Plan of Safe Care

Collaboration Protocol

Department of Children & Families and Northeast Florida Healthy Start Coalition
(Baker, Clay, Duval, Nassau and St. Johns Counties)

PURPOSE: To ensure that investigations involving children under the age of one (1), alleged to be substance exposed receive additional oversight during the early stages of the child protective investigation to increase positive outcomes, enhance critical thinking of staff and promote early childhood services collaboration and communication among service providers.

A *Plan of Safe Care* is not the equivalent of a safety plan. A *Plan of Safe Care* may identify child safety and risk issues within the family, but a safety plan is the only vehicle for implementing specific protective actions. A *Plan of Safe Care* is intended to facilitate a holistic, multi-disciplinary approach to responding to the needs of the entire family. A *Plan of Safe Care* is intended to be developed at the earliest point of the mother's use or infant's exposure has been identified.

At the point of the child welfare professional's contact with the family, a *Plan of Safe Care* should have already been developed by medical personnel, behavioral health specialists, or home visitor staff (e.g., *Healthy Start*, *Healthy Families*, *Connect*, etc.) who regularly interact with the mother prior to, or soon after, the birth of the infant. It is the child welfare professional's responsibility to determine if a *Plan of Safe Care* had previously been offered to the mother and, if not, re-assess the need for a plan to be implemented and monitored.

LEGAL AUTHORITY: The Child Abuse Prevention and Treatment Act (CAPTA) Reauthorization (2010) and P.L. 114-198, Comprehensive Addiction and Recovery Act of 2016, Title V, Section 503, CFOP 170-8.

CRITERIA: The Plan of Safe Care Protocol is applicable to all investigations meeting the following criteria:

- All investigations involving a newborn child or child under the age of one (1 year) with at least one of the following maltreatments:
  - Substance Exposed Newborn
  - Substance Misuse involving alcohol, illicit or prescription drugs

- All Investigations where one of the following conditions exist:
  - a newborn who tests positive for a substance at birth
  - a newborn who was exposed to substances in utero
  - a child under the age of one (1) whose parent or caregiver tests positive for an illegal or non-prescribed substance
  - parent/caregiver admits to using illicit substances or substances not prescribed to them or who abuses prescribed medications.
- Pregnant moms who are open to services, who may be drinking alcohol or misusing substances that may be harmful to their unborn child.

Child Protective Investigations

Investigations that meet the above criteria will be assigned to the Substance Exposed Newborn & Infant Unit where available and to a Certified Child Protective Investigator (CPI), to the extent possible. If the investigation cannot be assigned to a Certified CPI, a pre-commencement consultation between the CPI and CPI Supervisor (CPIS) must be completed prior to the commencement of the investigation.

If at any point during an investigation the child protective investigator (CPI) learns that an infant has been exposed prenatally to controlled substances or alcohol, the CPI shall:

Ask the mother if she was provided a *Plan of Safe Care* and encouraged to participate in a home visiting program (e.g., Healthy Start or Healthy Families, etc.). For children determined to be "Safe", the CPI shall encourage the parent(s) to participate in a home visiting program (e.g., *Healthy Start* or *Healthy Families*, etc.) to assess the need for, and implementation of, a *Plan of Safe Care*.

If a *Plan of Safe Care* was developed, the CPI shall contact the family's worker and confirm that a plan is in place, inquire about the family's level of engagement, and ask if there are any unmet needs that are not currently being addressed by the plan components.

Assess for the possibility of developmental delays in the infant and, if a delay is suspected, refer the infant to a local child developmental screening program. See the Developmental Screening Referral information below.

For children determined to be "Unsafe," the CPI shall contact medical and treatment personnel and attempt to obtain information on the immediate medical, placement and treatment needs of the infant and mother. The components of the *Plan of Safe Care* shall be incorporated and addressed in the Family Functioning Assessment – Investigation and be discussed at the case transfer staffing. If needed, a Plan of Safe Care shall be initiated. (Please see attached template.)

Substance Misuse Assessment/ Treatment Referral

Within one business day of identification, the CPI will refer the parent for a substance abuse assessment by a Family Intervention Specialist (FIS) representative and/or a Behavioral Health Consultant (BHC) to determine the appropriate level of substance misuse treatment needed. The CPI will explain to the parent the purpose and the need for the referral, to include the possible outcomes of non-engagement with the assessment or identified services.

Agency / Service	Agency Contact
Duval Gateway Connect (phone assessment)	**Please email this referral to: Gateway_Connect@gatewaycommunity.com Please ensure that the client calls Connect Number: 1-877-389-9966** **Any questions please direct to: Jasmine Herbert, jherbert@gatewaycommunity.com**
Duval Gateway Referral for FIS Services	**Please email referral form to: FIS@gatewaycommunity.com Any questions or concerns, please direct to: FIS Supervisor Christina Bivona**
Duval Gateway Referral for FIS Adolescent Services	**Please email referral form to: FIS@gatewaycommunity.com Any questions or concerns, please direct to: FIS Supervisor Christina Bivona**
Baker Meridian Behavioral Health-FIS	**Felicia A. Bryant, BS** **Meridian Behavioral Health Inc.** **Family Intervention Specialist** **Email: Felicia_bryant@MBHCI.org** **Number: 352-727-0318**
Nassau Starting Point Referral for FIS Services (attached)	**Please email referral for to: childwelfare@spbh.org Any questions or concerns, please call Team Leader Kayla Benoit: Phone: 904.225.8280 ext 444**
St. Johns County Epic Behavior Health Care	**Contact person: Kass Deboer** **Contact 904 806-2201**
Clay County Clay Behavioral Health Center (Clay County) Referral for FIS (adolescent & adult) (attached)	**Please email this referral to : ifsreferral@firstinclay.org Any questions please direct to: Nicole Saunders, Intensive Family Services Supervisor, Nicole.saunders@firstinclay.org**

Home Visiting Program Referral

All infants and mothers affected by prenatal substance exposure shall be referred to a home visitor program within one day of the identification.

The CPI or other Child Welfare Professional (CWP) will refer the parent by calling Northeast Florida Healthy Start Coalition Coordinated Intake and Referral (CI&R) at the Northeast Florida Healthy Start Coalition by visiting: http:nefhealthystart.org/connect and scanning the referral form QR Code, or by calling (904) 723-5422. CI&R will assist with identifying the appropriate level of services for the victim-child and family.

The CWP shall use the attached CI&R referral form to guide the telephonic referral process and to ensure CI&R staff have the necessary information to perform an expedited intake. CI&R staff will provide a detailed description of the available Home Visiting Programs that the family is eligible for and the family will select the one that best fits their identified needs and goals. CI&R will inform the CWP of the referrals made and if the family has engaged with the service provider(s).

Northeast Florida Healthy Start Coalition staff will document engagement efforts and status updates in FSFN.

Developmental Screening Referral

If the Child Welfare Professional (CWP) suspects developmental delays or if records indicate such, the child will be referred to a Developmental Screening Program.

Note: A referral to the Northeast Florida Healthy Start Coalition's Coordinated Intake and Referral (CI&R) will satisfy this requirement, provided the suspected developmental delay is included in the referral.

The Child Welfare Professional will explain the purpose and need for the referral and screening to the parent. The CWP will refer the child(ren) to the respective Early Steps program and include the child(ren)'s birth records or physician documentation of substance exposure, if available. The developmental screening program will complete a developmental assessment on the child(ren) using their respective screening tools (ASQs, SEAM, etc.) and will provide the outcome of the assessment to the CWP and

(ASQs, SEAM, etc.) and will provide the outcome of the assessment to the CWP and will advise them of the Family Service Coordinator's name and contact information if one is assigned. Early Steps will also contact the parent to discuss the outcome of the assessment and connect the family with any additional service referrals, as needed.

Early Steps will inform the CWP of any additional service referrals made and whether the family has engaged in services.

Developmental Screening Program	Agency Contact
Early Steps Northeastern Counties: Baker, Bradford, Clay, Duval, Nassau, St. Johns 910 North Jefferson Street Jacksonville, Fl 32209	**Phone: (904) 360-7022** **Fax: (904) 798-4545 or (904) 798-4544**
Early Learning Coalition of Duval I Help Me Grow 6500 Bowden Road Suite 290 Jacksonville, FL 32216	**Phone: (904) 208-2044 x29S** **Lilianna Ruiz-Rivera** **lruizrivera@elcduval.org**

Child Welfare Case Management Services

For infants coming into care involving prenatal exposure to a controlled substance or alcohol, the case manager shall determine if there is an existing Plan of Safe Care in place.

If a plan has been implemented, the case manager shall determine its effectiveness in meeting the needs of the mother, infant and other family members. If the plan has not been effective, the case manager shall work with the family to identify the challenges or barriers that have been problematic.

The case manager shall contact the family's worker and confirm that a plan is in place, inquire about the level of engagement and ask if there are any unmet needs or concerns that are not currently being addressed by the plan components.

The case manager shall continue to monitor any existing Plan of Safe Care to resolve any unmet needs, concerns or engagement issues. The family's progress and efficacy of the Plan of Safe Care shall be documented in the FFA-Ongoing or progress updates.

If a Plan of Safe Care has not previously been developed, the case manager shall ensure that all plan components are discussed in the FFA-Ongoing or Progress Update and include all essential unmet elements in the initial case plan as appropriate.

As part of a pre-birth assessment in an existing case, the case manager shall attempt to identify any prenatal drug use (controlled substances or alcohol) and ensure that, based on family needs, all necessary components of a Plan of Safe Care are addressed by the existing case plan. The case plan shall be modified to address any unmet needs that have been identified.

Northeast Florida Healthy Start Coalition (NEFHSC) Case Management

For infants, parenting families and pregnant women engaged in prevention services who are involved in prenatal exposure to a controlled substance or alcohol, the case manager shall determine if there is an existing Plan of Safe Care in place.

If a plan has been implemented, the case manager shall determine its effectiveness in meeting the needs of the mother, infant and other family members. If the plan has not been effective, the case manager shall work with the family to identify the challenges or barriers that have been problematic.

The case manager shall contact the family's worker and confirm that a plan is in place, inquire about the level of engagement and ask if there are any unmet needs or concerns that are not currently being addressed by the plan components.

The case manager shall continue to monitor any existing Plan of Safe Care to resolve any unmet needs, concerns or engagement issues. The family's progress and efficacy of the Plan of Safe Care shall be documented.

If a Plan of Safe Care has not previously been developed, the case manager will develop one with the family and upload in FSFN.

As part of a pre-birth assessment in an existing case, the case manager shall attempt to identify any prenatal drug use (controlled substances or alcohol) and ensure that, based on family needs, all necessary components of a Plan of Safe Care are addressed.

For newborns engaged in NEFHSC services, the case manager will interact with hospital staff, child welfare professionals and other known providers prior to a newborn's discharge from the hospital to ensure a Plan of Safe Care is developed.

Joint Visitation by Service Providers

All service providers (child welfare professionals, substance misuse treatment provider, developmental screening program, and home visiting program) are encouraged to conduct joint visits to commence services with the family in order to facilitate the exchange of information among agencies and the flow of information to the parent (to include an explanation to the parent regarding the need for services, CPI case closure activities, and possible outcomes of non-engagement).

Multi-Disciplinary (POSC) Staffing

At any time deemed necessary, the Child Welfare Professional or home visitor program staff may schedule a telephonic, Plan of Safe Care (POSC) staffing to include the substance misuse treatment provider, developmental assessment provider, and the home-visiting provider, and any additional service providers that were referred. The staffing participants will discuss the following, including but not limited to: (1) the progress of the parent(s)' substance misuse assessment/ treatment, (2) any parenting concerns/ parental capacity, (3) child(ren)'s developmental concerns/ needs, if any, (4) any other additional service provider input, (5) any follow up needed prior to closing the DCF investigation, and (6) potential date of DCF case closure).

If at any time during the child protective investigation the parent refuses to engage in services (substance misuse treatment, developmental assessment program, or home visiting program) or fails to follow through with the recommended treatment, then the CPI will staff the case with the Program Administrator (PA) to determine if there is sufficiency to warrant a staffing with Children's Legal Services for potential judicial action.

Quality Assurance

The Northeast Region Family Safety Program Office Quality Assurance staff will develop an ongoing and quarterly process for monitoring compliance with Plan for Safe Care Protocol and will provide data and related data analysis.

Collaborative Training and Outreach

The Department of Children and Families, community based care partners, local Substance Exposed Newborn and Safe Sleep Task Forces will work collaboratively with the Northeast Florida Healthy Start Coalition to develop and execute training to Child Welfare Professionals, Healthy Families/Healthy Start program staff, birthing hospitals, Medically Assisted Treatment (MAT) programs, pregnant and post-partum woman's (PPW) substance misuse treatment programs and other community stakeholders to engage them in developing Plans of Safe Care.

Plan of Safe Care Protocol Tip Sheet

Criteria:

Any investigation involving a pregnant Mom or newborn child or child under the age of one (1 year) with one or more of the following maltreatments:

- Substance Exposed Newborn
- Substance Misuse
- Substance Misuse -Alcohol
- Substance Misuse - Illicit Drugs
- Substance Misuse - Prescription Drugs

And where one of the following exists:

- a newborn child tests positive for a substance
- a newborn child was exposed to substances in utero
- a child under the age of one (1) whose parent or caregiver tests positive for an illegal or non-prescribed substance
- parent/caregiver admits to using illegal substances or substances not prescribed to them
- parent/caregiver abuses medications prescribed to them

Procedure:

Case will be assigned to SEN Unit and/or Certified CPI. If this is not possible then pre-commencement will occur with uncertified CPI.

Existing Plan of Safe Care:

At commencement the CPI will determine if there is an existing Plan of Safe Care which was developed prior to the receipt of the abuse report by contacting prior or current early childhood providers and/ or review of birthing hospital records. The CPI will determine the level of care outlined in the existing Plan for Safe Care, the need for any modifications to the plan and the parents' current compliance with the aspects of the plan.

Substance Abuse Treatment Provider:

Within one business day of identification, the CPI will refer the parent to FIS.

Home Visiting Program:

Within one business day of identification, the CPI will refer the parent to a Home Visiting Program by calling NEFHSC CI&R CONNECT at (904)723-5422.

Developmental Screening:

CPI will refer the child to a developmental screening (can be completed on referral to CI&R program)

Joint Visitation by Service Providers

Staffing:

If at any time the parent refuses to engage in services or fails to follow through with the recommended treatment, the CWP or provider will schedule MDT staffing or close-the-loop staffing with service providers.

Notification of DCF Case Closure

The CPI will notify all service providers via email of the firm anticipated closure date.

COORDINATED INTAKE AND REFERRAL FORM

Referred to: ☐ **Healthy Start** ☐ **Healthy Families** ☐ **Early Head Start (CHS)** ☐ **Early Head Start (Episcopal)** ☐ **Azalea** ☐ **NFP** ☐ **Magnolia** ☐ **Early Steps**

Address:		**Phone:**
From: (name of person making referral)	**Title:**	**Phone:**

CLIENT AND FAMILY INFORMATION

Client's Name: First Last M.I	**Social Security #**	**Date of Birth (mo/day/yr):**	**Age:**
Primary Caregiver's Name: First Last M.I		**MOB DOB (mo/day/yr):**	
Street address:	**County:**	**Zip code:**	
Email address:			

Medical Insurance covered by: ☐Medicaid # ___ ☐Private Insurance___ ☐No Insurance ☐Other ___	**Doctor's Name:**	**Best time to contact:**	**Home Phone #:** **Cell Phone #:**
Language of Preference: English Spanish Other	**Pre-Pregnancy:** **Wt:** lbs. **Height:** ft. in. **BMI:**	**Estimated Due Date:**	**# of weeks pregnant:**

Reason for Prenatal Referral:

☐No high school diploma/GED (1)
☐Not married (1)
☐Has experienced depression/hopelessness (1)
☐Of African descent (3)
☐Consumed alcohol or drugs in the last month (1)
☐Smoked cigarettes in the last month (1)
☐Does not want to be pregnant (1)
☐First pregnancy (2)
☐Previous pregnancy- baby born 3 weeks or more before due date (3)
☐Previous pregnancy-had a baby that weighed less than 5lbs. 8oz. (3)
☐Previous pregnancy-had a baby that was not born alive (stillborn or miscarriage) (3)
☐Age is less than 18 (1)
☐Pre-pregnancy BMI is less than 19.8 (1) or greater than 35.0 (2)
☐If not first pregnancy, pregnancy interval was less than 18 months (1)
☐Received prenatal care during the 2nd trimester (1)
☐Has an illness that requires ongoing medical care (2)
Please specify___
☐Other___

Score ___

Reason for Postnatal Referral:

Infant's Age:___ **Gender:** Male___ Female___

☐Abnormal conditions of the infant include one or more of the following: assisted ventilation (≥ 30 min), assisted ventilation (≥6 hrs), NICU admission, Newborn given Surfactant Replacement Therapy, Hyaline Membrane Disease/RD, or seizure of serious neurological dysfunction. (4)
☐ Infant's birth weight is less than 4 lbs. 7oz . (4)
☐ Infant transferred to another facility (4)
☐ Mother is not married (1)
☐ Principal source of payment Medicaid (1)
☐ Mother's race black (1)
☐ Father's name not present or unknown (1)
☐ Mother used tobacco during one of more trimesters (1)
☐ The number of prenatal visits is < two or unknown (1)
☐ Mother's age is less than 18 or unknown (1)
☐ Other___

Score ___

Client's Consent: I accept the invitation to participate in one of the Community Connect Home Visiting Program. I consent that this information be given to the County Health Department, Healthy Start Providers, and the Northeast Florida Healthy Start Coalition and shared with its programs: Healthy Start, Healthy Families, The Magnolia Project, Children's Home Society, Episcopal Children Services, The Azalea Project, and Nurse Family Partnership. I understand that this information will be held strictly confidential.

___
Signature of Participant, or Parent/Guardian Date

___
Referring Person's Signature Date

___
Referring Person's Title

Comments:

PROGRAM SCRIPTS (Prenatal)

The Azalea Project	The Magnolia Project	*Healthy Start*	Florida HEALTH Duval County *Healthy Start*	Nurse-Family Partnership
• Provides specialized education, services, and resources for women, babies, and families affected by substance abuse or usage. • Offers services to pregnant or newly delivered women and parenting women ages 18-44. • Offers weekly groups that promote health and wellness. This include yoga, knitting/crocheting, container gardening and more. ***NOTE:* Zip Code Specific, check Zip Code Directory**	• Services offer to women of childbearing age 15-44 which include Home Visits that are built around your schedule and individual needs • Will have a supportive case manager who will encourage you as you make your goals a reality. • Provides primary care services, nutritional classes, yoga, and group sessions. • Weekly classes available, which includes an interactive prenatal class with your partner ***NOTE:* Zip Code Specific, check Zip Code Directory**	• Goal is to assure a healthy pregnancy and build a support system for future goal setting for a healthy family. • Home visitors will meet with expectant parents who want and ask for support in having a healthy pregnancy. The frequency of visits will be determined by the initial risks factors. • Provide parents with information on resources for nutrition, safe sleep, breastfeeding and child spacing information.	• An experienced pregnancy coaches- a Nurse or Social Service Counselor will visit you at home or a location convenient to you and will address wellbeing in your pregnancy. • Once your baby is born they continue to see you and your baby up to age 3 to make sure YOU and the baby are doing well. • Coaches can give referrals to *Kohl's Safe Sleep*, and linkages to community resources.	• Free, voluntary program for first time moms. • Will be partnered with a registered nurse early in your pregnancy. • Receives ongoing home visits that continue through her child's second birthday. • This is a life changing program that combines passion with science. ***NOTE:* Located at UF Health, be sure to check the Zip Code Directory**

PROGRAM SCRIPTS (Prenatal)

Early Head Start		
• Goal is to assure a healthy pregnancy and to enroll your child into Early Head Start • Help build family goals based on the needs of the family • Provide education around the health and wellbeing of you as pregnant mother • Home Visitors will come once a week to work with you. ***NOTE:* Episcopal Children's Services is Zip Code Specific, check Zip Code Directory. CHS serves all of Duval County**	• Prevent child abuse & neglect • Offers education, coaching, and support for new and expecting parents • Tailored to addressing family needs • Voluntary, free, and delivered in the comfort of your own home • Flexible Hours • ASQ tools-measure child's milestones • Quarterly gatherings for mom's/social support • Baby items • Access goals for the family • Transportation assistance	

PROGRAM SCRIPTS (Infant)

	Early Head Start	***Healthy Start***	***Healthy Start***
• Home visits that are built around your schedule and individual needs. • A group of knowledgeable, energetic staff that support you as you navigate the daily ups and downs of parenthood. • Hands on curriculum that demonstrates how to use items from your home to create fun, educational experiences for you and your child. • Linkages to community resources	• Home visitors will come once a week to work with you and your child. • There will be daily routines, family interactions, and household materials used to help your child learn. • Twice a month a small group of children, families, and their home visitors will get together to socialize. • The goal is to assure your child is ready for school. ***NOTE:* Episcopal Children's Services is Zip Code Specific, check Zip Code Directory. CHS serves all of Duval County**	• Will have a child development coach. • Staff will give expert advice, and linkage to community resources. • Experienced care coordinators/ nurses will visit you at home or a convenient location for you to see how you are doing. • Will provide a developmental screen to make sure your baby is on track developmentally. They continue to see you to make sure your baby is doing well up to age 3.	• Home visits will provide you the parent with help and resources on Newborn health, such as breastfeeding and nutrition, development milestones and behaviors, as well as safe sleep practices • The Home Visitor will create daily routines that will be easy to follow for creating learning activities that is age appropriate for your child • There will be a monthly group for Home Visitors, families and children to socialize with one another and share positive child rearing experiences.

PLAN OF SAFE CARE

Name of Infant ______________________________ Date of Birth ______________

Name of Mother ______________________________

Name of Father ______________________________

1. **Mother's Substance Misuse and Mental Health Needs (please include all available information including mother's self-report)**

   (a) Substance Use History ______________________________

   (b) Mental Health History ______________________________

   (c) Treatment History ______________________________

   (d) Medication Assisted Treatment History ______________________________

   (e) Referrals for Services ______________________________

   (f) Plan for Mother ______________________________

2. **Infant's Medical Care**

   (a) Prenatal Exposure History ______________________________

   (b) Hospital Care (NICU), length of stay, diagnosis ______________________________

   (c) Other Medical or Developmental Concerns ______________________________

   (d) Pediatric Care and Follow Up ______________________________

(e) Referral to Early Intervention and other services

3. Mother's Medical Care

(a) Prenatal Care History

(b) Pregnancy History

(c) Other Medical Concerns

(d) Screening and Education

(e) Follow up Care with OB/GYN

4. Family/Caregiver/Father History and Needs

(a) Prior involvement with child welfare

(b) Child safety or risk concerns

(c) Parent-child relationship

(d) Family history

(e) Living arrangements and sibling information

(f) Current support network

(g) Current services

(h) Needed supports/services

Case Manager/Representative Responsible for Follow Up ______________________________

Agency______________________________Phone Number______________________

Recommendation ____

Additional Staffing Needs______________________Follow-Up Date ________________

Admission to NICU Date__________________Estimated Discharge Date_______________

Identified Goals:

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Mother/Caregiver Name (Please Print) ____________________________________

Mother/Caregiver Signature:__________________________________Date: ___________

Mother/Caregiver Contact Information: ___________________________________

Other Notes:

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