

BRIEF 3



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

LESSONS FROM IMPLEMENTATION OF PLANS OF SAFE CARE

OVERVIEW

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

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

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

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



BRIEFS IN THIS SERIES

BRIEF 01 • Identification and Notification

BRIEF 02 • Plans of Safe Care Data and Monitoring

BRIEF 03 • *Lessons from Implementation of Plans of Safe Care*

INTRODUCTION

CAPTA was amended by the [Comprehensive Addiction and Recovery Act \(CARA\)](#) in 2016. This legislation created changes related to Plans of Safe Care for infants born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a fetal alcohol spectrum disorder. CARA specifically required, among other provisions, that Plans of Safe Care focus on the needs of both infants and their families or caregivers.

States continue to make progress implementing the CARA amendments to CAPTA by updating their statutes, policies, and procedures; creating definitions for “affected by”; defining a Plan of Safe Care; implementing a monitoring system to capture the required data; and developing or enhancing key collaborations for a multidisciplinary approach to implementation.

NCSACW has provided TA to 16 states and 1 county since 2016, supporting the implementation of the CARA amendments to CAPTA. While these states are in compliance with CAPTA, many are expanding their Plan of Safe Care implementation to include infants and families not involved in the child welfare system, but who might benefit from the coordinated care of services. This includes building notification pathways with community partners and developing Plans of Safe Care during the prenatal period.

Subsequently, some state child welfare agencies are engaging a broader group of state and community partners, including infant and maternal health care providers, and other community agencies serving children and families.

Brief #3: Lessons from Implementation of Plans of Safe Care provides an overview of the progress, knowledge, and experience states have gained since the passage of CARA amendments to CAPTA.



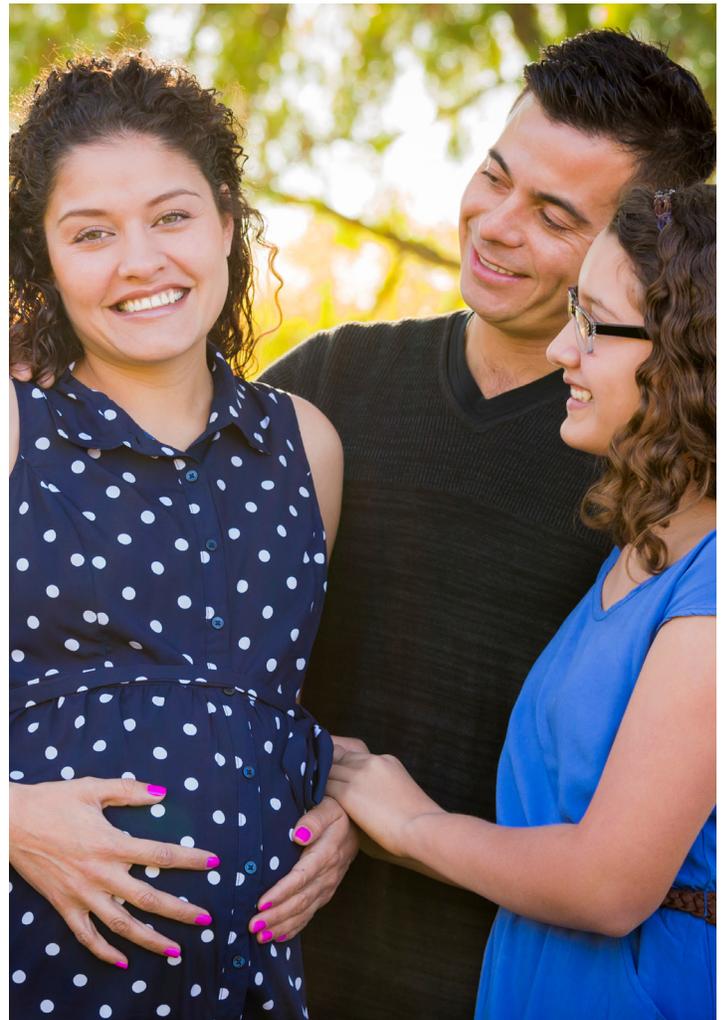
IMPLEMENTATION LESSON 1

A COMPREHENSIVE PLAN OF SAFE CARE REQUIRES COLLABORATION ACROSS KEY SYSTEMS

States recognized the need to build or enhance partnerships across key systems to ensure all affected infants and their families receive the necessary supports and services to thrive in the 2020 APSRs. NCSACW has found that a successful collaborative can: 1) identify who is responsible for completing and monitoring the Plan of Safe Care, 2) develop shared definitions and terminology across systems, and 3) enhance cross-systems communication to share information and exchange data. These successful collaboratives work strategically with the health care system—recognizing they are a critical partner in Plan of Safe Care implementation. Health care providers need to stay current with the requirements of the CARA amendments to CAPTA, influence policy development, participate in the development of uniform definitions and terminology across systems, and contribute to implementation efforts.

NCSACW has found that multiagency collaborative teams can help develop a flexible approach for Plans of Safe Care to accommodate the specific needs of each infant, parent, and family. As Plan of Safe Care implementation progresses, states must continue assessing the composition of the multiagency collaboration and identify key missing partners. Engaging agency partners in collaborative teams yields opportunities to expand the service array for families. Teams need partnerships with the following types of providers to improve access to and the quality of family-centered care for infants affected by prenatal substance exposure:

- Housing
- Domestic violence
- Employment
- Education
- Infant mental health
- Early childhood services and education
- Pediatric and primary care
- Obstetrics and other health care providers
- Substance use and mental health disorder treatment providers



Please view *Module 2: Collaborative Partnerships for Plans of Safe Care* in the Plan of Safe Care Learning Modules to explore steps to build, grow, and sustain collaborative teams.

Adding key partners to share responsibility for initiating and implementing Plans of Safe Care will improve the likelihood that families have more timely access to a broader array of services and supports. Meaningful collaboration across systems can result in improved outcomes for families.

States also emphasized that child welfare staff and other key stakeholders needed additional training on Plans of Safe Care in their 2020 APSRs. Ongoing training commonly focused on how to determine when a Plan of Safe Care is necessary, the required components of a Plan of Safe Care, and who should be involved in development of the Plans. Training that supports a family-centered approach can also focus on reducing stigma and parent engagement for all stakeholders working with parents affected by substance use disorders (SUDs). As states adjust and adapt their implementation policies and procedures, they should use their collaboratives to obtain feedback on implementation and provide ongoing training to partner agencies on any modifications to policies and practices.

STATE EXAMPLE: NEVADA

The Director of Nevada’s Department of Health and Human Services had CARA Plans of Care codified in regulation, which was pivotal in supporting implementation. The decision acknowledged that CARA was first and foremost a public health issue which must consider not only infants identified at birth, but also pregnant women with SUDs to enhance prenatal services, postpartum services, and services beyond that point. Collaboration between the Division of Public and Behavioral Health—within the Department of Health and Human Services—and medical and SUD treatment providers has been key to identifying a process that works for providers and meets the requirements of the CARA amendments to CAPTA.



IMPLEMENTATION LESSON 2

REDUCING THE STIGMA OF PARENTAL SUDS IS CRITICAL TO ENGAGING FAMILIES

Sites working with NCSACW have noted that stigma continues to be a primary barrier for engaging parents in services across systems. Parents who have a SUD are often fearful of working with health care providers and child protective service (CPS) staff due to potentially losing custody of their children and receiving harsh judgment. From NCSACW’s experience providing TA, collaboratives need representation across systems—including parents and family members with direct experience—to engage families with Plans of Safe Care. Reducing stigma for pregnant women with SUDs supports the implementation of a public health approach to Plans of Safe Care and improved outcomes for families. The addition of new partners, particularly public health, can help challenge attitudes and change practice across systems to better identify and respond to infants and families affected by prenatal substance exposure. Team members bring their own professional and personal experiences that inform strategies to reduce stigma toward parents—especially pregnant women—with SUDs, increase family access to trauma-informed services, provide training and education to the community, and ensure policies and procedures are aligned across systems.

From NCSACW's APSR review, collaboratives are expanding to include parents with personal experience (and family members) on oversight committees to inform policy and practice decisions as they implement Plans of Safe Care. To achieve authentic family engagement on committees, collaboratives need to adhere to guiding principles such as:

- Defining the role of committee members
- Acknowledging the differences in power among committee members
- Ensuring a shared understanding of terminology and purpose of the committee
- Ensuring committee meetings are accessible for all members or assigning other systems to oversee Plan of Safe Care implementation

Involving parents in the development of Plan of Safe Care policies and procedures builds trust and supports a family-centered approach.

To mitigate the effects of prenatal substance exposure and engage parents in services and supports before birth, some of the sites working with NCSACW are serving families during the prenatal period. This prevention strategy requires the collaborative to partner with prenatal care providers, educate them on how to identify and screen for SUDs, and combat the stigma that pregnant women with SUDs often encounter. Developing Plans of Safe Care during pregnancy has shown promising results in the areas of helping parents achieve recovery, enhancing their well-being prior to birth, and building protective capacities for families. Resources and interventions aimed at pregnant women and their families can also help prepare families for birth, engage pregnant women in SUD treatment services early, expand the support network for families, support recovery, reduce the need for child welfare involvement after birth, and prevent family separation of children affected by prenatal substance exposure.



STATE HIGHLIGHT: OKLAHOMA

A graphic of the state of Oklahoma in a teal color, with the letters 'OK' in white inside the state's outline.

Collaborative partners in Oklahoma are creating a continuum of services and support from the prenatal period through early childhood for families experiencing an SUD. Through a collaborative stakeholder process, Oklahoma has built upon previous efforts and lessons during three counties' participation in the Quality Improvement Center on Collaborative Community Court Teams (QIC-CCCT). Family treatment courts from Tulsa and Okmulgee counties used the convening power of their judicial officers to gather professionals from health care, child welfare, treatment agencies, and courts to implement Plans of Safe Care for infants with prenatal substance exposure.

As the sites began implementing Plans of Safe Care for newborns, they quickly identified a need to engage families earlier, prior to birth. Through partnerships with SUD treatment and healthcare providers, staff helped parents initiate prenatal Family Care Plans (as prenatal Plans of Safe Care are known in Oklahoma).

Early outcomes for families with Family Care Plans have been positive. Previously in Tulsa, infants born to women on medication-assisted treatment (MAT) during their pregnancy would experience pharmacological intervention, long neonatal intensive care unit (NICU) stays, and entry into foster care. **During the first 15 months of piloting Family Care Plans in Tulsa, none of the 20 newborns experienced pharmacological intervention or NICU stays—instead, all went home with their mother.** The treatment provider ensured these dyads continued to receive support while the Family Care Plan assisted the care coordination between providers for moms and infants.

Supported by In-Depth Technical Assistance (IDTA) through NCSACW, the Oklahoma Department of Mental Health and Substance Abuse Services will require contracted SUD treatment agencies to develop prenatal and postpartum Family Care Plans for their clients beginning in July 2021. The Core Team guiding the IDTA work is a multidisciplinary, cross-systems group that includes representatives from the Choctaw, Muscogee Creek, and Cherokee Nations. Oklahoma is also expanding the number of hospitals utilizing “TeamBirth,” an initiative led by Harvard’s Ariadne Labs focused on decreasing maternal mortality and increasing positive outcomes in labor and delivery. TeamBirth is designing interventions that span prenatal care, labor and delivery, and postpartum care. Oklahoma’s IDTA team is working with Harvard’s team to integrate Plans of Safe Care and supports for families experiencing a SUD into their body of work.



IMPLEMENTATION LESSON

3

COLLABORATIVES USING CONTINUOUS DATA ANALYSIS TO INFORM THEIR POLICIES AND PRACTICES INCREASE THE LIKELIHOOD OF SUCCESSFUL OUTCOMES FOR FAMILIES

States noted in their APSRs that Plan of Safe Care policies and procedures need revisions and updates after initial implementation. Some states updated and streamlined based on implementation lessons; others emphasized a need to improve their data collection process to improve implementation and service delivery. Collaborative teams should review and analyze available data on a regular basis to adjust service approaches as needed, assess how staff are delivering services and support ongoing funding.

STATE HIGHLIGHT: NEBRASKA

Nebraska's Department of Children and Family Services (CFS) continually reviews Plan of Safe Care data to identify supports needed for CFS staff. Externally, CFS continues to work with the Perinatal Quality Improvement Collaborative to help medical providers develop Plans of Safe Care. CFS updated the Notification Form and spreadsheet based on feedback from external partners. The updates included additional questions on characteristics of the mother and infant. These questions allow the state to understand current reporting practices. CFS is continually evaluating the existing processes as the state prepares to develop prenatal Plans of Safe Care.



PRACTICE AND POLICY IMPLICATIONS

Over the past five years, states have adapted and modified their Plan of Safe Care implementation strategies. States requesting TA from NCSACW are moving beyond compliance with CAPTA. IDTA sites are engaging a broader group of state and community partners, including infant and maternal healthcare providers. States are successfully aligning parallel initiatives (e.g., Perinatal Quality Collaboratives and Hospital Associations) to coordinate changes across systems, increase buy-in from stakeholders, and expand access to care for the target population.

Plans of Safe Care can help families increase health and well-being by mitigating risks and enhancing protective factors. As states continue to adjust their implementation of Plans of Safe Care, they can shift from a reactive, risk-based approach to a collaborative and proactive family-strengthening approach. A well-designed Plan of Safe Care can support parental resilience, increase social connections for families, provide access to services that help families understand child development and parenting strategies, connect families to concrete supports, and provide a foundation for the social and emotional development of infants.

Agencies can only accomplish these comprehensive goals by bringing together a strong multiagency collaboration that includes all necessary systems to support families.



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