The Role of Plans of Safe Care in Ensuring the Safety and Well-Being of Infants with Prenatal Exposure, Their Mothers and Families

A Discussion draft in Development of A Technical Assistance White Paper

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This white paper is intended to generate discussion among State and local policymakers and practitioners. The ideas are framed by Children and Family Futures staff and informed by our work with numerous communities across the nation on the public policy issues affecting children of parents with substance use disorders. The views do not reflect the official position or agreement with these ideas from any of the funding organizations of Children and Family Futures.
The Need

More than 500,000 infants are born each year to mothers who used tobacco (13.4 percent), alcohol (9.3 percent), or illicit drugs (5.3 percent) during pregnancy. The number of infants exhibiting the narrower criteria of “affected by illegal substance abuse or withdrawal symptoms or a fetal alcohol spectrum disorder” is unknown (see page 3, Defining Drug and Alcohol Affected, for additional discussion). For many of these children, this exposure has lifelong effects.

Many Federal and State programs aim to reduce substance use during pregnancy as well as the potential effects on infants and children, but there is no single Federal agency that is charged with responding to these risk factors or to coordinate a response across the multiple agencies. Legislation and administrative guidelines on risks to infants and young children involve more than a dozen Federal agencies, and dozens more at State and local levels. These agencies and professionals include health care, social services, treatment for substance use disorders, mental health, child welfare, developmental disabilities, home visiting, education, and more.

The Role of the Child Abuse Prevention and Treatment Act (CAPTA) in Meeting the Need

In the child welfare system, the Keeping Children and Families Safe Act of 2003 (amended in 2010) created new conditions for States to receive State grant allocations under the Child Abuse Prevention and Treatment Act (CAPTA). The changes were intended to provide the needed services and supports for infants, their mothers, and their families and to ensure a comprehensive response to the effects of prenatal exposure.

The legislative intent was to improve the likelihood of mothers obtaining treatment for their substance use disorder, not to mandate that prenatal exposure would automatically result in a substantiated case of child abuse or neglect. In referring to needed services, the CAPTA language makes clear that child welfare is only one of the agencies that must be involved. Since child welfare does not have responsibility for intervening prior to the birth event, other agencies and providers must be responsible for identifying such infants during the prenatal period or at birth and providing mothers the treatment services that are needed.

The committee report on H.R. 14 (2003) the House version of the Keeping Children and Families Safe Act, stated that the requirement was intended to “identify infants at risk of child abuse and neglect so appropriate services can be delivered to the infant and mother to provide for the safety of the child.” The authors of this bill called for…

“the development of a safe plan of care for the infant under which consideration may be given to providing the mother with health services (including mental health services), social services, parenting services, and substance abuse prevention and treatment counseling, and to providing the infant with referral to the statewide early intervention program funded under part C of the Individuals with Disabilities Education Act for an evaluation for the need for services provided under part C of such Act.”

2
Thus, the law intended that the function of Child Protective Services (CPS) is protecting a child who may be at increased risk of maltreatment, regardless of whether the State had determined that the child had been abused or neglected as a result of prenatal exposure.³

Recent attention generated in part by the nation’s current prescription drug and opioid epidemic has focused state agencies on the requirement that a Plan of Safe Care be implemented for these infants.⁴

On July 22, 2016, H.R. 4843, “Infant Plan of Safe Care” was signed into law under Title V, Section 503, of S. 524, “Comprehensive Addiction and Treatment Act of 2016” (CARA). The legislation requires the Plan of Safe Care to address the needs of both the infant and parent(s) while also increasing States’ accountability through monitoring by the U.S. Department of Health and Human Services (HHS) to better ensure States are complying with the CAPTA provisions. CARA also amends the legislation to include the needs of infants born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder.⁵ The changes in the law are highlighted on page 6.

Defining Drug- and Alcohol-Affected

Prior to the passage of CARA, one of the complicating factors in implementing the CAPTA provisions is that there is not a clear definition of the term “affected by illegal substance abuse.” The current language, “affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder” is clear that the CAPTA regulations apply to the infant who is identified as being affected by substance abuse (vs. the infant who is affected by illegal substance abuse).

Challenges still remain in defining what constitutes “affected by.” It is certainly easier to make that determination when an infant experiences a withdrawal syndrome. Yet, infants prenatally exposed to stimulants or alcohol without the full expression of Fetal Alcohol Syndrome may be “affected by” that exposure as evidenced by impaired growth, prematurity, or subtle neurodevelopmental signs that are more difficult to define in the newborn and infancy stages. Similarly, infants prenatally exposed to tobacco may be born with low birth weight, and, particularly in the context of other risk factors (e.g. continued exposure to tobacco), at risk for developing problems related to respiratory functions and behavior.

Communities are also challenged by operationalizing “withdrawal symptoms resulting from prenatal drug exposure” as infants who are prenatally exposed to illegal substances, as well as legal substances, (e.g. alcohol, opioid based medications, medications prescribed for the treatment of opioid use disorders or other conditions) can experience a withdrawal syndrome. Further complicating the issue is that misuse of legal substances (e.g. some prescription medications) can also result in the birth of an infant with a withdrawal syndrome. Although the legislation is clear that the previously described situations fall under the CAPTA requirements, some communities may be challenged by implementing the regulations in situations in which the infant’s withdrawal syndrome is due to the legitimate use of medications – particularly in communities in which prenatal substance exposure is grounds for criminal prosecution or as a basis to substantiate child abuse/neglect. Situations involving a withdrawal syndrome due to
legitimate use of medications may still require some level of intervention (e.g. the Plan of Safe Care), such as to ensure that the infant’s health care needs are met. It is clear that the different situations involving prenatal substance exposure requires different and varying levels of intervention from multiple service providers, and in whether the Plan of Safe Care is to be developed and what the Plan of Safe Care is to entail. These varying approaches cannot be developed and implemented without a comprehensive assessment of the family’s needs and strengths. The CAPTA regulations open the door to that comprehensive assessment for a larger group of infants and families.

We would suggest that States look to the intent of the CAPTA legislation – to improve the likelihood of mothers obtaining treatment for their substance use disorder while also offering clarity on and defining through State legislation or administrative policy how they are to define, identify, intervene and ensure the safety of infants and their families with prenatal substance exposure in the immediate post-partum period and through-out infancy.

The language in the CAPTA legislation calls for a response to drug- and alcohol-affected infants, but does not specify how this should be defined or operationalized. That leaves the definitional task up to States at this point. In the section of this paper on Developing Plans of Safe Care on pg. 14, we reference assessment tools that were created in the late 1980s during the cocaine epidemic that are excellent tools to adapt as States define these issues, as well as discussion on which system should develop and implement the Plan of Safe Care and what the Plan of Safe Care should include. See also Need for Multi-Agency Support in Implementing CAPTA on pg. 8 for discussion on specific policy and practice guidance.

We would suggest the following definition for State policymakers’ and practitioners to refine:

An alcohol- or other drug-affected infant is one in which there is any detectable physical, developmental, cognitive, or emotional delay or harm that is associated with parental action involving substance use or abuse.

States may want to consider the use of medical fragility or Medically Fragile Infants when defining this population of infants, as this is consistent with the Maternal and Child Health Bureau definition of children with special health care needs (CSHCN); children who have or are at increased risk of a chronic physical, developmental, behavioral, or emotional condition and require health care and related services of a type or amount beyond that required by children generally6. Appropriate interventions, including family-centered services and care coordination, should be considered in the context of this definition.

Similar to the current CAPTA language, we do not suggest that this definition is grounds for substantiating child abuse or neglect. Specifically, a mother participating in medication-assisted treatment is not grounds for substantiated child abuse or neglect.

Rather, a definition is warranted to assure that the full spectrum of intervention and supports are provided to ensure the safety of the infant and mother. Further, in the absence
of immediate safety concerns, the supports are provided to the mother, infant and family to maintain the mother/infant bond.

We would suggest pediatricians and other medical professionals are consulted for establishing the State’s definition. The following factors may be taken into account in developing that definition.\(^7\)

**In conjunction with known substance use during pregnancy:**

1. Signs of prenatal exposure detectable at birth and early infancy are assessed including:
   a. Facial characteristics of fetal alcohol syndrome\(^8\)
   b. Withdrawal as defined by neonatal abstinence syndrome\(^9\)
   c. Irritability
   d. Irregular and rapid changes in state of arousal
   e. Low birth weight
   f. Prematurity
   g. Difficulties with feeding due to a poor suck
   h. Irregular sleep-wake cycles
   i. Decreased or increased muscle tone
   j. Seizures or tremors

2. Evidence through prenatal screening of mother’s substance use including alcohol, tobacco, illegal drugs, prescription drugs used non-medically, or legal use of marijuana in States with legal use, at any time during pregnancy or screening of the mother and infant at the time of birth.

3. Mothers’ participation in a treatment program using medications as prescribed for an opioid use disorder or medical marijuana in those States in which medical marijuana is legal (again, inclusion of this group of mothers is to identify infants with possible prenatal substance exposure effects to ensure needed supports are provided to the family, not to classify this group of mothers as perpetrators of child abuse or neglect).

Additional factors, such as previous child welfare history that indicates an unresolved substance use issue, other risk factors, such as co-occurring mental health concerns, and continued exposure to tobacco, particularly in the context of other risk factors (e.g. infant born with small birth weight) can be considered in developing the Plan of Safe Care. Refer to *Developing Plans of Safe Care* on pg. 14 for additional information.
Section 103. NATIONAL CLEARINGHOUSE FOR INFORMATION RELATING TO CHILD ABUSE. [42 U.S.C. 5104]

a. ESTABLISHMENT. – The Secretary shall through the Department, or by one or more contracts of not less than 3 years duration let through a competition, establish a national clearinghouse for information relating to child abuse and neglect.

b. FUNCTIONS. – The Secretary shall, through the clearinghouse established by subsection (a) –

(5) maintain and disseminate information about the requirements of section 106(b)(2)(B)(iii) and best practices relating to the development of plans of safe care as described in such section for infants born and identified as being affected by illegal substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder.

Section 106. GRANTS TO STATES FOR CHILD ABUSE OR NEGLECT PREVENTION AND TREATMENT PROGRAMS. [42 U.S.C. 5106a]

A State plan… shall contain a description of the activities that the State will carry out using amounts received under the grant to achieve the objectives of this subchapter, including…

(B) an assurance in the form of a certification by the Governor of the State that the State has in effect and is enforcing a State law, or has in effect and is operating a statewide program, related to child abuse and neglect that includes –

(ii) policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born with and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition of such infants, except that such notification shall not be construed to –

(I) establish a definition under Federal law of what constitutes child abuse or neglect; or

(II) require prosecution for any illegal action;

(iii) the development of a plan of safe care for the infant born and identified as being affected by illegal substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder to ensure the safety and well-being of such infant following release from the care of healthcare providers, including through –

(I) addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver; and

(II) the development and implementation by the State of monitoring systems regarding the implementation of such plans to determine whether and in what manner local entities are providing, in accordance with State requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver.

(iv) procedures for the immediate screening, risk and safety assessment, and prompt investigation of such reports;…

(xxii) provisions and procedures for referral of a child under the age of 3 who is involved in a substantiated case of child abuse or neglect to early intervention services funded under part C of the Individuals with Disabilities Education Act (20 U.S.C. 1431 et seq.);

(d) ANNUAL STATE DATA REPORTS. – Each State to which a grant is made under this section shall annually work with the Secretary to provide, to the maximum extent practicable, a report that includes the following:

(15) The number of children referred to a child protective services system under subsection (b)(2)(B)(ii) [Note: this section is above related to notification to CPS and referrals to other appropriate services]

(16) The number of children determined to be eligible for referral, and the number of children referred, under subsection (b)(2)(B)(xxi), to agencies providing early intervention services under part C of the Individuals with Disabilities Education Act (20 U.S.C. 1431 et seq.).
(17)(A) The number of infants identified under subsection (b)(2)(B)(iii).
(B) The number of infants for whom a plan of safe care was developed under subsection (b)(2)(B)(iii);
(C) The number of infants for whom a referral was made for appropriate services, including services for the affected family or caregiver, as may be necessary under subsection (b)(2)(B)(iii).

SEC 114—MONITORING AND OVERSIGHT.
The Secretary shall conduct monitoring to ensure that each State that receives a grant under section 106 is in compliance with the requirements of section 106(b), which —
(1) shall—
   (A) be in addition to the review of the State plan upon its submission under section 106(b)(1)(A); and
   (B) include monitoring of State policies and procedures required under (ii) and (iii) of section 106(b)(2)(B); and
(2) may include —
   (A) a comparison of activities carried out by the State to comply with the requirements of section 106(b) with the State plan most recently approved under section 432 of the Social Security Act;
   (B) a review of information available on the Website of the State relating to its compliance with the requirements of section 106(b);
   (C) site visits, as may be necessary to carry out such monitoring; and
   (D) a review of information available in the State’s Annual Progress and Services Report most recently submitted under section 1357.16 of title 45, Code of Federal Regulations (or successor regulations).
The Need for Multi-Agency Support in Implementing CAPTA

It is clear that child welfare agencies cannot be charged with the sole responsibility for responding to prenatal substance exposure and infants who are affected by prenatal substance use. In fact, while data are largely incomplete, only a small percentage of these families are identified and are referred to the child protection system. Child welfare agencies typically cannot intervene until birth, and many do not receive timely notifications of drug- or alcohol-exposed births from hospitals and medical providers. This occurs even though for a State to receive a CAPTA grant, the governor assures that the State is enforcing a complying State law or that the child welfare agency operates a program that ensures that health care professionals notify Child Protective Services when such infants are identified.

A five-stage framework, set forth in a 2009 SAMHSA publication and included in the 2012 White House Office of National Drug Control Policy, specifies five stages which need to be part of comprehensive reform to effectively respond to pregnant women, their families and infants with prenatal exposure:

1) Pre-pregnancy public education to reduce substance use during pregnancy including tobacco, alcohol, and other drugs
2) Prenatal screening and engagement of pregnant women in treatment when indicated
3) Universal screening at birth to both deter substance use and to ensure infants who may be at increased risk and their families receive the intervention and supports that are needed to ensure their safety and well-being
4) Screening, assessment and intervention during infant and toddler stages (0-3 years) to remediate any developmental concerns and early identification and support for pre-school developmental care and education (3-5)
5) Ongoing support and age-appropriate interventions for children and adolescents (5-18) who may have neurodevelopmental or other effects.11

There is more than $400 billion of Federal expenditures that benefit children, which is allocated across many agencies.12 That array of resources underscores the critical roles that could be played by many agencies and providers at all five stages of this framework. Despite these resource allocations and potential expansion of substance use disorder treatment through the Affordable Care Act13 and parity legislation requiring substance use and mental health treatment benefits on par with medical care provisions,14 there remains a dramatic gap in substance use disorder treatment,15 particularly for family-centered care and for medications needed to treat opioid use disorders. Therefore, States need a two-pronged approach to achieve a multi-agency response to prenatal exposure:

1) A State-level strategic plan that sets forth broad system policies and practices, addresses barriers to multi-agency responses, sets and monitors benchmarks to improve outcomes for these families, and ensures the support of agencies’ leadership.
2) Local-level implementation plans to ensure the necessary policies, practice and communication protocols are in place that ensure a continuum of services, including Plans of Safe Care for infants, their mothers, and their families.
A State-level authority, reporting directly to the governor and charged with convening authority to work across agencies and providers, is needed to develop a strategic, multi-year response to the problems of prenatal substance exposure. The characteristics of that plan have been set forth below: it must be based on shared resources and cross-agency outcomes, rather than the province of a single agency. Its efforts must be monitored by legislative oversight and accountability to the governor’s budget authority. Clarifying the role of each participating agency requires measurable outcomes and specific timelines.

At the local government level, a multi-disciplinary approach is needed that draws on professional expertise across agencies and includes an initial response and triage process that assesses risk and protective factors but does not presume child abuse or neglect. This multi-disciplinary approach includes the development of a team comprised of partnering agencies, including, but not limited to, hospitals, private medical providers, maternal and child health, including home visiting, substance abuse and mental health services, and early intervention services.

The development of the Plan of Safe Care for each family must involve an assessment of the strengths of and challenges for the mother, her infant and her family. The plans are based on a preference that infants, mothers, and families can remain together. Reasons for placing an infant in protective custody would be based on immediate risk and safety concerns that are present and not mitigated by sufficient familial protective factors to provide for the infant’s safety. If the mother and infant are residing in or enter a residential treatment program, which can mitigate immediate safety concerns, removal of the infant from the mother’s care can be avoided. Regardless of the immediate placement decisions, the Plan of Safe Care must include specific follow up plans that support the family and focus on the longer-term well-being of the infant, mother and family.

The following criteria may go beyond provisions in current CAPTA laws. Yet, it is the experience of Children and Family Futures staff and our recommendations that they are needed in developing and implementing Plans of Safe Care. Setting the State’s policy context for an approach to families affected by substance use disorders is critical in providing guidance to local jurisdictions on the development and implementation of Plans of Safe Care.

**State Level Strategic Plans**

**Charge to the Governor’s Council**—A Governor’s interagency council could be charged with developing a comprehensive State Plan for implementation of Plans of Safe Care (PSC) to focus on reducing prenatal substance exposure and responding effectively to the needs of infants who are affected by prenatal substance exposure, to their mothers with substance use disorders and to their families. The charge of such entity is to develop, coordinate and support the child and family-focused service delivery system, emphasizing prevention, early intervention, and an array of community-based treatment services. The Governor’s Council would be tasked with evaluating the State’s existing legislation, policies and procedures that govern the State-wide implementation of the CAPTA provisions and determining if changes are needed in State laws or administrative rules. The Council would also be able to issue guidance to local jurisdictions that are charged with developing an effective response and Plan of Safe Care for infants and their families.
Membership of the Governor’s Council—This council could include the Departments of Health, including Public Health and Maternal and Child Health (including Home Visiting Division), Substance Use Disorder prevention and treatment, Mental Health, Social Services (Child Abuse Prevention and Protection Services), Early Intervention (IDEA Part C), Developmental Disabilities, Administrative Office of the Courts, State Department of Education, Department of Budget and Finance, the Medicaid Director, as well as representatives from the State Hospital Association, State branches of the American College of Obstetricians and Gynecologists (ACOG) and State branches of the American Academy of Pediatrics (AAP) and the Insurance Commissioner’s office who has oversight of private health insurers in the State. Previously existing councils at the state level such as Children’s Cabinets or Early Childhood Councils could be tasked with this role if given adequate emphasis and greater priority to the issues of responding to prenatal exposure and its effects.

Tasks of the Governor’s Council—At a minimum the plan could include:

Prevention of Infants with Prenatal Substance Exposure

- Strategies for raising awareness about the risks associated with alcohol, tobacco and other substance use during pregnancy. Specific strategies are developed to engage young women of childbearing age, including the adolescent and foster care population.
- Strategies that focus on changing the culture regarding substance use during pregnancy so that women and families are supported to make healthy decisions and to receive appropriate intervention and treatment when needed.

Screening, Assessment and Intervention during Pregnancy, at Birth and Childhood

- Implementing universal screening for substance use during pregnancy using an evidence-based reliable tool.
- Medicaid and private insurer requirements for coverage of screening during pregnancy and the minimum insurance benefit and payment rates (e.g., determining factors such as screening during prenatal care as a billable item in the Medicaid plan and at what rate and who can bill for that service) for treatment in accordance with Federal parity legislation and the Affordable Care Act.
- Demonstrate that policies and protocols for the notification to CPS of an infant with prenatal substance exposure to CPS are developed with hospitals and medical providers responsible for the delivery of such infants.
- A lead agency (e.g., a substance abuse treatment agency or the public health authority) is designated to ensure that multi-disciplinary and comprehensive assessments with the pregnant woman are conducted. However, the Medicaid agency, for example, may be charged with monitoring implementation of the assessments by determining that claims for routine prenatal care include billing codes for substance use disorder screening and assessments.
- A lead agency must also be designated that has the responsibility to ensure that a Plan of Safe Care is implemented for infants identified with prenatal exposure, their mothers and families. While signs and symptoms of neurological effects of prenatal exposure would not be evident
during pregnancy or in some cases at birth, the intent of designating which agency is responsible is to ensure that a plan is developed and that follow up with the family occurs to reduce longer-term effects and to foster the child’s development.

- A continuum of services for pregnant, post-partum and parenting women that acknowledges women’s treatment needs for evidence-based, family-centered and trauma-informed services and addresses barriers to accessing services for pregnant and parenting women. Steps to ensure that continuum include determining gaps in the availability of these services and the development of strategic plans to create such a continuum in States and communities.
- Practice protocols for women in treatment, particularly those receiving medication-assisted treatment, to ensure effective communication between substance use disorder treatment agencies and physicians providing medications.
- Policy and procedures to ensure home visiting or other programs that provide follow up to high risk infants include this population in their services and that all such infants receive those follow up services, regardless of their placement following discharge from the hospital (e.g., with mother and family or an out-of-home care placement).
- A policy for automatic referral to and assessment of need by IDEA Part C providers for infants born affected by substance use disorders as specified by CAPTA for substantiated child welfare cases under the age of 3; exposed to and affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a fetal alcohol spectrum disorder.
- The provision of evidence-based training to personnel across multiple domains, agencies, and disciplines to educate them on issues related to prenatal alcohol exposure and the diagnosis of fetal alcohol syndrome and the broad spectrum of associated disorders that fall within FASD. Criteria for diagnosing individuals who were exposed to alcohol and have neurodevelopmental deficits without any physical indicators of exposure have been presented in the DSM5 and should be communicated to health care providers.

**Data Collection and Monitoring**

- Identifying and resolving barriers to data collection and information sharing across agencies and systems
- Establishing state-wide performance measures and benchmarks with annual monitoring of the numbers, including the data points sufficient to monitor Plan of Safe Care implementation:
  - the prevalence of substance use during pregnancy
  - pregnant women who screen positive for substance use
  - the number of treatment admissions for pregnant women
  - infants born with prenatal substance exposure
  - notifications to child welfare of infants with prenatal exposure
  - the number of infants and families with implemented Plans of Safe Care
  - average hospital stays and costs for infants and mothers
  - infants with prenatal exposure who remain at home and those placed in custody of the State
  - the number of families receiving home visiting interventions or other on-going supportive services, including those covered by Plans of Safe Care
  - referrals to and receipt of early intervention services through IDEA Part C
• Assessment of data from hospitals and CPS on the needs of children and families to make appropriate policy updates.
• State policies on the appropriate follow-up time frames for collecting the data needed to monitor child and family benchmarks based upon an agreed-upon set of outcomes and indicators.
• Methods for evaluating costs of the continuum of care involved with Plans of Safe Care, including cost avoidance, in hospitals, child welfare, special education and other agencies.

The Community Level Plan of Safe Care for an Individual Infant, Mother and Family

Charge to the Community Team—A Community’s interagency team is charged with implementing the Governor’s Interagency Council’s decisions by developing a comprehensive practice protocol to focus on reducing prenatal substance exposure and responding effectively to infants who are affected by prenatal substance exposure, to their mothers with substance use disorders and to their families. The charge of such entity is to develop specific practice and communication protocols that coordinate the child and family-focused service delivery system, emphasizing prevention, early intervention, and an array of community-based treatment and support services for infants, children, and their families.

Membership of the Community Team—This team would include, at a minimum, representatives from the Departments of Health, including Public Health and Maternal and Child Health and Home Visiting Services, Substance Use Disorder Prevention and Treatment, Mental Health, Social Services (Child Abuse Prevention and Protection Services), Early Intervention Services, Developmental Disabilities, Juvenile/Dependency Courts, Office of Education as well as representatives from the Local Hospital Association, local representatives of the American College of Obstetricians and Gynecologists (ACOG) and local representatives of the American Academy of Pediatrics (AAP). These representatives should have decision-making authority to approve or provide needed services to children and families.

Tasks of the Community Team—At a minimum the Community Team would establish community goals that:

1) Implement an interagency memoranda of agreement that codifies agency roles and responsibilities in reducing prenatal exposure and responding to its effects.
2) Focus on changing the culture regarding substance use during pregnancy so that women and families are supported to make healthy decisions and to receive appropriate intervention and treatment when needed.
3) Implement a continuum of care that ensures infants, mothers and families can remain safely together with any needed community supports focused on their well-being.
4) Ensure appropriate placement for infants who cannot stay in the custody of their birth mother with preference for kin providers when possible.
5) Ensure coordination and avoid duplication of services for infants, mothers and families.
6) Identify resources, barriers to care and gaps in services including availability of appropriate resources and the effects of current eligibility criteria.
7) Identify and address information and data sharing barriers including aggregating, monitoring and changing practice and policies based on the data.
Practice Protocol Specific Tasks Include:

- Developing efficient methods for health care providers to identify and notify specific personnel in the CPS agency in accordance with provisions in CAPTA or the prevailing State’s law that implements the CAPTA requirements.
- Ensuring a prompt assessment of families for whom notifications are received by CPS to determine if there are immediate safety concerns and risk of future harm to the infant.
- Determining which infants require a Plan of Safe Care. Options may include those with positive results on the universal implementation of the screening tool during prenatal care and repeating that measure in the month prior to the expected due date and at birth. A Plan of Safe Care should be triggered by positive results on the screen or a positive toxicological screen 30 days prior to birth or at birth, or enrollment of an infant under the age of one year in the substantiated child abuse and neglect caseload who may have not been detected at birth as experiencing prenatal substance exposure.
- Establishing a procedure that assures families are included in the “assessment track” in communities with differential response or methods to assess for immediate safety concerns with the preference for maintaining the infant and mother bond.
- Developing methods for the assessments to be conducted by and coordinated with relevant agencies and service providers. This coordination may take the form of a family team meeting in which multiple disciplines work with the family to ensure a comprehensive assessment of strengths and needs of the infant’s and mother’s physical, social-emotional health and safety needs.
- Determining whether the community’s existing safety and risk assessment and intervention protocols are appropriate and sufficient for this group of families and enhancing those assessment tools and procedures as needed.
- Making determinations on how to support infants and families for whom medication assisted treatment is being used in accordance with the mother’s treatment plan.
- Determining the process for and content of an individual Plan of Safe Care which addresses the needs of the infant, mother and other family members identified by the multidisciplinary, comprehensive assessments.
- Ensuring other caregivers receive medical information, training and support to appropriately care for infants with prenatal exposure prior to discharge from the hospital when such infants will not be released to the care of his/her mother and family.
- Determining the appropriate timing for the development of the Plan of Safe Care with a preference that plans are developed with families prior to the infant’s birth so that the family is supported and there is communication among health providers, substance use disorder treatment agencies, child welfare and other community supportive agencies.
- Ensuring Plans of Safe Care are consistent with the individual family support plans that are required for all children accepted by early intervention services under Part C of the Individuals with Disabilities Education Act (IDEA).
• Developing the process for ensuring that families who are determined to have insufficient protective capacity to ensure the safety of the baby with prenatal substance exposure receive prompt investigation services by CPS.
• Implementing policies that ensure the infant’s safety plan includes a safety and risk assessment of the home environment, community and family support, mother’s recovery status and ongoing treatment needs (including her need and receipt of medication assisted treatment) as well as other health care needs in appropriate medical homes, and infants’ health, developmental, well-being and safety needs.

**Developing Plans of Safe Care**

Specific definition on what was to be included and who was to develop, implement and monitor Plans of Safe Care were not specified in the 2003 and 2010 amendments to CAPTA or in CARA 2016. While legislative intent in those changes to CAPTA included care for the infant’s mother, recognizing that her care and safety of the infant are intertwined, in practice, it does not seem that Plans of Safe Care have been consistently implemented.

Guidance on these questions was provided in the Children’s Bureau’s Child Welfare Policy Manual, in response to a question that was posed on September 27, 2011. The question states:

*Which agency is responsible for developing the plan of safe care and what is a plan of safe care, as required by section 106(b)(2)(B)(iii) of the Child Abuse Prevention and Treatment Act (CAPTA)?*

*Answer:* The statute does not specify which agency or entity (such as hospitals or community-based organizations) must develop the plan of safe care; therefore, the State may determine which agency will develop it. The plan of safe care should address the needs of the child as well as those of the parent(s), as appropriate, and assure that appropriate services are provided to ensure the infant's safety. There may be Federal confidentiality restrictions for the State to consider when implementing this CAPTA provision. ([http://www.acf.hhs.gov/cwpm/programs/cb/laws_policies/laws/cwpm/qacumm.jsp](http://www.acf.hhs.gov/cwpm/programs/cb/laws_policies/laws/cwpm/qacumm.jsp))

Legal and Related References*Child Abuse Prevention and Treatment Act (CAPTA), as amended (42 U.S.C. 5101 et seq.) ñ section 106(b)(2)(B)(iii).*


At the time of birth, assessing risk to determine if the infant can go home safely is paramount and is a critical component of the comprehensive assessment process (safety factors generally included in CPS investigations are clarified below).
However, the Plan of Safe Care moves beyond seeking information to substantiate allegations of child abuse or neglect. It specifically incorporates the mother’s (and potentially the father’s) need for treatment for substance use and mental disorders, appropriate care for the infant who may be experiencing neurodevelopmental or physical effects or withdrawal symptoms from prenatal substance exposure, and services and supports that strengthen the parent’s capacity to nurture and care for the infant and to ensure the infant’s continued safety and well-being. The plan also ensures a process for continued monitoring of the family and accountability of responsible agencies such as substance use disorder treatment, home visiting, public health, health care providers for the infant and mother.

The Plan of Safe Care would:

1) Be based on the results of a comprehensive, multidisciplinary assessment that is coordinated across disciplines to determine the infant’s and mother’s physical, social-emotional health and safety needs, as well as the mother’s strengths and parenting capacity.*
2) Assess immediate safety factors and risk of future maltreatment, including:
   • **Safety:** Deciding if a child is in danger of being hurt right now (Decision to remove)
   • **Risk:** Determining the possibility that a child may be hurt in the future (Decision to open a child welfare investigation case)
   • **Strengths:** Assessing the family’s positive qualities and resources available to care for the child
   • **Protective Capacities:** Determining if the parent has the ability or support system available to provide an environment that keeps children free from harm

Factors to consider when assessing safety and risk include:
   • Mothers’ or fathers’ child welfare-related history that indicates unresolved substance use disorders related to a prior case of child abuse or neglect
     ▪ Prior abuse and/or neglect reports related to substance use
     ▪ Siblings’ substance exposure prenatally or in the family environment
     ▪ Evidence of co-occurring mental health concerns that may affect immediate parenting capacity such as post-partum depression and substance use
     ▪ Mother’s willingness to seek treatment and parenting instruction
   • Family environmental challenges related to parental substance use disorders.
     Access to sufficient income and resources, employment history, and lack of health access to a medical home can all interact with substance use disorders, and can result in effects on infants in the home, including neglect. It is clear that poverty

*An example of a comprehensive assessment instrument is modeled after the Newborn Assessment developed in Kansas City and adapted by Los Angeles County which can be found at: [http://ican4kids.org/documents/CANProtocol/ap15.Hospital.pdf](http://ican4kids.org/documents/CANProtocol/ap15.Hospital.pdf). The Kansas City, MO example can be located at: [https://dss.mo.gov/cd/info/cwmanual/section2/ch6/sec2ch6sub2.htm](https://dss.mo.gov/cd/info/cwmanual/section2/ch6/sec2ch6sub2.htm)
alone does not connote an immediate safety concern, rather it is the family’s access to sufficient resources in combination with substance use disorders that may place an infant at higher risk.

For additional information, see *Factors Commonly Included in Assessments Conducted by Child Protective Services* on pg. 19.

3) Be completed when possible prior to the birth of the infant to facilitate engagement of parent(s), and communication among providers; or, when not possible, prior to discharge of the infant from the hospital;

4) Designate a lead agency responsible for oversight and monitoring of the plan including both needs of the infant and needs of the mother including treatment, mental health and other services;

5) Be both child- and parent-focused, recognizing that parents’ ability to do their part in carrying out such a plan will be as equally important as any role for public or private services;

6) Specify with whom the child will be discharged and ensure protective capacity of the parents and/or other family members are sufficient to care for the infant;

7) Include provisions for frequency and the entity responsible for follow up with families including providing home visiting services for all families with a Plan of Safe Care;

8) Specify a timeline for follow-up and monitoring;

9) Specify the details of referral of the child to developmental intervention

10) Be available online to relevant agencies with the appropriate privacy safeguards.

Plans of Safe Care should include the provision of services and supports that address the infant’s and mother’s physical, social-emotional health and safety needs, and foster the mother’s and family’s capacity to nurture and safely care for the infant. Many of the factors to be included in the plan are identified by various professionals throughout the mothers’ pregnancy, at the time of birth and at discharge from the hospital. For example, a mother’s post-partum care would typically be included in the hospital discharge plan. It is clear that many of the factors included in assessments, case planning and treatment plans are included in a Plan of Safe Care and are included in processes conducted in communities at present.

Yet, at present there is not sufficient communication among professionals to ensure that families of infants with prenatal substance exposure have sufficient supports and that infants with prenatal substance exposure have follow-up services to ensure their safety. Thus the plan requires the collaborative effort among community agencies and the family that ensures efficient communication across service systems, agencies and professionals.

Several key aspects differentiate a Plan of Safe Care for an infant with prenatal substance exposure, the mother and family from a typical safety plan developed by child welfare services which assesses for factors that have already occurred in a family and have been brought to the attention of the child welfare agency. Clearly, if it is determined that immediate safety factors are present and protective capacity is not clear to provide for the infant, the family should be moved into the investigation caseload of child protective services. In such instances, it is imperative that the infant’s caregivers (e.g. kin, foster parents) also be involved in discharge planning and caring for an infant with any medical concerns, as is likely for infants with Neonatal Abstinence Syndrome or Fetal Alcohol Syndrome.
In the following table, the assessments conducted to develop the Plan of Safe Care are delineated followed by the risk and protective factors that would be considered for families in which the child is not able to safely remain in the family’s custody.16
<table>
<thead>
<tr>
<th>DOMAINS</th>
<th>SERVICES AND SUPPORTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mother</strong></td>
<td></td>
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<tr>
<td><strong>Health</strong></td>
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<tr>
<td>• Pregnancy and Post-partum care</td>
<td></td>
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<tr>
<td>• Medical home is designated that is consistent with the family’s insurance plan and has responsibility for the primary care needs for the mother and family. Medical homes are often designated in States with Medicaid managed care plans</td>
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<tr>
<td>• Medication management is assessed and the Medical Home provider has responsibility to oversee including liaison with methadone or other medications used in assisting treatment</td>
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<tr>
<td>• Pain management</td>
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<tr>
<td>• Contraception and pregnancy prevention</td>
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<tr>
<td>• Support with breastfeeding</td>
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<tr>
<td><strong>Substance Use and Mental Disorders Prevention, Intervention and Treatment</strong></td>
<td></td>
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<tr>
<td>• Timely access to treatment is ensured by referrals and appropriate feedback across agencies.</td>
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<tr>
<td>• Engagement and retention outreach services and on-going recovery supports</td>
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<tr>
<td>• Appropriate treatment (gender-specific, family focused, accessible, medication assisted treatment, trauma)</td>
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<tr>
<td>• Mental health services including symptoms of depression and anxiety</td>
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<tr>
<td>• Intervention for domestic partner and family Violence</td>
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<tr>
<td>• Substance use and mental health treatment for partner and other family members</td>
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<tr>
<td><strong>Parenting/Family Support</strong></td>
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<tr>
<td>• Coordinated care management</td>
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<tr>
<td>• Home Visiting follow up services are provided including infant care, parent/infant boding, nurturing parenting guidance and skill development, safe sleep practices, and maternal support</td>
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<tr>
<td>• Child Care in developmentally appropriate programming when needed by the family</td>
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<tr>
<td>• Income support and safety net benefits eligibility determination and employment support</td>
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<tr>
<td>• Safe and stable housing determinations are made</td>
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<tr>
<td>• Need for transportation is assessed</td>
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<tr>
<td><strong>Infant</strong></td>
<td></td>
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<tr>
<td><strong>Health</strong></td>
<td></td>
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<tr>
<td>• Linkage to a medical home for infant primary health care is provided</td>
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<tr>
<td>• Need for high-risk infant follow-up Care is determined</td>
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<tr>
<td>• Referral to specialty health care as needed</td>
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<tr>
<td><strong>Development</strong></td>
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<tr>
<td>• Developmental screening and assessment</td>
<td></td>
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<tr>
<td>• Referral to developmental pediatrician as needed</td>
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<tr>
<td>• Referral to early intervention services for assessment, services and follow up</td>
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<tr>
<td>• Early care and education program to ensure developmental intervention and supports are provided by a program with expertise in young children who experienced prenatal substance exposure</td>
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</table>
### Factors Commonly Included in Assessments Conducted by Child Protective Services

| Immediate Safety Factors | • Physical harm or threat of children in the home  
| • Previous maltreatment of other children  
| • Sexual abuse allegations of other children in the home  
| • Failure to protect older children from harm  
| • Questionable explanation of injuries  
| • Refuses access to monitor the child or threatens to take the child out of the CPS agency’s jurisdiction  
| • Immediate needs of child not met  
| • Hazardous living conditions  
| • Impairment by substance abuse and parent is not active in treatment or recovery  
| • Domestic violence  
| • Child is danger to self/others  
| • Emotional/developmental/cognitive Impairment |
| Risk of Child Neglect Factors | • Current complaint includes neglect of other children in home  
| • Prior investigations  
| • Household has previously received CPS  
| • Number of children involved in the child abuse/neglect incident  
| • Age of younger child in household  
| • Primary caretaker provide physical care inconsistent with child needs  
| • Primary caretaker has a past or current untreated mental health problem  
| • Primary caretaker has historic or currently alcohol or drug problems and is not actively in treatment or recovery  
| • Characteristics of children in the household  
| • Unsafe housing |
| Risk of Child Abuse Factors | • Current complaint is for child abuse of other children in the home  
| • Number of prior abuse investigation  
| • Household has previously received CPS  
| • Prior injury to a child resulting from child abuse or neglect  
| • Primary caretaker’s assessment of incident  
| • Domestic violence in the household in the past year  
| • Primary caretaker characteristics  
| • Primary caretaker has a history of abuse or neglect as a child  
| • Secondary caretaker has historic or current alcohol or drug problem and is not actively in treatment or recovery  
| • Characteristics of children household |
Citations


5 In 2010, the law was amended to include the needs of infants born with and identified as being affected by *illegal* substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder. P.L. 111-320, CAPTA Reauthorization Act of 2010, signed into Public Law on December 20, 2010. Retrieved from https://www.congress.gov/bill/111th-congress/senate-bill/3817?q=%7B%22search%22%3A%5B%22P.L.+111%22%5D%7D&resultIndex=5


17 Ibid. Adapted from the American Humane Association (2016)