

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency**



Administrative Issuance: CFSA-06-20

TO: All CFSA Staff
FROM: Dr. Roque Gerald, Deputy Director for Clinical Practice
DATE: November 1, 2006
RE: Substance Abuse Treatment

Substance abuse is just one of multiple challenges confronting youth and families served by the Child and Family Services Agency (CFSA). As a maladaptive coping mechanism for individuals who have been traumatized, like many youth in foster care and their birth parents, substance abuse seriously aggravates the barriers to self-sufficiency and wellness. Therefore, it is incumbent upon social workers to assess a client's need for substance abuse treatment as part of any initial investigation and throughout the life of an ongoing case.

This administrative issuance outlines the requirements and procedures that CFSA staff must follow when referring clients for substance abuse treatment. The issuance also replaces the CFSA Substance Abuse policy. If you have any questions regarding this issuance, please contact the Multidisciplinary Unit or the Clinical Support Services Administrator.

There are currently three substance abuse specialists (SAS) in the Agency who provide clinical support and consultation for staff when parental or adolescent substance abuse is suspected or confirmed during the course of an investigation of alleged child maltreatment or throughout the life of an ongoing case. Two intake substance abuse specialists (ISAS) provide clinical support and consultation on child protective services (CPS) investigations while the Office of Clinical Practice (OCP) SAS provides clinical support and consultation for ongoing cases.

General Referral Process

1. Social workers shall complete either the relevant referral form (see Attachments A-C).
2. Social workers must complete the attached Authorization to Disclose Mental Health or Substance Abuse Information form in its entirety (Attachment D). This form allows the social worker to receive necessary but confidential information from the required Addiction Prevention and Recovery Administration (APRA) intake assessment.
3. Social workers shall take the SAS' assessment recommendations into consideration as part of overall case planning and identification of needed services for the client. If the recommendation for treatment appears to conflict with elements of the case plan or with the client's current state of affairs, it may be necessary for the social worker to identify alternate client options post-assessment.

Referrals from CPS Social Workers

1. The referring CPS social worker shall complete and submit the required documentation, including the social summary, mental evaluations, court orders, and court report, as applicable, for a substance abuse assessment to the ISAS.
2. The assigned ISAS shall schedule a substance abuse assessment to be completed at CFSA or in the community.
3. The ISAS shall complete the assessment and recommend a level of care to the CPS social worker and client within 2-24 hours of receipt of the initial referral. If there is an emergent need for services after hours, the CPS social worker is instructed to take the client directly to Detox at DC General Hospital, Building 12, for an assessment.
4. Within 2-24 hours after the assessment, if Detox is needed, ISAS shall contact APRA's Assessment and Referral Center (ARC) and forward the client's referral documentation, including related findings and recommendations for follow-up. Clients are not required to have an appointment before a referral is submitted for the intensive out-patient programs. ISAS shall notify the CPS social worker when the relevant client documentation has been sent to APRA to complete the assessment.
5. APRA's ARC is responsible for completion of client financial and medical assessments. This is the final step before substance abuse treatment services can be initiated.
6. The CPS social worker is responsible for documenting all contacts in FACES, including referral information.

Referrals from On-going Social Workers

1. The referring on-going social worker shall complete and submit the required documentation, including the social summary, mental evaluations, court orders, and court report, as applicable, for a substance abuse assessment to the OCP SAS.
2. In addition, on-going social workers shall attach a brief summary to the referral, including the following information:
 - a. Client background information (neglect or abuse)
 - b. Prior treatment history, including modality
 - c. Mental health diagnosis
 - d. Current prescriptions
 - e. Medical history (when available)
3. The substance abuse assessment shall be completed either by the OCP SAS at CFSA or by APRA. The location of the assessment shall be based on the time and resource needs (e.g., child care and transportation) of the client and social worker.
4. If the assessment is completed at CFSA, the OCP SAS shall attempt to place the client in a program, based on the identified level of need, or refer the case of APRA.
5. The OCP SAS shall review the referral package for completeness and appropriateness prior to submission to APRA for an intake assessment appointment.

6. The OCP SAS shall provide appointment information to the on-going social worker via email or a telephone call within 3 business days of the initial referral. Emergency referrals will be handled on a case-by-case basis.
7. The on-going social worker shall notify the client of the date and time of the appointment within 1 business day and also provide the client with the ARC telephone number (202-727-8609). The on-going social worker or designee shall provide support by accompanying the client to the appointment.
8. Substance abuse assessments for youth (up to 21 years of age) occur at the APRA Youth Central Intake Division located at 3720 Martin Luther King Jr. Ave., SE, 2nd Floor and the assessments for adults (21 years and older) occur at the APRA Adult Central Intake Division located at 1300 First Street, NE, 2nd Floor.
9. Clients must have a valid (photograph) ID to receive services.
10. If necessary, bus tokens shall be provided by the social worker for the client's round-trip transportation to the ARC. Tokens and fare cards can be obtained from the secretary of the on-going social worker's program manager.
11. The OCP SAS tracks the case with the follow-up calls to APRA. The on-going social worker may need to contact the OCP SAS for the following reasons:
 - a. There are concerns.
 - b. Other assistance is needed with the appointment.
 - c. Verification of appointments (kept or missed) is needed.
12. The on-going social worker is responsible for documenting substance abuse treatment goals and activities in the case plan; all contacts must be entered in FACES.

CHILD AND FAMILY SERVICES AGENCY
Office of Clinical Practice
Intake Substance Abuse Service Referral Form

Date of Request: ___/___/___ CPS Worker's Name: _____
Telephone # _____ Email Address: _____

Room # _____

Is this substance abuse services referral court ordered? Yes No

Is this referral the result of a FTM? Yes No

For Adult Use Only (ages 21 and over):

Client Name: _____ Female Male

DOB: ___/___/___ Social Security #: _____

CPS Referral Number# _____

Health Insurance provider and #: _____

Client Address: _____

Telephone Number: _____ Alt. Number: _____

Number of Children: _____ Ages: _____

Employed?: Yes No

Name of Employer: _____

If a "parent w/child" slot is available, can child (ren) enter TX w/the mother? Yes No
(Please be advised that most treatment programs of this type have a "cap" on the age and number of children that can reside in the program with their mother)

Client uses the following: Marijuana Cocaine Alcohol Heroin PCP Ecstasy
 Other (please specify): _____

Client has a history of the following:

Substance Abuse Treatment? Yes No

Legal Problems? Yes No

Medical Problems? Yes No

For Adolescents Only (ages 20 and younger):

Client Name: _____ Female Male

DOB: ___/___/___ Social Security #: _____

CPS Referral Number# _____

Health Insurance provider and #: _____

Client Address: _____

Telephone Number: _____

Legal status: Administrative Hold Shelter Care Committed

Custodial Parent/Legal Guardian Name: _____

Custodial Parent/Legal Guardian Address: _____

Client address if different from above: _____

School: _____ Last grade completed: _____

Is client in special education program? Yes No

Client uses the following: Marijuana Cocaine Alcohol Heroin PCP Ecstasy
 Other (please specify): _____

Client has a history of the following:

Substance Abuse Treatment? Yes No

Legal Problems? Yes No

Medical Problems? Yes No

Per client please include: A copy of the court order (if applicable) and a biopsychosocial summary.
A RELEASE OF INFORMATION MUST BE SIGNED

Child and Family Services Agency
400 6th Street, S.W.
Washington, D.C. 20024
Adolescent Substance Abuse Referral Form

Date of Referral: _____

Social Worker Name: _____

Program Area: CPS In-Home Adoptions

Telephone #: _____

Room #: _____

Client Name: _____ DOB: _____

Social Security #: _____ Medicaid#: _____

Telephone #: _____ FACES ID #: _____

Is this referral the result of a FTM? { } No { } Yes Date: _____ Facilitator Name: _____

Is the client a Committed Ward of the District of Columbia? { } Yes { } No

Custodial Parent/Legal Guardian Name: _____

Custodial Parent/Legal Guardian Address:

Client address if different from above: _____

Client School: __Sunrise Academy_____ Last grade completed: _____

Is client in special education program? { } Yes { } No

Client uses the following: { } Marijuana { } PCP { } Ecstasy { } Cocaine { } Alcohol

Other (Please specify): _____

Does the client have a DSM IV diagnosis? { } Yes { } No

If yes please identify diagnosis and medication: _____

Name of current Psychiatrist/Therapist: _____

Psychiatrist/Therapist Telephone #: _____

PLEASE DO NOT WRITE BELOW THIS LINE

Client referred to:

Program Name: _____

Program Location: _____

Telephone Number: _____ Contact Person: _____

Appt Date & Time: _____

Please return this form to Richard Davis, Substance Abuse Specialist (202)727-2409 Cubicle #4008
Please be sure to have the Release of Information signed and a Social Summary including client treatment history and drug of choice, any previous psychiatric or psychological evaluations completed (no more than 1 year old). If this is a court ordered referral, please include a copy of the order.

CHILD AND FAMILY SERVICES AGENCY
400 6th Street, S.W.
Washington, D.C. 20024
Adult Substance Abuse Referral Form

Date of Referral: _____

Social Worker Name: _____

Program Area: CPS In-Home Adoptions

Telephone #: _____

Room #: _____

Referral by way of:

In Person

Fax

E-Mail

Is this referral court ordered? Yes No

Is this referral the result of a FTM? No Yes Date: _____ Facilitator: _____

Client Name: _____

Female Male DOB: _____ FACES ID: _____

Social Security #: _____ Medicaid # _____

Client Address: _____

Telephone Number: _____ Alternate Number: _____

Number of Children: _____ Ages: _____

If a parent w/child slot is available can child (ren) enter TX w/the mother? yes no

(Please be advised that most treatment programs of this type have a "cap" on the age and number of children that can reside in the program with their mother)

Client uses the following: Marijuana Cocaine Alcohol Heroin PCP Ecstasy

Other (please specify): _____

FOR APRA USE ONLY:

Date client reported for initial screening/assessment: _____

Client has agreed to accept services

Client has declined services

Reason for non-compliance: _____

Client has been referred for the following treatment program:

Detoxification Inpatient Outpatient Intensive outpatient Aftercare

Program Name: _____

Program Address: _____

Length of Services: _____

Telephone Number: _____ **Contact Person:** _____

Return Completed form to: Richard Davis, CAC RAC

Substance Abuse Specialist (202) 727-2409

Office of Clinical Practice Cubicle # 4008

Please include: Copy of court order (if ordered), Social Summary (include drug use and treatment history), along with any psychiatric or psychological evaluations that may have been done recently (6mos- 1yr). RELEASE MUST BE SIGNED.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health
Addiction Prevention and Recovery Administration

Request for Release of Information/Authorization

Purpose: To document verification of the identity and authority of a person or entity you wish to disclose protected health information.

Client **Third Party** **Courts** **Other:** _____

Payment: Purpose is to obtain information regarding insurance coverage for substance abuse treatment that may be available under my insurance plan.

Effective Date: ____ / ____ / ____ Expiration Date: ____ / ____ / ____

Section A: Client Information Identification Number: Soc Sec #

Name: _____

Address: _____

Telephone: _____ Fax: _____ Email: _____

Gender: Male Female DOB: ____ / ____ / ____

Personal representatives signing on behalf of the individual must complete the following: N/A

Personal Representative's Name: _____

Authority to Act as Personal Representative: _____ Telephone: _____

Section B: Recipient/Requester Information: (Name and Address (if known) of Person or Entity to whom the Protected Health Information is to be disclosed.)

Name: _____

Company, Organization or Government Agency with which the person claims affiliation:

Child and Family Services Agency (CFSA)

Address: 400 6th St, SW Washington, DC 20024

Telephone: _____ Fax: _____ Email: _____

Protected Health Information to be Disclosed: TX Plan, Discharge Plan, TX Program attendance and progress, toxicology report.

Purpose of the Disclosure: Case Planning, Court Reporting, reunification and assessment.

How did you verify the recipient's identity and authority to the individual or to the company, organization or government agency?

Repetitive Disclosure:

Check if this disclosure is one of a series of repetitive accountable disclosures for a single purpose to the same person or entity.

Signature of Staff Member making disclosure: _____

Print Name: _____ Title: _____

Date: _____

Recommendation: _____

Section C: Release Authorization

I understand that my records are protected under the federal regulations regarding Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR, Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action or actions have been taken in reliance on it, and that in any event, this consent expires automatically as follows:

Until completion of the continuum of care with APRA.

(Give the date, and as need, the specifics of event or condition when this consent expires)

I authorize the Addiction Prevention and Recovery Administration (APRA) disclosure to the party as named in Section B: Requester Information. I also understand that this information cannot be redisclosed without my written authorization.

The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act of 1978. Disclosures may only be made pursuant to a valid authorization by the client, or as provided in titles III or IV of that Act. The Act provides for civil damages and criminal penalties for the violations.

Client Signature: _____

Date: _____

Section D: Privacy Officer Approval

Privacy Officer Signature: _____

Date: _____

Accept

Deny

Comments:

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

Include completed form in the individual's records.

Send a copy to the Assistant Privacy Officer and DOH Privacy Officer.