

BRIEF 2



HOW STATES SERVE INFANTS AND THEIR FAMILIES AFFECTED BY PRENATAL SUBSTANCE EXPOSURE

PLANS OF SAFE CARE DATA AND MONITORING

OVERVIEW

The National Center on Substance Abuse and Child Welfare (NCSACW), with support from the Administration on Children, Youth and Families (ACYF) Children’s Bureau (CB), has developed a series of briefs highlighting states’ approaches to serving infants and their families affected by prenatal substance exposure. These briefs derive from NCSACW’s review of states’ Annual Progress and Services Reports (APSRs) pertaining to Section 503 “Infant Plan of Safe Care” of the Child Abuse and Prevention Treatment Act (CAPTA) and years of practice-based experience providing technical assistance (TA) to support systems-level policy efforts and practice-level innovations to improve outcomes for these infants and families.

NCSACW HELPS STATES AND COMMUNITIES IMPROVE OUTCOMES FOR INFANTS AND THEIR FAMILIES AFFECTED BY PRENATAL SUBSTANCE EXPOSURE

Since the passage of the Comprehensive Addiction and Recovery Act (CARA) amendments to CAPTA in 2016, NCSACW has

- Responded to over 3,000 TA requests related to the prenatal substance exposure provisions in CAPTA, Plans of Safe Care, and neonatal abstinence syndrome
- Engaged 17 sites—including five Tribes and one county—in its In-Depth Technical Assistance program to support their efforts to implement the CARA amendments to CAPTA
- Convened two Policy and Practice Academies (2017, 2020), with 18 state teams and one county team to provide consultation on collaborative strategies to improve outcomes for infants and their families affected by prenatal substance exposure
- Supported two regional convenings—along with the Department of Health and Human Services regions 4, 6, 7, and 9, and their respective state teams—to advance their capacity to improve the safety, permanency, recovery, and well-being of infants and their families
- Visited eight state child welfare agencies in 2018 and 2019 to gain a greater understanding of the states’ policies and practices related to the CARA amendments to CAPTA. The site visits provided a forum to: 1) identify promising and best practices (as well as the challenges and barriers to the implementation of Plans of Safe Care), 2) learn about multidisciplinary efforts by the state to support implementation, and 3) identify TA needs
- Conducted 40 virtual and in-person interviews with child welfare, substance use treatment, healthcare, and legal professionals to gather information on how states and localities are serving infants and their families affected by prenatal substance exposure



BRIEFS IN THIS SERIES

BRIEF 01 • Identification and Notification

BRIEF 02 • *Plans of Safe Care Data and Monitoring*

BRIEF 03 • Lessons from Implementation of Plans of Safe Care

INTRODUCTION

CAPTA was amended by the [Comprehensive Addiction and Recovery Act \(CARA\)](#) in 2016. CARA, among other provisions, added requirements related to monitoring and data collection. The legislation required states to develop and implement monitoring systems regarding the implementation of Plans of Safe Care to determine whether, and in what manner, local entities provide referrals to, and delivery of, appropriate services for infants, families, and caregivers affected by substance abuse, withdrawal symptoms, or a fetal alcohol spectrum disorder.

CARA also amended the annual data reporting requirements in section 106(d) of CAPTA. States now report the following to the maximum extent practicable:

- Number 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
- Number of such infants for whom a Plan of Safe Care was developed
- Number of such infants for whom a referral was made for appropriate services, including services for the affected family or caregiver¹

While states have made significant progress implementing the CARA amendment to CAPTA, the provisions related to monitoring and reporting are particularly complex. States continue to explore ways to collaborate and communicate across systems to ensure all infants, caregivers, and families with a Plan of Safe Care receive the appropriate oversight of referrals and service delivery, and reporting happens to the maximum extent practicable.

Brief #2: *Plan of Safe Care Data and Monitoring* summarizes states' systems- and case-level strategies for monitoring Plans of Safe Care and fulfilling the amended annual data reporting requirements. This brief also highlights innovative ways states and local communities monitor and report on infants and families affected by prenatal substance exposure without an open child welfare case.



LEVELS OF MONITORING

State and local child welfare agencies vary in how they monitor Plan of Safe Care implementation and fulfill the annual reporting requirements. Some jurisdictions monitor at the systems level, others at the case level, and some use a combination of both to oversee referral and service provisions, and ensure compliance with federal reporting. For a vast majority of states, child welfare provides the system- and case-level monitoring for families with an open child welfare case.

As states and communities progress in implementing the CARA amendments to CAPTA, some have developed monitoring systems outside of child welfare, particularly for families that do not have an open case but would still benefit from a Plan of Safe Care and related community-based services and supports. From NCSACW's experience providing TA, implementing monitoring systems and fulfilling reporting requirements for these families require a data-driven, multisystem collaborative team approach.

SYSTEMS-LEVEL STRATEGIES

Thirty-three states described systems-level strategies for monitoring Plans of Safe Care in their APSRs in 2020. The most common strategies included:

- Updating data elements within state child welfare information systems to track details related to infants affected by prenatal substance exposure and Plans of Safe Care.
- Integrating Plans of Safe Care case reviews into continuous quality improvement practices to examine referrals and service delivery.

Some states reported they review and discuss their child welfare data and case review findings at interagency meetings to identify and understand implementation strengths and barriers. This also allows states to assess whether Plans of Safe Care actually help infants and their families or caregivers access and engage in services based on their identified strengths and needs.

NCSACW has found that having state-level administrators actively involved in the oversight of CARA implementation allows executive leadership, who have the authority to change state-level policies and practices, update data information systems, institute statewide trainings, and help resolve other implementation challenges. Leadership involvement can be part of ongoing quality assurance efforts to improve health and safety outcomes for children and families.



AGENCY HIGHLIGHT: DISTRICT OF COLUMBIA

To monitor implementation of the CARA amendments to CAPTA, the Child and Family Services Agency (CFSA) team meets quarterly to review child welfare data in their Statewide Automated Child Welfare System, *FACES.NET*. For these quarterly meetings, CFSA initially generated a data report known as *Hotline Calls with an Allegation of Positive Toxicology of a Newborn or Fetal Alcohol Spectrum Disorder*. This report included basic demographic information along with the allegation. CFSA modified the report over time to capture additionally pertinent data points such as the reporter's hospital, maltreatment type, drug type, risk level, prior history of positive toxicology, whether a nurse's visit occurred, age of infant (by days) at the time of referral, timely completion of the Plan of Safe Care, and the referral's status or disposition.



As practice evolved, CFSA also began conducting quarterly in-depth CARA Case Reviews. Current CARA Case Reviews examine the child welfare response to substance-exposed newborns and their caregivers, in addition to examining the joint development of the Plan of Safe Care with the caregivers and family. Reviewers then identified common themes before making recommendations to support the staff and strengthen CFSA's practice with this population. For families requiring ongoing child welfare services, the federal requirements of the Plan of Safe Care must be incorporated into the family's new or existing case plan. To that end, CFSA has initiated an examination of in-home cases as they relate to Plans of Safe Care.

All review findings are part of CFSA's ongoing examination of Plans of Safe Care for substance-exposed infants and their caregivers; the reviews specifically support CFSA's continuous quality improvement. The quarterly team meetings, in conjunction with the CARA Case Reviews, allow the CFSA to identify gaps and move quickly toward corrective actions and practice improvements.

CASE-LEVEL STRATEGIES

Twenty-seven states described case-level strategies for monitoring Plans of Safe Care in their APSR in 2020. The most common strategy involved using specialized CPS staff or units to oversee and coordinate Plan of Safe Care implementation for families with an open child welfare case. These specialized staff or units are typically responsible for developing the Plans of Safe Care, connecting families to support services, and updating the Plans of Safe Care based on the families' evolving strengths and needs. Several states also described having child welfare workers monitor as part of their role to provide ongoing case planning and engagement with families. Both strategies help support consistent Plan of Safe Care implementation.



NCSACW has found cross-system partnerships that include case-level information sharing are valuable for determining whether families are referred to and receive appropriate services, and whether the services in individual Plans of Safe Care improve outcomes. Specialized staff and units can follow up on referrals with multiple providers, make updates and adjustments to the Plan of Safe Care, and determine the need for additional services.

STATE HIGHLIGHT: NEW YORK

New York State awarded funding to local offices to use specialized staff for Plans of Safe Care monitoring. Full- or part-time behavioral health consultants, or public health nurses, are required to be co-located onsite at the Local Departments of Social Services (LDSS) and work directly with CPS and preventive services caseworkers. These specialized staff identify and support the behavioral health needs of both the adults and children affected by substance use disorders. These staff develop, implement, and monitor the Plan of Safe Care for infants prenatally exposed to substances. Districts receiving LDSS funding must submit quarterly reports to New York State detailing the number of



- Visits made with CPS and/or preventive services
- Plans of Safe Care developed, implemented, and monitored
- Screenings and/or assessments completed for children and adults by behavior health consultants and public health nurses
- Children and adults with a positive drug screen
- Referrals made by the behavioral consultant or public health nurse to services identified through the Plan of Safe Care form

MULTILEVEL MONITORING

Some states described using a combination of systems- and case-level strategies for monitoring Plans of Safe Care in their APSRs in 2020. These states used a variety of methods to monitor service referrals and determine if families were able to engage in services as part of the implementation of Plans of Safe Care. Within child welfare practice, a combination of these strategies included

- Conducting case level reviews to determine if staff made referrals to services, and services while identifying practices and processes that affect family engagement, retention, and outcomes
- Employing specialized child welfare units or positions to monitor Plans of Safe Care
- Integrating Plan of Safe Care records into quality assurance/continuous quality improvement processes
- Changing the state's child welfare information system to track referrals and service participation

Multilevel monitoring strategies also included states using team-based meetings across systems of care or assigning other systems to oversee Plan of Safe Care implementation.

NCSACW has found that multilevel monitoring strategies that include regular communication between local and state agencies reviewing notifications, reports, completed Plans of Safe Care, service array, and related family demographics help assess differences in how staff implement Plans of Safe Care policies across the state. Sharing local information with state agencies can inform state-level policy or practice changes, while helping to ensure consistent implementation quality.

STATE HIGHLIGHT: LOUISIANA



On a case level, child welfare supervisors monitor whether staff developed a Plan of Safe Care, made appropriate referrals, and followed up on those referrals. Louisiana's child welfare information system documents this information. On a regional level, the Department of Children and Family Services holds quarterly stakeholder team meetings with multidisciplinary professionals to monitor compliance with Plans of Safe Care, while ensuring appropriate services are available and delivered to substance-exposed newborns as well as affected caregivers and families. Child welfare consultants monitor these meetings to document and share relevant information at state-level meetings to discuss any systemic implementation issues.

SERVING FAMILIES OUTSIDE THE CHILD WELFARE SYSTEM

In most states CPS oversees the Plans of Safe Care for families with open child welfare cases due to child safety concerns. However, states continue to explore ways to implement Plans of Safe Care for families—with minimal to no child abuse or neglect risk factors—as part of their prevention efforts to mitigate child welfare involvement.

Eighteen states described their strategies for monitoring Plans of Safe Care for families that do not have an open child welfare case in their APSR in 2020. The most common was for CPS to partner with a community-based provider to oversee the Plans of Safe Care. States determined the agency based on the specific needs of the infants and their families as well as services available in the community.

CPS has partnered with agencies in public health, maternal and child health, home visitation, substance use disorder treatment, managed care, and health care. This strategy relies heavily on cross-system collaboration to provide a coordinated response to meet the health and substance use disorder treatment needs of the affected infants and their caregivers. To support cross-system collaboration and coordination, some states have: 1) established automated referral pathways from the CPS hotline to community-based service providers; 2) instituted a standard Plan of Safe Care form that is sharable across systems for data and reporting purposes; and 3) invested in ongoing training to ensure the systems understood the legislation, policies, and procedures in place to meet the requirements of the CARA amendments to CAPTA.



STATE HIGHLIGHT: ARIZONA

Arizona Superior Court's Juvenile Department in Maricopa County, with TA from the National Quality Improvement Center for Collaborative Community Court Teams (QIC-CCCT), convened a group of multidisciplinary professionals in June 2018 to form the Safe, Healthy Infants & Families Thrive (SHIFT) Collaborative. The SHIFT Collaborative transferred to the Maricopa County Department of Public Health in 2020, expanding its medical and public health sectors. SHIFT is now comprised of members from the legal, child welfare, medical, behavioral health, early intervention, and public health communities.



SHIFT developed a prenatal Plan of Safe Care called the "Prenatal Family Care Plan" and implemented a pilot project known as the "Prenatal Coordinated Care Pilot." In the pilot project, providers ensure appropriate referrals and resources exist for families to support their complex needs as early as possible during pregnancy. One partner in the SHIFT Collaborative, Hushabye Nursery, helps parents develop the Prenatal Family Care Plan to support and empower pregnant women in their recovery. Since January 2019 Hushabye has served 199 babies and families, with 82% of infants unified with their families. Hushabye currently serves 68 pregnant women.

Due to the SHIFT efforts, the state developed a plan to use a coordinated cross-systems approach with families during the prenatal period to improve health and well-being outcomes while reducing the need for ongoing child welfare involvement.

DATA COLLECTION AND REPORTING

As states update their child welfare information systems to provide systems-level monitoring, more can fulfill the CARA amended annual data requirements in CAPTA to the maximum extent practicable.

CB began collecting this data in fiscal year 2018 through state reports to the National Child Abuse and Neglect Data System (NCANDS). CB, in the [2019 Child Maltreatment Report](#), revealed that 47 states reported on the number of infants with prenatal substance exposure, 21 reported on the number of such infants with a Plan of Safe Care (for screened-in cases), and 20 reported on the number of such infants with a referral to appropriate services (for screened-in cases). The report also provides information on screening policies and other factors that influenced states' capabilities to fulfill the CARA data reporting requirements.

NCSACW found that as states advance their monitoring and data systems, there is an opportunity to not only track outcomes for infants and their families, but also to identify gaps in the system and target needed resources. Continuous quality improvement practices improve intervention and services, while ensuring that infants and their families or caregivers receive the supports and services identified on their Plans of Safe Care.



Administrative Datasets

CB collects information on children and families referred to or involved in the child welfare system. This information can help agencies and evaluators identify numerous factors related to serving children/infants affected by prenatal exposure including, but not limited to: 1) children/infants with substance exposure (i.e., child risk factors) or parental substance use (i.e., parental risk factors); 2) whether the alleged maltreatment occurred; 3) whether the child received a Plan of Safe Care; 4) whether the child entered the foster care system (including information on reunification, adoption, and guardianship); and 5) demographic information on race and ethnicity to examine disproportionality, the causes of disproportionality, and to develop strategies to reduce inequities for children affected by prenatal exposure.

There are two publicly² available datasets to examine these factors:

- [The Adoption and Foster Care Analysis and Reporting System](#) (AFCARS) is a federally mandated data collection system that provides information on all children in foster care for whom the state child welfare agency has responsibility for placement, care, or supervision.
- [The National Child Abuse and Neglect Data System](#) (NCANDS) is a voluntary data collection system that gathers information about reports of child abuse and neglect. *The Child File* dataset consists of child-specific data on all investigations or assessments of alleged child maltreatment that received a disposition in the reporting year.

CROSS-SYSTEMS DATA SHARING

States that have strengthened both their data systems and collaborative partnerships have also established innovative ways to share information across systems. They can more comprehensively meet the data reporting requirements of the CARA amendments to CAPTA, and use the information to better understand gaps in services, child welfare outcomes for infants, and the need for additional services for families. States that have community-based service providers develop and monitor Plans of Safe Care for infants and families without an open child welfare case can establish data-sharing agreements which can support child welfare's annual reporting requirements.



STATE HIGHLIGHT: NEW MEXICO



New Mexico established an online portal where staff can enter and share Plans of Care with the Children, Youth and Families Department, Department of Health, Tribal Social Services, Family/Caretakers, and Managed Care Coordinators. Once entered into the portal, all Plans of Care are sent to the Children, Youth and Families Department and the Department of Health for data collection purposes. Staff then screen the Plans of Care to track when and how referrals for services meet the specific needs of substance-exposed newborns and their families. The data, in de-identified form, then goes to the Children, Youth and Families Department, Department of Health/Children's Medical Services, and Human Services Department/Medicaid Division to help each of these systems work collaboratively to identify gaps in services statewide.

STATE HIGHLIGHT: GEORGIA



The Safety Section and the Division's Data Unit have established a relationship with the Department of Public Health's Maternal and Child Health Epidemiology Team. Together they compare how each agency captures data related to substance-affected infants while seeking opportunities to use shared data to inform cross-system efforts.

POLICY AND PRACTICE CONSIDERATIONS

The CARA amendments to CAPTA related to Plan of Safe Care monitoring and reporting are particularly complex. States continue to explore collaborative ways to ensure all infants, caregivers, and families with a Plan of Safe Care receive the appropriate oversight of referrals and service delivery, and reporting happens to the maximum extent practicable.

States have instituted a range of strategies to monitor Plans of Safe Care at the systems and case level. Although child welfare agencies often take the lead, several states use other systems to monitor Plans of Safe Care, particularly for families without open child welfare cases. When various partners share responsibility for developing and providing oversight, families are likely to have more timely access to a broader array of services and supports outside the child welfare system.

Implementing a collaborative approach to Plans of Safe Care may require collecting data from various system partners, each with its own information system that may or may not have the capacity to link with other data systems. To meet reporting requirements, collaborative teams must consider how to enable access to data across multiple agencies involved in implementing Plans of Safe Care. Sharing aggregate data across systems can help CPS agencies meet their requirements for reporting NCANDS, regardless of which system or agency is monitoring the Plans of Safe Care.

REFERENCES

- 1 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>.
- 2 Administrative child welfare datasets are available through the National Data Archive on Child Abuse and Neglect (NDACAN): <https://www.ndacan.acf.hhs.gov/datasets/datasets-list.cfm>



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