



National Center on
Substance Abuse
and Child Welfare



MODULE

3

PLAN OF SAFE CARE LEARNING MODULES

DETERMINING WHO NEEDS A PLAN OF SAFE CARE

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Prepared by the National Center on Substance Abuse and Child Welfare (NCSACW), this module is one of a five-part series on Plans of Safe Care for infants affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a fetal alcohol spectrum disorder (FASD), and their affected family or caregiver. The series is intended to provide technical assistance that guides state, tribal, and local collaborative partners who aim to improve systems and services for infants affected by prenatal substance exposure and their families. These technical assistance modules were developed by the NCSACW. The policy and practice strategies included in these modules are derived from NCSACW's years of practice-based experience providing technical assistance to states, tribes, and communities. Points of view or opinions expressed in this tool are those of the authors and do not necessarily represent the official position or policies of the Substance Abuse and Mental Health Services Administration or the Administration on Children, Youth, and Families.

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About This Module

The Child Abuse Prevention and Treatment Act (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 (FASD).” States have the opportunity to define this group of affected infants, and the definition each state develops has implications for which infants and families receive a Plan of Safe Care. This module will explore the steps states can take to define “affected by substance abuse” as they roll out a statewide Plan of Safe Care.

The Comprehensive Addiction and Recovery Act (CARA) amendments to CAPTA require:

“(iii) the development of a Plan of Safe Care for the infant born with and identified as being affected by substance abuse or withdrawal symptoms, or a fetal alcohol spectrum disorder to ensure the safety and well-being of such infant following release from the care of healthcare providers, including through –

(I) addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver”¹

The legislation does not define “affected by substance abuse or withdrawal” and leaves further clarification up to states. The Administration on Children, Youth and Families (ACYF) notes:

“We recognize that by deleting the term ‘illegal’ as applied to substance abuse affecting infants, the amendment potentially expands the population of infants and families subject to the provision. States have flexibility to define the phrase, ‘infants born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure,’ so long as the state’s policies and procedures address the needs of infants born affected by both legal (e.g., prescribed drugs) and illegal substance abuse.” (ACYF, 2017)

The CAPTA legislation requires that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of the birth of these infants. State teams can create their own definitions to help healthcare professionals identify which infants meet the criteria for notification to child welfare and which meet the criteria for the need to develop a Plan of Safe Care.

KEY IMPLEMENTATION CONSIDERATIONS

• *Distinguishing Between a Notification or Child Protective Services Report*

Section 106(b)ii of CAPTA stipulates that states provide an assurance that the state is operating a statewide program that includes policies and procedures to address the needs of infants and affected families or caregivers. This includes the development of a Plan of Safe Care for the infant born with and identified as being affected by substance abuse or withdrawal symptoms, or an FASD. CAPTA also includes a provision that healthcare providers involved in the delivery or care of infants meeting the criteria notify their local Child Protective Services (CPS) system.³

¹ Public Law 114-198, Comprehensive Addiction and Recovery Act of 2016. Sec. 503. (B)(iii).

² Administration on Children, Youth and Families. Children’s Bureau (2017). Program Instruction: ACYF-CB-PI-17-02. <https://www.acf.hhs.gov/sites/default/files/documents/cb/pi1702.pdf>. Retrieved 1/21/2019.

³ CAPTA as amended by P.L. 114-22 and P.L. 114-198, including the Justice for Victims of Trafficking Act of 2015 and the CARA of 2016: <https://www.acf.hhs.gov/sites/default/files/documents/cb/capta.pdf>

Consistent with the CAPTA statute that affirms that a notification shall not be construed to establish a definition under federal law of what constitutes child abuse or neglect, states recognize that some infants are not necessarily at risk of child abuse or neglect, and may not require a report to CPS. A notification is intended to initiate a Plan of Safe Care for affected infants and their affected family or caregiver. By contrast, a report to CPS is an indication a child may be at risk of abuse or neglect and could lead to a screened in report and assessment or investigation. Hospital screening practices that are not universal may result in disproportionate notifications or reports for minorities and low-income families. Infants requiring a report to CPS also require a Plan of Safe Care. Most states do not have a notification process that is separate from their reporting process for child abuse and neglect. In these states, both notifications and reports are received and addressed through their state child welfare systems. States use multiple approaches in responding to notifications. This includes initiating a child protection investigation or an in-depth assessment process. Assigned caseworkers assess family needs and connect the families to services. If abuse or neglect risks are identified, case workers transfer the families for more intensive services with child protective case workers. Some states opt to use existing alternative response pathways to address notifications. When notifications are addressed within the state's child welfare system, child welfare case workers typically develop and oversee the Plan of Safe Care.

Creating a separate notification process may provide an opportunity to create a public health response for infants and families when the Plan of Safe Care is developed outside of the child welfare system. In this model, a community provider would develop and oversee the Plan of Safe Care for families with no child abuse or neglect concerns. States use these separate notification pathways to support families that are typically 'screened out' and not provided further services or referrals. The separate notification pathways provide continued support to these families without increasing calls to child welfare's hotline or increasing child welfare's caseload of families. Non-case specific notification can reduce the number of families that are referred to child protective services. States may consider the following steps when creating a separate or distinct notification system:

- Finding an appropriate partner(s) to oversee Plans of Safe Care for families who do not appear to be a risk or safety concern. Refer to Module 4, "Implementing and Monitoring Plans of Safe Care" for more information on this topic.
- Using aggregate data to inform child welfare services on the number of infants born with and identified as being affected by substance abuse or withdrawal symptoms, or an FASD, the number of Plans of Safe Care created, and the number of these plans that include a referral for the infant or affected family member. CAPTA requires states, to the extent practicable, to report these data annually. States that use a separate notification pathway typically partner notifications with aggregate data collection. In these cases, states may be able to collect information about race/ethnicity, drug type, and test type in addition to the data on Plans of Safe Care, but will not be able to collect client level data. Developing guidance and training to help healthcare professionals discern whether a family requires a notification or a report. This additional data collection can aid states in addressing disproportionate reports on families of color to child welfare systems.
- Creating Notifications for Legally Prescribed Medications
Pregnant women taking medications prescribed by healthcare providers, such as methadone, buprenorphine, benzodiazepines, or opioids for pain management may result in an infant experiencing withdrawal and a positive toxicology screening. Depending on how the state defines affected by substance abuse, healthcare providers may be required to notify child welfare and develop a Plan of Safe Care for mothers taking legally prescribed substances, even though these families may be stable and safe. States can consider a notification pathway to a community provider to address infants exposed to legally prescribed medications. In this approach, a healthcare provider or other community agency outside of the child welfare system could provide the family with support and care management through the Plan of Safe Care that they may not otherwise receive.



Connecticut developed an online portal for hospital healthcare workers to enter information for all notifications and reports of infants born affected by substance abuse or withdrawal symptoms, or an FASD. The portal functions as a decision tree; based on answers to questions about child risk, the system will identify whether an affected infant requires a CPS report or a notification. If the infant only requires a notification, the healthcare professional develops a Plan of Safe Care. If the infant requires a report, the healthcare provider contacts the local CPS office, who then initiates a formal screening process for child abuse or neglect. Access the Connecticut portal [here](#).

• Ways to Develop Consensus

The definition of affected by substance abuse or withdrawal symptoms or FASD affects families and the multiple systems they interact with, including prenatal care providers, birthing hospital staff, public health nurses, child welfare systems, and substance use disorder (SUD) treatment providers. Each system provides a unique and important perspective:

- Healthcare providers focus on the physiological effects of exposure on the infant and woman
- SUD treatment professionals focus on parental substance use and recovery
- Child welfare focuses on risk, safety, and well-being of children

The state team developing the definitions of affected by substance abuse, withdrawal and an FASD should include representatives from the variety of systems and providers that will engage with these families. Healthcare providers—including neonatologists, OB/GYNs involved in the delivery and care of infants—utilize definitions of affected by substance abuse or withdrawal symptoms or fetal alcohol spectrum disorder to decide whether families and infants require a notification to child welfare at the time of birth. SUD treatment and medication-assisted treatment providers educate the pregnant women they serve about the potential child welfare response to infants based on the definitions. The state team can develop definitions that inform which infants require notifications and which infants require CPS reports, and the appropriate response, within or outside of the child welfare system. The team representatives also can benefit immensely from hearing perspectives and concerns of parents with lived experience, as the team works to reach consensus on a definition. Moreover, bringing stakeholders together early and often will help increase cross-system buy-in of the final definitions and support implementation and practice changes.

• Defining Affected by Substance Abuse

CAPTA states that a Plan of Safe Care must be developed for infants born with and identified as being affected by substance abuse, withdrawal or an FASD. States have flexibility in defining affected by substance abuse. The definitions help identify which infants require a Plan of Safe Care. State strategies for defining affected by substance abuse have varied across the country. Some states may rely on toxicology testing of the infant, the mother, or both during the birth event. They may also look at tests conducted on the mother during pregnancy. Universal screening procedures should be implemented to mitigate bias and stigma in screening persons of color and low-income individuals⁴. Note that a definition of affected by substance abuse is not an allegation of abuse or neglect, but only an indication of a need for a Plan of Safe Care. Infants who meet these criteria may require further screening by child welfare.

Infants who test positive for exposure may not display specific physiological symptoms, disabilities, or potential developmental delays as a result of prenatal substance exposure and other risk factors. When state definitions are based on toxicology testing, their definitions can include language that allows for healthcare provider subjectivity in

Representatives to include when developing definitions:

- Child welfare leadership
- State SUD treatment leadership
- Maternal and Child Health representatives
- SUD/medication-assisted treatment directors
- Mental health leadership
- OB/GYNs and pediatricians
- Neonatologists
- Attorneys who represent parents and children in cases of child abuse or neglect
- Home visitors, recovery coaches
- Early Intervention Providers
- People with lived experience

⁴ American College of Obstetricians and Gynecologists Committee Opinion Number 711, August 2017.

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diagnosing the effects of prenatal substance exposure on the infant. Including this language allows for unique situations where providers have concerns about exposure, but a test result has not validated exposure. It also supports healthcare providers' judgement when there is documented prenatal substance exposure but does not appear to result in an infant being affected by substance abuse at the time of birth.

States that do not rely on toxicology testing in their definition tend to rely on healthcare practitioner assessment based on their work with the mother, their observation of the infant, and their access to prenatal history. These states may provide additional definitions to support healthcare providers in their decision making, such as:

- **Defining substance abuse:** Expanding on the definition of substance abuse can help practitioners identify whether an infant is affected. Some states also define and use the term active to describe substance abuse.
- **Defining infant:** Identifying the child's age has helped some states determine when a notification is required. Some states have elongated the notification period for an FASD because it is difficult to diagnose FASD in young infants. This addresses the need to offer plans to families if a later diagnosis is made.
- **Defining controlled substance:** States have used their pre-existing statutory definitions of 'controlled substances' to identify which legal and illicit substances require a notification to child welfare, due to prenatal substance exposure.



New Jersey's definitions rely on toxicology testing and physician diagnosis. A substance-exposed infant is an infant:

- *Whose mother had a positive toxicology screen for a controlled substance or a metabolite thereof during pregnancy or at the time of delivery*
- *Who has a positive toxicology screen for a controlled substance after birth, which is reasonably attributable to maternal controlled-substance use during pregnancy*
- *Who displays the effects of prenatal controlled substance exposure or symptoms of withdrawal resulting from prenatal controlled substance exposure*
- *Who displays the effects of an FASD*

• Addressing Withdrawal Symptoms

The American Academy of Pediatrics defines withdrawal symptoms as 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. States that elect to define withdrawal symptoms are then challenged to identify which withdrawal-inducing substances require notification and a Plan of Safe Care. Infants exposed to substances that can cause withdrawal do not always experience withdrawal symptoms; moreover, withdrawal symptoms may not manifest until an infant has been discharged from the hospital. Many states opt to use state statutes that outline controlled substances to support their Plan of Safe Care definitions of an infant affected by substance abuse and their Plan of Safe Care policies and procedures. This approach rules out substances such as tobacco and certain antidepressants (e.g., selective serotonin reuptake inhibitors) that may lead to infant withdrawal.

Some infants exposed to substances that may precipitate withdrawal may require pharmacological interventions, while other infants may only require non-pharmacological interventions such as swaddling, skin-to-skin contact, and breastfeeding. Most state definitions do not address the different treatment modalities in determining if an infant experiences withdrawal. In these instances, healthcare providers must determine if an infant meets the criteria of withdrawal even if they only require non-pharmacological intervention. Note that many hospitals are making advancements in the non-pharmacological treatment of neonatal abstinence syndrome (NAS), making it possible to reduce pharmacological interventions. These interventions could possibly result in reductions in the number of infants who require a Plan of Safe Care due to symptoms of withdrawal. State teams should consider how this trend may affect the populations defined as needing a Plan of Safe Care. Ideally, the definition and identification of an infant affected by substance abuse or withdrawal symptoms, or an FASD, is based on the infant and mother's presenting information and history, and not the interventions they receive.

• Early Identification and Disparity Issues Related to Who Is Screened

The American College of Obstetricians and Gynecologists (ACOG) recommends that providers verbally screen *all* women for substance use⁶. Ideally, this screening would occur during each trimester with an evidence-based screening tool to complete the screening. Universal substance use screening of women during pregnancy can decrease decision biases by healthcare providers and ensure that women have early opportunities to access treatment and supports as needed. In most states, however, verbal screening with evidence-based screening tools is not implemented universally. Relying on toxicology testing alone only reflects substance use during a single point in time; the testing does not provide information about the frequency of substance use or the potential of substance use disorders. In the absence of universal screening, selection bias results in disproportionate screening and testing of low-income patients and patients of color. Including universal substance use screening in policies and practices related to this population would help ensure that all infants and their families affected by substance abuse, withdrawal, or an FASD receive the services and supports they may need.

• Ensuring an Appropriate Service Response

Assessing substance use during pregnancy and at the time of delivery can support an approach that is tailored to the different needs of families with an affected infant based on whether the mother:

- *Is taking an opioid medication for chronic pain or other medications (e.g., benzodiazepines) as prescribed by her healthcare provider, and has no known SUD*
- *Is receiving medication-assisted treatment (buprenorphine or methadone) for an opioid use disorder or is actively engaged in treatment for an SUD*
- *Is misusing prescription drugs or legal substances, or using illegal drugs, meets criteria for an SUD, and is not actively engaged in an SUD treatment program*

Using this information, state teams can match families with appropriate service providers to make sure that suitable prevention, intervention, and treatment services are included in the Plans of Safe Care. For example, SUD treatment agencies might take the lead to develop and implement the Plans of Safe Care for women actively engaged in treatment, along with support from early childhood intervention and child abuse prevention services to ensure that the development and safety needs of the infant are addressed appropriately. For more information on oversight of Plans of Safe Care, see Module 4, “Implementing and Monitoring Plans of Safe Care.”

• Information Sharing

States should consider how procedures regarding notification and reports include historical and current information about a patient’s substance use and treatment. With appropriate consent, hospital social workers and nurses can gather information about a patient’s adherence to SUD treatment, including medication-assisted treatment, during pregnancy. Information about treatment adherence during pregnancy can then inform healthcare providers involved with the delivery of infants affected by substance abuse or withdrawal symptoms, or an FASD, in discerning whether an infant requires a notification or a report. Treatment adherence information may include attendance at treatment sessions, toxicology results, level of engagement in SUD treatment services, and recovery history.

Women who are engaged in SUD treatment may agree to sign a consent to allow information-sharing between the birthing team and the SUD treatment provider. In some states that are piloting prenatal Plans of Safe Care, pregnant women may arrive at the hospital with a plan that already includes this important information that can then be shared with child welfare services. For more information about prenatal Plans of Safe Care, see Module 4, “Implementing and Monitoring Plans of Safe Care.”

States may find that specific guidance is needed on the information that hospitals, other healthcare providers, and child welfare workers should request from SUD/medication-assisted treatment providers to determine dosing and adherence to their treatment plans, and how to handle confidentiality laws related to SUD treatment.

- **Policy, Legislative, or Regulatory Changes**

After a state team has developed definitions related to infants affected by substance abuse, withdrawal symptoms and FASD, states need to determine which related statutes, policies, procedures, or regulations should be revised. In some states, definitions have prompted statutory changes. Many other states house their definitions within child welfare policies and operating procedures.

When states choose to house the definitions within child welfare policy or procedures, they must also work with their birthing hospitals to adopt the notification and reporting requirements. Because these requirements may be broadened to include notifications that may not be related to child abuse or neglect concerns, some states have added new health regulations requiring hospitals to update their reporting criteria to include these new definitions. See the New Jersey example in the “Resources” section below.

PLANNING STEPS

Convene a Multi-System State Team

Engage a multi-system state team to craft definitions of affected by substance abuse, withdrawal symptoms as a result of prenatal exposure, and FASD. Ensure all systems that engage with families are represented, including child welfare leadership, state SUD treatment leadership, maternal and child health representatives, SUD/medication-assisted treatment directors, OB/GYNs and pediatricians, neonatologists, early intervention providers, home visitors, recovery coaches, and people with lived experience.

Identify Populations that Need a Plan of Safe Care

Once definitions have been crafted, work with the multi-system state team to identify the populations needing a Plan of Safe Care. Identifying populations will ensure an appropriate service response. State teams can develop protocols to match families with appropriate providers based on need.

Review Current State Laws

Review current state law to discern whether legislative changes are required to implement the Plan of Safe Care. States may find that changes can be made through child welfare policy and/or health regulations.

Develop Supportive Tools

Develop tools to support local jurisdictions to implement the new definitions. Tools may include decision trees or flow charts that help practitioners to identify which families require notifications and which families require reports.

Provide Training on New Definitions & Responses

Provide training to hospitals, SUD, and medication-assisted treatment providers, and child welfare workers on the new definitions and responses to different populations of women and infants.

QUESTIONS TO DISCUSS WITH YOUR COLLABORATIVE TEAM

- How does the state define the population of infants affected by prenatal substance exposure, such as affected by substance abuse, withdrawal symptoms, prenatal substance exposure, and FASD?
- How might the proposed definitions of infants born with and affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or an FASD affect which families to include or exclude from the group requiring a Plan of Safe Care?
- How will the definition of infants affected by an FASD address the inherent challenge in diagnosing an FASD in infants and the broad spectrum of associated disorders within FASD? 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 would universal screening for substance use during pregnancy using an evidence-based screening tool affect which infants are identified as needing a Plan of Safe Care, particularly for minority and low-income populations?
- As your team comes to a consensus on who should receive a Plan of Safe Care, how would you adapt the approach to developing Plans of Safe Care for the different populations of women giving birth to infants with substance exposure?

RESOURCES

Connecticut

Connecticut has developed state legislation that directs providers involved in the delivery or care of affected newborns to notify the Department of Children and Families (DCF) through an online portal. The portal includes questions for the provider, which helps the healthcare provider determine whether the situation meets the threshold for a child welfare investigation. If an investigation is deemed to be necessary, an automated report is made through the online portal. Through the Recovery, Engagement, Access, Coaching & Healing (REACH) Program, the Connecticut Department of Mental Health and Addiction Services has 15 recovery navigators available in all five regions of the state who support the Plans of Safe Care and serve as navigators.

- [Plan of Safe Care Provider Frequently Asked Questions](#)
- [DCF Provider Bulletin on Plans of Safe Care](#)
- [Plan of Safe Care Template](#)
- [Online Notification Portal](#)

Delaware

Delaware's House Bill (HB) 140, also known as Aiden's Law, requires that healthcare providers involved in the delivery or care of infants determined to be affected by substance exposure notify the child welfare division in the jurisdiction of these infants. HB 140 requires a "coordinated, service-integrated response by various agencies in this state's health and child welfare systems to work together to ensure the safety and well-being of [identified] infants ... by developing, implementing, and monitoring a Plan of Safe Care." HB 140 includes state definitions of substance abuse, withdrawal symptoms, and infants with prenatal substance exposure.

- [HB 140: Aiden's Law](#)
- [Plan of Safe Care Template](#)

New Jersey

New Jersey's collaborative team defined the populations of infants and families that needed a Plan of Safe Care and developed regulations for the child welfare system and hospitals to ensure that notifications were occurring in accordance with the revised definitions and procedures. The following definitions and regulations were adopted into the New Jersey Administrative Code in January 2018.

- [Administrative Codes Related to Substance-Affected Infants](#)
- [Child Welfare Policy](#)

Additional resources are available at <https://ncsacw.acf.hhs.gov/>.

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THE PLANS OF SAFE CARE MODULES SERIES

Although federal and state policies, regulations, and decisions guide the implementation of Plans of Safe Care, local communities must determine how to interpret and operationalize state guidance. Additional modules in this series provide states and communities with the considerations they need to think about to best implement Plans of Safe Care to support the safety and well-being of families in their jurisdictions. These modules include the following:

- **Module 1: *Preparing for Plan of Safe Care Implementation***, explores the steps states can take to understand existing statutes and structures as they strategize how to effectively address the needs of infants affected by prenatal substance exposure and their families.
- **Module 2: *Establishing Collaborative Partnerships***, explores the steps states can take to build, grow, and sustain collaborative teams critical to a comprehensive approach to Plans of Safe Care.
- **Module 4: *Implementing and Monitoring Plans of Safe Care***, explores how collaborative teams can translate policy decisions into practice through implementation and case monitoring.
- **Module 5: *Overseeing State Systems and Reporting Data on Plans of Safe Care***, explores how to develop and monitor policies and procedures related to Plans of Safe Care and discusses the strategies to enhance collaborative teams' abilities to report data to the National Child Abuse and Neglect Data System.