use disorders.

National Institute on Drug Abuse Principals of Adolescent Substance Use Disorder Treatment

Principles of Adolescent Substance Use Disorder Treatment: A Research Based Guide

1. **Adolescent substance use needs to be identified and addressed as soon as possible.** Drugs can have long-lasting effects on the developing brain and may interfere with family, positive peer relationships, and school performance. Most adults who develop a substance use disorder report having started drug use in adolescence or young adulthood, so it is important to identify and intervene in drug use early.
2. **Adolescents can benefit from a drug abuse intervention even if they are not addicted to a drug.** Substance use disorders range from problematic use to addiction and can be treated successfully at any stage, and at any age. For young people, any drug use (even if it seems like only "experimentation"), is cause for concern, as it exposes them to dangers from the drug and associated risky behaviors and may lead to more drug use in the future. Parents and other adults should monitor young people and not underestimate the significance of what may appear as isolated instances of drug taking.
3. **Routine annual medical visits are an opportunity to ask adolescents about drug use.** Standardized screening tools are available to help pediatricians, dentists, emergency room doctors, psychiatrists, and other clinicians determine an adolescent's level of involvement (if any) in tobacco, alcohol, and illicit and nonmedical prescription drug use. When an adolescent reports substance use, the health care provider can assess its severity and either provide an onsite brief intervention or refer the teen to a substance abuse treatment program.
4. **Legal interventions and sanctions or family pressure may play an important role in getting adolescents to enter, stay in, and complete treatment.** Adolescents with substance use disorders rarely feel they need treatment and almost never seek it on their own. Research shows that treatment can work even if it is mandated or entered into unwillingly.
5. **Substance use disorder treatment should be tailored to the unique needs of the adolescent.** Treatment planning begins with a comprehensive assessment to identify the person's strengths and weaknesses to be addressed. Appropriate treatment considers an adolescent's level of psychological development, gender, relations with family and peers, how well he or she is doing in school, the larger community, cultural and ethnic factors, and any special physical or behavioral issues.
6. **Treatment should address the needs of the whole person, rather than just focusing on his or her drug use.** The best approach to treatment includes supporting the adolescent's larger life needs, such as those related to medical, psychological, and social well-being, as well as housing, school, transportation, and legal services. Failing to address such needs simultaneously could sabotage the adolescent's treatment success.
7. **Behavioral therapies are effective in addressing adolescent drug use.** Behavioral therapies, delivered by trained clinicians, help an adolescent stay off drugs by strengthening his or her motivation to change. This can be done by providing incentives for abstinence, building skills to resist and refuse substances and deal with triggers or craving, replacing drug use with constructive and

rewarding activities, improving problem-solving skills, and facilitating better interpersonal relationships.

8. **Families and the community are important aspects of treatment.** The support of family members is important for an adolescent's recovery. Several evidence-based interventions for adolescent drug abuse seek to strengthen family relationships by improving communication and improving family members' ability to support abstinence from drugs. In addition, members of the community (such as school counselors, parents, peers, and mentors) can encourage young people who need help to get into treatment—and support them along the way.
9. **Effectively treating substance use disorders in adolescents requires also identifying and treating any other mental health conditions they may have.** Adolescents who abuse drugs frequently also suffer from other conditions including depression, anxiety disorders, attention-deficit hyperactivity disorder (ADHD), oppositional defiant disorder, and conduct problems. Adolescents who abuse drugs, particularly those involved in the juvenile justice system, should be screened for other psychiatric disorders. Treatment for these problems should be integrated with the treatment for a substance use disorder.
10. **Sensitive issues such as violence and child abuse or risk of suicide should be identified and addressed.** Many adolescents who abuse drugs have a history of physical, emotional, and/or sexual abuse or other trauma. If abuse is suspected, referrals should be made to social and protective services, following local regulations and reporting requirements.
11. **It is important to monitor drug use during treatment.** Adolescents recovering from substance use disorders may experience relapse, or a return to drug use. Triggers associated with relapse vary and can include mental stress and social situations linked with prior drug use. It is important to identify a return to drug use early before an undetected relapse progresses to more serious consequences. A relapse signals the need for more treatment or a need to adjust the individual's current treatment plan to better meet his or her needs.
12. **Staying in treatment for an adequate period and continuity of care afterward are important.** The minimal length of drug treatment depends on the type and extent of the adolescent's problems, but studies show outcomes are better when a person stays in treatment for 3 months or more. Because relapses often occur, more than one episode of treatment may be necessary. Many adolescents also benefit from continuing care following treatment, including drug use monitoring, follow-up visits at home,[27] and linking the family to other needed services.
13. **Testing adolescents for sexually transmitted diseases like HIV, as well as hepatitis B and C, is an important part of drug treatment.** Adolescents who use drugs—whether injecting or non-injecting—are at an increased risk for diseases that are transmitted sexually as well as through the blood, including HIV and hepatitis B and C. All drugs of abuse alter judgment and decision making, increasing the likelihood that an adolescent will engage in unprotected sex and other high-risk behaviors including sharing contaminated drug injection equipment and unsafe tattooing and body piercing practices—potential routes of virus transmission. Substance use treatment can reduce this risk both by reducing adolescents' drug use (and thus keeping them out of situations in which they are not thinking clearly) and by providing risk-reduction counseling to help them modify or change their high-risk behaviors.

Components of Comprehensive Substance Use Treatment

The best treatment programs provide a combination of therapies and other services to meet the needs of the individual patient. Recommendations for the role of the Juvenile Justice System can play are offered at the National Institute of Health's National Institute of Drug Abuse's website.

What drugs are most frequently used by adolescents?

Alcohol and tobacco, followed by marijuana, are the drugs most commonly abused by adolescents. The next most popular substances differ between age groups. Young adolescents tend to favor inhalant substances (such as breathing the fumes of household cleaners, glues, or pens; see " What is the scope of inhalant use in the United States?, whereas older teens are more likely to use synthetic marijuana ("K2" or "Spice") and prescription medications—particularly opioid pain relievers like Vicodin® and stimulants like Adderall®. The effects of the use of inhalants can be found at: "What are the short- and Long-term effects of inhalant use?").

5. Special Populations

5.1 Pregnancy and Substance Use

The National Institute of Health's National Institute on Drug Abuse provides information on their website regarding the substance abuse while pregnant and breastfeeding.

Research shows that use of tobacco, alcohol, or illicit drugs or abuse of prescription drugs by pregnant women can have severe health consequences for infants. This is because many substances pass easily through the placenta, so substances that a pregnant woman takes also, to some degree, reach the baby. Recent research shows that smoking tobacco or marijuana, taking prescription pain relievers, or using illegal drugs during pregnancy is associated with double or even triple the risk of stillbirth

Regular drug use can produce dependence in the newborn, and the baby may go through withdrawal upon birth. Most research in this area has focused on the effects of opioid misuse (prescription pain relievers or heroin). However, more recent data has shown that use of alcohol, barbiturates, benzodiazepines, and caffeine during pregnancy may also cause the infant to show withdrawal symptoms at birth. The type and severity of an infant's withdrawal symptoms depend on the drug(s) used, how long and how often the birth mother used, how her body breaks the drug down, and whether the infant was born full term or prematurely.

Symptoms of drug withdrawal in a newborn can develop immediately or up to 14 days after birth and can include:

- blotchy skin coloring
- diarrhea
- excessive or high-pitched crying
- abnormal sucking reflex
- fever
- hyperactive reflexes
- increased muscle tone
- irritability
- poor feeding
- rapid breathing
- increased heart rate
- seizures
- sleep problems
- slow weight gain
- stuffy nose and sneezing
- sweating
- trembling
- vomiting

Effects of using some drugs could be long-term and possibly fatal to the baby:

- low birth weight
- birth defects
- small head circumference
- premature birth
- sudden infant death syndrome (SIDS)

For additional information on specific populations, including age and gender-based populations, can be found on SAMHSA's website.

5.2 Serious Physical Health Conditions

People who suffer from addiction often have one or more accompanying medical issues, which may include lung or cardiovascular disease, stroke, cancer, and mental disorders. Imaging scans, chest X-rays, and blood tests show the damaging effects of long-term drug abuse throughout the body. For example, research has shown that tobacco smoke causes cancer of the mouth, throat, larynx, blood, lungs, stomach, pancreas, kidney, bladder, and cervix.[19] In addition, some drugs of abuse, such as inhalants, are toxic to nerve cells and may damage or destroy them either in the brain or the peripheral nervous system.

- **Nicotine** is an addictive stimulant found in cigarettes and other forms of tobacco. Tobacco smoke increases a user's risk of cancer, emphysema, bronchial disorders, and cardiovascular disease. The mortality rate associated with tobacco addiction is staggering. Tobacco use killed approximately 100 million people during the 20th century, and, if current smoking trends continue, the cumulative death toll for this century has been projected to reach 1 billion.[24]
- **Alcohol** consumption can damage the brain and most body organs. Areas of the brain that are especially vulnerable to alcohol-related damage are the cerebral cortex (largely responsible for our higher brain functions, including problem solving and decision making), the hippocampus (important for memory and learning), and the cerebellum (important for movement coordination).
- **Marijuana** is the most commonly abused illegal substance. This drug impairs short-term memory and learning, the ability to focus attention, and coordination. It also increases heart rate, can harm the lungs, and can increase the risk of psychosis in those with an underlying vulnerability.
- **Prescription medications**, including opioid pain relievers (such as OxyContin® and Vicodin®), anti-anxiety sedatives (such as Valium® and Xanax®), and ADHD stimulants (such as Adderall® and Ritalin®), are commonly misused to self-treat for medical problems or abused for purposes of getting high or (especially with stimulants) improving performance. However, misuse or abuse of these drugs (that is, taking them other than exactly as instructed by a doctor and for the purposes prescribed) can lead to addiction and even, in some cases, death. Opioid pain relievers, for instance, are frequently abused by being crushed and injected or snorted, greatly raising the risk of addiction and overdose. Unfortunately, there is a common misperception that because medications are prescribed by physicians, they are safe even when used illegally or by another person than they were prescribed for.
- **Inhalants** are volatile substances found in many household products, such as oven cleaners, gasoline, spray paints, and other aerosols, that induce mind-altering effects; they are frequently the first drugs tried by children or young teens. Inhalants are extremely toxic and can damage the heart, kidneys, lungs, and brain. Even a healthy person can suffer heart failure and death within minutes of a single session of prolonged sniffing of an inhalant.
- **Cocaine** is a short-acting stimulant, which can lead users to take the drug many times in a single session (known as a "binge"). Cocaine use can lead to severe medical consequences related to the heart and the respiratory, nervous, and digestive systems.
- **Amphetamines**, including methamphetamine, are powerful stimulants that can produce feelings of euphoria and alertness. Methamphetamine's effects are particularly long-lasting and harmful to the brain. Amphetamines can cause high body temperature and can lead to serious heart problems and seizures.

- **MDMA (Ecstasy or "Molly")** produces both stimulant and mind-altering effects. It can increase body temperature, heart rate, blood pressure, and heart-wall stress. MDMA may also be toxic to nerve cells.
- **LSD** is one of the most potent hallucinogenic, or perception-altering, drugs. Its effects are unpredictable, and abusers may see vivid colors and images, hear sounds, and feel sensations that seem real but do not exist. Users also may have traumatic experiences and emotions that can last for many hours.
- **Heroin** is a powerful opioid drug that produces euphoria and feelings of relaxation. It slows respiration, and its use is linked to an increased risk of serious infectious diseases, especially when taken intravenously. People who become addicted to opioid pain relievers sometimes switch to heroin instead, because it produces similar effects and may be cheaper or easier to obtain.
- **Steroids**, which can also be prescribed for certain medical conditions, are abused to increase muscle mass and to improve athletic performance or physical appearance. Serious consequences of abuse can include severe acne, heart disease, liver problems, stroke, infectious diseases, depression, and suicide.
- **Drug combinations**. A particularly dangerous and common practice is the combining of two or more drugs. The practice ranges from the co-administration of legal drugs, like alcohol and nicotine, to the dangerous mixing of prescription drugs, to the deadly combination of heroin or cocaine with fentanyl (an opioid pain medication). Whatever the context, it is critical to realize that because of drug–drug interactions, such practices often pose significantly higher risks than the already harmful individual drugs.

For additional information the physical health effects of substance abuse please visit SAMHSA's website.

6. Accessing Substance Use Services

It is recommended that juvenile probation staff work closely with their local county drug and office to identify, access, and coordinate services. Local offices can determine what drug and alcohol resources might be available to families and assist with understanding the regulations and legal requirements laws that apply to accessing drug and alcohol services for youth.

6.1 County Drug and Alcohol Offices and Other Resources

The PA Department of Drugs and Alcohol Programs ~~Services~~ website has tools to assist in navigating benefits, locating county drug and alcohol offices. locating care providers in geographical area, and other information. This information can be accessed at PA Get Help Now and hotline number 1-800-662-HELP. In the *Benefits Navigator* section, of the website, county drug and as alcohol offices can be located. The county drug and alcohol office can help youth, families, and juvenile probation officers through the options that may be available. In some areas, one office may serve multiple counties. The county offices focus on recovery and addiction treatment services.

6.2 Relapse Prevention

Unfortunately, individuals with drug and/or alcohol addictions are susceptible to relapse. Addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain; they change its structure and how it works. These brain changes can be long lasting and can lead to many harmful, often self-destructive, behaviors.

Relapse is defined as a return to drinking, drug use or process addiction behaviors following a period of abstinence. Relapse vulnerability is associated with cravings and urges to use. With addiction, relapses are a common part of the disease. According to the National Institute on Drug Abuse, relapse can occur during or after treatment, which requires treatment adjustment or a return to treatment.

The chronic nature of addiction means that relapsing to drug use is not only possible but also likely. Relapse rates are similar to those for other well-characterized chronic medical illnesses such as diabetes, hypertension, and asthma, which also have both physiological and behavioral components. Treatment of chronic diseases involves changing deeply imbedded behaviors. For the addicted patient, lapses back to drug use indicate that treatment needs to be reinstated or adjusted, or that alternate treatment is needed.

Collaborative, comprehensive case plans that include the cognitive behavioral interventions that develop and practice skills to deter or prevent relapse are crucial. These case plans may include, but are not limited to the development of skills to:

- Identify and avoid situations that place the youth at risk to use drugs and/or alcohol
- Avoid of associations with users
- Employ refusal skills
- Cope with cravings and urges
- Utilize support resources

- Comply with requirements of the youth's case plan
- Willingness to submit to random and frequent urine screens

6.3 Recovery

The adoption of recovery by behavioral health systems in recent years has signaled a dramatic shift in the expectation for positive outcomes for individuals who experience mental and/or substance use conditions. Today, when individuals with mental and/or substance use disorders seek help, they are met with the knowledge and belief that anyone can recover and/or manage their conditions successfully. The value of recovery and recovery-oriented behavioral health systems is widely accepted by states, communities, health care providers, peers, families, researchers, and advocates including the U.S. Surgeon General, the Institute of Addiction Medicine, and others.

SAMHSA has established a working definition of recovery that defines recovery as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. Recovery is built on access to evidence-based clinical treatment and recovery support services for all populations. Learn more about SAMHSA's Working Definition of Recovery . SAMHSA has an Office of Recovery and information and resources can be found at this link Office of Recovery | SAMHSA.

SAMHSA has delineated four major dimensions that support a life in recovery:

- **Health**—overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and, for everyone in recovery, 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 the independence, income, and resources to participate in society
- **Community**—having relationships and social networks that provide support, friendship, love, and hope

Hope, the belief that these challenges and conditions can be overcome, is the foundation of recovery. A person's recovery is built on his or her strengths, talents, coping abilities, resources, and inherent values. It is holistic, addresses the whole person and their community, and is supported by peers, friends, and family members.

The process of recovery is highly personal and occurs via many pathways. It may include clinical treatment, medications, faith-based approaches, peer support, family support, self-care, and other approaches. Recovery is characterized by continual growth and improvement in one's health and wellness that may involve setbacks. Because setbacks are a natural part of life, resilience becomes a key component of recovery.

Resilience refers to an individual's ability to cope with adversity and adapt to challenges or change. Resilience develops over time and gives an individual the capacity not only to cope with life's challenges but also to be better prepared for the next stressful situation. Optimism and the ability to remain hopeful are essential to resilience and the process of recovery

Because recovery is a highly individualized process, recovery services and supports must be flexible to ensure cultural relevancy. What may work for adults in recovery may be very different for youth or older adults in recovery. For example, the promotion of resiliency in young people, and the nature of social supports, peer mentors, and recovery coaching for adolescents and transitional age youth are different than recovery support services for adults and older adults. Learn more about Cultural and Linguistic Competency.

The process of recovery is supported through relationships and social networks. This often involves family members who become the champions of their loved one's recovery. They provide essential support to their family member's journey of recovery and similarly experience the moments of positive healing as well as the difficult challenges. Families of people in recovery may experience adversities in their social, occupational, and financial lives, as well as in their overall quality of family life. These experiences can lead to increased family stress, guilt, shame, anger, fear, anxiety, loss, grief, and isolation. The concept of resilience in recovery is also vital for family members who need access to intentional supports that promote their health and well-being. The support of peers and friends is also crucial in engaging and supporting individuals in recovery.

For additional information regarding recovery please visit SAMHSA Office of Recovery.

6.4 Medication Assisted Treatment

Medication-assisted treatment (MAT), including opioid treatment programs (OTPs), combines behavioral therapy and medications to treat substance use disorders.

6.4.1 Medication Assisted Opioid Treatment in Adolescents

The following information was excerpted from a 2016 policy statement of the American Academy of Pediatrics for the use of medication-assisted treatment in adolescents.

> *In 2002, the US Food and Drug Administration approved the use of buprenorphine for patients 16 years and older.[13] Buprenorphine is a partial opioid agonist with high affinity for the opioid receptor. Buprenorphine binding results in gentle stimulation of the opioid system, which, like methadone, can ameliorate the highs and lows associated with full agonists with short and moderate half-lives. An expansive body of research has shown the effectiveness of buprenorphine for treating adults with opioid use disorders,[14] and 2 randomized controlled trials have examined the therapeutic efficacy of buprenorphine combined with substance use counseling in adolescents and young adults. Marsch et al[15] found that adolescents 13 to 18 years of age who received 2 weeks of buprenorphine treatment were more likely to continue medical care compared with those who received clonidine for the same period of time. A trial conducted by Woody et al[16] compared 2 detoxification regimens among adolescents and young adults 15 to 21 years of age. One group received 8 weeks of buprenorphine before tapering, and the second group received 2 weeks. Adolescents who received 8 weeks had lower rates of illicit opioid use while they were taking buprenorphine, and the differences quickly disappeared once the medication was discontinued. The findings led the authors to conclude that there is no obvious reason to stop medications in adolescent patients who are doing well on buprenorphine. Matson*

et al[17] found that continued buprenorphine compliance is associated with an increase in treatment and can help adolescents achieve long-term sobriety. In general, youth have lower rates of treatment retention compared with adults, underscoring the need to deliver developmentally appropriate treatment to achieve best outcomes.

You can find the full American Academy of Pediatrics policy statement and other information on Medication Assisted Treatment at their website. For additional information on Medication Assisted Treatment please visit SAMHSA website.

6.4.2 Naloxone

Medication Assisted Treatment should not be confused with the opioid overdose reversal medication, Naloxone (brand names such as Narcan, Evzio, etc.). Naloxone is a prescription medicine that can be used with adults and children when they are experiencing an opioid overdose or a possible opioid overdose.

Naloxone should be administered as soon as possible. It does NOT take the place of emergency medical care. Persons who administer Naloxone should get emergency medical help right away after the first dose, even if the person wakes up.

6.5 Community Support Groups

The following represents only a partial list of some of the most widely available self-help/recovery support groups:

Alcoholics Anonymous (AA) - www.aa.org: An international fellowship of men and women who come together to share their experience, strength and hope with the purpose of staying sober and helping other alcoholics to achieve sobriety. The only requirement for membership is a desire to stop drinking. Services and materials are available in Spanish, French and English.

Al-Anon/ALATEEN - www.al-anon.alateen.org: Al-Anon/Alateen offers hope and recovery to all people affected by the alcoholism of a loved one or friend, whether the person you are concerned about is still drinking or not. Support for friends and families.

Adult Children of Alcoholics (ACA) - www.adultchildren.org: Adult Children of Alcoholics is an anonymous Twelve Step program for people who grew up in an alcoholic or otherwise dysfunctional home.

Cocaine Anonymous (CA) - www.ca.org: A fellowship of men and women who share their experience, strength and hope with each other so that they may solve their common problem and help others to recover from their addiction; the primary purpose is to stay free from cocaine and all other mind-altering substances, and to help others achieve the same freedom.

Crystal Meth Anonymous - www.crystalmeth.org: Crystal Meth Anonymous is a fellowship of men and women who share their experience, strength and hope with each other, so they may solve their common problem and help others to recover from addiction to crystal meth. The only requirement for membership is a desire to stop using.

Dual Recovery Anonymous - www.draonline.org: An independent, twelve-step, self-help organization for people with a dual diagnosis of chemical dependence and an emotional or psychiatric illness. Dual Recovery addresses how both illnesses affect all areas of life.

Marijuana Anonymous (MA) - www.marijuana-anonymous.org: Marijuana Anonymous is a 12-Step fellowship that addresses the common problem of marijuana addiction. There are in-person and online meetings. The only requirement for membership is a desire to stop using marijuana.

Narcotics Anonymous (NA) - www.na.org: NA is a fellowship of men and women who come together for the purpose of sharing their recovery from drug abuse. NA members are working together in a spirit of unity and cooperation to carry their message of recovery. The only requirement for membership is the desire to stop using.

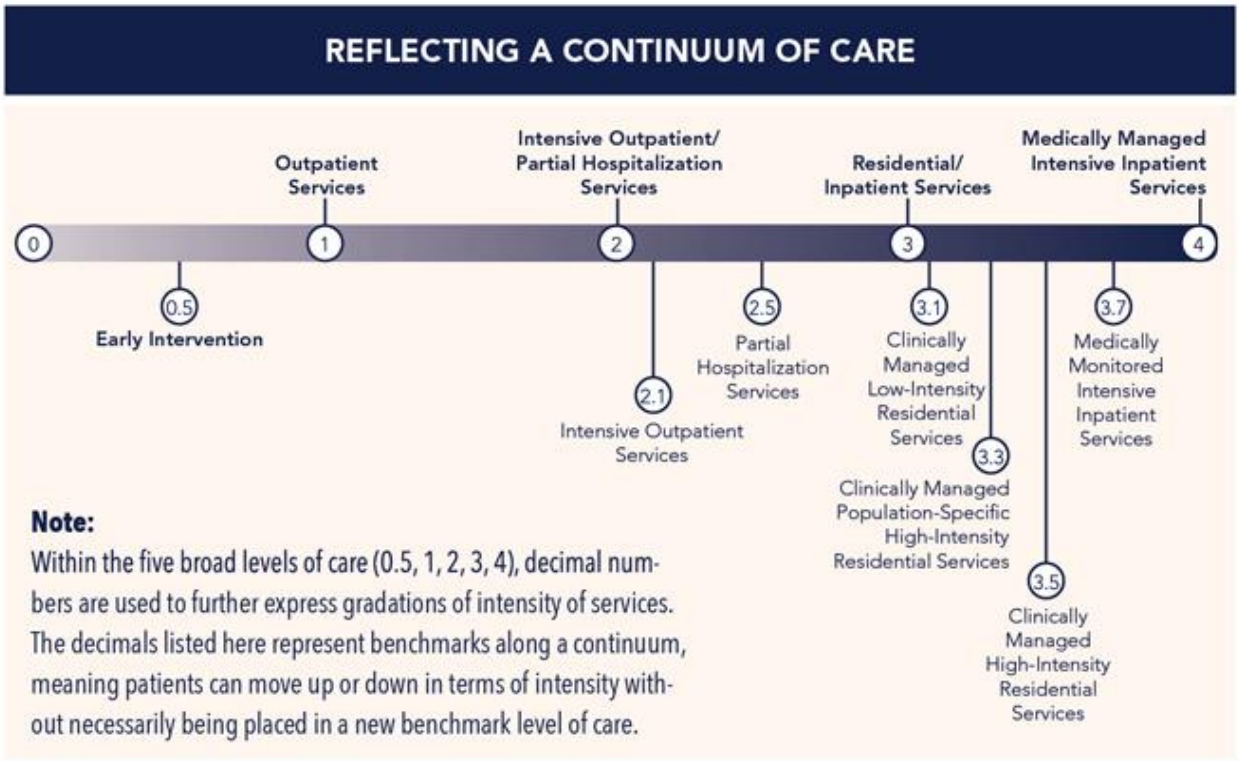
Nar-Anon Family Groups (Nar-Anon) - www.nar-anon.org: Nar-Anon is a twelve-step program designed to help relatives and friends of addicts recover from the effects of living with an addicted relative or friend.

Nicotine Anonymous - www.nicotine-anonymous.org: Nicotine Anonymous is a 12 Step Fellowship of people helping each other live nicotine-free lives. Nicotine Anonymous welcomes all those seeking freedom from nicotine addiction, including those using cessation programs and nicotine withdrawal aids.

PRO ACT Recovery Support Services - www.councilsepa.org/pro-act-recovery-support-services PRO-ACT works to reduce the stigma of addiction, ensure the availability of adequate treatment and recovery support services, and to influence public opinion and policy regarding the value of recovery.

7. American Society of Addiction Medicine (ASAM) Level of Care

ASAM's treatment criteria provide separate placement criteria for adolescents and adults to create comprehensive and individualized treatment plans. Adolescent and adult treatment plans are developed through a multidimensional patient assessment over five broad levels of treatment that are based on the degree of direct medical management provided, the structure, safety and security provided, and the intensity of treatment services provided.



Through this strength-based multidimensional assessment the ASAM criteria addresses the patient's needs, obstacles and liabilities, as well as the patient's strengths, assets, resources and support structure.

8. Pennsylvania Drug and Alcohol Statues and Regulations

8.1 Act 53 of 1997 - General Provisions

Amending the act of April 14. 1972 (P.L.221, No.63), entitled, as amended, "An act establishing the Pennsylvania Advisory Council on Drug and Alcohol Abuse; imposing duties on the Department of Health to develop and coordinate the implementation of a comprehensive health, education and rehabilitation program for the prevention and treatment of drug and alcohol abuse and drug and alcohol dependence; providing for emergency medical treatment; providing for treatment and rehabilitation alternatives to the criminal process for drug and alcohol dependence; and making repeals," adding a definition; providing for the commitment of minors; and further providing for financial obligation.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Section 2(b) of the act of April 14, 1972 (P.L.221, No.63), known as the Pennsylvania Drug and Alcohol Abuse Control Act, is amended by adding a definition to read: Section 2. Definitions:

(b) As used in this act:

"Minor" means any person under the age of eighteen years,

Section 2.

Section 5 of the act is amended to read: Section 5. Admissions and Commitments. —[Admissions] Except as provided in section 12.1 of this act, admissions and commitments to treatment facilities may be made according to the procedural admission and commitment provisions of the act of *[October 20, 1966 (P.L.96), known as the "Mental Health and Mental Retardation Act of 1966."] July 9, 1976 (P.L.817, No.143), known as the "Mental Health Procedures Act."*

Section 3. The act is amended by adding a section to read:

Section 12.1, Commitment of Minors. —(a) A parent or legal guardian who has legal or physical custody of a minor may petition the court of common pleas of the judicial district where the minor is domiciled for commitment of the minor to involuntary drug and alcohol treatment services, including inpatient services, if the minor is incapable of accepting or unwilling to accept voluntary treatment. The petition shall set forth sufficient facts and good reason for the commitment. Such matters shall be heard by the division or a judge of the court assigned to conduct proceedings under 42 Pa.C.S. Ch. 63 (relating to juvenile matters) involving children who have been alleged to be dependent or delinquent.

(b) Upon petition pursuant to subsection (a), the court:

(1) Shall appoint counsel for the minor.

(2) Shall order a minor who is alleged to have a dependency on drugs or alcohol to undergo a drug and alcohol assessment performed by a psychiatrist, a licensed psychologist with specific training in drug and alcohol assessment and treatment or a certified addiction counselor. Such assessment shall include a recommended level of care and length of treatment. Assessments completed by certified addiction counselors shall-lie based on the Department of Health approved drug and alcohol level of care criteria and shall be reviewed by a case management supervisor in a single county authority.

The court shall hear the testimony of the persons performing the assessment under this subsection at the hearing on the petition for involuntary commitment.

(c) Based on the assessment defined in subsection (b), the court may order the minor committed to involuntary drug and alcohol treatment, including in-patient services, for up to forty-five days if all of the following apply:

(1) The court finds by clear and convincing evidence that: (1) the minor is a drug dependent person; and (ii) the minor is incapable of accepting or unwilling to accept voluntary treatment services.

(2) The court finds that the minor will benefit from involuntary treatment services.

(3) Where the court decision is inconsistent with the level of care and length of treatment recommended by the assessment, the court shall set forth in its order a statement of facts and reasons for its disposition.

(d) A minor ordered to undergo treatment due to a determination pursuant to subsection (c) shall remain under the treatment designated by the court for a period of forty-five days unless sooner discharged. Prior to the end of the forty-five-day period, the court shall conduct a review hearing in accordance with subsection (c) for the purpose of determining whether further treatment is necessary. If the court determines-that further treatment is needed, the court may order the minor recommitted to services for an additional period of treatment not to exceed forty-five days unless sooner discharged. The court may continue the minor in treatment for successive forty-five-day periods pursuant to determinations that the minor will benefit from services for an additional forty-five days.

Section 4. Section 13 of the act is amended to read:

Section 13. Financial Obligations. —{a) Except for minors, all persons receiving treatment under this act shall be subject to the provisions of Article V of the act of October 20. 1966 (P.L.96), known as the "Mental Health and Mental Retardation Act of 1966," in so far as it relates to liabilities and payments for services rendered by the Commonwealth.

(b) In the case of proceedings undersection 12.1 of this act, unless the court finds that the parent or legal guardian is without financial resources, the parent or legal guardian shall be obligated for all of the following:

(1) Court costs.

(2) Counsel fees for the minor.

(3) The cost of assessment and treatment services.

Section 5. Nothing in this act shall relieve, restrict or expand the obligations of any insurer, health maintenance organization, third-party administrators, hospital plan corporation or health services plan corporation doing business in this Commonwealth with respect to the coverage of drug and alcohol benefits, as set forth in Article VI-A of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, section 2334 of the act of April 9, 1929 (P.L.l77, No.175), known as The Administrative Code of 1929, the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act, or 40 Pa.C.S. Chs. 61 (relating to hospital plan corporations) and 63 (relating to professional health services plan corporations).

Section 6. All acts and parts of acts are repealed insofar as they are inconsistent with this act.

Section 7. This act shall take effect in 60 days.

APPROVED—The 26th day of November, A.D. 1997.

THOMAS J. RIDGE

8.2 Requirements for Commercial Group Health Plans, Health Maintenance Organizations (HMOs) and Children's Health Insurance Program (CHIP)

Act 106 of 1989

Act 106 (P.L. 1989-106, No. 755) requires all commercial group health plans, HMOs, and the Children's Health Insurance Program (CHIP) to provide comprehensive treatment for alcohol and other drug addictions. State law, such as Act 106, does not apply to federal health plans such as Medicare or veterans' benefits.

<u>Minimum</u> benefits:

- All services must be in facilities licensed by DDAP.
- Inpatient Detoxification:
    - Hospital or non-hospital facility, licensed by DDAP;
    - Minimum 7 days per admission;
    - Minimum 4 admissions per lifetime.
- Non-Hospital Residential:
    - Facility must be licensed by DDAP;
    - Minimum 30 days per year;
    - Minimum 90 days per lifetime.
- Outpatient:
    - Facility must be licensed by DDAP;
    - Minimum 30 full-session visits or equivalent partial visits per year;
    - Minimum 120 full-session visits or equivalent partial visits per lifetime.

- Additional treatment:
    - An additional 30 sessions of Outpatient or Partial Hospitalization are provided per year may be exchanged on a 2:1 basis to secure up to 15 additional non-hospital residential treatment days.
- Family counseling and intervention services within facilities licensed by DDAP.
- Reasonable deductible or copayment plans, or both, may be applied to benefits.

Per the *PA Insurance Department, Drug and Alcohol Use and Dependency Coverage, Notice 2003-06*

"Under the act, the only lawful prerequisite before an insured obtains nonhospital residential and outpatient coverage for alcohol and drug dependency treatment is a certification and referral from a licensed physician or licensed psychologist. It is the Department's determination that the same prerequisite applies for inpatient detoxification coverage. The certification and referral in all instances controls both the nature and duration of treatment."

- This notice was upheld by the Pennsylvania Supreme Court May 27, 2009.

Act 106 of 1989 states:

"All group health or sickness or accident insurance policies …shall include within the coverage …benefits for alcohol or other drug abuse and dependency…Inpatient detoxification… of four admissions for detoxification and reimbursement or admission may be limited to seven (7) days of treatment…Non-hospital residential…for a minimum of thirty (30) days per year for residential care. Outpatient…for a minimum of thirty outpatient, full-session visits…subject to a lifetime limit, for any covered individual, of one hundred and twenty out-patient, full-session visits."

8.3 Release of Treatment Records

Act 126 of 1998

Act 126 of 1998 amended the Juvenile Act to allow for the release of drug and alcohol treatment information to a court, county children and youth agency, or a juvenile probation officer. Therefore, Act 126 removed the state law restrictions and required compliance only with federal confidentiality provisions, thereby expanding the degree to which systems are allowed to share confidential information. The amendment allows for joint case planning between the child welfare, juvenile justice and drug and alcohol systems. Bulletin 00-02-03 establishes protocols to share drug and alcohol information in compliance with federal 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. The hope is to achieve better outcomes for the entire family, not just the individual receiving services. In order to access the information, the child welfare worker must first attempt to obtain a written consent from the client to release and exchange drug and alcohol information. Should the client refuse, then the child welfare worker should provide a copy of the court order to the drug and alcohol treatment provider (this court order should also be provided when the client does sign a consent form).

Information that may be exchanged:

County Children and Youth Agency/ Juvenile Probation

- Court Order
- Court Report
- Permanency Plan
- Risk Assessment
- Social Summary

Drug and Alcohol Providers

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

***The Juvenile Act – 42 Pa. C.S. § 6301 et seq*.**

§ 6352.1. Treatment Records.

Notwithstanding any other provision of law, drug and alcohol treatment records or related information regarding a child who is alleged or who has been found to be dependent or delinquent, or the child's parent, shall be released to the county agency, Court or juvenile probation, upon the consent of the child or the child's parent or upon an Order of Court. The disclosure of drug and alcohol treatment records under this section shall be obtained or ordered in a manner that is consistent with procedures, limitations and criteria set for the in regulations adopted by the Department of Health and Human Services relating to the confidentiality of drug and alcohol treatment records. The county agency, Court or juvenile probation officer shall only use the records to carry out the purposes of this chapter and shall not release the records to any other person. The Court may order the participation of the county agency or juvenile probation officer in the development of a treatment plan for the child necessary to protect the health, safety or welfare of the child, to include discussions with the individual, facility or program providing treatment and the and the child or the child's parent in furtherance of a disposition under section 6351 (relating to disposition of dependent child).

8.4 Drug and Alcohol Confidentiality and Information

Act 33 of 2022 makes Pennsylvania's SUD confidentiality requirements consistent with federal law. Act 33 also prohibits DDAP from issuing or enforcing regulations that restrict disclosure of records or information that are permitted by federal law, such as 4 Pa. Code § 255.5. Federal regulations for confidentiality applicable to federally-assisted SUD treatment providers can be found at 42 CFR Part 2. A significant majority of licensed SUD treatment providers meet the criteria to be considered federally-assisted under 42 CFR 2.12(b).

An informed and voluntary consent for disclosure of information must be located in the client record. The consent must be in writing and include all the requirements addressed in 42 CFR 2.31 Consent Requirements. The consent must identify the name or names of the persons or entities to which the disclosure is made (42 CFR 2.31(a)(4)). It also must specify how much and what kind of information is to be disclosed, including an explicit description of the SUD information that may be disclosed (42 CFR 2.31(a)(3)). Consents to probation officers or agencies should only be for the purpose related to legal proceedings or compliance with legal requirements.