	GEORGIA DIVISION OF FAMILY AND CHILDREN SERVICES CHILD WELFARE POLICY MANUAL			
	Chapter:	(19) Case Management	**Effective Date:**	November 2020
	Policy Title:	Plan of Safe Care for Infants Prenatally Exposed to Substances or a Fetal Alcohol Spectrum Disorder (FASD)		
	Policy Number:	19.27	**Previous Policy #:**	N/A

CODES/REFERENCES

O.C.G.A. § 15-11-30 Rights and Duties of Legal Custodian
O.C.G.A. § 15-11-101 Medical and Psychological Evaluation Orders When Investigating Child Abuse and Neglect
O.C.G.A. § 19-7-5 Reporting of Child Abuse and Neglect
O.C.G.A. § 49-5-8 Powers and Duties of Department of Human Services
O.C.G.A. § 49-5-41 Persons and Agencies Permitted to Access Records
Title IV-E of the Social Security Act Sections 471(a)(15)(D), 472(a)(1), and 472(f)
Title 42 of the Code of Federal Regulations (C.F.R) § 8.12(f)
Title 45 CFR Parts 1355.38(a)(5), 1356.21(b)(3)(i), 1356.21(d), 1356.21(k), and 1356.67
Child Abuse and Treatment Prevention (CAPTA)
Comprehensive Addiction and Recovery Act of 2016 (Public Law 114-198)
Health Insurance Portability and Accountability Act (HIPAA)
J.J. v. Ledbetter-Release of Information of Confidential Records

REQUIREMENTS

The Division of Family and Children Services (DFCS) shall:

1. In partnership with other agencies providing services to the family, develop and implement a Plan of Safe Care for families with infants identified as being affected by substance abuse (illegal and/or legal), or withdrawal symptoms resulting from prenatal drug exposure; or a Fetal Alcohol Spectrum Disorder (FASD) (see Practice Guidance: Prenatal Exposure-Affected).
   NOTE: This includes reports involving prenatal abuse as defined in Intake policy 3.4 Intake: Intakes Involving Substance Use or Abuse, Prenatal Exposure, Prenatal Abuse or Fetal Alcohol Spectrum Disorder.
2. Assess the health and substance use needs of the infant, caregiver and other family members in accordance with the following policies:
   a. 20.5 Special Circumstances: Infants Prenatally Exposed to Substances (No Maltreatment) when there are no allegations of maltreatment; and
   b. 19.26 Case Management: Case Management Involving Substance Abuse or Use when there are allegations of maltreatment (prenatal abuse).
   c. 19.24 Case Management: Family Treatment Court when the family is participating in family treatment court.
3. Conduct a Plan of Safe Care meeting:
   a. Within five calendar days of receiving the substance abuse assessment from the

substance use disorder treatment provider, when maltreatment is alleged; or
   b. Within 14 calendar days of the intake notification that contain no allegations of maltreatment.
4. Ensure that the Plan of Safe Care addresses:
   a. The health and substance abuse treatment needs of the infant and parent/caregiver; and
   b. The needs of the other family members affected by the substance use/abuse.
5. Identify the agency responsible for monitoring the Plan of Safe Care during the Plan of Safe Care meeting.
6. Monitor the Plan of Safe Care to determine whether referrals are made and delivery of appropriate services to the affected infant, family or caregiver:
   a. Ensure the Plan of Safe Care is incorporated into the case plan if the case is transitioned to Family Preservation Services or Foster Care.
   b. Follow up with the responsible agency for monitoring the Plan of Safe Care, prior to case closure, if the DFCS case is expected to close.
7. Adhere to confidentiality and HIPAA provisions outlined in policies 2.6 Information Management: Confidentiality/Safeguarding Information and 2.5 Information Management: Health Insurance Portability and Accountability Act. Obtain a signed Authorization for Release of Information (ROI) to facilitate sharing of information with providers and to initiate referrals, when applicable.
   NOTE: Utilize program specific ROI when required, i.e. Children 1st.
8. Document all case activities in Georgia SHINES within 72 hours of occurrence.

PROCEDURES

The Social Services Case Manager (SSCM) will:

1. Assess the health and substance use disorder needs of the infant, caregiver and other family members.
   a. If there are no allegations of maltreatment conduct the assessment in accordance with policy 20.5 Special Circumstances: Infants Prenatally Exposed to Substances (No Maltreatment).
   b. If there are allegations of prenatal abuse conduct the assessment in accordance with policy 19.26 Case Management: Case Management Involving Substance Abuse or Use.
   c. If the family is participating in family treatment court, ensure the assessment is conducted in accordance with policy 19.24 Case Management: Family Treatment Court.
2. Prepare for the Plan of Safe Care meeting:
   a. Review and analyze all information gathered from the assessment to determine the health and substance use needs of the infant, caregiver and other family members, including, but not limited to the following:
      i. Substance use disorder assessment from the substance use disorder treatment provider, other assessments conducted, etc.;
      ii. Children's 1st screening results;
      iii. Health information collected for the infant, other children, and mother's medical provider, hospital discharge records, etc.
      iv. Interviews with the mother, other caregivers, and other family members;
      v. Observation of the infant, other children and caregivers;

vi. Observation of the home;
vii. Other information as appropriate.

b. Initiate a staffing with the Social Services Supervisor (SSS), to discuss at a minimum:
   i. The impact of the substance/alcohol use by the mother and any other caregivers in the home on the care and protection of the infant and other children in the home.
   ii. The mother's compliance with MAT, if applicable;
   iii. The mother and other caregiver's functioning including physical health, mental health, life management, relationships, parenting, etc.;
   iv. The health care, developmental or other needs of the infant and any other children in the home;
   v. Current formal or informal supports;
   vi. Recommendations for the Plan of Safe Care and participants to include in the meeting.

c. Schedule the meeting and invite all identified participants (e.g., family members, informal support system, the individuals identified by the mother, Children 1st or Babies Can't Wait, medical professionals, substance and alcohol treatment professionals, including medication assisted treatment providers, and WTRS staff).

3. Conduct the Plan of Safe Care meeting:
   a. Engage the participants in a discussion regarding the identified needs of the infant, other children in the home, mother, and other family members. See Practice Guidance: What to Include in the Plan of Safe Care for the areas to include in the discussion.
   b. Discuss how each identified need will be addressed and by whom. Include whether services are already being provided or are needed.
   c. Identify and obtain agreement regarding the responsible party for referrals, provision of services for the infant, other children in the home, mother, and other family members.
   d. Identify and obtain agreement with the agency or agencies that will be responsible for monitoring the services provided to the family, if the case will not be opened for child welfare services beyond the Investigation or Special Circumstance Investigation.
      i. Obtain the agreement in writing to monitor the plan when the agency or agencies are willing to do so.
      ii. If the agency or agencies are unwilling to provide written agreement, then document the name of the agency or agencies, the name(s) and title(s) of the representativeness who agreed to monitoring the services, the date and time of the agreement and names of witnesses to the agreement.
   e. Complete the written Plan of Safe Care using the Plan of Safe Care form (see Forms and Tools: Plan of Safe Care).
4. Implement and monitor the Plan of Safe Care.
   a. Make referrals for services identified in the meeting, in accordance with policy 19.17 Service Provision; and/or follow up with other parties responsible for making referrals to determine if the referrals have been made and/or initiated, including but not limited to:
      i. Substance use disorder treatment and/or any other recommendations from the

substance use disorder assessment.
   ii. Medical or other providers regarding services for the infant, mother and other household members.
   iii. Children 1st regarding the referral for the developmental screening and any subsequent services for the infant and other children in the home.
b. Engage the parents/caregivers to determine if services have been initiated and are being provided in accordance with the plan.
c. Incorporate the Plan of Safe Care into the case plan for ongoing monitoring, if the case is transferred to Family Preservation Services or Foster Care (see policies 8.3 Family Preservation Services: Case Planning and 10.23 Foster Care: Case Planning).
d. Follow up with the provider responsible for monitoring the Plan of Safe Care prior to case closure, if DFCS case will be closed after the Investigation or Special Circumstance Investigation.

5. Document all activities related to the assessment, development and monitoring of the Plan of Safe Care, including uploading the completed Plan of Safe Care to Georgia SHINES within 72 hours of occurrence.

PRACTICE GUIDANCE

Plan of Safe Care

The Child Abuse Prevention and Treatment Act (CAPTA) requires that healthcare providers identify and make referrals to child protective services of infants affected by prenatal drug exposure including Fetal Alcohol Spectrum Disorder (FASD), and that "plans for safe care" be developed for infants, mother and their family members. A Plan of Safe Care is a *process* that involves a multi-agency partnership with families to develop a written plan for families affected by prenatal exposure to substances and/or alcohol, that:

1. Ensures the safety and well-being of infants following release from the care of healthcare providers;
2. Addresses the health and substance use disorder treatment needs of the infant and affected family or caregiver;
3. Ensures the provision of services to address the identified needs of the infant, family and caregiver;
4. Monitors the plan to ensure services are addressing the identified needs.

The Plan of Safe Care incorporates into one document the plans from various agencies providing services to the family, such as the child welfare assessment, hospital discharge plan, substance use treatment case plan and prenatal care plan to address the medical, behavioral, developmental, social and emotional well-being of the family. Coordinated services to the family ensures timely access to a continuum of care, minimizes barriers to accessing care, improves infant and maternal outcomes, and facilitates identification of the family's overall needs and engagement into the appropriate services.

When is a Plan of Safe Care Required

The Plan of Safe Care is required when a healthcare provider has identified that an infant has been affected by substance abuse; or withdrawal symptoms resulting from prenatal drug exposure; or a Fetal Alcohol Spectrum Disorder. This identification may occur during any stage of DFCS involvement, including at birth, or later during the infant's development and/or as symptoms manifest. DFCS may develop the Plan of Safe Care prior to the birth of an infant, if

child welfare is providing services due to other children in the home and the family agrees.

While prenatal exposure may include cases with child maltreatment (prenatal abuse) not all cases requiring a Plan of Safe Care involve maltreatment. Some examples of cases involving prenatal exposure with no allegations of maltreatment are as follows:

1. The infant is prenatally exposed resulting from the mother's use of prescribed medication for an illness. The mother is following her medication and treatment plan, as verified by her healthcare provider.
2. The infant is prenatally exposed resulting from the mother being given prescribed medication during the delivery process.
3. The infant is prenatally exposed due to the mother's participation in a Medication Assisted Treatment (MAT) program for a substance use disorder. The mother is in compliance with her medication and treatment plan, as verified by the substance treatment provider and her healthcare provider.

Prenatal Exposure – Affected

An infant "affected" by prenatal exposure to substance use means:

1. The infant is experiencing symptoms of withdrawal, or exhibiting harmful effects in his/her physical appearance or functioning due to exposure to substances (legal or illegal); or
2. The infant has tested positive for the presence of a substance or a metabolite thereof in his/her body, blood, urine or meconium; or
3. The infant has symptoms of a Fetal Alcohol Spectrum Disorder; or
4. The mother testing positive for illegal substances at the birth of the infant; or
5. The mother testing positive for prescription drugs due to misuse at the birth of the infant; or
6. The mother self-disclosed at the birth of the infant a substance or alcohol use problem and use during pregnancy.

Prenatal Exposure and Infant Development

The full impact of prenatal substance exposure depends on several factors, including: the frequency of use during pregnancy, timing, the type of substances used by pregnant women, co-occurring environmental deficiencies, and the extent of prenatal care (AIA, 2012). The effects of parental substance use disorders on a child can begin before the child is born. Research suggests powerful effects of legal drugs, as well as illegal drugs on prenatal and early childhood development (HHS SAMHSA, 2014). Maternal drug and alcohol use during pregnancy have been associated with premature birth, low birth weight, slowed growth, and a variety of physical, emotional, behavioral, and cognitive problems (AIA, 2012; National Institute on Drug Abuse [NIDA], 2011).

Fetal alcohol spectrum disorders (FASD) are a set of conditions that affect an estimated 40,000 infants born each year to mothers who drank alcohol during pregnancy (Prevention First, n.d.). Children with FASD may experience mild to severe physical, mental, behavioral, and/or learning disabilities, some of which may have lifelong implications (e.g., brain damage, physical defects, attention deficits) (National Organization on Fetal Alcohol Syndrome, 2012). Research suggests that some of the negative outcomes of prenatal exposure can be improved by supportive home environments and positive parenting practices (NIDA, 2011). Symptoms of

FASD can include facial abnormalities, growth deficiencies, skeletal deformities, organ deformities, central nervous system handicaps and behavioral problems. These symptoms can have lifelong implications for children who were exposed to alcohol in the womb; however, some FASD children who receive special education and adequate social services are more likely to reach their developmental and educational potential than those who do not receive those services. FASD diagnostic conditions include:

1. Type I: Fetal Alcohol Syndrome with confirmed maternal exposure.
2. Type II: FAS without confirmed maternal exposure.
3. Type III: Alcohol-related birth defects (ARBD)
4. Type IV: Alcohol-related neurodevelopmental disorder (ARND).

Neonatal Abstinence Syndrome[1]

Neonatal abstinence syndrome (NAS), formerly known as "withdrawal symptoms, may occur when a pregnant woman takes drugs such as heroin, codeine, oxycodone (OxyContin), methadone or buprenorphine. Because the baby is no longer getting the drug after birth, the withdrawal may occur as the drug is slowly cleared from the baby's system. Symptoms may appear within a few hours of birth to 14 days after birth, and depend on the type of substance used, length of time used, etc. Symptoms generally include but is not limited to, blotchy skin coloring (mottling), diarrhea. excessive crying or high-pitched crying, excessive sucking, fever. hyperactive reflexes, increased muscle tone, irritability, poor feeding, rapid breathing, seizures, sleep problems, slow weight gain, stuffy nose, sneezing, sweating, trembling (tremors), vomiting.

Prenatal Exposure and Child and Adolescent Development

Children and youth of parents who use or abuse substances and have parenting difficulties have an increased chance of experiencing a variety of negative outcomes (Felitti et al., 1998; HHS, 1999; Staton-Tindall et al., 2013) including: poor cognitive, social, and emotional development, depression, anxiety, and other trauma and mental health symptoms, physical and health issues, and substance use problems.

Parental substance use can affect the well-being of children and youth in complex ways. For example, an infant who receives inconsistent care and nurturing from a parent engaged in addiction-related behaviors may suffer from attachment difficulties that can then interfere with the growing child's emotional development. Adolescent children of parents with substance use disorders, particularly those who have experienced child maltreatment and foster care, may turn to substances themselves as a coping mechanism. In addition, children of parents with substance use issues are more likely to experience trauma and its effects, which include difficulties with concentration and learning, controlling physical and emotional responses to stress, and forming trusting relationships (Staton-Tindall et al., 2013).

Considerations for Developing and Implementing Plans of Safe Care

When developing, and implementing the Plan of Safe Care, consider the following:

1. The post-partum period is a time of "unique vulnerability" for the mother due to:
    a. Increased stress associated with motherhood, infant care, sleep deprivation

1 MedlinePlus [Internet]. Bethesda (MD): National Library of Medicine (US); [updated 2016 Aug 23]. Neonatal abstinence syndrome; [updated 2015 Nov15; reviewed 2016 Sep 12; cited 2016 Sep12]; [about 2 p.]. Available from: https://medlineplus.gov/heartattack.html

b. Limited social support and resource availability
c. Increased financial demands
d. Pain and physical recovery from delivery
e. Physiologic transition from pregnant to non-pregnant state

2. Alcohol and substances cause significant changes in brain chemistry, which affects a person's mood, thinking, behavior and perception. It can be difficult for a person to follow through on scheduling and keeping appointments; therefore, it is essential that Social Services Case Managers assist families with making and keeping appointments or identify a responsible person to assist the family.
3. The mother's or father's child welfare-related history that indicates unresolved substance use disorders related to a prior case of child abuse or neglect;
4. Any prior abuse and/or neglect reports related to substance use and response to agency intervention or substance abuse treatment;
5. Whether any siblings have been prenatally exposed to substances or have been exposed in the home or family environment;
6. Evidence of co-occurring mental health concerns that may affect immediate parenting capacity such as post-partum depression and substance use;
7. The mother's willingness to seek treatment and parenting instruction;
8. Family environmental challenges due to parental substance use disorders; and
9. Access to sufficient income/resources, employment, and lack of access to a medical home can all interact with substance use disorders, and could impact the infant.

What to include in the Plan of Safe Care[2]

1. **Needs of the mother:**
   a. Health care
   b. Identification by the mother of a consistent and stable primary caregiver
   c. Medication management
   d. Pain management
   e. Breast Feeding, if recommended by the physician.
   f. Substance use and mental health, should include the following:
      i. Timely access
      ii. Engagement, retention and recovery supports
      iii. Appropriate treatment (i.e. gender-specific, family focused, accessible, medication assisted treatment, trauma responsive)
      iv. Depression/anxiety/domestic violence
      v. Identify and assist the mother in accessing the appropriate assessments and treatment services.
   g. Parenting/Family Support:
   h. Coordinated case management/home visits to assess/address infant care, parent/infant bonding, nurturing, mother's understanding of the special care needs of the infant(s) and ability to provide such care, parenting guidance and skill development, safe sleep practices, and maternal support.
   i. Child Care

2 Adapted from: *Developing a Plan of Safe Care for Infants with Prenatal Substance Exposure, their Mothers and Caregivers: Collaborative Approaches Learned in a Six Site Initiative Part Two* presented by Linda Carpenter, Jill Gresham, Mollie Green, and Dr. Mishka Terplan at the Child Welfare League of America's 2016 National Conference August 1, 2016 in Orange County, California in conjunction with Children and Family Futures.

j. Benefits/Eligibility Determination
    i. Employment support
    ii. Housing
    iii. Transportation
k. Supportive network (having relationships and social networks that provide support, friendship, love, and hope)[3]

2. **Needs of the Infant:**
    a. Healthcare
        i. Identification of a consistent pediatrician/healthcare provider
        ii. Referral to specialty care, as indicated
        iii. High-risk follow-up care
    b. Safety with the caregivers
    c. Developmental screening and assessment
    d. Linkage to Early Intervention Services
    e. Early care and education program
3. **Needs of other children in the home:**
    a. Identification of a consistent pediatrician/healthcare provider
    b. Safety with the caregivers
    c. Developmental screening and assessment
    d. Linkage to Early Intervention Services
    e. Early care and education program
4. **Needs of other family members:**
    a. Substance use disorder assessment and treatment
    b. Mental health assessment and treatment
    c. Pain management
    d. Medication management
    e. Parenting skills (i.e. bonding, nurturing, understanding of the special care needs of the infant and the ability to provide it, safe sleep practice, etc.)
    f. Their ability to meet the care and protection needs of the infant and any other children living in the home.

Monitoring the Plan of Safe Care

Ensuring the services identified in the Plan of Safe Care is implemented is critical to assuring the ongoing health and substance abuse needs of the infant and family. The Plan of Safe Care will address actions and services for the infant and family's needs that support the family achieving long-term recovery. Therefore, the needs must be incorporated into the case plan if the case is transferred to Family Preservation Services or Foster Care to ensure ongoing monitoring. If the family does not continue child welfare services with DFCS, another individual or agency must be identified to monitor the plan of safe care. This could be the medical provider, Babies Can't Wait or other providers already involved with the family and who can obtain information to monitor the plan.

Plan of Safe Care vs. Safety Plan

3 Recovery and Recovery Support. SAMHSA. https://www.samhsa.gov/recovery Last Updated: 10/05/2015

A Plan of Safe Care is different from a safety plan aimed at addressing present or impending danger situations that have already occurred.[4] A safety plan is designed to control safety threats and have an immediate effect, and stays in effect as long as the threats to child safety exist and the family remains unable to provide for the child's safety."[5] The Plan of Safe Care moves beyond the immediate safety factors to the ongoing health, treatment and well-being needs of the infant and family. Therefore, it can remain in effect even when a comprehensive assessment indicates there is no need for child welfare services or after the termination of child welfare services.

Five-Point Intervention Framework[6]

Since many Substance Exposed Infants (SEI) are not identified prenatally or at birth, an approach that addresses all stages of development for the affected child is critical. Most previous work related to SEIs has focused on pregnancy and the birth event. However, a more comprehensive view is needed that takes multiple intervention opportunities into account, beginning with pre-pregnancy and continuing throughout a child's developmental milestones. The framework around which this report is organized asserts that there are five major timeframes when intervention in the life of the SEI can reduce the potential harm of prenatal substance exposure:

1. Pre-pregnancy: This timeframe offers the opportunity to promote awareness of the effects of prenatal substance use among women of child-bearing age and their family members;
2. Prenatal: This intervention point encourages health care providers to screen pregnant women for substance use as part of routine prenatal care and make referrals that facilitate access to treatment and related services for women who need those services;
3. Birth: Interventions during this timeframe incorporate testing newborns for substance exposure at the time of delivery;
4. Neonatal: Developmental assessment and the corresponding provision of services for the newborn as well as the family at this intervention point, immediately after the birth event, are the emphasis; and
5. Throughout childhood and adolescence: This timeframe calls for ongoing provision of coordinated services for both child and family.

FORMS AND TOOLS

Authorization for Release of Information
Authorization for Release of Information (Spanish)
Know Your Rights: Rights for Individuals on Medication-Assisted Treatment
Plan of Safe Care

---

4 Adapted from: *Developing a Plan of Safe Care for Infants with Prenatal Substance Exposure, their Mothers and Caregivers: Collaborative Approaches Learned in a Six Site Initiative Part Two* presented by Linda Carpenter, Jill Gresham, Mollie Green, and Dr. Mishka Terplan at the Child Welfare League of America's 2016 National Conference August 1, 2016 in Orange County, California in conjunction with Children and Family Futures.

5 Child and Family Services Review (CFSR) E-Training Platform https://training.cfsrportal.org/section-2-understanding-child-welfare-system/3016

6 Young, N. K., Gardner, S., Otero, C., Dennis, K., Chang, R., Earle, K., & Amatetti, S. (2009). Substance- Exposed Infants: State Responses to the Problem. HHS Pub. No. (SMA) 09-4369. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://ncsacw.samhsa.gov/files/Substance-Exposed-Infants.pdf