



***A Planning Guide: Steps to Support a
Comprehensive Approach to Plans of Safe Care***

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National Center on
Substance Abuse
and Child Welfare

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This tool is a draft for discussion. NCSACW welcomes feedback from stakeholders about the content and usability of the tool.

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Introduction

Hundreds of thousands of infants are born in the US each year having experienced prenatal exposure due to their mother's use of substances during pregnancy.¹ The short- and long-term effects vary by substance and many other family and environmental factors. Many children are not known to have long-term effects of prenatal substance exposure, or the effects are subtle and do not compromise the child's long-term well-being. However, for some children, this exposure can have lifelong consequences related to growth, behavior, cognition, executive functioning, language, and achievement.² Each year in the US, infants experience prenatal exposure to tobacco (488,000), alcohol (352,000), or illicit drugs (220,000) due to their mother's use during pregnancy.³ The long-term well-being of infants with substance exposure improves with early identification and appropriate developmental interventions. Engaging pregnant women with substance use disorders in treatment and other services as a component of prenatal care⁴ also has strong benefits by mitigating or preventing negative birth outcomes.

In 2016, Congress amended the Child Abuse Prevention and Treatment Act (CAPTA) regarding infants and their families. Requirements were added to emphasize that Plans of Safe Care address the needs of infants who are identified as affected by substance abuse, experience withdrawal symptoms, or have fetal alcohol spectrum disorders (FASD). Development of a services plan for the infant and their family/caregiver is stipulated. Diverse stakeholders play critical roles in detecting and responding to the needs of these infants and their families and caregivers. States are currently working to meet CAPTA requirements and the needs of infants and their families in the context of the current opioid epidemic.

The National Center on Substance Abuse and Child Welfare (NCSACW), a program of the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Administration on Children, Youth and Families (ACYF), prepared this document to support policy makers, administrators, and service providers. The goal of the document is to foster collaborative responses across multiple systems to improve safety, permanency, and well-being outcomes for infants, recovery for their parents, and to meet the needs of families and caregivers. The information is derived from NCSACW's years of practice-based experience providing technical assistance to states, tribes, and communities. This document is not policy direction nor guidance but rather a technical assistance tool to assist stakeholders as they consider what steps to take in developing a comprehensive and effective approach to using Plans of Safe Care to improve the outcomes for infants with prenatal substance exposure and their families.

Step 1: Understand CAPTA and CARA Legislation – CAPTA has been amended several times, most recently in 2016 by section 503 of the Comprehensive Addiction and Recovery Act (CARA). A good understanding of this legislation is important for communities to determine their desired approach to Plans of Safe Care.

Step 2: Know your State Systems – There is great diversity in how state child welfare, substance use treatment, and healthcare systems are organized, governed, and administered. States, tribes, and localities benefit from understanding existing statutes and structures related to infants with prenatal substance exposures and their families/caregivers.

Step 3: Determine who receives a Plan of Safe Care – There are a number of different populations of infants and family members or caregivers who might need a Plan of Safe Care based on operational definitions determined by the state, tribe, or locality.

Step 4: Identify Partners for a Comprehensive Plan of Safe Care Approach – A diverse array of partners support infants with prenatal substance exposure and their families/caregivers within a state or community. A strong team of state, tribal, and/or local partners with decision making authority and a shared interest to support these infants and families/caregivers is helpful in developing an approach to Plans of Safe Care.

Step 5: Define Plans of Safe Care – CAPTA legislation provides opportunities for states, tribes, and communities to define what is to be included in all Plans of Safe Care.

Step 6: Create a Notification System and Protocol for Plans of Safe Care – CAPTA legislation requires notification to Child Protective Services (CPS) of infants and their families/caregivers who need a Plan of Safe Care. A clearly-defined process for notification and response can support the many agencies who may identify these infants and their families.

Step 7: Assess Needs to Guide Individual Plans of Safe Care – A comprehensive assessment of infant and family/caregiver needs helps identify services and supports to be included in individual Plans of Safe Care.

Step 8: Develop and Implement Individual Plans of Safe Care – State, tribes, and localities can determine which agencies and partners are best suited to develop and implement Plans of Safe Care and identify or enhance the service array available to support the plan's implementation.

Step 9: Manage Individual Plans of Safe Care – Implementation teams and agencies charged with the development of Plans of Safe Care can determine how and who will manage these plans to ensure they are addressing the safety of infants with prenatal substance exposure by serving their needs as well as those of their families/caregivers.

Step 10: Oversee State Systems and Report Data on Plans of Safe Care – CAPTA identifies the data that states are to report to the maximum extent practicable about Plans of Safe Care and the assurances that Governors are required to sign to receive their CAPTA state grant. This opportunity can allow states to put systems in place to sufficiently collect and report on required data elements and monitor if Plans of Safe Care deliver appropriate

Steps to Support a Comprehensive Plan of Safe Care Approach

This section is a component of a technical assistance tool developed by the National Center on Substance Abuse and Child Welfare (NCSACW), a program of the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Administration on Children, Youth and Families, Children's Bureau. This tool aims to assist stakeholders as they review and modify policies and procedures for the development, implementation, and monitoring of Plans of Safe Care. Information is drawn from NCSACW's experience in provision of technical assistance to states and communities.

States, tribes, and local communities face several key decisions as they implement the Child Abuse Prevention and Treatment Act (CAPTA). The following steps can guide state and local teams as they consider key policy and practice considerations and develop procedures for implementing Plans of Safe Care. Each of the steps are paired with associated discussion questions and state examples to inform thoughtful and robust conversation as states and communities work to meet CAPTA requirements and address the needs of affected infants and their families.

Step 1: Understand CAPTA and CARA Legislation

In 2016, Section 503 of the Comprehensive Addiction and Recovery Act (CARA) modified sections of CAPTA related to infants with prenatal substance exposure and Plans of Safe Care. In addition, CARA outlined requirements for state data collection and reporting in National Child Abuse and Neglect Data System (NCANDS) to the maximum extent practicable.

See the following documents for federal law and policy related to Infants with Prenatal Exposure and Plans of Safe Care:

- CAPTA 2016, as amended by CARA:
<https://www.acf.hhs.gov/sites/default/files/cb/capta2016.pdf>
- CARA § 5108-Monitoring and oversight:
<https://www.law.cornell.edu/uscode/text/42/5108>
- Children's Bureau Child Welfare Policy Manual:
https://www.acf.hhs.gov/cwpm/public_html/programs/cb/laws_policies/laws/cwpm/policy_ds_p.jsp?citID=351

The National Center on Substance Abuse and Child Welfare (NCSACW) has developed a brief technical assistance tool that summarizes CAPTA, and the changes made by CARA, related to infants with prenatal substance exposure and Plans of Safe Care. This tool can be found in Appendix 3: CAPTA Substance Exposed Infant Statutory Summary.

The Administration for Children and Families (ACF) issued guidance on requirements and best practices for implementing Plans of Safe Care in two Program Instructions and one Information Memorandum. These materials outline information to be included in states' Annual Progress and Services Reports related to Plans of Safe Care policy development, practice implementation, and state oversight, including a governor's assurance. The ACF materials also identify best practices for supporting states' capacity to address families with infants affected by prenatal substance exposure and

their families/caregivers. The Information Memorandum provides information on the NCSACW resource, *A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders: Practice and Policy Considerations for Child Welfare, Collaborating Medical and Service Providers* ([https://ncsacw.samhsa.gov/files/Collaborative Approach_508.pdf](https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf)) a tool to help communities develop and implement these best practices.

See the following documents for more details on the Administration for Children and Families guidance:

- August 26, 2016 Information Memo:
<http://www.acf.hhs.gov/sites/default/files/cb/im1605.pdf>
- January 17, 2017 Program Instructions:
<https://www.acf.hhs.gov/sites/default/files/cb/pi1702.pdf>
- April 10, 2017 Program Instructions:
<https://www.acf.hhs.gov/sites/default/files/cb/pi1705.pdf>

A close review of available legislation and guidance can assist communities as they consider their approach to Plans of Safe Care.

Planning Questions

- Have partners reviewed relevant law, policy, and guidance available from the federal government?
- Do key partners have an understanding of CAPTA and the recent CARA amendments to CAPTA?

Step 2: Know your State Systems

Implementing state statutes and policies may differ based on how state child welfare, substance use treatment, and healthcare agencies are organized and administered. These differences may affect local procedures and practices related to the development, implementation, and management of Plans of Safe Care. A comprehensive approach to Plans of Safe Care begins with a review of existing state statutes, policies, and procedures to focus the state team on any needed changes to comply with CAPTA, the recent changes enacted through CARA, and how to address the needs of infants and their families/caregivers.

The types of decision making by implementation teams depends on the structure of the state's child welfare agency and the array of state-level implementation partners, including the state substance use treatment agency and healthcare system. Local regional child welfare offices implementing state-administered child welfare programs may receive more guidance on requirements from the state child welfare department. Implementation teams can identify how best to respond to these state directives. For state-led, county-administered child welfare programs, implementation teams may have the ability to make more decisions about how to respond to state guidance within their local context. Although state policies, regulations, and decisions guide local implementation, implementation teams develop procedures and protocols to translate those decisions into practice.



For all states, CAPTA requires the Governor to assure that the state has policies and procedures for health care providers involved in the delivery and care of an infant “affected by substance abuse, withdrawal symptoms or Fetal Alcohol Spectrum Disorder” to notify their local CPS agency. That identification and notification is not intended to be the sole grounds to substantiate child abuse or neglect. State team development of the Plan of Safe Care approach can be affected by how state hospital and healthcare systems are administered, organized, and connected to state child welfare and substance use treatment agencies. For implementation teams, understanding healthcare systems can affect how teams create policies, procedures, and protocols to ensure awareness among healthcare professionals and notification to CPS.

Twenty-five states include some aspect of prenatal exposure in their statutory definitions of child maltreatment and many states identify health care providers as mandatory reporters of suspected child abuse and neglect. In those states, notification to CPS may constitute a report of child abuse or neglect and, based on the state's policies, may require an assessment or investigation. In states that do not include prenatal substance exposure in their child abuse or neglect statute, state policies will dictate how the notification to CPS is to be assessed.

Development of Plans of Safe Care in the prenatal period is voluntary and dependent upon state statute and policy. The CAPTA requirements do not apply to families during this time and child welfare services generally do not take jurisdiction prior to an infant's birth. A substance use disorder treatment agency or healthcare agency might develop an initial Plan of Safe Care during the prenatal period and communicate with the child welfare agency about the plan before or at the infant's birth. Understanding the state structure, statutes, legislation, policies, and procedures, including how the state systems collaborate and communicate, can help identify how to work effectively among child welfare, substance use treatment, and healthcare system partners in developing a comprehensive approach to Plans of Safe Care.

Planning Questions

- Does the state have a statute that includes some aspect of prenatal exposure in the statutory definitions of child maltreatment?
- Does the state have a statute that requires mandated reporters involved in the delivery and care of an infant "affected by substance abuse, withdrawal symptoms or Fetal Alcohol Spectrum Disorder" to notify their local CPS agency? Does the state have a statute that defines who is a mandated reporter?
- Are there state statutes in place that identify roles and responsibilities for development and implementation of Plans of Safe Care?
- How does child welfare currently respond to notifications or reports of infants affected by prenatal substance exposure?

The **National Conference of State Legislatures** provided a [review of recent legislation](#) related to infants with prenatal substance exposure in April 2017.

The **Child Welfare Information Gateway** maintains [a State Statutes Series](#), a resource to search statutes and policy by individual States on issues related to child abuse and neglect, child welfare, and adoption.

Step 3: Determine who receives a Plan of Safe Care

CAPTA does not define or provide a list of diagnostic criteria for the term “affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder.” States have the opportunity to define this group of affected infants and this definition has implications for which infants and families receive a Plan of Safe Care.

Evidence that an infant is “affected by” the mother’s substance use can include impaired growth, preterm birth, or subtle neurodevelopmental signs that are more difficult to define in the newborn and infancy stages. Many states rely on positive toxicology screens of an infant as one element, but not the sole criteria, in defining an affected infant. Infants with prenatal exposure to stimulants or alcohol without the full expression of Fetal Alcohol Spectrum Disorder (FASD) could be “affected by” that exposure. Similarly, infants prenatally exposed to tobacco might be born with low birthweight and have an increased risk of impaired respiratory functions and neurobehavioral concerns. States can benefit from taking into account the factors listed below when developing their definitions for infants affected by substance abuse, withdrawal symptoms, or fetal alcohol spectrum disorder.

In conjunction with known substance use during pregnancy, signs of prenatal exposure detectable at birth and in early infancy can include:

- Facial characteristics of fetal alcohol syndrome
- Symptoms of withdrawal including diagnosis of neonatal abstinence syndrome
- Irritability
- Irregular and rapid changes in arousal
- Low birthweight
- Prematurity
- Difficulties with feeding due to poor suck
- Irregular sleep–wake cycles
- Decreased or increased muscle tone
- Seizures or tremors

Adapted from Messinger, D., & Lester, B. (2005). Prenatal Substance Exposure and Human Development. In A. Fogel & S. Shanker. (Eds.), *Human Development in the 21st Century: Visionary Policy Ideas from Systems Scientists*. Bethesda, Maryland: Council on Human Development.

Using the definition of children with special health care needs as a basis for defining infants who are substance-affected could guide states as they consider the breadth and depth of services needed to support infants and their families for optimal well-being. The Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA) defines children with special health care needs as: “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 generally.”⁵ Recognizing infants with prenatal substance exposure as medically fragile children with special health care needs may also help communities see the benefits of implementing a public health approach to address the needs of these infants and their families/caregivers.

States may benefit from consulting with pediatricians and other health-care professionals to establish the definitions of affected infants. Consensus on the definitions by state and local agencies, private practitioners, hospitals, and other stakeholders is important to ensure provision of the full spectrum of interventions and supports needed to safeguard the infant's and family's safety and well-being.

Identifying infants with "withdrawal symptoms" resulting from prenatal drug exposure is also complex. Infants with prenatal exposure to either legal or illegal substances (including alcohol, benzodiazepines, opioid-based medications, and medications prescribed to treat opioid use disorders) sometimes experience withdrawal symptoms. Furthermore, maternal smoking during pregnancy can exacerbate an infant's withdrawal symptoms.

The American Academy of Pediatrics identifies that withdrawal symptoms mean a group of behavioral and physiological features in the infant that follow the abrupt discontinuation of a substance that has the capability of producing physical dependence and warns that "no clinical signs of withdrawal in the neonate should be attributed to in utero exposure to alcohol or other drugs without appropriate assessment and diagnostic testing to rule out other causes."⁶

Challenges with accurate diagnosis of infants with FASD at birth may make it difficult to ensure that these infants are included in a community's approach to Plans of Safe Care. Communities can identify the age at which infants are initially screened and implement policies that support pediatricians and child care providers to do ongoing screening and assessment. Defining when an infant can be identified as having been born with prenatal exposure and the ages of infants for whom Plans of Safe Care are to be developed guides notification requirements and Plan of Safe Care development.

Unique Populations of Women

Universal substance use disorder screening of women during pregnancy can decrease biases about who to screen and ensure that women have opportunities to access treatment and supports, if needed. While toxicology panels might also be appropriate for pregnant women and new mothers to identify the presence of a substance, testing cannot identify the reason for the presence of that substance nor the effect of the substance on the infant.

States and local implementation teams can develop screening and assessment procedures to classify the woman's substance use experience.



These assessments can support an approach that responds to different groups of families with an affected infant based on whether the mother:

- Is taking opioid medication for chronic pain or medications (e.g., benzodiazepines) and has no known substance use disorder.
- Is receiving medication-assisted treatment (buprenorphine or methadone) for an opioid use disorder or is actively engaged in treatment for a substance use disorder.
- Is misusing prescription drugs or using legal or illegal drugs, meets criteria for a substance use disorder, and is not actively engaged in a substance use disorder treatment program.

After identifying the unique populations of women, the state team might match those populations with appropriate service providers to ensure inclusion of appropriate prevention and intervention services in the Plan of Safe Care. For example, substance use disorder treatment agencies might partner with CPS to develop and implement the Plan of Safe Care for women actively engaged in treatment.

Planning Questions

- How does the state define infants affected by prenatal substance exposure, such as “affected by substance abuse,” “withdrawal symptoms,” and “Fetal Alcohol Spectrum Disorder”?
- How might the definition of “infant born with” affect the age at which a child is eligible to receive a Plan of Safe Care?
- How will the definition address challenges with diagnosing FASD in infants and the broad spectrum of associated disorders within FASD?
- How might the definition of “infants born with and affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder” affect which families to include in or exclude from the group requiring a Plan of Safe Care?
- How might universal screening for substance use during pregnancy using an evidence-based screening tool affect identification of infants needing a Plan of Safe Care?
- How might the Plan of Safe Care approach be adapted for unique populations of women giving birth to infants with substance exposure?

State Example

Delaware introduced [HB 140](#), Aiden’s Law in April 2017 to address CAPTA prenatal exposure provisions. The bill identifies a definition of the terms “infant with prenatal substance exposure” and “withdrawal symptoms” focused on addressing directions from ACF about changes in the definition made by the 2016 CARA amendments to CAPTA. Additionally, the bill outlines a collaborative response policy with different partners developing and overseeing Plans of Safe Care based on unique populations of families. While this bill did not make it through committee, the associated fiscal note was funded.

Step 4: Identify Partners for a Comprehensive Plan of Safe Care Approach

Role of State Teams

Policies and procedures that direct the Plan of Safe Care may benefit from the input and resources of multiple state agencies. A state-level agency that reports to the governor and has convening authority to work across agencies can provide leadership to this multiagency planning group. The planning group, often called a state team, can develop a comprehensive response to infants with prenatal substance exposure, families and their caregivers that draws on the expertise of staff in several state agencies and groups and adheres to the requirements laid out in CAPTA. The state team can develop collaborative partnerships for coordinating and supporting a family-focused system that delivers prevention, early intervention, public health, and community-based treatment services.

The state teams that oversee this collaborative work could be existing state councils or subcommittees, such as children’s cabinets or early childhood councils, or newly formed groups designed specifically to address the needs of infants with

prenatal substance exposure and their families/caregivers. The state team’s lead entity or entities benefit from expertise in developing and sustaining multidisciplinary collaborative partnerships. The state might give these entities new authorities so that they can respond to prenatal exposure, including the authority to propose changes to current state statutes and policies.

The planning group would benefit from assessing its membership to identify gaps in agencies and organizations to provide the services. The NCSACW document titled, *A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders: Practice and Policy Considerations for Child Welfare, Collaborating Medical, and Services Providers* (page 18) is a guide for collaborative planning and considerations of potential partners. It can be accessed at: [https://ncsacw.samhsa.gov/files/Collaborative Approach 508.pdf](https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf).

Role of Implementation Teams

Implementation teams develop policies, protocols, and/or procedures to translate state decisions into practice. The implementation team accomplishes these goals by developing practice, communication, and information-sharing procedures to coordinate the child and family-focused service delivery system. The implementation team can benefit from emphasizing coordination of prevention, early intervention, and an array of

State Team Representatives may include:

- Public Health
- Maternal and Child Health
- Home Visiting
- Substance Use Disorder Prevention and Treatment
- Mental Health
- Child Abuse Prevention and Child Protection Services
- Early Intervention and Developmental Services
- Courts
- Education
- Budget and Finance
- Medicaid & Private Insurance
- Hospital Associations
- Medical Providers, such as Obstetricians and Pediatricians

community-based treatment and support services for infants, children, and their families.

Multiple agencies coordinate services to address the unique experiences of each family member to best serve the diverse needs of infants with substance exposure and their family/caregiver. It may be easier for a single agency to provide all needed programs—but this may be less effective or efficient than ensuring that different agencies with unique expertise and resources provide the needed services and supports. Child welfare agencies, substance use disorder treatment agencies, health care providers, judicial officers and attorneys, public health agencies, and community partners benefit from their involvement in this collaborative effort through enhancements in training, resources, shared information, and improved outcomes.

Ideally, partners who are working with or needed by the family collaboratively develop individual Plans of Safe Care. NCSACW's experience suggests that these partners may include the obstetrician/gynecologist, pediatrician, neonatologist, or other hospital provider; home visitor; substance use treatment clinician and medication-assisted treatment clinician; child welfare provider; and the family or caregiver. Communities implementing a collaborative approach benefit from clear communication procedures and data reporting roles to ensure that data and policies are shared.

Planning Questions

- Which members will the state team and implementation team include? What types of authority do they need for their agency to contribute to the team? What are the possible outcomes of omitting a critical member?
- How can state and implementation teams establish agency roles and responsibilities related to reducing prenatal exposure and responding to its effects?
- What partners can be included when determining the necessary components in a Plan of Safe Care template or policy?
- How can state teams support the development of Plans of Safe Care?
- How can state and implementation teams use this work to change the culture around substance use during pregnancy to support healthy decision making and receipt of appropriate interventions and treatment by women and families?

State Example

New Jersey is developing a comprehensive, unified plan coordinating multiple initiatives to address the opioid epidemic, including a focus on neonatal abstinence syndrome and Infants with Prenatal Substance Exposure (IPSE). They have an emphasis on addressing the entire spectrum of IPSE needs and improve collaboration to address the multiple IPSE intervention opportunities. One recent accomplishment of this collaborative team includes the launch of the New Jersey [Maternal Wraparound Program \(MWRAP\)](#). This jointly-funded program provides intensive case management, home visiting, and recovery coaching to pregnant and post-partum women. MWRAP case managers will oversee the Plan of Safe Care.

Step 5: Define Plans of Safe Care

In their January 17, 2017 Program Instruction, ACF states:

“while CAPTA does not specifically define a “plan of safe care,” CARA amended the CAPTA state plan requirement at 106(b)(2)(B)(iii)(1) to require that a plan of safe care address the health and substance use disorder treatment needs of the infant and affected family or caregiver. We want to highlight that this change means that a plan of safe care must now address not only the immediate safety needs of the affected infant, but also the health and substance use disorder treatment needs of the affected family or caregiver. Consistent with good casework practice, the plan should be developed with input from the parents or other caregivers, as well as any collaborating professional partners and agencies involved in caring for the infant and family.”

In practice, a Plan of Safe Care may be defined as a document that inventories and directs services and supports to ensure the safety and well-being of an infant affected by substance abuse, withdrawal or FASD, including services for the infant and their family/caregiver. A Plan of Safe Care can specify the agencies that provide specific services, outline communication procedures among the family and provider team and guide the coordination of services across various agencies with the family.

Plans of Safe Care go beyond the immediate safety factors of an infant and address their ongoing health, development, and well-being as well as the treatment and other services needs of their family/caregiver. Plans of Safe Care may incorporate services and supports for diverse, longer-term needs, including physical and mental health, substance use treatment, parenting education, infant developmental screening, and other family needs.

While child welfare will likely not become involved until after the birth of a child, various professionals can identify factors to include in Plans of Safe Care throughout a woman’s pregnancy, at the time of birth, and at discharge from the hospital. The Plan of Safe Care brings together the services identified from these providers in a family-focused plan to meet the needs of the infant, family, and caregiver. During pregnancy, a Plan of Safe Care can identify how notification to the CPS agency will be made when the birth has occurred, confirm to CPS that a Plan of Safe Care has been developed, and identify the local agency that could lead implementation of the plan after the infant’s release from the hospital. The prenatal care provider might collaborate with the CPS agency before the birth (e.g., in the month before the due date) to establish or refine the Plan of Safe Care.

NCSACW’s experience providing technical assistance suggests that effective Plans of Safe Care are:

- *Interdisciplinary* across health and social service agencies;
- Based on the results of a *comprehensive, multidisciplinary assessment* of physical and social-emotional health and safety needs of the infant and the parents or caregivers;^{7,8}

- *Family focused* to assess and meet the needs of each family member as well as overall family functioning and well-being by building on each family member's strengths, challenges, and, for the mother and father, parenting capacity;⁹
- Completed, when possible, in the prenatal period to facilitate *early engagement* of parent(s) and communication among providers or, when not possible, before the infant's discharge from the hospital;¹⁰
- *Easily accessible* to relevant agencies with the appropriate confidentiality safeguards to facilitate information sharing;
- *Collaborative* in identifying appropriate lead agencies to be accountable for the care management and for plan development, implementation, management, communication, and data submission;¹¹and,
- Grounded in *evidence-informed practices*, such as a preference that infants, mothers, and families remain together whenever possible.

There is not a uniform national or state template for a Plan of Safe Care that fits all urban, rural, and suburban settings or meets the needs of all parents and children. Communities might consider the domains below in determining what elements to include in a Plan of Safe Care beyond those already included in their standard child welfare safety plan developed by child welfare partners. Although this list is not exhaustive, it provides an outline of elements to consider.

Considerations for Plans of Safe Care		
Mother		
Domain	Provider	Types of Services of and Supports
Primary and obstetric and gynecologic care	Prenatal Care Physicians, Nurses, and/ or healthcare agencies	<ul style="list-style-type: none"> • Pre-pregnancy and prenatal screening • Medical home or primary care provider for primary health care management • Pregnancy and postpartum obstetrical, gynecological, and family planning • Prenatal education and support • Substance use disorder treatment, including medication-assisted treatment • Pain management • Breastfeeding coaching and support for enhanced bonding and attachment • Care for co-occurring mental health conditions, particularly maternal depression
Parents/Caregivers		
Domain	Provider	Types of Services of and Supports
Substance use and mental disorders prevention, and treatment, especially if required for	Mental Health Clinician; Substance Use Treatment Counselors or community treatment agencies in partnership with	<ul style="list-style-type: none"> • Substance use disorder care management to enhance treatment access and retention via outreach services and ongoing recovery supports • Designated treatment provider who is, to the extent possible, knowledgeable about child welfare, delivers gender-specific programming, is family focused, is trauma informed, and provides trauma-specific treatment

postpartum depression	Child Welfare Providers as needed	<ul style="list-style-type: none"> • Mental health services, including for symptoms of depression and anxiety, and trauma-specific treatment • Substance use and mental health treatment for other family members or caregivers
Parenting/ Family Support	Social Worker; Case Manager; Home Visitor; Perinatal Nurse or community agencies designated to provide, family focused services in partnership with Child Welfare Providers as needed	<ul style="list-style-type: none"> • Education on appropriate care for the infant experiencing neurodevelopment effects, physical effects or withdrawal symptoms • Coordinated care management for parents and family in conjunction with child welfare and other partners • Follow-up services, such as infant care, parent/infant bonding support, nurturing parenting coaching and skill development, safe sleep practice support, and parental support with appropriate intensity based on individual family needs through such methods as on-site education, classes, and short-term in-home and longer-term home visits • Education on potential child welfare involvement and Plans of Safe Care • Evidence-based home visiting services • Evidence-based parent-child therapy • Interventions for intimate partner and family violence • Child care in developmentally appropriate programming • Income and employment support • Safety net benefits eligibility determination • Recovery support, including safe and stable housing and transportation assistance

Infant

Domain	Provider	Types of Services of and Supports
Health	Family Physician; Pediatrician or Primary Care Provider in partnership with Child Welfare Providers as needed	<ul style="list-style-type: none"> • Linkage to a medical home, pediatrician, or primary care provider • High-risk infant follow-up care • Referral to specialty health care
Development	Early Intervention Specialist; Developmental Pediatrician or early childhood services agency in partnership with Child Welfare Providers as needed	<ul style="list-style-type: none"> • Coordination of early care, developmental, and education programming with child welfare and other partners as needed. • Developmental interventions and supports provided by staff with knowledge of and expertise in young children and expertise in working with infants with prenatal substance exposure • Developmental screening and assessment and re-assessments for services included in Part C of IDEA for infants and toddlers with developmental delays or who have physical or mental conditions likely to result in developmental delays • Developmental pediatrician

Plans of Safe Care may differ from standard CPS safety plans, substance use treatment plans, and hospital discharge plans in a number of ways. CPS safety plans may focus on immediate safety of a child, while Plans of Safe Care focus on the safety and well-being of infants by addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver. This process may include more extensive follow-up plans that support families and focus on the longer-term well-being of the infant and family or caregiver. Substance use treatment plans may focus on treatment of adults, while Plans of Safe Care may include the treatment and broad services of the whole family including the infant and parent-child dyad. Hospital discharge plans may focus on the health and well-being of the infant, while Plans of Safe Care include the ongoing health and development of the infant as well as the educational and substance use disorder treatment needs of the family/caregiver who will be caring for the infant.

Current child welfare safety plans, substance use treatment plans, and hospital discharge plans can strengthen Plans of Safe Care. Providing the full range of currently-available prevention and intervention services along with additional services to meet the family or caregiver's on-going service needs benefit Plans of Safe Care. A well developed and implemented Plan of Safe Care may prevent the removal of an infant from his/her family or provide a good opportunity for quick reunification if initial placement is away from the birth mother and/or father. A strong Plan of Safe Care benefits an infant and their caregiver by addressing their treatment needs, regardless of immediate child placement decisions.

Planning Questions

- What information needs to be included in a Plan of Safe Care or in a Plan of Safe Care template?
- What elements of a Plan of Safe Care are specific to birth mothers, fathers, caregivers, other family members and infants?
- Which services could be considered for infants with substance exposure to enhance their short-term and long-term health, safety, and well-being outcomes? How would referral and assessment under Part C of IDEA (which addresses early intervention providers) affect those outcomes?

State Examples

The **Vermont** Department for Children and Families, Family Services Division, issued a memo on December 12, 2017 providing protocols and guidance to Vermont State and Community Hospitals and Family Practice Providers on addressing requirements in CAPTA for substance-exposed newborns. This memo identifies a number of tools to support these protocols including a flow chart, notification form, Plan of Safe Care Template and FAQ.

- [Vermont DCF Memo](#)
- [CAPTA Flow Chart](#)
- [Notification Form](#)
- [Plan of Safe Care Template](#)
- [Plan of Safe Care and Notification FAQ](#)

Virginia's Handle with C.A.R.E. Initiative, led by the Virginia Department of Behavioral Health and Developmental Services, is developing a Plan of Safe Care guidance package that includes information and resources related to development and implementation of Plans of Safe Care. The package includes a [Plan of Safe Care Template](#).

Step 6: Create a Notification System and Protocol for Plans of Safe Care

Identification of an infant affected by substance abuse or withdrawal symptoms or FASD triggers the CAPTA-required notification to the CPS agency and the development, implementation, and management of the Plan of Safe Care. When a health care provider notifies the CPS agency of an affected infant, intake staff determine how to respond based on state-specific law, policy, and protocols.

Twenty-five states include some aspect of prenatal exposure in their statutory definitions of child maltreatment. In these states, intake workers receive notifications and automatically screen-in cases for triage into a range of child welfare responses based on standard intake questions, safety/risk assessment, and state specific requirements.

In the other states without statutory definitions of prenatal exposure as child maltreatment, a health-care provider's notification to CPS of an affected infant may not generate an automatic screened-in response from CPS. Intake workers assess safety and risk factors for potential child maltreatment to determine if a notification is to be screened-in or screened-out. Screened-out cases are those where there is not enough information on which to follow up or if the situation reported does not meet the State's legal definition of abuse or neglect. For cases screened-in, CPS might be the most appropriate entity to develop and implement Plans of Safe Care. For cases screened-out, implementation teams might convene to determine which agency can take the lead to develop and monitor Plans of Safe Care, based on state statutes or policies.

Local implementers have the flexibility to establish the appropriate assessment and data collection procedures for these notifications. The Children's Bureau's *Child Welfare Policy Manual* does note that "there may be Federal confidentiality restrictions for the State to consider when implementing this [Plan of Safe Care] CAPTA provision."¹² In states that do not define prenatal exposure as child abuse or neglect, the required notification to CPS might conflict with regulations governing health records privacy when the exposure was associated with the mother's use of medications under a physician's direction and there are no child safety concerns. Hospital staff are mandated reporters of suspected child abuse or neglect, but, in the absence of specific abuse or neglect concerns, the state's mandated reporter laws might not apply to these cases. Clarity on these issues of confidential information and communication protocols benefit families when they are implemented in states and communities.

States might consider clarifying, in statute or policy, the distinction between the notification required by CAPTA to the local CPS agency and the submission of a child abuse and neglect report to a child welfare agency. Although both types of reports lead to creation and implementation of a Plan of Safe Care, the child welfare agency might not be involved with families that do not have immediate safety concerns or who are not considered high risk for child abuse or neglect. Making this distinction in statute or policy may provide flexibility to CPS agencies and encourage consistent implementation of the requirement to notify the local CPS agency of affected infants who meet the CAPTA definition.

Planning Questions

- How does the state define “notifications” and how will it develop effective notification systems and protocols?
- What is the process for notification to CPS? What information will be provided in the notification process?
- How can teams ensure that the perspectives and needs of health care providers involved in the delivery or care of infants are included in the development of policies and procedures for notifying the CPS agency of infants with prenatal substance exposure?
- How can the state team support healthcare providers to implement policies and procedures for notifying CPS including who to notify, under what circumstances as well as when and where to notify?
- How can the state team address current barriers and challenges to the notification process?
- How can health care providers ensure that their notification complies with state law and CAPTA requirements?
- What processes are necessary to ensure prompt assessment of families with CPS notifications to identify if they are in need of child welfare investigation, other alternative child welfare responses or assignment/hand off to a community partner?

State Example

The **North Carolina** Plan of Safe Care Interagency Collaborative (POSCIC) has been working to address requirements of states to respond to the recent changes to CAPTA legislation and meet the needs infants affected by prenatal substance exposure and their families. The POSCIC has developed a webinar outlining the proposed role of hospitals in supporting North Carolina's implementation of recent federal Child Abuse Prevention and Treatment Act (CAPTA) amendment under the Comprehensive Addiction and Recovery Act (CARA) legislation. In addition, an FAQ to address the state's approach to Infant Plans of Safe Care is available.

- [Webinar: The Role of Hospitals in Plans of Safe Care](#)
- [Notification Process and Response Pathways FAQ](#)
- [Example Notification Referral Form](#)

Step 7: Assess Needs to Guide Individual Plans of Safe Care

A multidisciplinary, family-focused approach suggests an initial screening and assessment process that identifies families requiring assistance and their health and social service needs. Implementation teams can use their assessment with families, paired with their collective knowledge of the current service array in their community, to develop an individual Plan of Safe Care.

An assessment for development of a Plan of Safe Care can include child abuse and neglect risk and protective factors, infant health and development, and family members' and caregivers' need for substance use disorder treatment, and other health and social service supports. This multidisciplinary approach may differ from typical child welfare safety and risk assessment practice in that it may include such partners as birthing hospitals, substance use disorder treatment providers, primary care providers, home visiting, and public health agencies.

CPS safety plan processes used for assessment tracks in differential response programs and those used for investigations of child abuse or neglect allegations can identify useful elements for a comprehensive Plan of Safe Care. Safety plan processes that determine immediate safety factors, risks to the child, and family's protective capacity to mediate those risks are particularly important in development of Plans of Safe Care. These assessment procedures often call for the determination of the factors listed in the table below. This list is not meant to be exhaustive, rather it is provided to help identify and enhance CPS assessment practices related to infants with prenatal substance exposure and to implement Plans of Safe Care for the infant inclusive of the family/caregiver treatment and services.¹³

Figure 2: Factors Commonly Included in CPS Assessments

Immediate Safety Factors	Risk of Child Neglect Factors	Risk of Child Abuse Factors
<ul style="list-style-type: none"> • Physical harm or threat of harm to children in the home • Previous maltreatment of other children • Sexual abuse allegations involving other children in the home • Failure to protect children from harm • Questionable explanation of injuries • Refusal of access to monitor the child or threatens to take the child out of the CPS agency's jurisdiction • Child's unmet immediate needs • Hazardous living conditions • Impairment by substance use and parent not active in treatment or recovery • Domestic violence • Emotional, developmental, or cognitive impairment 	<ul style="list-style-type: none"> • Current complaint that includes neglect of other children in the home • Prior investigations • Previous receipt of CPS services • Number of children involved in the child abuse or neglect incident • Younger age of child in household • Physical care by primary caretaker that is inconsistent with the child's needs • Past or current untreated mental health problem of the primary caretaker • Past or current alcohol or drug problems of the primary caretaker, who is not actively in treatment or recovery • Characteristics of children in the household • Unsafe housing or lack of housing stability, with frequent moves or evictions 	<ul style="list-style-type: none"> • Current complaint about abuse of other children in the home • Number of prior abuse investigations • Previous receipt of CPS services by household • Prior injury to a child resulting from child abuse or neglect • Primary caretaker's assessment of the incident • Domestic violence in the household in the past year • Primary caretaker characteristics • Primary caretaker with a history of abuse or neglect as a child • Secondary caretaker with a past or current alcohol or drug problem who is not active in treatment or recovery • Characteristics of children in the household

NCSACW's experience suggests that a comprehensive Plan of Safe Care assessment may also address:

- The parents' need for substance use and mental disorders treatment
- Mother's and father's child welfare-related history which may indicate unresolved substance use disorders related to a prior case of abuse or neglect
- Mothers history of prenatal care
- Siblings' prenatal substance exposure or exposure in the family environment
- Parents' willingness to seek treatment and other services, such as parenting education and coaching
- Parents' criminal history
- Family environmental challenges that may be associated with parental substance use disorders or that could be exacerbated by active substance use disorders and be associated with child neglect, such as income and resources, housing-related stress, employment history, and health care access.

It can be challenging to gather all the information for a comprehensive assessment to inform the Plan of Safe Care before the infant is discharged from the hospital.

Therefore, partners might work together when pregnant women with substance use disorders are identified during prenatal care to gather sufficient information to identify and respond to the immediate health, safety, and treatment needs of the pregnant woman. Preparation to address the anticipated services needed for the infant and family or caregiver at the time of birth can improve services and decrease stress on providers working to coordinate services. Gathering this information when the pregnant or postpartum woman is identified suggests a need for protocols for communication and information sharing among providers specified in the Plan of Safe Care. This kind of coordination across agency, provider, and system boundaries requires clear communication and procedures to address confidentiality concerns.



Planning Questions

Are the community's safety and risk assessment and intervention policies appropriate and sufficient for these families? If not, which modifications to current safety and risk assessment practices might ensure that infants with substance exposure, mothers, and families remain safely together with needed community supports focused on their well-being?

How do current assessment policies or procedures ensure the completion of safety and risk assessments of the home environment, community and family supports, and other health-care needs in appropriate medical homes along with the infant's health, developmental, well-being, and safety needs?

How do current assessment policies and procedures address the mother's recovery status and ongoing treatment needs, including her need for and receipt of medication-assisted treatment?

How can modifications to current safety and risk assessment practices in the child welfare agency, prompted by the need to develop Plans of Safe Care, ensure appropriate placement for infants who cannot stay in their birth mother's and/or father's custody?

How might a multidisciplinary, comprehensive assessment support the development of the Plan of Safe Care?

State Example

Kansas has modified child welfare policy to implement a detailed process to define and address Pregnant Women Using Substances and Substance Exposed Infants. This process includes definitions of the populations addressed by the policy, notification to CPS of women during pregnancy or at birth and detailed guidance on how to assess families for assignment to a services track or further investigation. Regardless of the track determined appropriate, direction is provided for how a Plan of Safe Care is to be developed by child welfare staff or a Community Family Service Provider.

- [Plan of Safe Care Policy](#)
- [Plan of Safe Care Development Overview](#)
- [Plan of Safe Care Template/Form](#)
- [Assessment Guide for Plan of Safe Care Development](#)

Step 8: Develop and Implement Individual Plans of Safe Care

Some states currently have statutes or policies that identify roles and responsibilities for the development and implementation of Plans of Safe Care. Other states might revise their statutes, policy manuals, or practice protocols to delineate roles and responsibilities across partners for notification, development, and implementation of Plans of Safe Care. Because CAPTA does not specify the agency that should develop, implement, and oversee individual Plans of Safe Care, states and/or local communities can decide which entity(ies) will take on these roles. States might consider assigning different organizations to partner with the CPS agency and take on specific roles and responsibilities for implementing Plans of Safe Care based on the needs of the infants and families, agency mandates, and services available in the community.

Timing can affect which partners are able to help develop the Plan of Safe Care. For example, in most states, the child welfare agency will only develop a Plan of Safe Care after the child's birth. But a substance use disorder treatment agency or prenatal care provider might develop an initial Plan of Safe Care during the prenatal period and communicate with the child welfare agency about the plan before the infant's birth.

Screening and assessment procedures can help identify appropriate providers to deliver prevention and intervention services to a woman, her infant, and other family members or caregivers. For cases assessed as having concerns related to safety and risk for child maltreatment, CPS might be the most appropriate entity to implement Plans of Safe Care. For cases not assessed as having concerns related to safety and risk for child maltreatment, local teams might convene to determine which agency can take the lead to develop and manage Plans of Safe Care based on state statutes or policies. A range of community partners or collaborative teams can implement the Plan of Safe Care with families that do not have allegations of child abuse or neglect.

The table below highlights three populations of women who may require a Plan of Safe Care and providers that could lead implementation for that plan, based on the unique needs of that population and timing of plan implementation.

Population of Pregnant and Postpartum Women	Potential Entity to Oversee a Plan of Safe Care	
	Developers of Plans of Safe Care in the Prenatal Period	Developers of Plans of Safe Care at Birth
Using opioid medications for chronic pain or other legal medications (e.g., benzodiazepines) that can produce withdrawal symptoms and has no substance use disorder	Prenatal care provider with pain specialist or other physician	Maternal and child health postpartum service providers (e.g., home visiting and Healthy Start providers) and community-based child welfare agencies that provide prevention services
Receiving medication-assisted treatment (buprenorphine or methadone) for an opioid use disorder or engaged in treatment for a substance use disorder	Prenatal care provider with opioid treatment program or waived buprenorphine prescriber and/or therapeutic treatment provider	Opioid treatment or therapeutic substance use disorder treatment providers with maternal and child health partners or child welfare
Misusing prescription drugs or using legal or illegal drugs, meet criteria for a substance use disorder, and are not engaged in a treatment program	Prenatal care provider or high-risk pregnancy clinic with substance use disorder treatment agency	CPS and other child welfare service agencies

Policies that direct systems to develop and implement Plan of Safe Care prenatally or directly after birth when development in the prenatal period is not possible, can help to ensure adequate time for comprehensive assessment of family strengths and challenges and planning for the array of services to be provided. Collaboration of prenatal service providers with substance use treatment providers and other community agencies before birth can reduce the emergency responses and information gathering in the short period when the infant remains in the hospital after birth. Earlier implementation of individual Plans of Safe Care offers opportunities to mitigate negative physical effects of substance exposure on the infant and address a mother's health, wellness, and social support needs.

Development of Plans of Safe Care in the prenatal period is voluntary, because CAPTA requirements do not apply to families during this time and child welfare services don't take jurisdiction prior to an infant's birth.

Generally, identification of substance use during pregnancy does not trigger a risk and safety investigation by a child welfare agency, and child welfare agencies do not intervene before an infant's birth. CPS agencies might become involved with pregnant women because of concerns about older children in the home or a concurrent CPS case involving other children. More often, only prenatal care providers and substance use treatment agencies interact with pregnant women. These agencies could take the lead in developing Plans of Safe Care during the prenatal period, with support from collaborative partners knowledgeable about the needs of infants.

During pregnancy, a Plan of Safe Care can identify how notification to the CPS agency will be made when the birth has occurred, confirm to CPS that a Plan of Safe Care has been developed, and identify the local agency that could lead implementation of the plan after the infant's release from the hospital. The prenatal care provider might collaborate with the CPS agency before the birth (e.g., in the month before the due date) to establish or refine the Plan of Safe Care.

For women whose substance use was not identified during pregnancy, effective screening for a substance use disorder is necessary at the time of delivery, as is newborn substance exposure screening, through standardized policies and practices. Providers can screen the woman through interviews and self-reports using questionnaires or valid screening instruments at the time of birth. Universal substance use disorder screening can decrease biases about who to screen and ensure that women have opportunities to access treatment and supports. While toxicology panels might also be appropriate for pregnant women, new mothers, and infants to identify the presence of a substance, testing cannot identify the reason for the presence of that substance nor the effect of the substance on the infant.

Local practice considerations and input from the collaborative implementation team guide the various aspects of the infant and family's or caregiver's care management. For each domain included in Plans of Safe Care, certain providers can be designated as the lead care coordinator based on the needs of each family and the available local service array.

CAPTA does not specify the implementation period for Plans of Safe Care. States could base the period covered by their Plans of Safe Care on determinations made by a child welfare safety and risk assessment. If this assessment doesn't indicate a specific duration, implementation teams could consider the durations of home visiting programs as a guide for ongoing parenting support. For example, the Safe Care Program, an in-home parent skill-building program designed for families identified as being at-risk for child maltreatment, lasts 18 to 22 weeks and Parents as Teachers, an early childhood parent education program for at-risk families, lasts more than a year. The criteria for selecting the a Plan of Safe Care's coverage period may stem from a comprehensive family assessment that includes the caregiver's need for parenting support, current substance use experience, participation in treatment, and/or recovery stability as well as the child's developmental service needs.

Planning Questions

- At what point in time is the Plan of Safe Care developed? What are the benefits of developing a Plan of Safe Care during the prenatal period? At what point are the services in a Plan of Safe Care initiated?
- Which organization(s) may develop Plans of Safe Care?
- What resources are available in the community that the team can access or blend to support Plans of Safe Care implementation?
- How can a team align services for infants, mothers, and other caregivers in the Plan of Safe Care while avoiding duplication and ensuring that all elements are addressed?
- What mechanisms will ensure that Plans of Safe Care are consistent with the individual family support plans for children receiving early intervention services under Part C of IDEA? Child welfare case plans? Substance use treatment plans? Hospital discharge plans?
- When an infant with prenatal exposure is not released from the hospital to his or her mother's care, how can the team ensure that other caregivers receive medical information, training, and support to appropriately care for the infant?
- What education, training and information might the lead agency developing and implementing Plans of Safe Care need? Are those needs different if the lead agency is child welfare? Substance use treatment? Health care or public health?
- How can the team identify the continuum of services that infants, parents, and caregivers need? How can the team identify gaps in these services? Does the family have any access barriers to these services, such as those related to timing, intensity, or cost?
- How might processes for development and implementation of Plans of Safe Care be different for infants affected by substance exposure who have no known immediate safety concerns?
- How might processes for development and implementation of Plans of Safe Care be different when parents have no current or previous substance use disorder? When parents are engaged in a substance use disorder treatment plan (including use of medication-assisted treatment)? When parents are in recovery?

Planning Questions (continued)

- How might the services identified for a mother differ if the lead agency for development of the Plan of Safe Care were a child welfare agency versus a prenatal care or substance use treatment provider? What about the care provided to the infant?
- How might universal screening for substance use during pregnancy using an evidence-based screening tool affect identification of infants needing a Plan of Safe Care? How might this screening affect the care a mother receives?

State Example

Kentucky is moving toward a “system of care” to address the concerns of substance use prior to pregnancy, during the prenatal period, through post-delivery and childhood. This includes work with hospitals by the Kentucky Department of Public Health on guidelines for treatment of infants with NAS, multidisciplinary assessments, and discharge planning for such infants and their mothers as well as collaborative team development of guidelines and templates for POSC implementation provided as guidance for training to regional collaboratives.

- [Systems of Care to Support Plan of Safe Care](#)

Step 9: Manage Individual Plans of Safe Care

Plans of Safe Care benefit from management to determine progress toward completion of goals and evolving needs of the infant and family/caregiver. CAPTA does not specify the duration for Plan of Safe Care, so state or implementation teams can decide how long to manage plan implementation. Factors indicating that the infant and family needs have been met and that the infant and family no longer require oversight can help guide the necessary duration.

In addition to safety, ongoing review of an infant's health status and screening for developmental progress can be included in the Plan of Safe Care. These screenings and assessments may happen during routine pediatric care, such as well-baby checkups, or through procedures that engage early intervention providers familiar with assessment and services to support infants and children with developmental delays, including IDEA Part C providers at the state and local level. Ongoing review of the caregiver's ability to consistently attend to the health and development of the infant can be included in a Plan of Safe Care. The use of evidence-based tools to support ongoing assessment of challenges and growth in family functioning can help guide the management of the Plan of Safe Care. An example of such a tool is the North Carolina Family Assessment Scale (NCFAS) which is a practice-based assessment of family functioning in a range of domains. More information about the NCFAS can be found at: http://www.nfnp.org/Portals/0/Documents/assessment_tools_overview.pdf

Recovery Stability

Plans of Safe Care are also intended to address the family/caregiver's treatment needs. Substance use disorder treatment is a component of overall and sustained recovery, which SAMHSA defines as the "process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential."¹⁴ SAMHSA identifies four major dimensions of recovery:

- **Health:** Overcoming or managing one's disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being
- **Home:** Maintaining a stable and safe place to live in
- **Purpose:** Conducting meaningful daily activities, such as having a job, attending school, volunteering, and having independent income and resources to participate in sobriety
- **Community:** Having relationships and social networks that provide support, friendship, love, and hope

For community partners that are monitoring Plans of Safe Care, assessing parents' and caregivers' service needs in each of these dimensions of recovery and providing the supportive services to meet these needs is critical to ensuring the safety and well-being of infants and families or caregivers. Determining treatment effectiveness requires communities to do more than simply ask whether a parent or caregiver is abstinent and instead assess the stability of recovery and continuing needs for support based on all four recovery dimensions.

There are several ways to provide support for recovery. Substance use disorder treatment professionals, community partners, and child welfare professionals can connect parents or caregivers and families to needed services that support recovery

and family healing. These services might include economic support, vocational and employment support, housing, parenting skills, medical care, and community and social support services.



There are no universally agreed-on tools to measure recovery, but some communities have used a combination of existing tools for this purpose. Expert work groups and focus groups of individuals in recovery have identified measures from the World Health Organization's Quality of Life Index and the Addiction Severity Index as realistic tools for assessing important recovery dimensions.¹⁵ Communities could incorporate these tools into their assessments and the Plans of Safe Care they

develop. They can also use these tools to assess parental or caregiver progress and infant safety as part of their Plans of Safe Care.

Information Sharing in Plans of Safe Care

Information sharing is a key ingredient for the management of Plans of Safe Care. Although individual organizations might assess the family independently, sharing the results with key stakeholders is vital to developing an informed Plan of Safe Care. Partners can execute memoranda of understanding between organizations to facilitate information sharing. Clarifying confidentiality laws that apply to different systems and standardizing informed consent forms compliant with these laws can facilitate information sharing. A resource on information sharing is provided as Section 3.1, "Developing Communication Structure and Protocols" in the NCSACW publication entitled, *Screening and Assessment for Family Engagement, Retention and Recovery (SAFERR)* and can be access at:

https://ncsacw.samhsa.gov/files/Communication_Templates.pdf . Communication and information sharing are important when determining if linkages to services identified in the Plan of Safe Care were accessed, the extent of caregiver engagement in services, and the progress of the infant and their family/caregiver.

Planning Questions

- Which organization(s) manage Plans of Safe Care?
- What is the duration of a Plan of Safe Care? When do you know that a Plan of Safe Care is no longer needed?
- What information sharing policies, protocols and practices are in place that will support or hinder management of the Plan of Safe Care?
- How does the entity or entities implementing the Plans of Safe Care affect the information collected, shared, and reported?
- How might management of Plans of Safe Care be different if the child welfare agency takes the lead as opposed to a health care, early intervention, home visiting, or substance use treatment agency?
- How will the team collect and share critical information about individual cases to review the progress and ongoing needs of infants and families or caregivers?

State Example

Illinois' Department of Children and Family Services uses a [Recovery Matrix Assessment for Parents](#) to measure and document progress in recovery for parents of substance-exposed newborns and families whose children have been removed because of a parent's substance use.

Step 10: Oversee State Systems and Report Data on Plans of Safe Care

The number of infants “affected by substance abuse or withdrawal symptoms or a Fetal Alcohol Spectrum Disorder” can be difficult to identify in existing data sets due to challenges related to definitions and data collection gaps. States might review the extent to which their agencies currently collect the data that CAPTA specifies for reporting to Children’s Bureau and determine if changes are needed. Changes could include new policies, procedures, and training programs to ensure data collection, analysis, and reporting.

CAPTA legislation requires that the CPS agency report quantitative data to the Children’s Bureau through the NCANDS “to the extent practicable.” These data elements include:

- The number of infants identified as being affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or FASD;
- The number of infants for whom a Plan of Safe Care was developed; and
- The number of infants for whom referrals were made for appropriate services, including services for the affected family or caregiver.

Partners can identify barriers to collecting these data, such as challenges with information sharing across agencies or lack of data systems capable of capturing necessary information, and report these barriers in their State Annual Progress and Services Report (APSR) to the Children’s Bureau. NCSACW’s experience suggests that identifying these barriers is an important early step in resolving data collection and reporting challenges.

Updates to data collection policies and procedures are critical in guiding partner agencies as they develop and implement Plans of Safe Care, particularly those outside of CPS. Regardless of which partner or entity develops, implements, and oversees Plans of Safe Care, the CPS agency is responsible for submitting data to NCANDS and describing its state system in its annual CAPTA report. Qualitative information may include information about policies and procedures in place to implement Plans of Safe Care and systems created to determine whether and how local entities are providing, in accordance with state requirements, referrals to appropriate services for the infant and affected family or caregiver.

In 2017 the Children’s Bureau directed state child welfare agencies to provide qualitative information in their APSR with details of updates to state laws, policies, procedures, and systems to address the needs of infants born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder including those related to Plans of Safe Care. Full details on the qualitative information to be included in State APSR are often released through program instructions from ACF in the spring for reports due mid-summer.

Planning Questions

- How does the state develop, enhance, or support systems for local communities to collect data needed for annual reports on affected infants and their families and caregivers to ACF's Children's Bureau?
- How will the team collect data on infants with substance exposure and their parents or caregivers? Which sources will provide this information? How will the team analyze and share this information to inform policy and enhance practice?
- Does a single entity or system capture and report the necessary elements or have the capacity to do so? If not, which entities have access to the required information, and which data need to be shared to ensure that reporting requirements under CAPTA are met?
- How can states use their health information technology systems for the necessary data collection and reporting?

State Example

Massachusetts' [Neonatal Quality Improvement Collaborative Statewide Database](#) includes key outcome and process measures related to the care of infants in hospitals with neonatal abstinence syndrome and other effects of prenatal exposure. Hospitals enter data on these infants after appropriate data use agreements are in place. The collected data include treatment modality, length of stay, discharge disposition, and follow-up care received.

Collaborative Practice Lessons for Serving Infants with Prenatal Substance Exposure and their Families/Caregivers

This section is a component of a technical assistance tool developed by the National Center on Substance Abuse and Child Welfare (NCSACW), a program of the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Administration on Children, Youth and Families, Children's Bureau. This tool aims to assist stakeholders as they review and modify policies and procedures for the development, implementation, and monitoring of Plans of Safe Care. Information is drawn from NCSACW's experience in provision of technical assistance to states and communities.

Although the Child Abuse Prevention and Treatment Act (CAPTA) focuses on the responsibilities of child protective service (CPS) agencies, the 2010 and 2016 amendments also emphasized the benefits of an interagency approach. No single agency has the resources, information base, or expertise needed to meet the full scale and range of challenges faced by infants with prenatal substance exposure and their families and caregivers. Diverse stakeholders play critical roles in detecting and responding to the needs of infants with prenatal substance exposure and their families/caregivers. The implementation of evidence-based programs by a multidisciplinary team with strong partnerships supports effective use of resources and builds on diverse perspectives. Early engagement of this multidisciplinary team during the development of state legislation, policies, and procedures allows the extensive planning needed to draw on the team's expertise and perspectives.

NCSACW provides resources that support communities as they establish and enhance collaborative practice. These resources include *Screening and Assessment for Family Engagement, Retention and Recovery (SAFERR)*¹⁶ and *A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders*.¹⁷ NCSACW's collaborative practice lessons, gleaned from years of research and extensive practice-based experience, provide insight into the development of Plans of Safe Care.

This section provides an overview of these key lessons and how state and local teams may benefit from their consideration.

Collaborative Practice Lessons

1

Lesson 1: Do not assume that all partners share or clearly understand the team's mission and values without in-depth discussion.

Teams implement Plans of Safe Care in an environment that touches on partners' deepest beliefs and attitudes about parenting, privacy, substance use, and the roles of public agencies. The assumption that all parties agree on these beliefs and attitudes can block progress because teams might ignore or downplay the importance of these values-based disagreements and differences. Teams need to consider these value issues with care and avoid dismissing minority views or assuming that all agencies agree with perceived majority views. A collaborative values review, using a tool such as the Collaborative Values Inventory (<https://ncsacw.samhsa.gov/collaboration/collaboration-values-inventory.aspx>), or facilitated discussions of underlying values is a necessary prelude to partners' agreement about the team's mission.

2 Lesson 2: Do not assume that public agencies are the only important stakeholders in creating and implementing Plans of Safe Care.

When federal legislation leads to program implementation, teams might assume that only certain state and local agencies need to implement the new procedures. But in the arena of prenatal exposure and its effects, private service providers—including physicians and their medical staff, hospitals, and pharmacies—also have critical roles. Consensus among government agencies might have no effect on the behaviors and practices of private physicians or hospitals. Some private-sector providers, for example, might underreport infants with substance exposure or not screen newborns for prenatal substance exposure. They might also be resistant to complying with federal regulations and have difficulty trusting publicly-funded treatment agencies. Teams need to air these perspectives and address their causes to make collaborative teams truly effective in changing practice to support Plans of Safe Care.

3 Lesson 3: Agree on mechanisms to share information on priority indicators of the progress and success.

The agencies that make up the team need to share information with one another despite differences in technological capacity to transfer and link datasets and privacy boundaries established by law, practice, and attitudes. Effectively sharing data requires knowledge of the confidentiality provisions for health care information in the Health Information Portability and Accountability Act¹⁸ as well as the special considerations for records privacy and the release of information for persons enrolled in substance use disorder treatment in Title 42 of the Code of Federal Regulations. Agreeing to collect data on prenatal exposure is the first challenge; agreeing to share those data with other agencies and service providers is a second, equally complex challenge. Without an agreed-on set of indicators of progress, partners might exchange sizable amounts of data that are not the right benchmarks of improved outcomes of Plans of Safe Care for their intended beneficiaries.

4 Lesson 4: Use strong evaluation and performance monitoring tools to ensure that the team is implementing evidence-based and practice-informed programs and that these programs are improving outcomes for the infants and families that partners serve.

Each agency that is part of a team might evaluate its own programs and practices, but such evaluations might not address the effect of cross-agency programs. For example, family drug courts have found that they need agreements and cross-system data collection to measure both child-welfare outcomes and treatment outcomes.

Teams that use evidence-based practices, such as medication-assisted treatment or proven parent-child interventions (e.g., Parent-Child Interaction Therapy or Multisystemic Family Therapy), need to evaluate the fidelity of the programs they deliver with the original, proven model. Evaluation and performance monitoring also requires assessing the program's effectiveness for the intended beneficiaries. These evaluations need to address the ways in which the distinct characteristics of families in a community might differ from the characteristics of participants in the original research.

Alternatively, if reports on the original research do not describe the characteristics of the families served, teams need to assess the outcomes of implementing the program model in families with substance use disorders or for infants with substance exposure. Not all evidence-based programs are appropriate for all communities and with all families.

Many of the services that have been provided to this population have not undergone rigorous research. Creating performance monitoring systems with quality assurance methods and rapid cycle feedback is critical for compiling practice-based evidence. Implementation teams need both efficient data collection and program professionals' informed analysis of what the data indicate about the team's progress and success in achieving the participating agencies' goals.

5 Lesson 5: Family-focused policies and programs create a balanced focus on infants and parents or caregivers.

Agencies with experience, training, and funding focused primarily on children or on adults are challenged by the need to consider both parents or caregivers and infants in planning services that respond to whole-family needs and strengths. This is especially true for developing and managing Plans of Safe Care, which inherently address the needs of both parents or caregivers and children through interagency and multidisciplinary services.

6 Lesson 6: Leadership of a collaborative effort demands both accountability for results and carefully nurtured relationships that multiply resources.

Interagency collaboration has both objective dimensions that can be measured quantitatively and subjective dimensions related to effective relationships.¹⁹ The use of impact measures alone leaves out assessments of the resources and relationships necessary to achieve that impact. Similarly, reliance on relationship measures only can result in a group that “plays well together” but has difficulty tracking the results of its processes and planning. The key is not to review what the agencies and members of the team are doing but, rather, whether the children and families are doing better as measured by agreed-on indicators of progress. Plans of Safe Care can improve outcomes if they include measures of all three of these elements—resources, relationships, and results. The ultimate test of a team's products, including Plans of Safe Care, is whether the team has made resources available that are grounded in good working relationships that it has carefully developed and nurtured over time, rather than mandated by formal agreements.

7 Lesson 7: Diverse resources coordinated among multiple partners are necessary to comprehensively addressing the range of needs for infants and families. An inventory of available resources can help local teams understand the full array of services that a Plan of Safe Care might be able to use to serve infants and parents or caregivers.

Many federal and state programs aim to reduce substance use during pregnancy and their potential effects on infants and children. But no single federal, state, or local agency is charged with providing a comprehensive response or coordinating responses

across multiple agencies. In fact, laws and administrative guidelines on addressing the risks to infants and young children come from more than a dozen federal agencies and dozens more state and local agencies. These agencies and professionals offer such services as health care, social services, substance use disorders treatment, mental health care, child welfare services, developmental disabilities services, home visits, and education.

Groups working to reduce prenatal substance exposure and respond to its effects have found that very few agencies have access to an updated inventory of the full range of available resources for children and families. Implementing Plans of Safe Care benefits from collaboration among health care providers, other community agencies, and the family to ensure efficient communication across service systems, agencies, professionals and families. Tools to help teams develop cross-system practice and communication procedures are available by contacting NCSACW at ncsacw@cffutures.org or 866.493.2758.

Appendix 1: Planning Template

This section is a component of a technical assistance tool developed by the National Center on Substance Abuse and Child Welfare (NCSACW), a program of the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Administration on Children, Youth and Families, Children's Bureau. This tool aims to assist stakeholders as they review and modify policies and procedures for the development, implementation, and monitoring of Plans of Safe Care. Information is drawn from NCSACW's experience in provision of technical assistance to states and communities.

Step 1: Understand CAPTA and CARA Legislation

- Have partners reviewed relevant law, policy and guidance available from the federal government?
- Do key partners have an understanding of CAPTA and the recent CARA amendments to CAPTA?

Step 2: Know your State Systems

- Does the state have a statute that includes some aspect of prenatal exposure in the statutory definitions of child maltreatment?
- Does the state have a statute that requires mandated reporters involved in the delivery and care of an infant “affected by substance abuse, withdrawal symptoms or Fetal Alcohol Spectrum Disorder” to notify their local CPS agency? Does the state have a statute that defines who is a mandated reporter?
- Are there state statutes in place that identify roles and responsibilities for development and implementation of Plans of Safe Care?
- How does child welfare currently respond to notifications or reports of infants affected by prenatal substance exposure?

Step 3: Determine who receives a Plan of Safe Care

- How does the state define infants affected by prenatal substance exposure, such as “affected by substance abuse,” “withdrawal symptoms,” and “Fetal Alcohol Spectrum Disorder”?
- How might the definition of “infant born with” affect the age at which a child is eligible to receive a Plan of Safe Care?
- How will the definition address challenges with diagnosing FASD in infants and the broad spectrum of associated disorders within FASD?
- How might the definition of “infants born with and affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder” affect which families to include in or exclude from the group requiring a Plan of Safe Care?
- How might universal screening for substance use during pregnancy, using an evidence-based screening tool, affect identification of infants for a Plans of Safe Care?

- How might the Plan of Safe Care approach be adapted for unique populations of women giving birth to infants with substance exposure?

Step 4: Identify Partners for a Comprehensive Plan of Safe Care Approach

- Which members will the state team and implementation team include? What types of authority do they need for their agency to contribute to the team? What are the possible outcomes of omitting a critical member?
- How can state and implementation teams establish agency roles and responsibilities related to reducing prenatal exposure and responding to its effects?
- What partners can be included when determining the necessary components in a Plan of Safe Care template or policy?
- How can state teams support development of Plans of Safe Care?
- How can state and implementation teams use this work to change the culture around substance use during pregnancy to support healthy decision making and receipt of appropriate interventions and treatment by women and families?

Step 5: Define Plans of Safe Care

- What information is to be included in a Plan of Safe Care or in a Plan of Safe Care template?
- What elements of a Plan of Safe Care are specific to birth mothers, fathers, caregivers, other family members and infants?
- Which services could be considered for infants with substance exposure to enhance their short-term and long-term health, safety, and well-being outcomes? How would referral and assessment under Part C of IDEA (which addresses early intervention providers) affect those outcomes?

Step 6: Create a Notification System and Protocol for Plans of Safe Care

- How does the state define “notifications” and how will it develop effective notification systems and protocols?
- What is the process for notification to CPS? What information will be provided in the notification process?
- How can teams ensure that the perspectives of health care providers involved in the delivery or care of infants are included in the development of policies and procedures for notifying the CPS agency of infants with prenatal substance exposure?
- How can the state team support healthcare providers to implement policies and procedures for notifying CPS including who to notify, under what circumstances as well as when and where to notify?
- How can the state team address current barriers and challenges to the notification process?

- How can health care providers ensure that their notification complies with state law and CAPTA requirements?
- What processes are necessary to ensure prompt assessment of families with CPS notifications to identify if they are to receive a child welfare investigation, other alternative child welfare responses or assignment/hand off to a community partner?

Step 7: Assess Needs to Guide Individual Plans of Safe Care

- Are the community's safety and risk assessment and intervention policies appropriate and sufficient for these families? If not, which modifications to current safety and risk assessment practices might ensure that infants with substance exposure, mothers, and families remain safely together with community supports focused on their well-being?
- How do current assessment policies or procedures ensure the completion of safety and risk assessments of the home environment, community and family supports, and other health-care needs in appropriate medical homes along with the infant's health, developmental, well-being, and safety needs?
- How do current assessment policies and procedures address the mother's recovery status and ongoing treatment needs, including her need for and receipt of medication-assisted treatment?
- How can modifications to current safety and risk assessment practices in the child welfare agency, prompted by the need to develop Plans of Safe Care, ensure appropriate placement for infants who cannot stay in their birth mother's and/or father's custody?
- How might a multidisciplinary, comprehensive assessment support the development of the Plan of Safe Care?

Step 8: Develop and Implement Individual Plans of Safe Care

- At what point in time is the Plan of Safe Care be developed? What are the benefits of developing a Plan of Safe Care during the prenatal period? At what point are the services in a Plan of Safe Care be initiated?
- Which organization(s) may develop Plans of Safe Care?
- What resources are available in the community that the team can access or blend to support Plan of Safe Care implementation?
- How can a team align services for infants, mothers, and other caregivers in the Plan of Safe Care while avoiding duplication and ensuring that all elements are addressed?
- What mechanisms will ensure that Plans of Safe Care are consistent with the individual family support plans for children receiving early intervention services under Part C of IDEA? Child welfare case plans? Substance use treatment plans? Hospital discharge plans?

- When an infant with prenatal exposure is not released from the hospital to his or her mother's care, how can the team ensure that other caregivers receive medical information, training, and support to appropriately care for the infant?
- What education and information might the lead agency developing and implementing Plans of Safe Care need? Are those needs different if the lead agency is child welfare? Substance use treatment? Health care or public health?
- How can the team identify the continuum of services that infants, parents, and caregivers need? How can the team identify gaps in these services? If a sufficient quantity of services appears to be available, does the family have any access barriers to these services, such as those related to timing, intensity, or cost?
- How might processes for development and implementation of Plans of Safe Care be different for infants affected by substance exposure who have no known immediate safety concerns?
- How might processes for development and implementation of Plans of Safe Care be different when parents have no current or previous substance use disorder? When parents are engaged in a substance use disorder treatment plan (including use of medication-assisted treatment)? When parents are in recovery?
- How might the services identified for a mother differ if the lead agency for development of the Plan of Safe Care were a child welfare agency versus a prenatal care or substance use treatment provider? What about the care provided to the infant?
- How might universal screening for substance use during pregnancy using an evidence-based screening tool affect identification of infants needing a Plan of Safe Care? How might this screening affect the care a mother receives?

Step 9: Manage Individual Plans of Safe Care

- Which organization(s) manage Plans of Safe Care?
- What is the duration of a Plan of Safe Care? When do you know that a Plan of Safe Care is no longer needed?
- What information sharing policies, protocols and practices are in place that will support or hinder management of the Plan of Safe Care?
- How does the entity or entities implementing the Plans of Safe Care affect the information collected, shared, and reported?
- How might management of Plans of Safe Care be different if the child welfare agency takes the lead as opposed to a health care, early intervention, home visiting, or substance use treatment agency?
- How will the team collect and share critical information about individual cases to review the progress and ongoing needs of infants and families or caregivers?

Step 10: Oversee State Systems and Report Data on Plans of Safe Care

- How does the state develop, enhance, or support systems for local communities to collect data needed for annual reports on affected infants and their families and caregivers to ACF's Children's Bureau?
- How will the team collect data on infants with substance exposure and their parents or caregivers? Which sources will provide this information? How will the team analyze and share this information to inform policy and enhance practice?
- Does a single entity or system capture and report the necessary elements or have the capacity to do so? If not, which entities have access to the required information, and which data need to be shared to ensure that reporting requirements under CAPTA are met?
- How can states use their health information technology systems for the necessary data collection and reporting?

Appendix 2: State Examples

This section is a component of a technical assistance tool developed by the National Center on Substance Abuse and Child Welfare (NCSACW), a program of the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Administration on Children, Youth and Families, Children's Bureau. This tool aims to assist stakeholders as they review and modify policies and procedures for the development, implementation, and monitoring of Plans of Safe Care. Information is drawn from NCSACW's experience in provision of technical assistance to states and communities.

This section provides examples from states related to the development and implementation of an approach to infants with prenatal substance exposure and their families/caregivers, including Plans of Safe Care. These tools and examples can help states and agencies understand the requirements of the Child Abuse Prevention and Treatment Act (CAPTA) and consider the options for their communities as they determine how to best serve these families.

Substance Exposed Infants in Depth Technical Assistance Project

Since September 2014, NCSACW has supported a special initiative to help states respond to growing concerns about opioid use during pregnancy; the increasing number of infants with prenatal exposure, particularly those with neonatal abstinence syndrome; and the lack of coordinated and ongoing services needed to support infants, families, and caregivers during the critical postpartum and infancy period. The initiative focused on strengthening collaboration and linkages among child welfare, mental health and substance use disorder treatment, public health and medical communities, home visiting and early intervention systems, and other key stakeholders to improve outcomes for infants with prenatal exposure, their mothers, and families. During the latter part of the engagement with these states, the Comprehensive Addiction and Recovery Act of 2016 (CARA), went into effect, including Title V, Section 503, "Infant plan of safe care." The legislation made several changes to CAPTA. As a result of these changes, NCSACW provided states an additional year of technical assistance to understand the critical components of the statute and actions needed to comply. States are currently working to meet the latest CAPTA requirements as well as the expanding needs of infants with substance exposure and their families and caregivers in the context of the current opioid epidemic. A summary of their experience and lessons can be found at this link:

https://ncsacw.samhsa.gov/files/IDTA_Executive_Summary.pdf.

2017 Policy Academy Project

In February 2017, the Substance Abuse and Mental Health Services Administration and the Administration on Children, Youth and Families conducted a policy academy on implementing the changes in CAPTA. Several states participated and received time-limited technical assistance from the NCSACW. A summary of the policy academy and the states' experiences can be found at this link:

https://ncsacw.samhsa.gov/files/Policy_Academy_Dissemination_Brief.pdf

State Examples: Plan of Safe Care Statute and Legislation

The following states have considered or enacted legislation related to policies and procedures to address the needs of infants affected by prenatal exposure and development of Plans of Safe Care for these infants and the families/caregivers

- **Connecticut:** [Enacted HB6997](#)
- **Delaware:** [Proposed HB140](#)
- **Florida:** [Withdrawn SB1400](#)
- **Louisiana:** [Act 359 previously HB678](#)
- **Michigan:** [Introduced HB397](#); [Introduced HB398](#)
- **Nevada:** [State Law 432B](#)
- **North Dakota:** [SB2251](#)
- **South Carolina:** [Pre-filed HB3823](#)
- **Virginia:** [Enacted HB1786](#)

For information on additional legislation related to infants with prenatal substance exposure you can review the [National Conference of State Legislatures April 2017 Review](#).

State Examples: Definitions

The following states have defined affected infants in statute, policy or explanatory documents.

- **Delaware:** [Definition of "infant with prenatal substance exposure" and "withdrawal symptoms"](#)
- **New Jersey:** [Definition of "substance affected infants"](#)
- **North Carolina:** [Definition of "substance affected infants"](#)

For more information about definitions of "infant born with and identified as being affected by substance abuse or withdrawal symptoms or Fetal Alcohol Spectrum Disorder", contact the National Center on Substance Abuse and Child Welfare (NCSACW) at ncsacw@cffutures.org.

State Examples: State and Local Teams

The following states have developed collaborative state and/or local teams for development of policies, procedures and practices that support infants with prenatal substance exposure and their families or caregivers and implementation of the state's Plan of Safe Care approach.

- **Arizona:** [Taskforce on Preventing Prenatal Exposure](#)
- **Colorado:** [Substance-Exposed Newborn Steering Committee](#)
- **Connecticut:** [Keeping Infants Drug Free Project](#)
- **Delaware:** [Child Protection Accountability Commission](#)
- **Kentucky:** [Moms Maternal Assistance Toward Recovery Collaboration](#)

- **Minnesota:** [Integrated Care for High Risk Pregnancies Initiative](#)
- **New Jersey:** [Maternal Wraparound Program](#)
- **North Dakota:** [Taskforce on Substance Exposed Newborns](#)
- **Vermont:** [Children and Recovering Mothers Collaborative](#)

For examples of state and local teams in **Florida, Maryland, North Carolina, New Jersey, New York** and **Virginia** or more information about development, governance, participation or roles of state and local teams contact the National Center on Substance Abuse and Child Welfare (NCSACW) at ncsacw@cffutures.org.

State Examples: Defining a Plan of Safe Care

The following states have templates and/or written policies to guide what elements are included in Plans of Safe Care for their states or communities.

- **Delaware:** [Plan of Safe Care Template \(pg. 27\)](#)
- **Georgia:** [Plan of Safe Care Policy and Template](#)
- **Kansas:** [Plan of Safe Care Template](#)
- **Vermont:** [Plan of Safe Care Template](#)
- **Virginia:** [Plan of Safe Care Template \(Appendix D\)](#)
- **Washington:** [Plan of Safe Care Template](#)

For additional examples from **Florida, New Hampshire, New York** and **Oregon** contact the National Center on Substance Abuse and Child Welfare (NCSACW) at ncsacw@cffutures.org.

State Examples: Notification Processes and Response Pathways

The following states have detailed processes for notification to child welfare of infants with prenatal substance exposure to ensure development of a Plan of Safe Care.

- **Louisiana:** [Information Gathering and Response Pathways for Notifications](#)
- **Maryland:** [Notification Policy, Reporting Form and Response Pathways](#)
- **New Jersey:** [Regulation on Notification Definitions and Hospital Notification Policy](#)
- **North Carolina:**
 - [Plan of Safe Care FAQ: Notification Process and Response](#)
 - [Example Notification Referral Form](#)
- **Vermont:**
 - [Notification Process and Guidance](#)
 - [Notification Flow Chart](#)
 - [Notification Form](#)
- **Virginia:** [Notification Process Legislation](#)

For more information about notification policies and protocols, contact the National Center on Substance Abuse and Child Welfare (NCSACW) at ncsacw@cffutures.org.

State Examples: Policies, Procedures and Practice Guidance on Infants with Prenatal Substance Exposure and Plan of Safe Care

The following states have legislation, policies, procedures, practice guidance and programming focused on the development and implementation of Plans of Safe Care.

- **Arizona:** [Infant Care Plan Policy](#)
- **Arkansas:** [Guidance on Plans of Safe Care for infants born with FASD](#)
- **Delaware:** [Proposed Legislation Defining Plan of Safe Care Development](#)
- **Georgia:** [Plan of Safe Care Policy](#)
- **Iowa:**
 - [Safe Plan of Care Policy and Procedure Guidance \(pg. 30\)](#)
 - [Direction to Health Care Providers on Safe Plans of Care](#)
- **Kansas:**
 - [Plan of Safe Care Policy](#)
 - [Assessment Guide for Plan of Safe Care Development](#)
 - [Plan of Safe Care Development Overview for Families](#)
- **Kentucky:** [Systems of Care to Support Plan of Safe Care Development](#)
- **Louisiana:** [Plan of Safe Care Development Coordinated Response Policy](#)
- **Missouri:** [Plan of Safe Care Guidance](#)
- **North Carolina:**
 - [Guidance on Plan of Safe Care Development](#)
 - [Draft Plan of Safe Care Policy](#)
- **North Dakota:**
 - [Legislation on Plan of Safe Care Development in Alternative Response](#)
 - [Guide to Alternative Response Assessments and Plans of Safe Care](#)
- **Vermont:**
 - [Plan of Safe Care Process](#)
 - [Plan of Safe Care Development Flow Chart](#)
 - [Plan of Safe Care Development FAQ](#)
- **Virginia:**
 - [Procedures for Development of Plans of Safe Care](#)
 - [Guidance for Health Care Professionals on Plans of Safe Care](#)
- **Washington:** [Plan of Safe Development](#)

For examples of policy and practices developed in **Florida, New Hampshire, New York, Oregon** or more information about implementing a collaborative approach to Plans of Safe Care, contact the National Center on Substance Abuse and Child Welfare (NCSACW) at ncsacw@cffutures.org.

State Examples: Policies, Procedures and Practice Guidance on Infants with Prenatal Substance Exposure

The following states have developed policies, procedures, practices or guidance to support systems to address the unique needs of infants with prenatal substance exposure.

- **Arizona:** [Best Practice Guide for Health Plans related to Prenatal Exposure](#)
- **Delaware:** [Policy for Identification of Infants with Prenatal Exposure and FASD](#)
- **Maryland:** [Policy Directive on Substance Exposed Newborn Program](#)
- **Minnesota:** [Best Practice Guide for Responding to Prenatal Substance Exposure](#)
- **Tennessee:** [Best Practice Guide for Infants with Prenatal Substance Exposure](#)

For more information about policies, procedures and guidance for a collaborative response to supporting infants with prenatal substance exposure and their families, contact the National Center on Substance Abuse and Child Welfare (NCSACW) at ncsacw@cffutures.org.

State Examples: Information Sharing and Monitoring to Support Plans of Safe Care

The following states have resources focused on monitoring and information sharing to support Plans of Safe Care.

- **Kentucky:** [Neonatal Abstinence Syndrome Confidentiality and Reporting Legislation](#)
- **Illinois:** [Recovery Matrix Assessment for Parents](#)
- **Nevada:** [State Law on Information Sharing for Plans of Safe Care](#)

For more information about information sharing and monitoring in Plans of Safe Care, contact the National Center on Substance Abuse and Child Welfare (NCSACW) at ncsacw@cffutures.org.

State Examples: Oversight and Data Collection

The following states have developed legislation and collaboration to support data collection related to Plans of Safe Care.

- **Massachusetts:** [Neonatal Quality Improvement Collaborative Database](#)
- **Kentucky:** [Neonatal Abstinence Syndrome Reporting Legislation](#)
- **Virginia:** [Neonatal Abstinence Syndrome Reporting Legislation](#)

For more information about information sharing and monitoring in Plans of Safe Care, contact the National Center on Substance Abuse and Child Welfare (NCSACW) at ncsacw@cffutures.org.

Appendix 3: Child Abuse Prevention and Treatment Act (CAPTA) Substance Exposed Infant Statutory Summary

This section is a component of a technical assistance tool developed by the National Center on Substance Abuse and Child Welfare (NCSACW), a program of the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Administration on Children, Youth and Families, Children's Bureau. This tool aims to assist stakeholders as they review and modify policies and procedures for the development, implementation, and monitoring of Plans of Safe Care. Information is drawn from NCSACW's experience in provision of technical assistance to states and communities.

The Keeping Children and Families Safe Act of 2003²⁰ created new conditions for states to receive grant allocations under the Child Abuse and Prevention Treatment Act (CAPTA). The grant conditions were intended to provide needed services and support for infants, their mothers, and their families, and to ensure a comprehensive response to the effects of prenatal drug exposure.

The legislation required that governors of states receiving a CAPTA grant assure the federal government that they have policies and procedures for the following:

- Appropriate referrals to child protection service systems and for other appropriate services, to address the needs of infants born with and identified as affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure
- 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 except that such notification shall not be construed to establish a definition under federal law of what constitutes child abuse or require prosecution for any illegal action
- A Plan of Safe Care for the infant born with and identified as being affected by illegal substance abuse or withdrawal symptoms
- Immediate screening, risk and safety assessment, and prompt investigation of such reports

The CAPTA Reauthorization Act of 2010²¹ made further changes related to prenatal exposure issues to include identification of infants affected by Fetal Alcohol Spectrum Disorder (FASD) and a requirement for the development of Plans of Safe Care for infants affected by FASD. It also added the following reporting requirements to the Annual Progress and Services Report:

- The number of children referred to a child protective services system born with and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure or FASD
- The number of children involved in a substantiated case of abuse or neglect determined to be eligible for referral, and the number of children referred to agencies providing early intervention services under Part C of the Individuals with Disabilities Education Act

The Comprehensive Addiction and Recovery Act (CARA) of 2016²² went into effect July 22, 2016, including Title V, Section 503, “Infant Plan of Safe Care.” The legislation (PL 114-198) makes several changes to CAPTA. The law:

- Removes the term “illegal” in regard to substance abuse
- Requires that Plans of Safe Care address the needs of both the infant and the affected family or caregiver
- Specifies that data on affected infants and Plans of Safe Care be reported by states to the maximum extent practicable. Such data includes:
 - The number of infants identified as being affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or FASD
 - The number of infants for whom a plan of safe care was developed
 - The number of infants for whom referrals were made for appropriate services—including services for the affected family or caregiver
- Requires that states develop and implement 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

The 2016 changes were made in the context of attention generated by the nation’s prescription drug and opioid epidemic, which has focused state agencies on the requirement to implement a Plan of Safe Care for these infants.

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