



National Center on
Substance Abuse
and Child Welfare

Special Topic:

Understanding Prenatal Substance Exposure and
Child Welfare Implications

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Introduction

The National Center on Substance Abuse and Child Welfare (NCSACW) developed the Child Welfare Training Toolkit to educate child welfare workers about substance use and co-occurring disorders among families involved in the child welfare system. The training is intended to provide foundational knowledge to help child welfare workers:

1. Understand substance use and co-occurring disorders.
2. Identify when substance use is a factor in a child welfare case.
3. Learn strategies for engaging parents and families in services.
4. Understand potential effects for the parent, children, and caregivers.
5. Learn the importance of collaboration within a system of care. Through a deeper understanding of these topics, child welfare workers can apply knowledge gained to their casework and improve their own practice.

The Training Toolkit consists of 10 modules—7 core and 3 special topics training modules:

Module 1: Understanding the Multiple Needs of Families Involved with the Child Welfare System

Module 2: Understanding Substance Use Disorders, Treatment, and Recovery

Module 3: Understanding Co-Occurring Substance Use Disorders, Mental Health/Trauma, and Domestic Violence

Module 4: Engagement and Intervention with Parents Affected by Substance Use Disorders and Mental Health/Trauma

Module 5: Case Planning, Family Strengthening, and Planning for Safety for Families with a Substance Use Disorder

Module 6: Understanding the Needs of Children of Parents with Substance Use or Co-Occurring Disorders

Module 7: Collaborating to Serve Parents with Substance Use Disorders

Special Topic: Considerations for Families in the Child Welfare System Affected by Methamphetamine

Special Topic: Considerations for Families in the Child Welfare System Affected by Opioids

Special Topic: Understanding Prenatal Substance Exposure and Child Welfare Implications

The entire Training Toolkit can be delivered in a series, or each module can be delivered individually as a stand-alone training. Each module is approximately 2 hours in length and contains a range of materials that can be adapted to meet the needs of child welfare trainers for in-person workshops or more formal training sessions. This flexibility allows the facilitator to determine the best format and timing for the training, according to the needs of the agency and staff. The special topics, in particular, lend themselves to brown-bag or lunchtime trainings.

Each module includes a Facilitator's Guide with training goals and learning objectives, a PowerPoint presentation, resources, and references. The PowerPoint presentation contains talking points and key details in the notes section of the slides. These talking points are not intended to serve as a script to read aloud to attendees, but rather as key points to highlight while presenting. Facilitators are encouraged to infuse their own content knowledge, expertise, and real-world experience to bring the training to life. NCSACW integrated discussion questions and experiential activities throughout the training sessions.

The Facilitator's Guide includes a list of resources where facilitators and participants can find additional information on related topics. Facilitators can customize content to include state or local child welfare practice information and terminology where appropriate.

NCSACW provides a free online tutorial, [*Understanding Substance Use Disorders, Treatment, and Family Recovery: A Guide for Child Welfare Professionals*](#), which is a self-guided online training that complements the content of this Training Toolkit. Toolkit facilitators may encourage the training participants to complete the online tutorial to augment their knowledge. The online tutorial is approved for 4.5 Continuing Education Units.

Intended Audience

The Training Toolkit contains information considered foundational for child welfare practice. The content is general enough for all child welfare workers, but it should be tailored to the audience's experience and role in child welfare practice (such as investigations, in-home services, or ongoing case management) to enrich the learning opportunity.

Facilitator Qualifications

Facilitators should be knowledgeable about substance use disorders, mental health, and child welfare systems. They should be familiar with the laws and policies that affect child welfare agency decision-making to ensure that the information is presented in the proper context. If the facilitator does not have specific knowledge in substance use disorders or mental health, he or she should partner with local substance use and mental health treatment agencies for support.

Terminology

Field-specific terms are used during the course of this training. To understand the purpose and intended meanings of these terms, please review the Trainer Glossary at <https://ncsacw.samhsa.gov/training/toolkit>. This glossary is also a useful resource for training participants.

Special Topic Description and Objectives

The goal of this special topic training is to understand the unique needs of infants with prenatal substance exposure and their families. The training will cover the effects of prenatal substance use on an infant by providing an overview of fetal alcohol spectrum disorders (FASDs), neonatal abstinence syndrome (NAS), neonatal opioid withdrawal syndrome (NOWS), and withdrawal symptoms. Participants will gain knowledge in screening and treatment referrals for affected family members, including services to address the needs of infants who were prenatally exposed. Collaboration between the systems of care to serve infants and their families is critical for successful outcomes. The training will also highlight amendments made to the Child Abuse Prevention and Treatment Act (CAPTA) by the Comprehensive Addiction and Recovery Act (CARA) of 2016, specifically related to infants with prenatal substance exposure and their families.

After completing this training, child welfare workers will:

- Discuss the context and prevalence of prenatal substance use.
- Identify the effects of prenatal substance use on infants and their families.
- Discuss FASDs, NAS, and NOWS.
- Increase knowledge of screening and referral for treatment and resources.
- Identify the treatment needs of parents and infants.
- Value collaboration between systems of care for successful outcomes.
- Understand the implications of the CARA amendments to CAPTA related to infants with prenatal substance exposure and their families.

Training Tips

- ✓ Partner with medical providers on screening and treatment for infants with prenatal substance exposure.
- ✓ Use the *** **bolded** discussion questions integrated in the module talking points to enrich the training.
- ✓ Share or incorporate agency policy and procedures on infants with prenatal substance exposure.
- ✓ Integrate information on the plan of safe care used in your state.
- ✓ Contact the National Center on Substance Abuse and Child Welfare for more information about using the Collaborative Values Inventory, a self-administered questionnaire that provides jurisdictions with an anonymous way of assessing the extent to which group members share ideas about the values that underlie their collaborative efforts, in your community.

Materials

- ✓ Computer and projector
- ✓ Speakers
- ✓ Internet access
- ✓ PowerPoint slides
- ✓ Facilitator's Guide

- ✓ Flip chart paper or white board (for use as a visual aid during discussion)

PowerPoint Presentation and Talking Points

Slide 1


Special Topic: Understanding Prenatal Substance Exposure and Child Welfare Implications

Child Welfare Training Toolkit





National Center on
Substance Abuse
and Child Welfare

Acknowledgment



**National Center on
Substance Abuse
and Child Welfare**

*A program of the Substance Abuse and Mental Health Services Administration (SAMHSA)
and the Administration for Children and Families (ACF), Children's Bureau*



SAMHSA
Substance Abuse and Mental Health
Services Administration

**Children's
Bureau**

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This toolkit was developed by the National Center on Substance Abuse and Child Welfare (NCSACW), an initiative of the Department of Health and Human Services jointly funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) and the Administration on Children, Youth and Families (ACYF), Children's Bureau's Office on Child Abuse and Neglect (OCAN).


Learning Objectives

After completing this training, child welfare workers will:

- Discuss the context and prevalence of prenatal substance use
- Identify the effects of prenatal substance use on infants and their families
- Discuss Fetal Alcohol Spectrum Disorders (FASDs), Neonatal Abstinence Syndrome (NAS), and Neonatal Opioid Withdrawal Syndrome (NOWS)
- Increase knowledge of screening and referral for treatment and resources
- Identify the treatment needs of parents and infants
- Value collaboration between systems of care for successful outcomes
- Understand the implications of amendments to the Child Abuse Prevention and Treatment Act (CAPTA) made by the Comprehensive Addiction and Recovery Act (CARA) of 2016 related to infants with prenatal substance exposure and their families

The goal of this special topic training is to understand the unique needs of infants who were prenatally exposed to substances and their families. The training will cover the effects of prenatal substance use on an infant; including an overview of Fetal Alcohol Spectrum Disorder (FASD), Neonatal Abstinence Syndrome (NAS), Neonatal Opioid Withdrawal Syndrome (NOWS) and withdrawal symptoms. Participants will gain knowledge in screening and treatment referrals for affected family members, including services to address the needs of infants who were prenatally exposed. Collaboration between the systems of care to serve infants and their families is critical for successful outcomes. A summary of the amendments made to the Child Abuse and Prevention Treatment Act (CAPTA) by the Comprehensive Addiction and Recovery Act (CARA) specifically related to infants with prenatal substance exposure and their families will be highlighted.

Collaborative Values Inventory



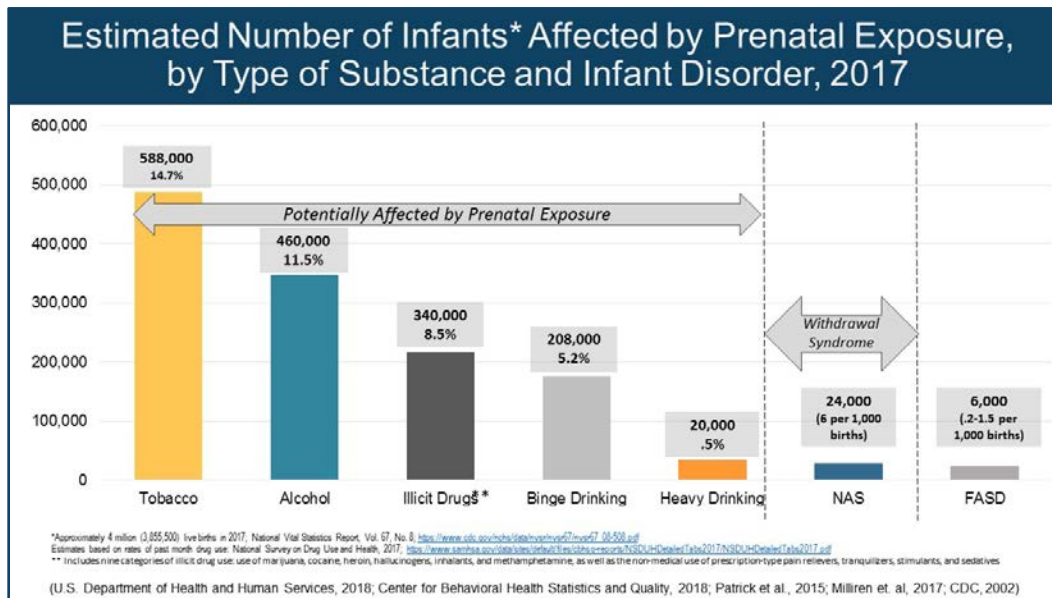
- In different circumstances, any person could be a parent with a substance use disorder
- Newborns with positive tests for illegal drugs should be removed from their parent's custody
- Medication-assisted treatment, prescription drugs that treat opioid addiction, should be made available to pregnant women
- When a parent refuses substance use disorder treatment they should face penalties
- Substance use disorder treatment will only be effective if a parent wants treatment

(Children and Family Futures, 2017)

Differences in values among participants are important to recognize, as they may come up in the training and can come up with the families participants are working with. These questions can be asked at the beginning of this training to help understand the different values and perspectives participants bring to the training. Have a brief discussion with participants on how their individual values can affect their work with families.

*****Review the slide questions from *The Collaborative Values Inventory (CVI)*, a validated tool that assesses how much a group shares beliefs and values that underlie its work. Participants can share their experiences or keep their answers private. Discussion should be limited to understanding value clarification, instead of debating individual answer to questions. Participants will fall along a continuum.**

Slide 5

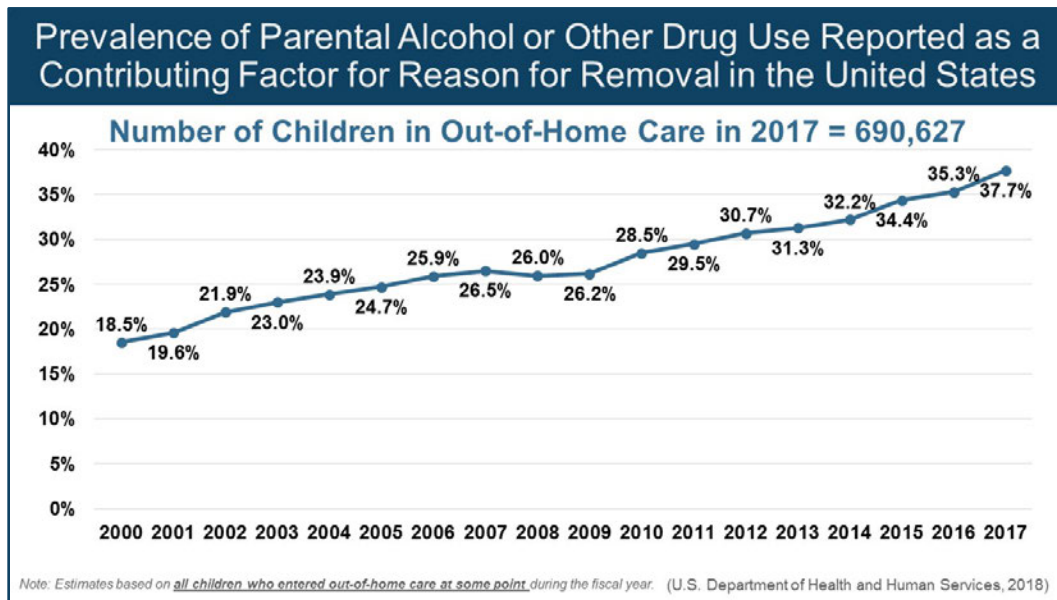


Because prenatal substance exposure incidence is not collected systematically in any current data sources, including hospital data, it can be difficult to determine exactly how many infants may be affected. Some formal diagnoses exist for neonatal abstinence syndrome and fetal alcohol spectrum disorder, but only a small percentage of the total number of infants who have been affected by prenatal exposure receive these diagnoses. Through looking at the National Survey on Drug Use and Health, we have some data on substance use by pregnant women that point to the number of infants who may be born affected by prenatal exposure. None of these data take into account challenges with screening and identifying infants with prenatal exposure, making it all the more difficult to identify the actual prevalence of infants affected by prenatal substance exposure.

*Percentages are applied to the almost 4 million infants born in 2017 (Source: U.S. Department of Health and Human Services, 2018).

** Includes nine categories of illicit drug use: use of marijuana, cocaine, heroin, hallucinogens, and inhalants, as well as the non-medical use of prescription-type pain relievers, tranquilizers, stimulants, and sedatives (Source: Center for Behavioral Health Statistics and Quality, 2018).

Slide 6

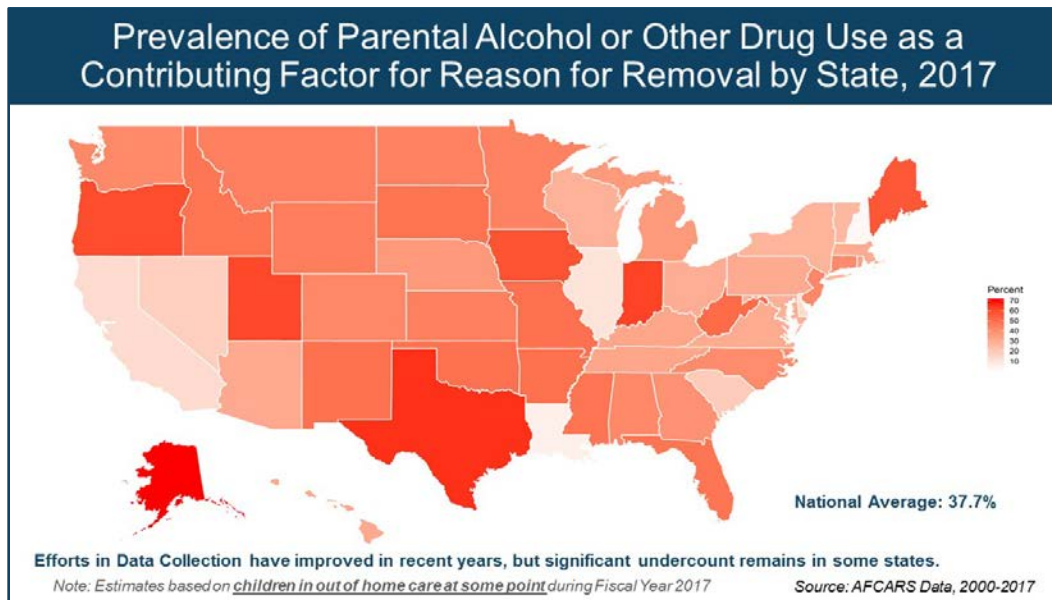


This slide represents the children in out-of-home care during the fiscal year in which parental alcohol or other drug use was a contributing factor for removal. While it does appear that the percentage of cases with parental alcohol or drug use has been increasing over the past 15 years, it is important to note that some of this increase could be due to better identification, data collection, and worker training—and may not all be attributable to an increase in substance use disorder. Additionally, in this data collection tool, multiple reasons for removal can be listed and, in some jurisdictions, only the first identified reason may be included in the data set; so, for cases where parental alcohol or drug use is identified as a factor later in child welfare care OR in conjunction with other factors, it may not be represented in the number presented here.

Prevalence of parental AOD as a contributing factor for removal within a given amount of time: it is helpful in understanding the “burden to the system” at a given time.

Explanation of data presented: The % of children in OOHC who had AOD listed as a reason for removal (there can be more than 1 reason listed for removal). In 2017, there are 690,627 children in OOHC and 258,770 with parental AOD as a contributing factor for removal.

Slide 7



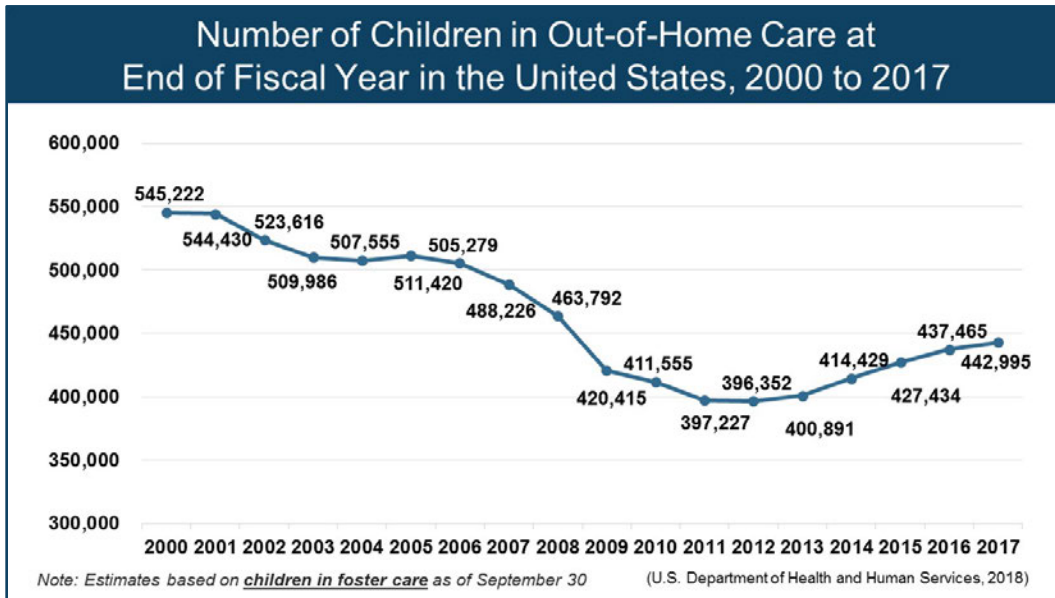
What percentage of cases involve parental substance use?

Based on AFCARS data from 2017, this map shows the prevalence of alcohol or other drug use as a contributing factor for removal by state. As you can see, this varies widely by state due to differences in reporting and policies about how this data is captured and inputted into state data systems that feed the AFCARS data. This variation likely contributes to a substantial undercount of children removed with parental alcohol or other drug use as a contributing factor.

In many child welfare cases, substance use is not identified as a contributing factor until the point it is impossible to ignore, making it more difficult to intervene and creating greater impact on the children in the family.

Some of the states with higher rates of parental alcohol or other drug use as a contributing factor for removal have implemented universal screening, training on data collection and entry, or other training or data policies that have improved the accuracy of their data.

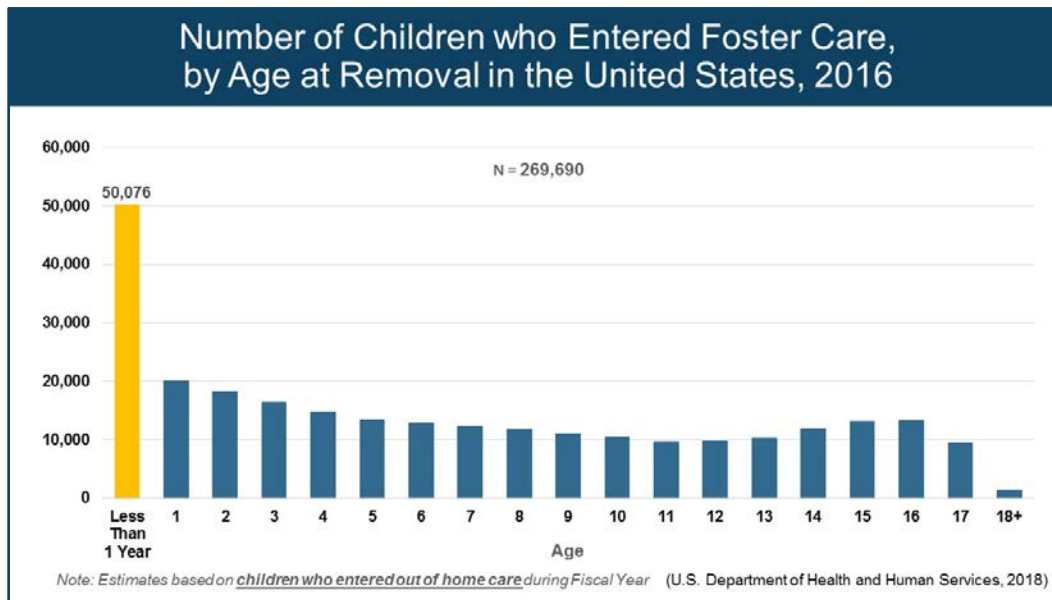
Slide 8



The graph provides information about kids who are **in** care as of September 30th of the listed year based on AFCARS data. It's not about those who are entering out-of-home care but rather those who remain in care.

The key takeaway for this slide is after a decade of decreasing the number of children in out-of-home care, that trend began to reverse in 2012–2013. The increasing number of children in care result from both new intakes as well as children who are remaining longer in care.

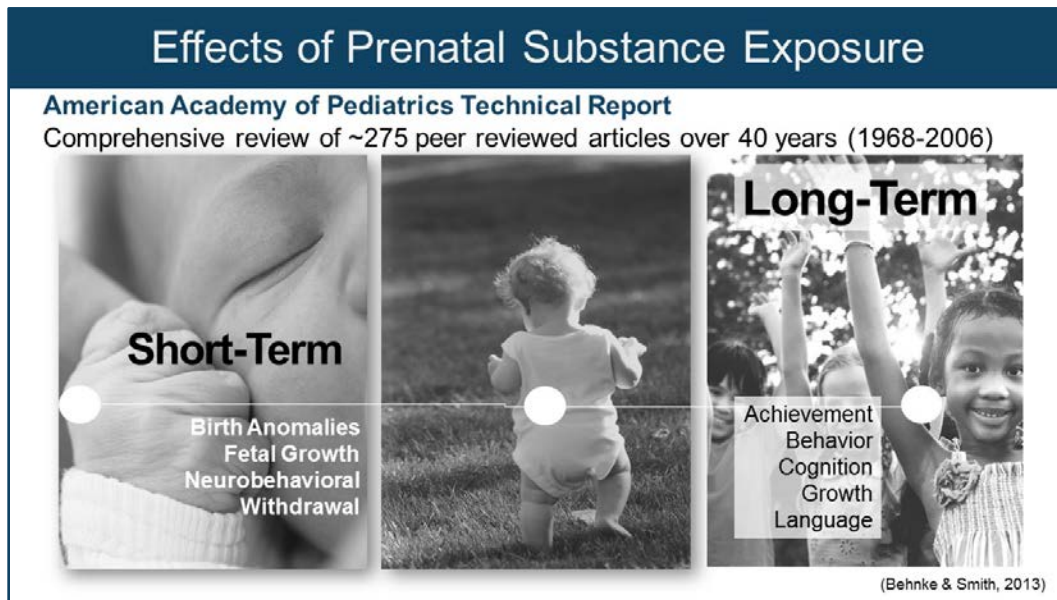
Slide 9



AFCARS data from 2017 shows the number of children entering foster care by age group, with children under 1 representing the largest group by far. This is due to the concern that these very young children are more susceptible to negative effects of the most common reasons for removal across all age groups, including parental substance use and neglect.

Explanation of data presented: The number of children who entered out-of-home care during Fiscal Year by age. A total of 269,690 children entered foster care in 2017.

Incidence of foster care entry by age. Incidence is more helpful in understanding changes in events occurring over time. Incidence only includes new cases, and doesn't take length of event into consideration at all. Incidence rates can vary much more than prevalence, especially with longer-lasting events, and don't necessarily provide an overview of the entire system.



Now that we have looked at the data, let's look at the effects of prenatal substance exposure.

The American Academy of Pediatrics published a technical report that includes a comprehensive review of approximately 275 peer reviewed articles spanning 40 years (1968-2006). While the article date is 2013, the research it is based on is from articles only up to 2006, so we are still learning a great deal about how prenatal substance exposure affected infants and children.

It's important to note that in practice it is rare to find a child who is exposed to only one substance, and the point is not to compare across substances but to point out similarities in some developmental domains, to recognize that more research is needed and that polysubstance use should be expected when looking at developmental outcomes.

- This knowledge is very much in a state of flux and we don't have all the information we need to make this a solid ANSWER.
- Very few individuals are single substance users so it is not easy to parse this out by substance.
- While opioids have a strong effect on short-term withdrawal symptoms, other substances such as alcohol, cocaine, marijuana and nicotine show more effects on long-term outcomes.
- Prenatal exposure to alcohol has effects in 9 of 10 developmental domains studied, including short-term/birth outcomes and long-term outcomes.
- There are some substances and outcomes for which there is not consensus or not enough data to determine consensus.

Short-Term Effects of Prenatal Substance Exposure

	Growth	Anomalies	Withdrawal	Neurobehavioral
Alcohol	Strong Effect	Strong Effect	No Effect	Effect
Nicotine	Effect	No consensus	No Effect	Effect
Marijuana	No Effect	No Effect	No Effect	Effect
Opiates	Effect	No Effect	Strong Effect	Effect
Cocaine	Effect	No Effect	No Effect	Effect
Methamphetamine	Effect	No Effect	Lack of Data	Effect

(Behnke & Smith, 2013)

Presenter may want to point out the withdrawal effect of opiates, but other substances, alcohol in particular, have shown strong effects in the other domains of child development.

Long-Term Effects of Prenatal Substance Exposure

	Growth	Behavior	Cognition	Language	Achievement
Alcohol	Strong Effect	Strong Effect	Strong Effect	Effect	Strong Effect
Nicotine	No consensus	Effect	Effect	Effect	Effect
Marijuana	No Effect	Effect	Effect	No Effect	Effect
Opiates	No Effect	Effect	No consensus	Lack of Data	Lack of Data
Cocaine	No consensus	Effect	Effect	Effect	No consensus
Methamphetamine	Lack of Data	Lack of Data	Lack of Data	Lack of Data	Lack of Data

(Behnke & Smith, 2013)


Similarly, for alcohol, it's important to note that there has been an effect demonstrated in each of the domains of child development for the longer-term outcomes. This may be attributed to the fact that alcohol may have been studied more than the other substances.

It's also important to note the lack of longer-term outcome studies related to methamphetamine exposure.

Complex Interplay of Factors

Interaction of various prenatal and environmental factors:

- Family characteristics
- Family trauma
- Prenatal care
- Exposure to multiple substances (alcohol and tobacco)
- Early childhood experiences in bonding with parent(s) and caregiver(s)
- Other health and psychosocial factors



(American College of Obstetricians and Gynecologists, 2017; Bandstra et al., 2010; Baldacchino et al., 2014; Nygaard et al., 2015)

Many factors influence how an infant is affected by prenatal and postnatal exposure to substances, not just the physical exposure to the substance in utero. Screening and assessing families across all domains helps us better understand the effect of parental substance use disorder on infants and children.

*****Looking at the factors listed on this slide, use flip chart paper to highlight each category. What are the types of information under each category that participants would want more information from families to help understand how an infant might be affected by the prenatal or postnatal environment? For example, under Family Characteristics, participants want to gather information about the living situation, information on substance use, or co-occurring challenges among family members in the household and family supports in place.**

Continue to make a list of the types of information needed under each category.

Challenges to Mother-Infant Dyad Affected by Substance Use Disorders

For the Mother	For the Child
Altered responses	Developmental Harm
Stigma/Negative Stereotypes	Neglect or Physical Harm
Lack of parenting role models	Repeated Exposure: in-utero or secondary exposure
Low parental confidence	Altered trajectories of development due to parental responsiveness
Lifestyle changes related to drug seeking and drug use	Risk of child maltreatment and physical harm
Exposure to Violence or Chaotic Environment	Exposure to Violence
Maternal Brain Changes <ul style="list-style-type: none"> • Normal infant cues perceived as irritating • Difficulties with self-regulation 	Effects on child development and emotional well-being
Psychiatric Comorbidities <ul style="list-style-type: none"> • Depression, anxiety, PTSD 	Acquired infections with health and developmental consequences
Health Concerns <ul style="list-style-type: none"> • HIV, Hep C, HSV, STDs 	

(Velez & Jansson, 2008; Velez & Jansson, 2015)

There are a number of challenges for a mother-infant dyad affected by a substance use disorder. Some are specific to the mother's use (exposure), while others are related to the environments often accompanying drug use and drug seeking.

Additionally, the effects of stigma and shame can impact parenting and parenting confidence. Parenting confidence can affect bonding and infant well-being.

- Challenging behaviors such as irritability, uncoordinated movements, dysregulated sleep-awake patterns, hypertonicity, and autonomic signs of stress, frequently displayed by an infant undergoing neonatal abstinence syndrome, can initiate altered caregiver behaviors, which have been considered an additional teratogenic effect of prenatal substance exposure.
- Understanding and responding to neurobehavioral dysfunction of the newborn may help to promote the infant's self-organization and self-regulating abilities. However, a mother with a substance use disorder may have physical and psychological well-being that is debilitated in the perinatal period, and her ability to recognize and respond to the newborn's cues may be limited.
- Multiple factors affect the mother's emotional and physical availability to help regulate and organize her newborn exhibiting neonatal abstinence syndrome. Maternal substance use, mood disorders, and adverse childhood experiences may influence maternal responses to the newborn cues.
- Deeply held cultural beliefs and negative stereotypes frequently result in punitive responses toward the substance dependent pregnant and parenting woman by the providers who are most poised to positively impact the mother and child.

Fetal Alcohol Spectrum Disorder (FASD)

Fetal Alcohol Spectrum Disorder (FASD)

Fetal Alcohol Spectrum Disorder:

- A non-diagnostic umbrella term describing the range of effects that can occur in an individual whose mother consumed alcohol during pregnancy
- These effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications

Possible diagnoses within the spectrum include:

- Fetal Alcohol Syndrome (FAS)
- Partial Fetal Alcohol Syndrome (pFAS)
- Alcohol- Related Neurodevelopmental Disorder (ARND)
- Static Encephalopathy/Alcohol- Exposed (SE/AE)
- Neurobehavioral Disorder/Alcohol Exposed (ND/AE)

(National Council on Alcoholism and Drug Dependence, Inc., 2015)

Diversity in the range of diagnosis and symptoms of fetal alcohol spectrum disorder can make the disorder challenging to understand and identify. Child welfare staff should understand that fetal alcohol spectrum disorder can look very different for different infants/children due to this wide ranging spectrum.

Fetal Alcohol Spectrum Disorder (FASD)

Prevalence of fetal alcohol spectrum disorders:

- Estimated at 9.1 per 1,000 live births,
- A review of in-school screening and diagnosis studies suggest that the national rate could potentially be closer to 50 per 1,000

Factors that influence the effect that alcohol has on the developing fetus:

- Amount of alcohol
- Pattern and timing of exposure
- Genetics
- Mother's use of tobacco and/or other substances
- Mother's health and nutrition
- Mother's level of stress and/or trauma
- Mother's age

(May et al., 2009; Guerri, Bazinet, & Riley, 2009)

Many children with fetal alcohol spectrum disorders remain undetected because there is a lack of accurate, routine screening in prenatal clinics and pediatric settings. Thus, current prevalence figures underestimate the magnitude of these disorders, but studies do show that children in foster care have an increased likelihood of having a fetal alcohol spectrum disorder.

Possible Effects of Fetal Alcohol Spectrum Disorder

- **Exposure to alcohol in utero can lead to impairment in the following neuropsychological domains:**
 - Intellectual performance
 - Executive function
 - Learning and memory
 - Language
 - Visual-spatial ability
 - Motor Function
 - Attention
 - Activity Levels
- **Prenatal alcohol exposure can also lead to behavioral problems such as:**
 - Adaptive dysfunction
 - Academic difficulties
 - Increased rates of psychiatric disorders

(Mattson et al., 2011)

Knowing about the less clear or visually apparent expressions of fetal alcohol spectrum disorder is important for child welfare staff when creating appropriately supportive case plans that can address the needs and unique challenges that infants and children with fetal alcohol spectrum disorder may face.

Considerations of attention and cognitive deficits are important when considering what interventions to put in place and how to provide those interventions.

The key takeaway is that many children affected by fetal alcohol spectrum disorder do not have physical abnormalities. It is important to ask all mothers about their use of alcohol or other drug use during pregnancy to properly intervene and refer to services.

Unique Aspects of Fetal Alcohol Spectrum Disorder

- Alcohol is legal and perceived as a “low threat” substance making prevention challenging
- Diagnosis requires a medical evaluation and neurodevelopmental assessment conducted by a multidisciplinary team (Cook et al., 2016)
- Neurobehavioral outcomes depend on the dose and pattern of alcohol consumption and the developmental stage when the fetus was exposed (Mattson et al., 2011)
- Primary disabilities resulting from FASD can lead to secondary disabilities including:
 - Issues in school
 - Mental health problems
 - Inappropriate sexual behavior
 - Alcohol and drug use
 - Involvement in the criminal justice system without early intervention and treatment (Benz et al., 2009)

(Cook et al., 2016; Mattson et al., 2011; Benz et al., 2009)

Screening: Because alcohol is legal, it may be challenging for a child welfare staff to distinguish between appropriate alcohol use and a use disorder. Universal screening using an evidence-based tool can help a child welfare worker make this distinction and determine when a child needs a referral to services.

Prevention: While there is no research that points to there being any safe amount of alcohol to consume at pregnancy, people see alcohol as “not that dangerous” in many groups, particularly young adults. Therefore, accurate education about the possible effects of alcohol consumption during pregnancy is important for parents.

Diagnosing fetal alcohol spectrum disorders can be difficult because there is no specific diagnostic medical test and a broad range of symptoms and signs are included under the fetal alcohol spectrum disorder umbrella. Greater awareness and consistent screening are needed to be effective in identifying and diagnosing fetal alcohol spectrum disorders. Pediatricians should consider fetal alcohol spectrum disorders when evaluating children with developmental problems, behavioral concerns, or school failure. These diagnoses should be considered for children in foster care, especially if drug or alcohol use by a parent was a contributing factor for their involvement in the system.

Neonatal Abstinence
Syndrome (NAS) and
Neonatal Opioid Withdrawal
Syndrome (NOWS)

Neonatal Abstinence Syndrome and Neonatal Opioid Withdrawal Syndrome

Neonatal Abstinence Syndrome*:

- Refers to withdrawal symptoms resulting from exposure to a variety of substances including opioids, nicotine, benzodiazepines and certain serotonin reuptake inhibitors

Neonatal Opioid Withdrawal Syndrome:

- Withdrawal from opioid exposure

** These terms are sometimes used interchangeably*

(American College of Obstetricians and Gynecologists, 2017; Jansson et al., 2009; Substance Abuse and Mental Health Services Administration, 2018; Jones et al., 2012)



There is not a lot of clarity about the use of these terms. Neonatal abstinence syndrome is a broader term about the withdrawal symptoms from prenatal substance exposure and neonatal opioid withdrawal syndrome is specific to opioid withdrawal.

However, in practice the neonatal abstinence syndrome is often used as the term to indicate opioid withdrawal. Neonatal abstinence syndrome can be overlooked or misdiagnosed as infants seizures, feeding abnormalities, etc. so the importance of universal screening of mothers for substance use disorders is important. If a child welfare staff has concerns about a parent or caregivers substance use, regardless of the infant's diagnosis, it is important to screen those parents and connect them to a substance use disorder provider for a full assessment when indicated by the screening tool.

Neonatal abstinence syndrome is comprised of physiologic signs and behaviors that indicate a dysfunctional regulation of the central and autonomic nervous systems, and is variable in its expression in affected infants.

Neonatal abstinence syndrome can be the result of a mother who took an opioid pain medication as prescribed or was part of a medication assisted treatment program for individuals with a prior substance use disorder. Neonatal abstinence syndrome or neonatal opioid withdrawal syndrome are medical terms to describe medical symptoms or behaviors and does not necessarily define risk to children.

<p>The reporting of neonatal abstinence syndrome has increased over the past 15 years</p> <p>A number of data sources have looked at the incidence of neonatal abstinence syndrome. While it appears that the incidence is rising due to the opioid epidemic, it is unclear whether this rise is due to increased attention to neonatal abstinence syndrome and improvements in identification, or an increase in infants being born with neonatal abstinence syndrome.</p>	<table><tr><td data-bbox="690 327 959 548"><p>In 2000, 1.2 per 1000 hospital births were diagnosed as having Neonatal Abstinence Syndrome</p><p>(Patrick et al., 2012)</p></td><td data-bbox="1000 436 1289 730"><p>In 2016 data from 23 hospitals in the US pediatric system indicate 20 per 1000 live births were diagnosed as having Neonatal Abstinence Syndrome</p><p>(Milliren et al., 2017)</p></td></tr></table>	<p>In 2000, 1.2 per 1000 hospital births were diagnosed as having Neonatal Abstinence Syndrome</p> <p>(Patrick et al., 2012)</p>	<p>In 2016 data from 23 hospitals in the US pediatric system indicate 20 per 1000 live births were diagnosed as having Neonatal Abstinence Syndrome</p> <p>(Milliren et al., 2017)</p>
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Data on the incidence of neonatal abstinence syndrome is limited to publically available, state-level data, with rates varying widely across states.

Between 2000 and 2009, the incidence of neonatal abstinence syndrome increased threefold from 1.2 to 3.4 per 1,000 hospital visits (Patrick et al., 2012). From 2009 – 2012, neonatal abstinence syndrome incidence continued to increase from 3.4 to 5.8 per 1,000 hospital visits. This represents an increase in incidence of 383% (Patrick et al., 2015).

The CDC examined publically available data from 1999 – 2013 and found similar results, with neonatal abstinence syndrome incidence increasing from 1.5 to 6.0, representing a 300% increase (Ko et al., 2016). The rates of neonatal abstinence syndrome continue to rise with data from 2016 that included 23 hospitals in the US Pediatric system indicating an incidence of 20 per 1,000 live births. (Milliren et al., 2017).

While the data isn't perfect, it is important to note the increases and continue to identify policies and provide appropriate services for these infants that are evidence-based and include their parents/caregivers.

Neonatal Abstinence Syndrome and Neonatal Opioid Withdrawal Syndrome

- Neonatal abstinence syndrome occurs with notable variability, with **50-80%** of exposed infants developing symptoms
- Of those infants who develop symptoms, approximately **50%** receive treatment
- Neonatal opioid withdrawal syndrome is an expected and treatable condition that follows prenatal exposure to opioids
- Symptoms generally begin within 1-3 days after birth but may take 5-10 days to appear

(American College of Obstetricians and Gynecologists, 2017; National Institutes of Health, 2014; Hudak & Tan, 2012; Jansson et al., 2009; Substance Abuse and Mental Health Services Administration, 2018; Jones et al., 2012)






Not all infants exposed to opioids experience neonatal abstinence syndrome or neonatal opioid withdrawal syndrome and we do not know all the factors that lead to the development of these syndromes. Timing of onset is related to the characteristics of the substance used by the mother and the time of last dose. Most infants exposed to opioids are exposed to multiple substances.

How infants are cared for seems to make a big difference in the duration of symptoms and many infants respond well to nonpharmacological treatment (examples of this are mothers rooming in with babies, skin to skin contact, etc. – decreasing or eliminating the need for medication).

Symptoms of these syndromes include:

- Blotchy skin
- Difficulty with sleeping and eating
- Trembling
- Irritability
- Difficult to soothe
- Diarrhea
- Slow weight gain
- Sweating
- Hyperactive reflexes
- Increased muscle tone

Unique Risks of Neonatal Abstinence Syndrome

		
Cues from babies are difficult to interpret because of:	Inaccurate interpretation of cues by parents leads to:	Lack of training and/or protocols among hospital staff can lead to:
<ul style="list-style-type: none">• Escalation of neonatal abstinence syndrome display• Use of medication• Prolonged hospital stay	<ul style="list-style-type: none">• Decreases in parenting confidence• Inappropriate response	<ul style="list-style-type: none">• Over/under medication• Premature hospitalization discharge• Re-hospitalization
<small>(Velez & Jansson, 2008; Velez & Jansson, 2015)</small>		

There are a number of reasons that neonatal abstinence syndrome presents risks to mother-infant dyad including:

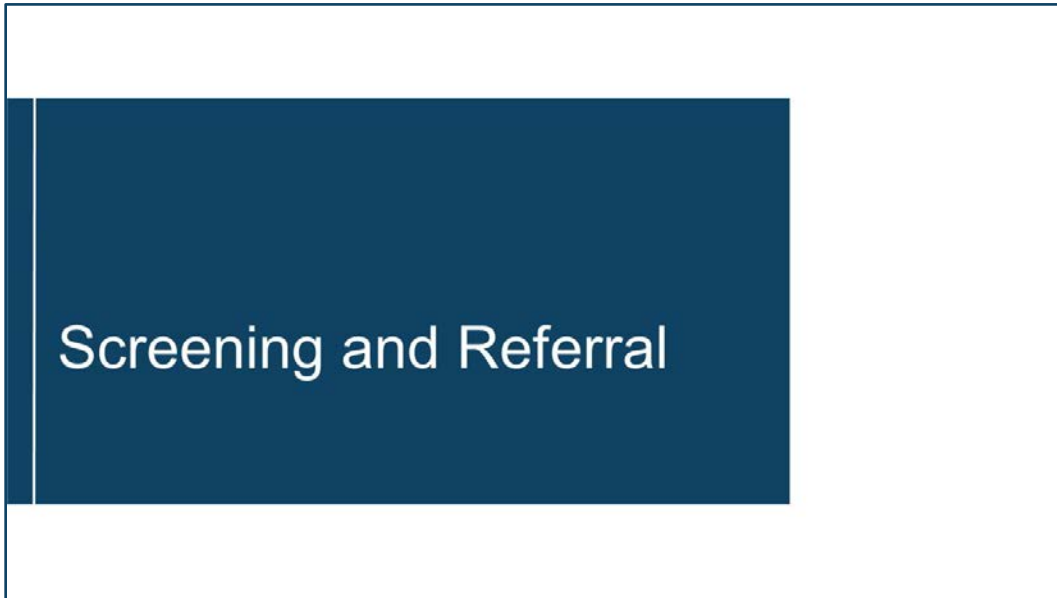
- Babies not exhibiting certain cues due to their neonatal abstinence syndrome and parents not understanding what the baby needs
- Challenges for parents in interpreting these cues as well as confidence in their ability to parent – particularly among first-time parents
- A lack of training about substance use disorders and effects of prenatal substance exposure among hospital staff creating stigma and inconsistent support to the infant/parent

The disorganized rather than adaptive behaviors displayed by each infant undergoing the effects of in-utero exposure may impair basic functions such as feeding, sleeping, and the ability to be alert and communicate clear cues to caregivers. Understanding and responding to neurobehavioral dysfunction of the newborn may help to promote the infant's self-organization and self-regulating abilities.

Child welfare workers need to consider these challenges when creating case plans for these infants to ensure that their parents/caregivers are receiving services that address their ability to bond and care for infants with these unique challenges. Parents/caregivers with substance use disorders will likely need treatment as well as recovery supports that address their parenting role in order to safely meet the needs of these infants.

Remember that some infants are experiencing neonatal abstinence syndrome as a result of participating in a medication-assisted treatment program during pregnancy or being prescribed a medication during pregnancy for a medical condition. The environmental risks for these populations may be very different.

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These opportunities, challenges and practice strategy suggestions were developed from practice-based wisdom developed through work of the National Center on Substance Abuse and Child Welfare contract working with sites through in-depth technical assistance. This slide represents information compiled through work with Round 1 and Round 2 sites of the Substance-Exposed Infants In-Depth Technical Assistance project and is represented in the Substance-Exposed Infants In-Depth Technical Assistance report from 2017.

While child welfare staff are not often involved with families prenatally, they can encourage their health care counterparts to screen pregnant women to identify substance use disorders prenatally and encourage entry into treatment. Child welfare staff can also encourage substance use disorder treatment partners to encourage parents to consider their parenting role while they are in treatment and recovery and provide supports to substance use disorder treatment partners in connecting parents in treatment and recovery programs to parenting and education and support services.

Child welfare staff can work with hospital partners to create consistent birth protocols that are not punitive for new parents but that identify the needs of the infant and the parents for the infant to remain safe while providing an opportunity for that infant to bond with their parent/caregiver and create a strong attachment.

Ongoing supports are important to include in the case plans of infants with prenatal exposure to ensure that they are maintaining optimal well-being through development assessments and services, getting appropriate healthcare services for their unique needs and have healthy, safe caregivers that have the supports they need to bond, attach and parent these infants.

Practice Strategies to Support Infants with Prenatal Substance Exposure and their Families



- Use the convening power of partners to meet with hospitals and health providers to create change
- Clarify how substance use disorders are identified during pregnancy
- Ensure effective treatment solutions for infant and family are available
- Understand the recovery process – some parents can safely remain/reunify with children when they are in treatment and recovery

These opportunities, challenges and practice strategy suggestions were developed from practice-based wisdom developed through working with sites through in-depth technical assistance.

In a collaborative team, the child welfare partner can offer great power in convening groups to address the needs of families by considering the needs of the parent in order to ensure a strong bond and secure attachment for the infant that will allow for optimal well-being as well as the needs of the infant for safety.

Practice Strategies to Support Infants with Prenatal Substance Exposure and their Families




- Hospitals universally screen mothers at delivery
- Infants are tested based on identified criteria and policies
- Hospitals understand and follow notification criteria
- Non-pharmacological treatments for Neonatal Abstinence Syndrome are used, including breastfeeding and rooming-in where not contraindicated

These practice strategy suggestions were developed from practice-based wisdom developed through work of the National Center on Substance Abuse and Child Welfare contract working with sites through in-depth technical assistance.

Child welfare workers should ask hospitals about their screening and testing policies during delivery. Understand if the hospital uses non-pharmacological treatments. This information is important when developing a case plan to ensure that parents can participate in the process when safety is not a concern. Knowing about these standards and policies before the birth event can help child welfare workers be prepared to develop these case plans and to know what partners might be available to help them make case planning decisions and recommendations.



Medication-Assisted Treatment



As part of a comprehensive treatment program, medication-assisted treatment has been shown to:

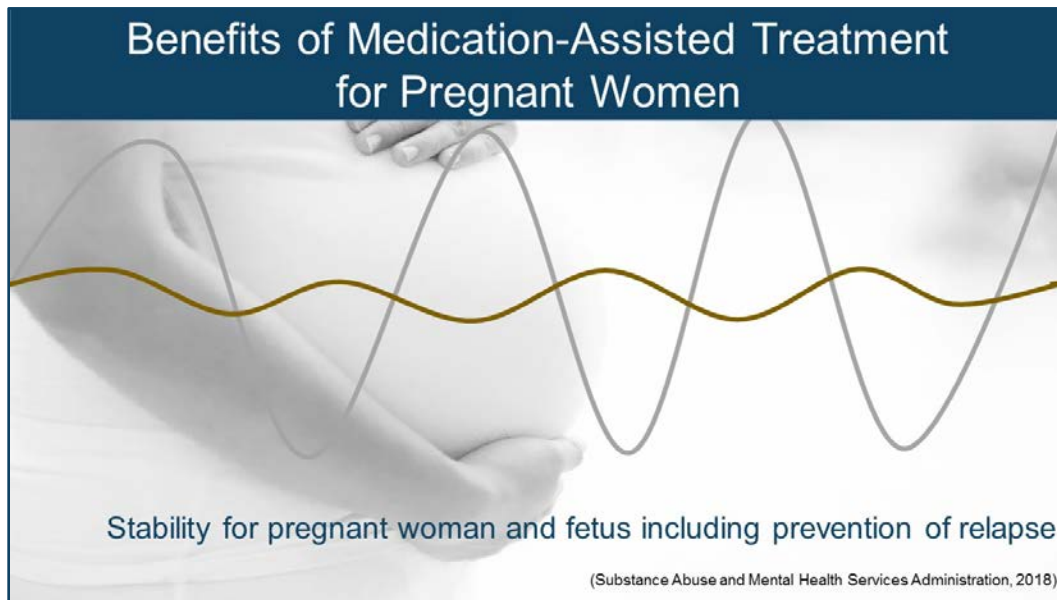
- Increase retention in treatment
- Decrease illicit opioid use
- Decrease criminal activities, re-arrest and re-incarceration
- Decrease drug-related HIV risk behavior
- Decrease pregnancy-related complications
- Reduce maternal craving and fetal exposure to illicit drugs

(Fullerton et al., 2014; American College of Obstetricians and Gynecologists, 2017; Dolan et al., 2005; Gordon et al., 2008; Havnes et al., 2012; Kinlock et al., 2008)

Discuss the following reasons for why it is important to use medication-assisted treatment to support positive outcomes for both the mother and the infant:

- Increases retention in treatment
- Decreases illicit opioid use
- Decreases criminal activities, re-arrest and re-incarceration
- Decreases drug-related HIV risk behavior
- Decreases pregnancy-related complications
- Reduces maternal craving and fetal exposure to illicit drugs

It is important to remember that, in medication assisted treatment, medication is just one part of the overall treatment. Medication supports individuals in attending to other elements of their treatment and recovery plan including therapy, mental health counseling, employment counseling and a myriad of other services to support their treatment and recovery.



Benefits of medication-assisted treatment during pregnancy:

- Direct Effect
 - Prevents erratic maternal opioid levels and protects the fetus from repeated episodes of withdrawal
 - Decreases the likelihood of mother relapsing and the potential dangers that go along with relapse
- Indirect Effects
 - Decreases risks to fetus of infection from HIV, hepatitis and sexually-transmitted diseases
 - Reduces the incidence of obstetrical and fetal complications

Though medication maintenance in the setting of comprehensive service provision during pregnancy significantly improves pregnancy outcomes for opioid dependent women, including decreases in pre-term birth and infection disease transmission, its use has implications for the infant, most notably the neonatal abstinence syndrome.

Although the infant may experience neonatal abstinence syndrome at birth, the other risk factors associated with parental use of alcohol or other drugs are diminished for women who have been stable in treatment during pregnancy, as well as their infants.

Medications Used to Treat Opioid Use Disorders

- Methadone (50-year research base)
- Buprenorphine (Subutex; 2010- MOTHER Study)
- Buprenorphine-Naloxone Combination (Suboxone®; Zubsolv)
- Naltrexone Extended-Release (Vivitrol®) – once per month injection
- Naloxone (Narcan®) – Reverses overdose

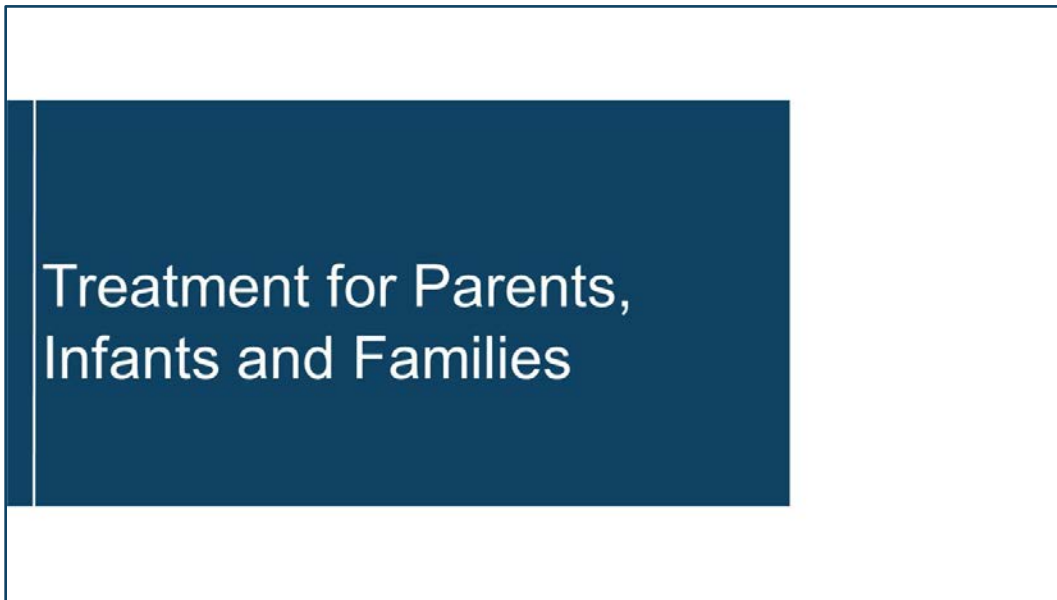
} **Used During Pregnancy**

“...opiate dependence is a medical disorder and ... pharmacologic agents are effective in its treatment.”

(National Institute on Drug Abuse, 2016; National Institute on Drug Abuse, 2017; Jones et al., 2012)

There are a diverse range of medications that can be used to treat opioid use disorders in conjunction with a comprehensive substance use treatment program.


For pregnant women, considerations about benefits to the infant related to development of neonatal abstinence syndrome, necessary lengths of stay in the hospital setting and likelihood of relapse/return to use should be reviewed with their physician and opioid treatment provider to determine the appropriate course of action, as evidence on benefits and drawbacks of each medication is still emerging.



Supporting the Mother/Infant Dyad

- The neonatal period is an optimal time to begin interventions to optimize dyadic interaction
- Improving clinician attitudes positively impact dyadic interactions
- Nurses who demonstrated caring behaviors towards mothers were better able to help them recognize and interpret infant cues, thus enhancing mother-infant interactions

(Velez & Jansson, 2008; Velez & Jansson, 2015)



Interventions that support a mother to read and respond to her baby's cues have been shown to improve mother-infant interaction and improve child safety and well-being. Positive attitudes and supportive clinicians can enhance these interactions and improve their effect. Child welfare workers can build these types of interventions into case plans to best support an infant's safety and well-being through appropriate services to parents.

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Interventions for infant treatment focused on simplified approach to assessment, nonpharmacological therapies, care outside of the NICU and empowering messages to parents that led to...



...substantial and sustained **decreases** in average **length of stay**, proportion of **infants treated with morphine**, and **hospital costs**.

(Grossman et al., 2017)

Research shows that supporting parents in recovery with time with their children to bond and providing encouraging and supportive messages can improve the outcomes for infants in their first days of life in the hospital. Child welfare staff can implement protocols in a way that supports this bonding, allows for observation of the parent and child interaction to improve safety decision making, and provides education and support to parents that may allow the parent and infant to remain together safely.

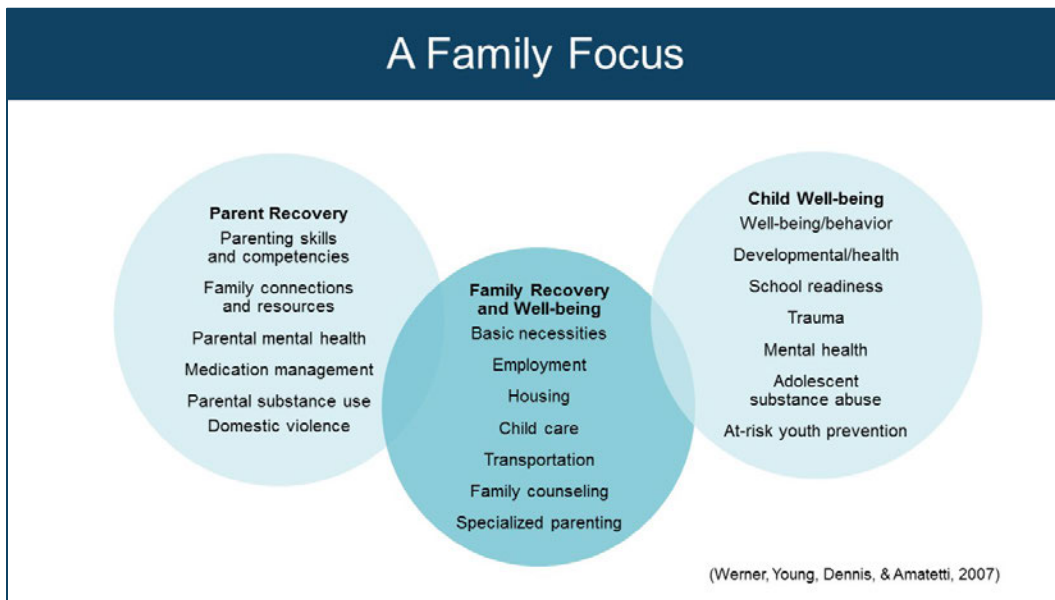
Postpartum Period

The postpartum period can be a challenging time for mothers using opioids and those with substance use disorders...

- Women who use opioids during pregnancy are at increased risk of depression, anxiety, and maternal death compared to those not using opioids
- Recent studies indicate that nearly half of maternal deaths in the postpartum period may be related to substance use and 1 in 5 specifically related to overdose
- Women with opioids use disorders are more susceptible to overdose between 7 and 12 months postpartum than any other time during pregnancy or the year after their infant's birth
- Women are more likely to overdose during pregnancy and throughout the first year postpartum if they are not on pharmacotherapy to treat their opioid use disorder

(Mehta et al., 2016; Metz et al., 2016; Whiteman et al., 2014; Schiff et al., 2018)

Some studies have shown that nearly 50% of maternal deaths in the postpartum period are related to substance use and overdose.




When serving a family holistically, the focus is on the parent's recovery, the child's well-being, and the family recovery and well-being as a whole.

- Services to support parent's recovery should address:
 - Parenting skills and competencies
 - Family connections and resources
 - Parental mental health
 - Medication management
 - Parental substance use
 - Domestic violence
- Services that support child well-being must address:
 - Well-being/behavior
 - Developmental/health
 - School readiness
 - Trauma
 - Mental health
 - Adolescent substance use
 - At-risk youth prevention
- Supporting the entire family's recovery and well-being means providing:
 - Basic necessities
 - Employment
 - Housing

- Child care
- Transportation
- Family counseling
- Specialized Parenting

Benefits of Family-Centered Substance Use Disorder Treatment




Mothers who participated in the Celebrating Families! Program and received integrated case management showed significant improvements in **recovery**, including reduced mental health symptoms, reduction in risky behaviors, and longer program retention (Zweben et al., 2015).

Women who participated in programs that included a **“high” level of family and children’s services** were **twice as likely to reunify** with their children, as those who participated in programs with a “low” level of these services (Grella, Hser & Yang, 2006).

Retention and completion of comprehensive substance use treatment have been found to be the **strongest predictors of reunification** with children for parents with substance use disorders (Green, Rockhill, & Furrer, 2007; Marsh, Smith, & Bruni, 2011).

Review the outcomes of family-centered treatment.

Rethinking Family Recovery



- Parents' recovery occurs in the context of family relationships
- Services that strengthen families and support parent-child relationships help keep children safe

~85% of children in substantiated abuse and neglect cases either stay home or go home

(Children and Family Futures created estimate based on Child Welfare Outcomes Report Data, 2013)

If parental substance use impacts children and family relationships, child well-being and parent recovery must also occur in the context of family relationships.

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Collaborative Practice in Child Welfare

The Importance of Collaboration

Substance use and child maltreatment are often **multi-generational problems** that can only be addressed through a coordinated approach across multiple systems to address needs of both parents and children

(Boles, et al., 2012; Dennis, et al., 2015; Drabble, 2007)

Parental substance use disorders are a factor in many child welfare cases, and research linking the two issues is compelling. Substance use and child maltreatment are often multi-generational problems that can only be addressed through a coordinated approach across multiple systems to address needs of both parents and children. Collaboration supports better outcomes for families.

The Necessity of Collaboration

Meaningful collaboration across systems that includes agreement on **common values**, enhanced **communication** and **information sharing**, blended funding and data collection for **shared outcomes**...

...results in improved outcomes for families including **increased engagement and retention** of parents in substance use treatment, **fewer children removed** from parental custody, **increased family reunification** post-removal and **fewer children reentering** the child welfare system and foster care.

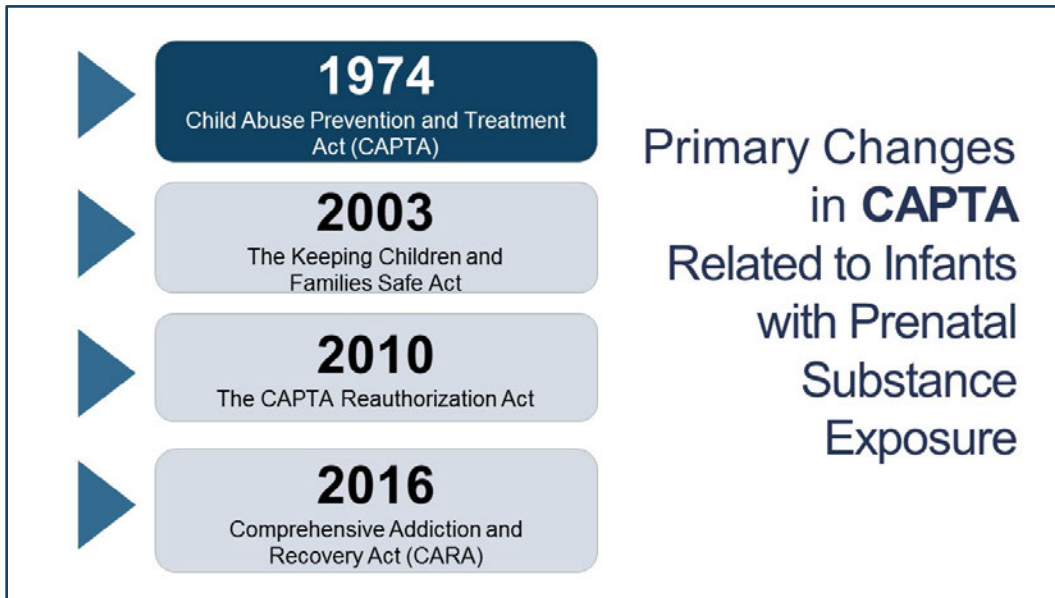
(Boles, et al., 2012; Dennis, et al., 2015; Drabble, 2007)

Families in treatment experience benefits when child welfare professionals understand the context of the parent's substance use disorders and how treatment works. Collaboration promotes these benefits for families:

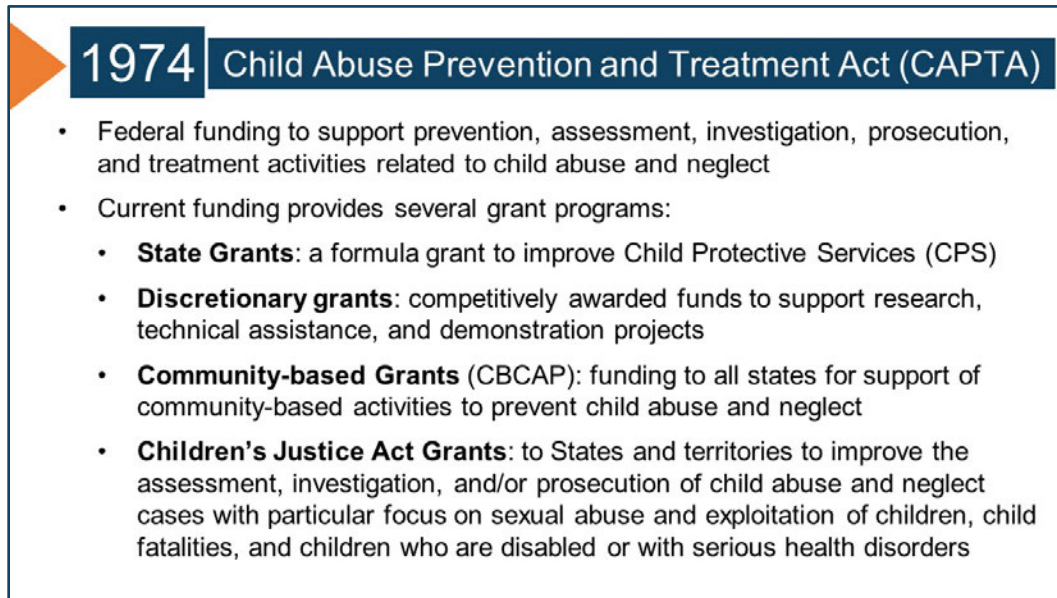
- Improves family engagement and enhances family outcomes:
 - Parents with substance use disorders often know their children are endangered and may avoid treatment for fear of losing them. Collaborative treatment can help parents provide for their children's safety and well-being and focusing on this fact can help engage and retain parents in the treatment process. This collaborative support is particularly important for parents of infants and young children who may not have access to other supportive relationships.
- Reduces family stress:
 - Parents with substance use disorders are often stressed by parenting responsibilities, which can contribute to abuse or neglect. The parents may need help to prevent future abuse or neglect or to reduce the risk of future maltreatment. By collaborating with treatment professionals, child welfare professionals can help parents develop the skills to effectively parent within the context of their recovery program. Professionals can work together to time and deliver services in a way that maximizes parent success.
- Helps families meet requirements:
 - Child welfare and dependency court requirements may differ from the treatment requirements. This can produce stress for parents who are trying to meet all the requirements, thus prompting relapse. Working collaboratively, child welfare professionals can increase the treatment counselors' awareness of these pressure points to help clients meet federal and state timelines, as well as achieve goals regarding their children. Treatment professionals can also help child welfare professionals understand parent triggers that may lead to relapse.

- Improves planning and information sharing:
 - Understanding the needs of parents with substance use disorders improves working with them and optimizes family outcomes. Substance-using parents are almost always affected by relationships with children, partners, parents, and siblings and may be dealing with trauma and other co-occurring mental health disorders. Understanding the context of a parent's addiction will help child welfare professionals collaboratively work with treatment professionals to plan and coordinate treatment approaches and child welfare services such as safety planning, child visitation, and post-reunification supports that will enhance positive outcomes. Treatment professionals are often asked to give child welfare professionals information about their clients' progress in treatment or to testify in court, which raises issues of confidentiality. By collaborating with child welfare colleagues, treatment professionals can identify how to share critical information that will help the client without violating client confidentiality.

Child Welfare Legislation Related to Infants with Prenatal Exposure



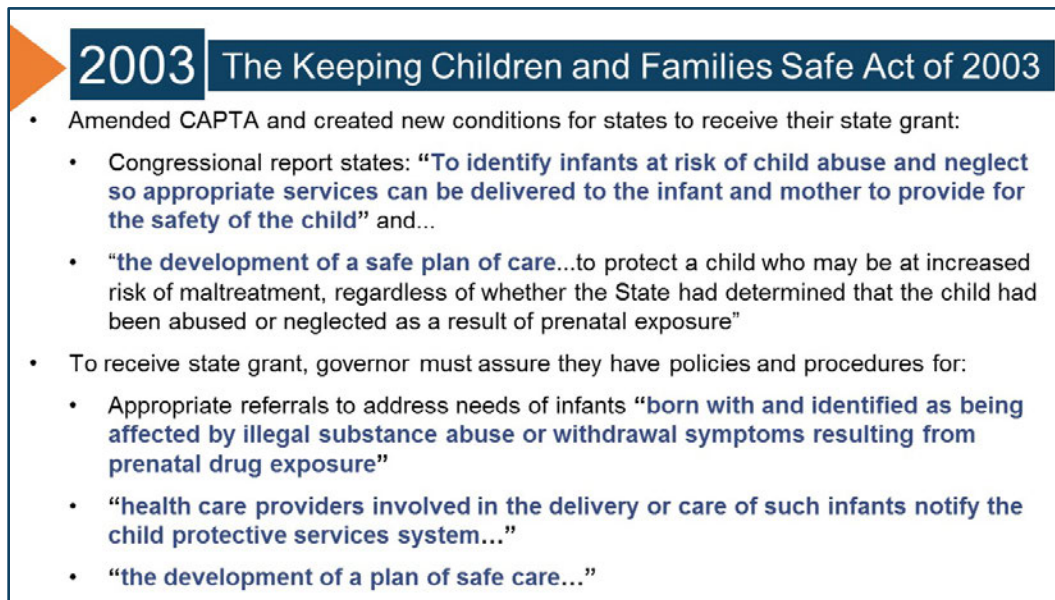
Child Abuse Prevention and Treatment Act legislation covers many elements of funding, education, research and policy related to child abuse and neglect. The amendments highlighted here are those specifically related to Infants with Prenatal Substance Exposure.



1974 Child Abuse Prevention and Treatment Act (CAPTA)

- Federal funding to support prevention, assessment, investigation, prosecution, and treatment activities related to child abuse and neglect
- Current funding provides several grant programs:
 - **State Grants:** a formula grant to improve Child Protective Services (CPS)
 - **Discretionary grants:** competitively awarded funds to support research, technical assistance, and demonstration projects
 - **Community-based Grants (CBCAP):** funding to all states for support of community-based activities to prevent child abuse and neglect
 - **Children's Justice Act Grants:** to States and territories to improve the assessment, investigation, and/or prosecution of child abuse and neglect cases with particular focus on sexual abuse and exploitation of children, child fatalities, and children who are disabled or with serious health disorders

CAPTA was first created for diverse purposes in 1974.

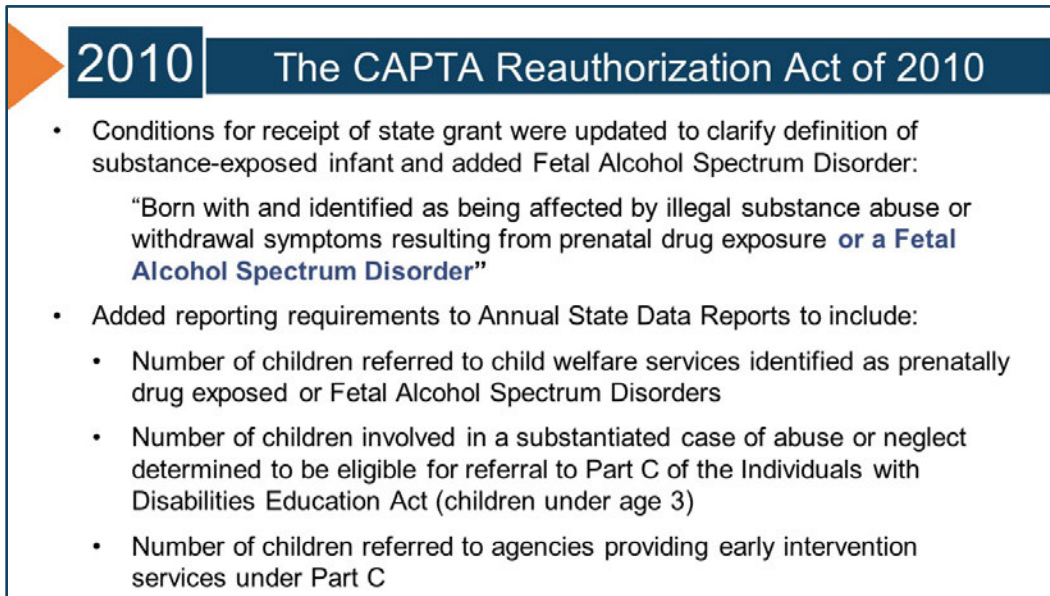


2003 The Keeping Children and Families Safe Act of 2003

- Amended CAPTA and created new conditions for states to receive their state grant:
 - Congressional report states: “**To identify infants at risk of child abuse and neglect so appropriate services can be delivered to the infant and mother to provide for the safety of the child**” and...
 - “**the development of a safe plan of care...**to protect a child who may be at increased risk of maltreatment, regardless of whether the State had determined that the child had been abused or neglected as a result of prenatal exposure”
- To receive state grant, governor must assure they have policies and procedures for:
 - Appropriate referrals to address needs of infants “**born with and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure**”
 - “**health care providers involved in the delivery or care of such infants notify the child protective services system...**”
 - “**the development of a plan of safe care...**”

The first time that a Plans of Safe Care for infants with prenatal exposure was mentioned was in 2003 amendments to CAPTA made by the “Keeping Children and Families Safe Act”; at this time a governor’s assurance of policies and procedures to provide referrals to address these infants’ needs, requirements for health care providers to make notifications and for development of Plan of Safe Care was required.

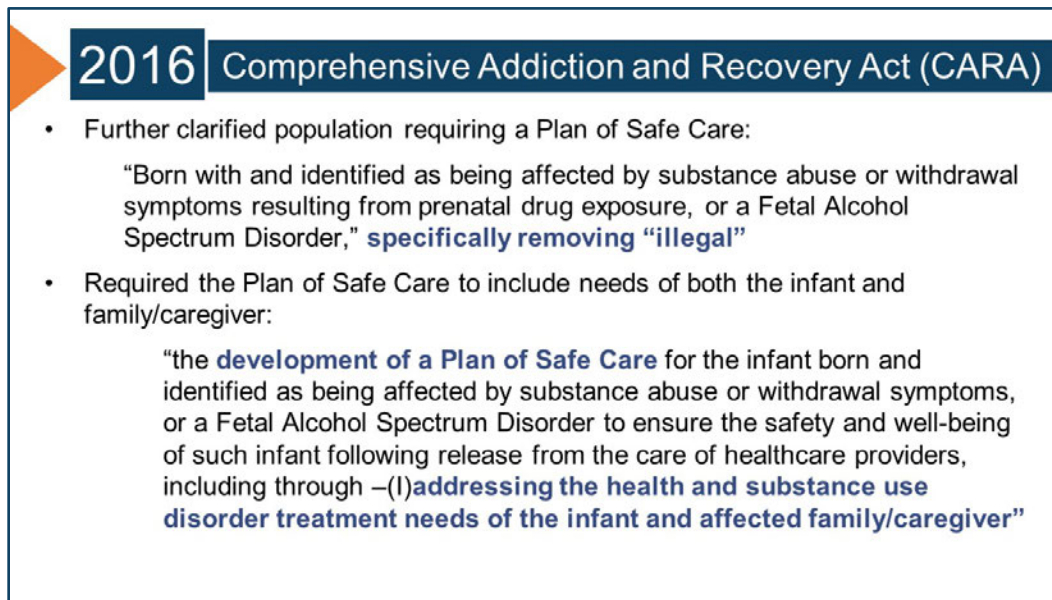
At the same time, this legislation amendment required a **notification** to child welfare for infants being born with and identified as being affected by illegal substance abuse or withdrawal symptoms. The word notification was used, not a report or allegation. States have operationalized notification differently.



2010 The CAPTA Reauthorization Act of 2010

- Conditions for receipt of state grant were updated to clarify definition of substance-exposed infant and added Fetal Alcohol Spectrum Disorder:
“Born with and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure **or a Fetal Alcohol Spectrum Disorder**”
- Added reporting requirements to Annual State Data Reports to include:
 - Number of children referred to child welfare services identified as prenatally drug exposed or Fetal Alcohol Spectrum Disorders
 - Number of children involved in a substantiated case of abuse or neglect determined to be eligible for referral to Part C of the Individuals with Disabilities Education Act (children under age 3)
 - Number of children referred to agencies providing early intervention services under Part C

In 2010, amendments were made that clarified that fetal alcohol spectrum disorder was included in the group of infants considered to be “effected by illegal substance abuse” and reporting requirements were added to annual state data reports. Again, many child welfare departments were already including fetal alcohol spectrum disorder infants in their safety planning and case planning services and didn’t make changes to policies at this time.



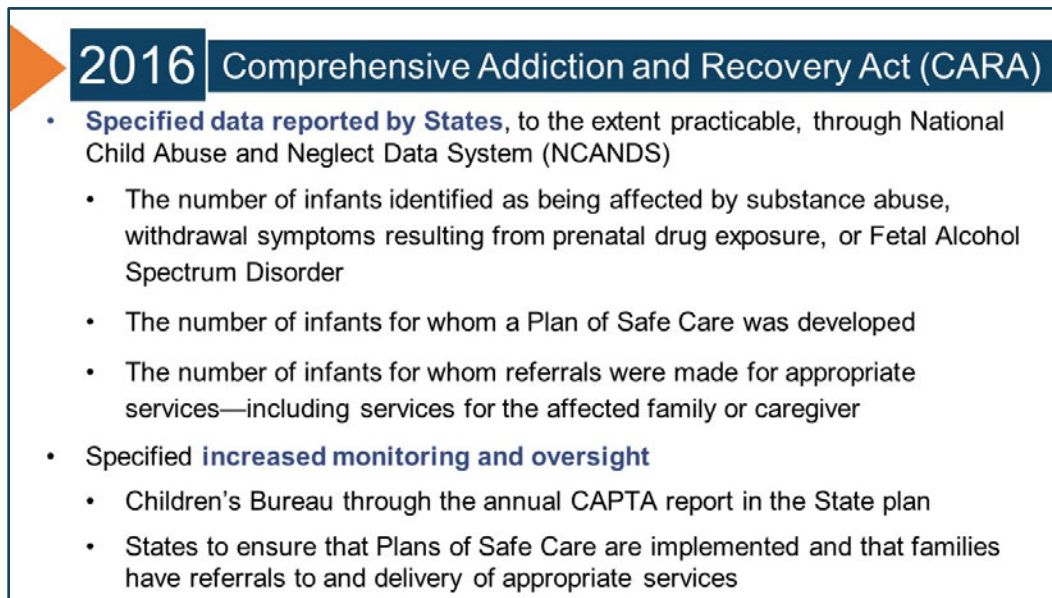
2016 Comprehensive Addiction and Recovery Act (CARA)

- Further clarified population requiring a Plan of Safe Care:
“Born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder,” **specifically removing “illegal”**
- Required the Plan of Safe Care to include needs of both the infant and family/caregiver:
“the **development of a Plan of Safe Care** for the infant born 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 –(l)**addressing the health and substance use disorder treatment needs of the infant and affected family/caregiver”**

2016 changes made by CARA have renewed the focus on these infants and their families.

2016 required the needs of family/caregivers be addressed and removed the term “illegal,” forcing many states to change policies about which infants received plans of safe care and what was included in those plans.

2016 amendments also required that the health and substance use disorder treatment needs of the infant and affected family/caregiver be addressed as part of a Plan of Safe Care.



2016 Comprehensive Addiction and Recovery Act (CARA)

- **Specified data reported by States**, to the extent practicable, through National Child Abuse and Neglect Data System (NCANDS)
 - The number of infants identified as being affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or Fetal Alcohol Spectrum Disorder
 - 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
- Specified **increased monitoring and oversight**
 - Children's Bureau through the annual CAPTA report in the State plan
 - States to ensure that Plans of Safe Care are implemented and that families have referrals to and delivery of appropriate services

Data collection, reporting and federal monitoring/oversight requirements were made in 2016. Due to these requirements, child welfare systems, many for the first time, formalized protocols and practice implementation that substantially changed when and who received Plans of Safe Care as well as what information was contained in those plans and how that information was collected and shared.

*****Insert information about how your agency is implementing Plans of Safe Care. Include policy, procedure and practice requirements for participants.**

CAPTA Plans of Safe Care Best Practices

- Can be developed prior to birth of the infant
- Includes a comprehensive, multidisciplinary assessment
- Has multiple intervention points: pregnancy, birth, and beyond
- Addresses needs of infant and family or caregiver
- Puts structure in place to ensure coordination of, access to, and engagement in services

While no federal guidance defines a plan of safe care, these best practices may be used to create a useful tool for collaborative teams who are coordinating to address the needs of the infant and their family/caregiver.

The Plan of Safe Care provides a way to operationalize services to mother and baby. It's clear that the needs of this population are multi-layered. The Plan of Safe Care provides a vehicle to coordinate across systems so that all of the different service needs can be met.

If partners exist in the community or child welfare policy allows (such as in Vermont), development of a Plan of Safe Care prior to the birth of the infant supports systems, including the family, to prepare for the birth of an infant who may have special needs. Having a plan in place prevents a need to revert to crisis mode.

Beyond the pregnancy, the plan ensures that services continue beyond the birth event. The often forgotten "postpartum" period is critical – it's a time of major stress and life changes for the mother, mothers are at particularly high risk for relapse and post-partum depression, and of course the needs of the infant who is prenatally exposed must be identified and addressed.

Since the plan is not just a one-time document and seeks to drive a comprehensive service array, a structure to ensure coordination of, access to, and engagement in services is helpful. The Plan of Safe Care provides a way to operationalize services to mother and baby.

In a sense, the Plan of Safe Care can be seen as the coordination of multiple care plans – the hospital discharge plan which includes recommendations for the mother and infant's care, the care plan developed by the pediatrician or specialist, the child welfare case plan, the mother's substance use treatment plan, etc.



Although a Safety Plan, Discharge Plan, or Treatment Plan may address some of the components in a Plan of Safe Care, they have different purposes and, individually they may not include all the needed components.

Child welfare system 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.

Why Should We Do Plans of Safe Care?

Expectations based on experiences with grantees and knowledge of the benefits of collaboration:

- Healthier babies and families
- Improved collaboration and cost saving

Based on experiences with states and practice based wisdom about benefits of collaboration, the potential benefits of plans of safe care include improved health of infants, improved family functioning, improved parent health, improved infant safety, improvements in collaboration that can create cost saving, and improvement in processes that can create cost savings.

*****Insert information on Plans of Safe Care in your state.**



**National Center on
Substance Abuse
and Child Welfare**

A Program of the

Substance Abuse and Mental Health Services
Administration

Center for Substance Abuse Treatment

and the

Administration on Children, Youth and Families

Children's Bureau

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