STARTEGY BRIEF

STRONG FAMILIES

How can Plans of Safe Care help infants and families affected by prenatal substance exposure?

This brief was developed in partnership with Children and Family Futures. For additional information about substance use disorder and child welfare, see Casey Family Programs resources on the topic.

In 2021, almost 50,000 children in the U.S. were referred to child protective services as infants with prenatal substance exposure,[1] and over a third of children who entered out-of-home care had parental alcohol or drug use as an identified reason for removal.[3] Although parental substance use and prenatal substance exposure often are cited as factors for children entering foster care, **the presence of a substance use disorder alone never should be the determining factor on removal**. Instead, decisions on family separation must be based on an assessment of how substance use disorder within a family is affecting child safety.

A **Plan of Safe Care** is designed to ensure the safety and well-being of an infant with prenatal substance exposure by addressing the health and substance use disorder treatment needs of both the infant and the affected family or caregiver. A Plan of Safe Care has been shown to reduce child safety risks related to substance

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use disorders within a family and therefore is an effective strategy for keeping families safely together and preventing the need for foster care.

For infants with prenatal substance exposure, Plans of Safe Care bring together affected families and various service providers — including maternal and infant healthcare, substance use disorder treatment, mental health treatment, early childhood, child welfare. This collaborative approach ensures a comprehensive response that prevents crisis-based reactions, ensures infant safety, promotes healthy child development, and strengthens family protective factors.[3]

This brief describes key considerations, decision points, and jurisdictional examples for implementing Plans of Safe Care.

Plans of Safe Care

Since 2003, there have been three significant changes in requirements about implementing Plans of Safe Care. There is great variation among states, both in terms of the implementation of their policy and procedures[4] and the rate of infants placed in out-of-home care due to substance use disorder-related issues.[5]

The **Keeping Children and Families Safe Act of 2003** created new conditions, including the Plan of Safe Care, for states to receive grant allocations under the **Child Abuse and Prevention Treatment Act (CAPTA)**.[6,7] The legislation required states receiving a CAPTA grant to implement **policies and protocols** for the following:

- Appropriate referrals to child protection services and other relevant systems to address the needs of infants born with and identified as affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure.
- A requirement that health care providers involved in the delivery or care of such infants **notify** the child protective services agency of the occurrence of such condition **except that such notification shall not be construed to establish a definition under federal law of what constitutes child abuse or require prosecution for any illegal action**.
- The development of a Plan of Safe Care for the infant born with and identified as being affected by illegal substance abuse or withdrawal symptoms.
- Immediate screening, risk, and safety assessment, and prompt investigation of such reports.

EVOLVING TERMINOLOGY

An increasing number of jurisdictions are adopting the term "Family Care Plan" in lieu of — or used interchangeably with — "Plan of Safe Care." "Family Care Plan" is considered a less stigmatizing term and therefore may enhance engagement of services. The Office of National Drug Policy's Model Substance Use During Pregnancy and Family Care Plans Act supports the development of family care plans.

The **CAPTA Reauthorization Act of 2010**[8] amended the requirements by adding fetal alcohol spectrum disorder (FASD) to the definition of an infant affected by substance abuse.[9] More recently, the CAPTA requirements were amended under the **Comprehensive Addiction and Recovery Act (CARA) of 2016**[10], which was passed in response to the nation's opioid epidemic, and included the following changes to the CAPTA provisions:

- Removed the term "illegal" when referring to substance abuse.
- Required that Plans of Safe Care meet the needs of both the infant and the family or caregiver affected by substance use disorder.
- Specified data reporting on infants and Plans of Safe Care, including the number of infants: 1) identified as being affected by substance abuse, withdrawal

symptoms resulting from prenatal drug exposure, or FASD; 2) with a Plan of Safe Care; and 3) receiving referrals for appropriate services including those for the affected family or caregivers.

- Requires states to develop and implement monitoring systems for Plans of Safe Care to determine whether — and in what manner — local entities provide, in accordance with state requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver.

Key implementation steps

The National Center on Substance Abuse and Child Welfare (NCSACW) provides expert technical assistance to help states make policy and practice changes that improve outcomes for children and families affected by substance use and mental health disorders. NCSACW has worked extensively with states, tribes, courts and communities on the planning and implementation of Plans of Safe Care, and recommends jurisdictions consider the following planning steps:

1. **Establish a collaborative structure** that considers the various systems involved in caring for families affected by substance use disorders, including maternal and infant care providers, substance use disorder treatment, child welfare, early childhood providers, mental health treatment, and individuals with lived expertise. Since there are many systems involved and no single entity is ultimately responsible, the governor's office has a critical role to play in leading and driving the state collaboration and ensuring that infants and families' needs are being met, often through the creation of a state-level task force.

2. **Review current state policies and practices** to ensure state teams have comprehensive knowledge of relevant legislation, policies, and statutes that drive procedures and practice with families affected by prenatal substance exposure.

3. **Create an inventory** of existing programs for families affected by prenatal substance exposure to highlight strengths and gaps in services and inform a strategic approach. An inventory based on the stages of child development can be particularly informative.

4. **Develop clear guidance** that includes clarification of the CAPTA requirements. Given states have flexibility, several key decisions points should be discussed

ADDITIONAL GUIDANCE

After passage of CARA, the Children's Bureau issued the following:

- Program Instruction 17-02 (2017) helps states implement the CAPTA provisions pertaining to infants affected by substance use disorder.
- Information Memorandum 16-05 (2016) informs states of the changes in CAPTA as a result of CARA and describes collaborative-based best practices to improve outcomes for families affected by prenatal substance exposure.
- Program Instruction 23-01 (2023) offers guidance to states on updating the 2024 Annual CAPTA Report including: 1) an update on states continued efforts to support and address the needs of infants born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a FASD; 2) how states are using the CAPTA State Grant funding to support the development, implementation and monitoring of Plans of Safe Care; 3) changes made to policy or practice and/or lessons learned from implementation of Plans of Safe Care; 4) any multi-disciplinary outreach, consultation, or coordination states have taken to support Plan of Safe Care implementation; 5) the current monitoring processes of Plans of Safe Care to determine whether — and in what manner — local entities are providing referrals to and delivery of appropriate services to infants and affected family members and caregivers; and 6) implementation challenges.

and explored (see *Plan of Safe Care: Key Points of Clarification*).

5. **Convene local implementation teams** to pilot protocols and policies. These teams service as effective vehicles for testing out different strategies.

6. **Develop and implement a cross-systems data tracking and quality assurance system** for resource allocation and strategic planning.

7. **Understand the effects and resolution for implicit bias and disparities**, including making sure there are universal protocols in place for screening, and equitable access to services. Services should also be gender-responsive, available in languages other than English, and family-centered and accepting of various family compositions.

Jurisdictional examples

The following examples illustrate how states and tribes have implemented Plans of Safe Care and operationalized key decision points. For additional information about various state approaches, see: *How States Serve Infants and Their Families Affected by Prenatal Substance Exposure*, a series of three briefs and webinars[11] developed by NCSACW highlighting innovative policies and practices.

Connecticut

State leaders launched an online portal for hospital health care providers to enter information on all infants born with prenatal substance exposure. The portal system generates guidance about whether the provider needs to make a report of potential child abuse or neglect to the Department of Children and Families (DCF) or a notification of the identification of an affected infant. A DCF report is to be made only when there are concerns about the safety of the infant **and** when the prenatal exposure is a result of maternal substance misuse.

There are various points, including prior to the birth of the infant or prior to discharge from the birth hospital, in which the Plan of Safe Care can be developed. All Plans of Safe Care must include a lead provider that the parent selects. DCF and community providers, together with pregnant women with substance use disorders, are encouraged to develop prenatal Plans of Safe Care. Birth hospitals must verify Plans of Safe Care with the lead developer. If it cannot be verified, the portal will direct the case to the child maltreatment report track. Birth hospitals are to work with the family to develop a Plan of Safe Care prior to hospital discharge when a prenatal plan is not available.

DCF receives de-identified information on the notification form, including ZIP code, community type (urban, rural, suburban), and notifications/reports and Plans of Safe Care by race/ethnicity. DCF aggregates the data to better assess needs, allocate resources, and identify racial disproportionality in screening results, notifications, and Plans of Safe Care. The portal enables the state to report on: 1) the number of infants affected by prenatal substance exposure; 2) for whom a Plan of Safe Care was developed; and 3) who received a service referral. For more information, see:

ADDRESSING STIGMA

Stigma attached to substance use and mental health disorders can drive away the families that need to be served. For more information, see: *Disrupting Stigma: How Understanding, Empathy, and Connection Can Improve Outcomes for Families Affected by Substance Use and Mental Disorders.*

PLANS FOR SAFE CARE: KEY POINTS OF CLARIFICATION

- **What** is a plan of safe care?
- **When** is a plan of safe care developed?
- **Which** families need a plan of safe care?
- **Who** develops and implements a plan of safe care?
- **How** is child welfare notified of an infant with prenatal substance exposure?

Connecticut's CAPTA Notification FAQ and CAPTA Plan of Safe Care FAQ.

Kentucky
The state's "system of care" is based on a comprehensive approach to coordinated services spanning various points of intervention from pre-pregnancy through postpartum and beyond. Kentucky's approach includes: 1) providing expanded prevention services to women of childbearing age both prior to and during pregnancy; 2) expanding treatment services to include universal screening, brief intervention, and referral to treatment services as a routine part of prenatal care; and 3) expanding the availability of treatment, including medication-assisted treatment and support services to pregnant women and parents.

A cross-system state team developed a toolkit to help local sites implement a Plan of Safe Care approach. The toolkit enables sites to:

- Develop a vision of services and partnerships.
- Identify current programs, services, and partners.
- Develop an education plan for partners.
- Ensure comprehensive, high-quality, and evidence-based services.

Local Community Mental Health Centers lead Plan of Safe Care collaboratives in Kentucky. The collaboratives include representatives from child protective services, substance use disorder treatment providers, OBGYNs, birthing hospitals, and pediatricians.

Nebraska
Nebraska's Department of Health and Human Services created two pathways for health care providers to notify child protective services. First, if health care providers identify an infant as either unsafe or at risk of abuse or neglect, they must report their concerns to the Nebraska Child Abuse and Neglect Hotline. Second, if health care providers do **not** have safety concerns, they can notify child protective services using a form with **no identifying information**, using the following criteria:

- Parent is stable and engaged in medication-assisted treatment with a licensed physician.
- Parent is receiving opioid-based treatment for chronic pain by a licensed physician.
- Parent is stable and engaged in treatment for other non-opioid substance use — including alcohol — with a licensed provider or physician, or parent is considered stable in a recovery program.
- Infant is at risk for FASD; and/or
- Parent is engaged in substance use or misuse (including marijuana) but the physician has determined that the situation does not present a concern about abuse or neglect, which would require filing a report.

New Mexico
The law in New Mexico requires health care professionals to assess whether an infant has been exposed to substances at birth. Plans of Care apply to any newborn identified as having been exposed to any substance at any time during the pregnancy. Once health care professionals create a Plan of Care, they must make a referral to the Medicaid managed care organization or children's medical services for care coordination and monitoring.

This law specifies that **exposure to substance use on its own is not considered child abuse or neglect**. Health care professionals concerned about a parent's

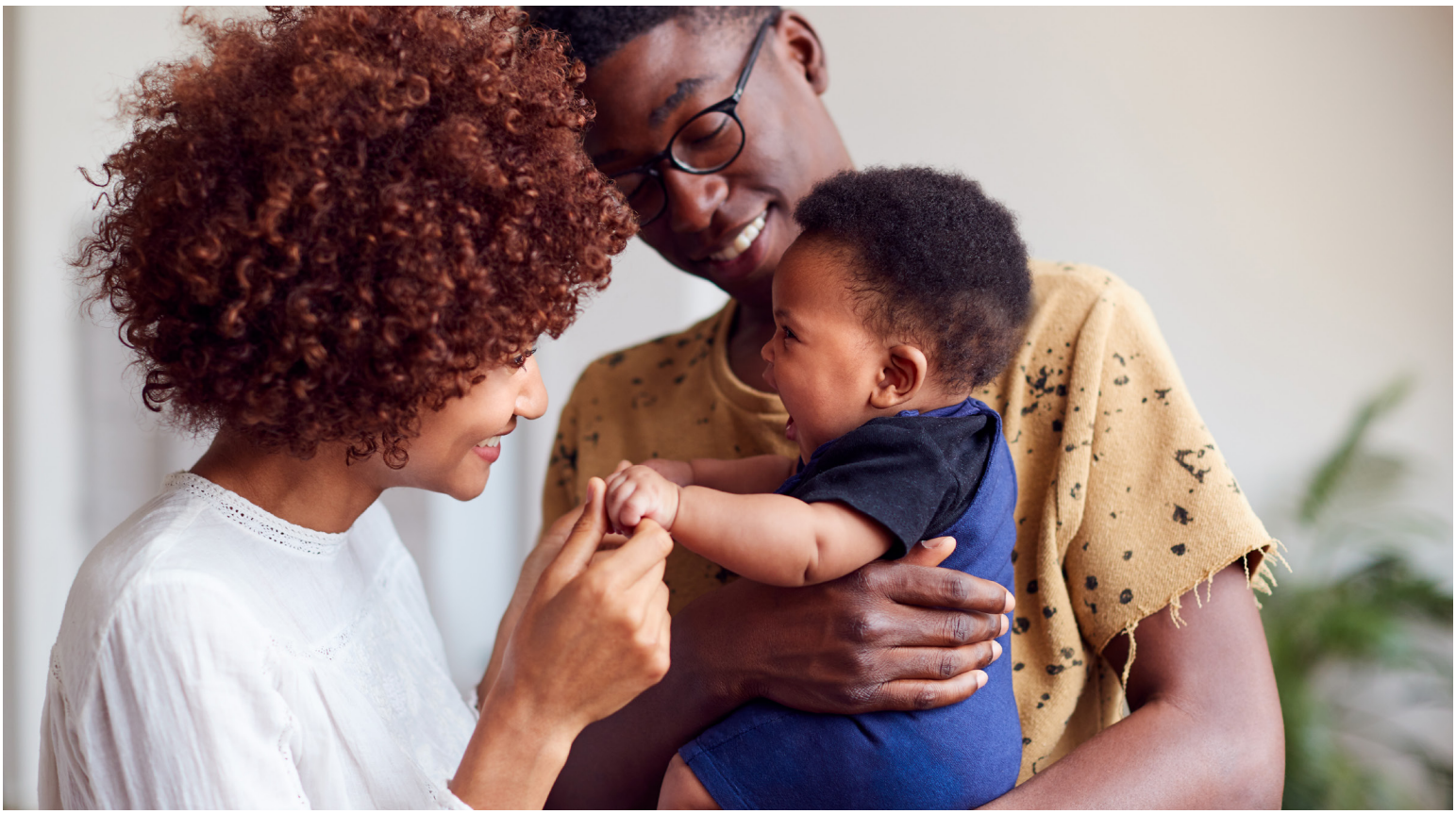
IMPLEMENTATION RESOURCES

- *National Center on Substance Abuse and Child Welfare: Plan of Safe Care Learning Modules*
- *National Center on Substance Abuse and Child Welfare: Key Considerations for Applying an Equity Lens to Collaborative Practice*
- *Legislative Analysis and Public Policy Association Model Substance Use During Pregnancy and Family Care Plans Act.*

PLANS OF SAFE CARE IN INDIAN COUNTRY

State child protection agencies have obligations under the Indian Child Welfare Act (ICWA) to notify tribes of any involuntary proceeding in a state court involving an Indian child. States must also provide active efforts to prevent family separation and, if separation occurs, reunify the family. Tribes do not receive CAPTA funds, so they are not obligated to implement a Plan of Safe Care. However, some tribes have initiated wellness plans to support infants affected by prenatal substance exposure and their families.

Tribes have unique considerations when implementing family wellness plans. For example, tribes must consider whether to create a standalone program, integrate with a state's Plan of Safe Care approach, or a combination of both. In part, these considerations are informed by the tribe's available resources, relationship with state or county child protection agencies, whether the tribe has tribal dependency courts or joint jurisdiction courts, and the support of tribal governance and leadership of an approach that best meets the needs of tribal infants and families. Understanding the intent behind Plans of Safe Care and how the state is implementing CAPTA is an important step in deciding whether to integrate with the existing system or develop a tribal program for the infants and parents or caregivers. The Tribal Family Wellness Plan Learning Modules are designed to guide tribal-led collaboratives to reduce the impact of substance use disorder on pregnant and parenting families, improve systems and services to reduce prenatal substance exposure, prevent family separation, and support infant and family wellness.



PREVENTION SERVICES

The Family First Prevention Services Act created a new funding stream, Title IV-E prevention services, to prevent placement of children into out-of-home care. Prevention services include substance use and mental health prevention and treatment services, and in-home services for parents. State child protection agencies can claim reimbursement for service interventions that have been approved in the Title IV-E Prevention Services Clearinghouse and are included in their states' five-year Title IV-E prevention program plan.

As of April 2023, the Screening, Brief Intervention, and Referral to Treatment system received a rating of Promising in the Clearinghouse.

COMPANION BRIEFS

For more information on substance use disorder and interventions for families and infants affected by prenatal substance exposure, see the following companion strategy briefs:

- *How can the child welfare system support families affected by substance use disorders?*
- *What are some developmentally appropriate interventions for infants and children affected by prenatal substance exposure?*
- *What are some evidence-based interventions to prevent and mitigate the effects of prenatal substance exposure?*

ability to care for an infant still can make referrals to New Mexico's Children, Youth and Families Department, but the law is designed to help families remain together, mitigate safety concerns, and provide individualized support and services.

New Mexico is currently gathering data directly from families that participated in a Plan of Care to understand what worked well and identify opportunities for improvement. New Mexico is also examining its data for families with a Plan of Care to understand how many had child protection agency involvement and where the infants currently reside (with their parents, in state custody, or in other placements).

Oklahoma

Collaborative partners in Oklahoma are creating a continuum of services and support from the prenatal period through early childhood for families affected by a substance use disorder. Through a collaborative stakeholder process, Oklahoma has gathered professionals from health care, child welfare, treatment agencies, and courts to implement Plans of Safe Care.

Early outcomes have been positive for families with a Plan of Safe Care (known in Oklahoma as a Family Care Plan). Prior to a Family Care Plans pilot in Tulsa, infants born to parents undergoing medication-assisted treatment during pregnancy would experience pharmacological intervention, long neonatal intensive care unit (NICU) stays, and entry into foster care. During the first two years of the pilot, none of the 50 newborns experienced pharmacological intervention or NICU stays, and all of the infants went home with their parent(s) following hospital discharge. The treatment provider ensured families received continued support and the Family Care Plan assisted care coordination between providers for parents and infants.

In an Oklahoma County pilot, pregnant persons with an opioid use disorder who sought prenatal care through the STAR (Substance Use, Treatment, and Recovery) Prenatal Clinic received Family Care Plans. About 90% of the 108 newborns were discharged home with their parent(s) and continued to receive in-home services and care coordination. The Oklahoma Department of Mental Health and Substance Abuse Services, supported by In-Depth Technical Assistance

through NCSACW, is requiring contracted substance use disorder treatment agencies to develop prenatal and postpartum Family Care Plans for pregnant and postpartum clients. The Safely Advocating for Families Engaged in Recovery (SAFER) initiative will begin a statewide implementation of prenatal and postpartum Family Care Plans in 2023.

Washington

Washington's Department of Children, Youth and Families (DCYF) partnered with stakeholders to develop a set of criteria specifying when a child protection report or notification is required. There are separate Plan of Safe Care pathways based on which families are determined in need of child protection agency intervention. For families not requiring intervention, DCYF partnered with Help Me Grow Washington, a service referral system, to implement the Plan of Safe Care and ensure service access and engagement. Maternal and infant care providers can make an online referral to the Help Me Grow program. When a family does require DCYF intervention, caseworkers develop and manage the Plan of Safe Care.

To learn more, visit Questions from the field at Casey.org.

1 U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2023 3). Child Maltreatment 2021.

2 U.S. Department of Health and Human Services. (2022). The AFCARS report: Preliminary FY 2021 estimates as of June 28, 2022 - No. 29.

3 Delaware State Epidemiological Outcomes Workgroup (SEOW) project. (n.d.). Infants with Prenatal Substance Exposure. The 2022 Delaware Epidemiological Profile. Substance Use, Mental Health, and Related Issues prepared for Director Joanna Champney and the Delaware Division of Substance Abuse and Mental Health & The Delaware State Epidemiological Outcomes Workgroup.

4 Legislative Analysis and Public Policy Association. (2022). Substance Use During Pregnancy and Child Abuse or Neglect: Summary of State Laws, October 2022.

5 Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. (2021). Foster Care Entry Rates Grew Faster for Infants than for Children of Other Ages, 2011–2018.

6 Library of Congress, Congress.Gov. H.R. 14, Keeping Children and Families Safe Act of 2003.

7 Library of Congress, Congress.Gov. S.342 - Keeping Children and Families Safe Act of 2003.

8 Library of Congress, Congress.Gov. S.3817 - CAPTA Reauthorization Act of 2010.

9 For a detailed history, see: About CAPTA: A Legislative History.

10 Library of Congress, Congress.Gov. S.524 - Comprehensive Addiction and Recovery Act of 2016.

11 Series of 3 briefs and corresponding webinars:

- Brief 1: Identification and Notification and webinar: Summarizes steps states took to implement the 2016 CARA amendments to CAPTA — focusing on modifications to state statutes, establishing a difference between notification and reporting to CPS, and developing shared definitions to identify and serve infants and their families affected by prenatal substance exposure.
- Brief 2: Plans of Safe Care Data and Monitoring and webinar: Reviews states' systems- and case-level strategies for monitoring Plans of Safe Care and fulfilling the amended annual data reporting requirements in CAPTA. This brief also highlights innovative ways states and local communities monitor Plans of Safe Care for infants and families without an open child welfare case.
- Brief 3: Lessons from Implementation of Plans of Safe Care and webinar: Provides an overview of the progress, knowledge, and experience states have gained since the passage of the CARA amendments to CAPTA. The three highlighted lessons include systems collaboration, reducing stigma, and using data to implement effective policies and practices.

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