Mother & Baby Substance Exposure Toolkit

Best Practice No. 29

A part of the California Medication Assisted Treatment Expansion Project

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Develop a dyad-centered Plan of Safe Care

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Labor and Delivery, Nursery/NICU, and Transition of Care

Overview

California Penal Code 11165.13 was amended in 1990 with language indicating that a "positive toxicology screen at the time of the delivery of an infant is not in and of itself a sufficient basis for reporting child abuse or neglect," but would require "…any indication of maternal substance abuse to lead to an assessment of the needs of the mother and child." According to California Penal Code 123605, the assessment must be established by protocol "…between county health departments, county welfare departments, and all public and private hospitals in the county…" More recently, in 2016, the federal Comprehensive Addiction and Recovery Act (CARA) amended the long-standing Child Abuse Prevention and Treatment Act (CAPTA) to require development of a Plan of Safe Care, a concept that encourages a comprehensive, multidisciplinary care plan that addresses the needs of both infant and mother/caregiver. While there is still discussion about the interpretation of these state and federal regulations, it is clear that the Plan of Safe Care shifts the response to maternal and infant substance exposure from one centered predominantly on newborn safety to one that anticipates the needs of the mother/baby dyad.

This Best Practice addresses the Plan of Safe Care for the dyad, regardless of whether the mother and newborn are discharged together, or parental rights have been temporarily suspended. Because evidence demonstrates that retention of the mother/baby dyad is preferable to separation, attention to her well-being is essential to the welfare of the dyad.

Key elements of a dyad-centered Plan of Safe Care are the development of structured protocols at the county and hospital level, comprehensive assessment of needs and assets, collaborative wraparound care, transparency, and the identification and engagement of community partners.

Why we are recommending this best practice

A dyad-centered Plan of Safe Care will facilitate positive outcomes for the mother and baby. Having these services in place during the pregnancy and certainly prior to postpartum discharge support mothers to acquire or optimize the skills necessary to provide a safe and nurturing environment for the dyad and family. There is an opportunity and an obligation to ensure new families have the best opportunities afforded them.

Strategies for Implementation

Structured Protocols: Although protocols may have been developed years ago in response to CA Penal Code 11165.13 and Health and Safety Code 123605, new evidence supports best practices that address the effects of adverse childhood events (ACE) on long term health and wellbeing, attachment and bonding, early intervention, the treatment of substance use disorder (SUD), and the role of protective factors in eliminating or mitigating risk in families and communities. While no one template fits all situations, domains covered in the Plan of Safe Care might include:

- Maternal primary, obstetric, and gynecological care, including interconception care and family planning
- Behavioral health and substance use prevention, treatment, and recovery
- Parenting and family support
- Infant and family safety, including intimate partner violence
- Infant health and child development, including primary care, early intervention, and infant and early childhood mental health (IECHM) services

The adoption and implementation of standardized protocols to develop, execute, and monitor a Plan of Safe Care for all women and children in need is critical. Further, the Plan of Safe Care protocol should reflect the collaborative expertise of key agencies at the county level (e.g., behavioral health and substance use treatment departments, social service departments, Child Protective Services (CPS), etc.), and multiple disciplines in the hospital and other health care settings (e.g., pediatric and OB/GYN health care providers, medical social work, etc.).

Collaboration: To provide a Plan of Safe Care for the dyad, community-based organizations and agencies must collaborate to make wrap-around services covering the above domains easily accessible. To address the needs of the mother, communities must come together to support her with a network of programs and providers that transcend stigma and engage mothers with respect and trust, are trauma-informed, and have expertise in the care of women with substance use disorders (SUDs). Similarly, addressing the needs of the infant should include providers and agencies skilled in high risk infant follow-up, Early Head Start and other early intervention programs, and primary care pediatric providers with expertise in managing infants exposed to substances or at risk for neurodevelopmental challenges. The mother/caregiver must be the core member of this partnership. The partnership should include:

- Primary care providers
- Medication assisted treatment (MAT) providers (office-based or narcotics treatment programs) or other treatment and recovery programs
- Public health nursing, including home visitation programs
- Behavioral health providers
- Peer support
- Board-certified lactation consultant if the mother desires to breastfeed or provide expressed breastmilk (and it’s not medically contraindicated)

Providing Transparency: From the initial meeting with the mother, clarity of purpose is fundamental, and expectations are based on how each individual program or service can meet the needs of the dyad. Assessment of the mother’s needs, with consideration for her self-efficacy, SUD treatment, and recovery, will support her goal attainment. Follow through with plans and interventions developed with her input will further a sense of security in the relationship. Communication between community supports should occur with full knowledge and consent from the mother and include her whenever possible. Community partners should maintain transparency with each other to avoid duplication of services and provision of conflicting information to the mother, which may confuse and overwhelm her.

Presently, guidance regarding interpretation of the federal and state legislation in this area

is not straightforward, and hopefully will be clarified soon. Counties vary in how they address the Plan of Safe Care requirement within their communities. In many instances, CPS will take the lead; however, if there is no CPS involvement, or CPS does not address the provision of services to the mother, the community should be ready to support mothers with trauma-informed programs and partners that employ the Five Protective Factors model (refer to the Resources Section of this Best Practice). If CPS engagement is anticipated, full understanding of the laws and resources will afford medical and other service providers the ability to have more transparent conversations with mothers.

Community Partners: The partners from the community may include: CPS, Cal-Works eligibility, behavioral health providers, peer support workers, hospital social workers, MAT providers, recovery programs specific to parenting women, First 5, mother-infant intervention programs (e.g., Minding the Baby or Parents as Teachers), Regional Center, Early Start, Medicaid, and Women, Infants and Children (WIC). Communities may identify and designate additional partners specific to their region.

Federal and State Child Welfare Regulations: In 2016, the Comprehensive Addiction and Recovery Act (CARA) amended the Child Abuse and Prevention Treatment Act (CAPTA) to require the development of a Plan of Safe Care for all children referred to their agency who are born affected by legal or illegal substance use, have withdrawal symptoms resulting from prenatal drug exposure, or have indications of Fetal Alcohol Spectrum Disorder.

In response to California Penal Code 11165.13, and the Federal CARA/CAPTA amendments, the California Department of Social Services (CDSS) All County Letters (17-92 and 17-107) state, “when investigating a referral, the county child welfare agency must assess and identify any safety threats to the child, including any safety threat posed by the parent’s substance abuse. The caseworker must document such safety threats when completing statewide safety assessment tools. This also includes the completion of a risk assessment. If the caseworker determines the caregiver has the protective capacity to mitigate such safety threats and/or risks with appropriate services while keeping the child in the home or placement, the caseworker shall develop a safety plan as described in CDSS Manual of Policies and Procedures, section 31-002(s) (2)… to permit the child to remain in the home with specific, timely actions that mitigate the identified safety threats.”

Initial Steps to Consider

- Contact the county Public Health Department (Maternal Child and Adolescent Health), Child Protective Services, and/or Hospital Council to determine if a current protocol exists for the identification of perinatal substance exposure and the development of Plans of Safe Care that is consistent with state and federal law.
- If a county-level protocol does not exist, or needs revisions, establish a county-level multidisciplinary Plan of Safe Care Committee. Stakeholders to engage might include champions from the aforementioned agencies, Pediatrics, Obstetrics, Midwifery, Family Medicine, Addiction Medicine, Psychiatry, Behavioral Health, Family Treatment Court, and community organizations that serve this population (essential for culturally appropriate and engaging care). Protocols should address at least the following:
    - Define which mothers and newborns will qualify for a Plan of Safe Care and whether it will be used only for substance exposed mothers and infants as mandated or for the many other families at risk (e.g., prematurity, intimate partner violence, mental health issues, etc.).
    - Identify who will oversee implementation of the Plan of Safe Care, and at which stage of the pregnancy the plan of safe care may be initiated. Current CDSS All

County Letters assign that responsibility to the local CPS agency regardless of whether the newborn is discharged in the care of the mother.
    - Identify key community-based organizations and resources and establish relationships including with primary care providers, substance use treatment and recovery providers, community resources for collaborative support of vulnerable families, home visitation, parenting classes, lactation support, addiction support (if needed), and early intervention services.
    - Outline ongoing care plans that identify family challenges and strengths (and tools to support those assessments, such as Protective Factors Survey 20 or 30), detail recommended/required resources and supports to ensure ready access to those services, and include contact information and appointments for benefit of the family and support network.
    - Prioritize continuity of care with maternal treatment and recovery providers and with infant care providers wherever possible and appropriate
    - Ensure that the Plan of Safe Care covers a sufficient duration to ensure a foundation of stability.
    - Include a comprehensive release of information consent signature page (see Delaware's Plan of Safe Care example) to facilitate timely information sharing and coordination between organizations to ensure shared understanding and accountability.

- Ensure that hospital protocols are in place for the identification of substance exposed mothers and infants and the development and implementation of Plans of Safe Care for the dyad. These should be consistent with local, state, and federal policies and regulations.

- Ensure families and providers are educated about the Plan of Safe Care, what to expect in the hospital and beyond, the focus on maintaining the mother/baby dyad, and the potential for CPS involvement.

- Engage the mother/caregiver in collaborative decision making around what supports are most valuable for them and any anticipated challenges for program participation while maintaining sobriety, work obligations, or court hearings.

- Consider using the Plan of Safe Care as a dynamic document that may evolve over time in response to regular assessments of the parent and infant health and well-being.

- Ensure sufficient monitoring of maternal depression and anxiety, continuing recovery, and parental capacity to meet her infant's and her own needs. There are many conflicting demands placed on these mothers such as attachment, sustaining employment, recovery, and the voluntary programs we recommend.

- Consider using a consultant or the complete reference below to implement of a Plan of

Safe Care.

The relationships we build across departments and in the community will afford us a greater support network, and transparency and accountability in caring for our most vulnerable new families during a peak emotional time. The dyad-centered Plan of Safe Care is an opportunity for providers to leverage community resources and ensure optimal support of new families impacted by substance use or other risk factors.

Kayla

In the past year, the hospital Kayla delivered at held a monthly meeting to develop and refine a thorough county-wide Plan of Safe Care (POSC). These meetings consisted of interdisciplinary representatives from the inpatient hospitals, outpatient clinics, CPS, community organizations, and health care system clients. They have been developing, refining, and organizing roll out plans for policies and procedures that link the practices of the entire community through the processes of urine toxicology, outpatient and inpatient screening, support opportunities, inpatient management, and ultimately the coordination and documentation of a POSC. The team has effectively kept their focus on keeping families intact and supporting the family as a unit.

After delivery, Kayla's primary care provider and primary outpatient social worker (SW) called a team meeting to review and adjust (as needed) Kayla's POSC. Kayla was involved in this meeting as it focused on her as the most important piece of Baby M's health and well-being. She was given time to ask questions, discuss concerns and invite any further support. Prior to this meeting, Kayla's traumatic life history was also briefly reviewed in the POSC as well as the services and safe guards that were already in place (MAT, GED attainment, and more).

Prior to Kayla's discharge, the outpatient SW, who is responsible for tracing the POSC and is the team member who best knows Kayla, provided further support. Kayla identified herself as early in sobriety and continuing to struggle with feelings of anxiety that were triggered in the role as a new parent. Kayla chose a supportive housing community resource that felt like the right fit for her family, and her primary SW assigned referrals to this program to be completed. The inpatient SW had met a representative from this community program at the monthly POSC meeting and felt comfortable describing their services and participation requirements. This added to Kayla's comfort to explore this option of support.

Resources

1. National Center on Substance Abuse and Child Welfare. A Planning Guide: Steps to Support a Comprehensive Approach to Plans of Safe Care. March 2018 Draft. Retrieved 4/10/19.

2. A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders.

3. Children and Family Futures presentation with national statistics, overall background,

concept of family-centered treatment and suggestions for the implementation of Plans of Safe Care.

4. Delaware Plan of Safe Care Template Example.
5. Vermont Plan of Safe Care Template Example.
6. National Center on Substance Abuse and Child Welfare. Child Abuse and Prevention Treatment Act (CAPTA) Substance Exposed Infants Statutory Summary.
7. The Protective Factors Framework.
8. Protective Factors Survey
9. Ac P Yurok Tribe Health and Human Services. Healthy Circles Intake Form.

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2. Perinatal Health Care. California Health and Safety Code, Section 123605. California Legislature. http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=123605&lawCode=HSC. Accessed December 19, 2019.
3. Substance Abuse and Mental Health Services Administration. Family-centered treatment for women with substance use disorders – history, key elements and challenges. https://www.samhsa.gov/sites/default/files/family_treatment_paper508v.pdf Accessed December 19, 2019.
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Heather Briscoe

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Dr. Heather Briscoe is an Assistant Professor at University of California, San Francisco based at Zuckerberg San Francisco General Hospital in the Department of Pediatrics. She is a pediatric hospitalist and is engaged in a number of projects around the interface of pregnancy and social complexity including an active role in the Plan of Safe Care Community Collaborative of San Francisco. She is particularly interested in how substance use policy affects pregnant women both positively and negatively with regard to utilization of prenatal care, access to needed resources, family unity & safety, and trauma-informed patient-centered care.

Helen DuPlessis

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Dr. Helen DuPlessis is a Principal at Health Managment Associates.

She has a rich history of involvement in healthcare administration for a variety of organizations, expertise in program and policy development, practice transformation, public health, maternal, and child health policy, community systems development, performance improvement, and managed care. Prior to joining HMA, Dr. DuPlessis served as the chief medical officer with St. John’s Well Child and Family Center. Other notable professional experiences include her work as senior advisor to the UCLA Center for Healthier Children, Families and Communities where she provided leadership, research, program development support, counsel and representation to local, state and national efforts, and community level systems transformation. She also trained and mentored students in various disciplines and educational levels.

Jacqueline Rad

MSN, RN

Jacqueline Rad is the nurse manager for the Family Birth Center at Sutter Lakeside Hospital where she provides patient-centered care to mothers and newborns exposed to opioids, and teaches providers and nurses about the challenges these families face.

Kelly Brandon

MSN, RNC, CNS, IBCLC

Kelly Brandon, MSN, RNC, CNS, IBCLC has been a nurse for over a decade. She currently works as a Perinatal Clinical Nurse Specialist at Zuckerberg San Francisco General Hospital and Trauma Center where she oversees the training, education, policy writing and implementation of nursing care in the Birth Center at ZSFGH. Prior to her nursing work she was a counselor and program manager for a street outreach program in downtown San Francisco. Kelly focuses her clinical work by involving compassion, kindness, and patient autonomy in every encounter.

Mimi Leza

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Mimi Leza is the Perinatal Services Coordinator for Ventura County Public Health and currently the co-chair of the Perinatal Substance Use Taskforce of Ventura County. Her background is in Pediatric nursing with extensive experience in caring for NICU babies with NAS and children with prenatal substance use exposure. As a Public Health Nurse, she specialized in providing case management for pregnant and parenting women with SUD and recruiting and training perinatal providers in the SBIRT process.