



INFORMATION PACKET

SAFE CHILDREN

What are infant plans of safe care and some examples of state responses to infants affected by substance abuse?

This information packet was developed from reports and materials produced by the National Center on Substance Abuse and Child Welfare, an initiative funded by the Substance Abuse and Mental Health Services Administration and the Administration on Children, Youth and Families. Technical assistance and additional information can be accessed through their website: www.ncsacw.samhsa.gov or emailing: ncsacw@cffutures.org

Background

While the prevalence of infants with prenatal substance exposure in the child welfare caseload is difficult to quantify given states' variation in identification and reporting practices, according to the U.S. Department of Health and Human Services (2016):

The rate of opioid misuse and dependence is escalating in many communities, including amongst pregnant and parenting women. In addition, many communities are experiencing high rates of overdose deaths and treatment for substance use disorders. Substance use disorder treatment systems are reporting increases in the number of individuals seeking treatment for opioid use disorders. Child welfare systems are reporting increases in caseloads, primarily among infants and young children coming into foster care, and hospitals are reporting increases of infants experiencing Neonatal Abstinence Syndrome associated with opioid use during pregnancy.¹



casey family programs

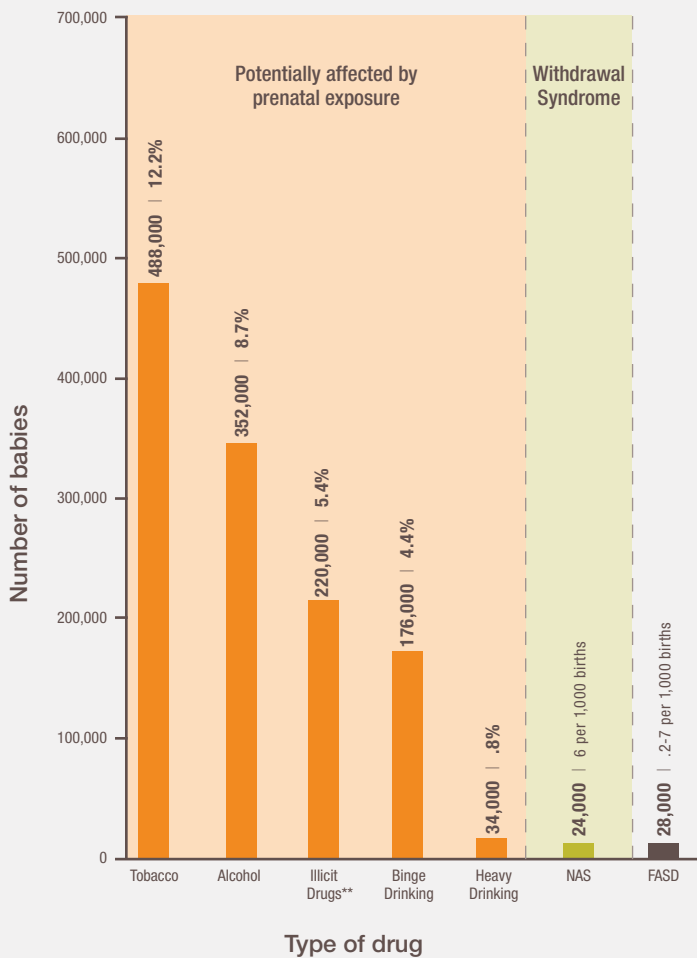
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A study of 38 states found that the average rate of neonatal hospital stays involving substance use experienced a cumulative increase of 71% between 2006 and 2012, increasing from 5.1 to 8.7 per 1,000 neonatal stays.² As a result, according to the National Center on Substance Abuse and Child Welfare (2017), “younger children make up a larger percentage of children in out-of-home care with children under

six representing over 50% of children in care. This alarming rate of young children coming into care is especially troubling, as children ages 0–3 are especially vulnerable.”³

The graphs below, developed by the National Center on Substance Abuse and Child Welfare (2017), highlight these trends:⁴

Estimated number of infants* affected by prenatal exposure, 2016

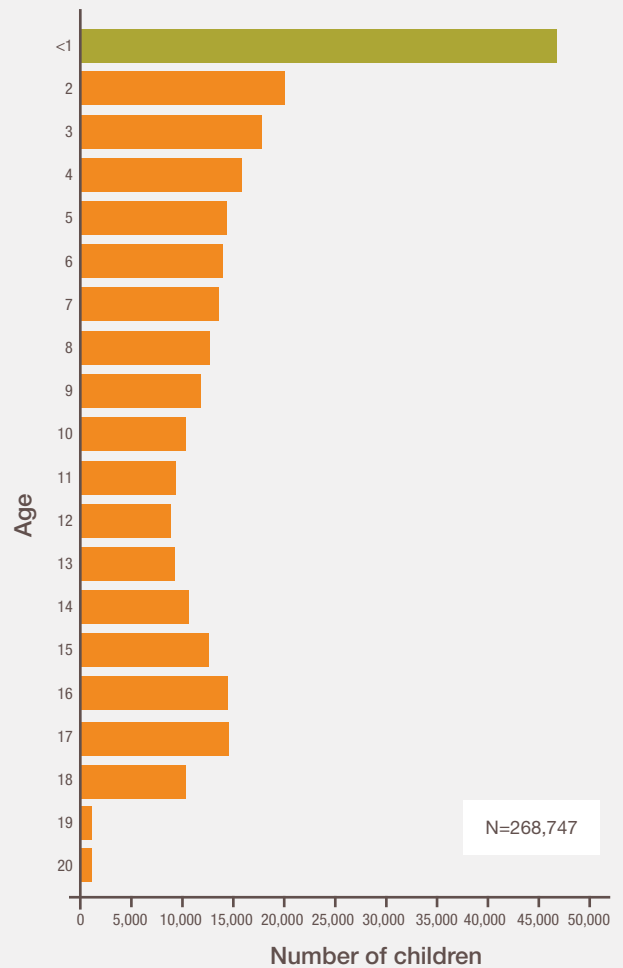


*Percentages are applied to the almost 4 million infants born in 2016 (Source: National Vital Statistics Report, 2017)

**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: Substance Abuse and Mental Health Services Administration. (2014). Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, NSDUH, Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Source: National Vital Statistics Report, 2014

Number of children who entered foster care, by age at removal in the United States, 2015



Note: Estimates based on all children who entered foster care during Fiscal Year.

Source: AFCARS Data, 2016

Legislative and policy context

The plan of safe care for infants requires a state that receives Child Abuse Prevention and Treatment Act (CAPTA) grants to (1) address the health and substance use disorder treatment needs of the affected infant and family or caregiver, and (2) specify a system for monitoring the local provision services in accordance with these state requirements.⁵

The Comprehensive Addiction and Recovery Act (CARA) of 2016 built on previous legislation in 2003 and 2010 to provide the framework for comprehensively addressing the opioid epidemic, including planning for the safe care of infants born with substance use disorders or showing withdrawal symptoms. CARA addresses six areas that are necessary for a coordinated response: prevention, treatment, recovery, law enforcement, criminal justice reform, and overdose reversal.

The following section summarizes the original 2003 federal legislation, which established requirements for states to create plans of safe care for infants affected by substance abuse or withdrawal symptoms, as well as the subsequent amendments to this legislation in 2010 and 2016.

The Keeping Children and Families Safe Act of 2003 created new conditions for states to receive grant allocations under the Child Abuse and Prevention Treatment Act (CAPTA). The grant conditions were

intended to provide needed services and support for infants, their mothers, and their families, and to ensure a comprehensive response to the effects of prenatal drug exposure. The legislation required that governors of states receiving a CAPTA grant assure the federal government that they have **policies and procedures** for the following:

- Appropriate referrals to child protection service systems and for other appropriate services, 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 system 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.**
- 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.



The **CAPTA Reauthorization Act of 2010** made further changes related to prenatal exposure issues. The Act specifically required the identification of infants affected by **Fetal Alcohol Spectrum Disorder (FASD)** and a requirement for the development of **Plans of Safe Care** for infants affected by FASD. It also **added the following reporting requirements** to the Annual Progress and Services Report related to the number of children:

- Referred to a child protective services system born with and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure or FASD.
- Involved in a substantiated case of abuse or neglect determined to be eligible for referral, and the number referred to agencies providing early intervention services under Part C of the Individuals with Disabilities Education Act.

The **Comprehensive Addiction and Recovery Act (CARA)** of 2016 went into effect July 22, 2016, including Title V, Section 503 - "Infant Plan of Safe Care." The 2016 changes to CAPTA were made in the context of attention generated by the nation's prescription drug and opioid epidemic. Changes include:

- **Removes** the term "illegal" when discussing substance abuse.
- **Requires** that Plans of Safe Care address the needs of both the infant and the affected family or caregiver.
- **Specifies data reporting** on affected infants and Plans of Safe Care, including the number of infants: (a) identified as being affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or FASD; (b) With a Plan of Safe Care; and (c) Receiving referrals for appropriate services — including services for the affected family or caregiver.
- **Requires** that states develop and implement monitoring systems for Plans of Safe Care to determine whether and in what manner local

entities are providing, in accordance with state requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver.

The Administration for Children and Families has provided the following additional guidance to jurisdictions on implementing this legislation:

Program Instruction (PI) 1603 (2016) offers updates to the CAPTA state plan requirement on Services to Substance-Exposed Newborns.⁶

Information Memorandum (2016) informs states of the enactment of CARA and provides basic information on the resulting changes in CAPTA for child abuse or neglect prevention and treatment programs.⁷

Program Instruction 1702 (2017) guides states on implementing provisions in CAPTA, as amended by CARA, relating to infants affected by substance abuse.⁸

Key implementation considerations

The National Center on Substance Abuse and Child Welfare (NCSACW) provides national expertise and technical assistance to support states in making policy and practice changes that improve outcomes for children and families affected by substance use disorders. NCSACW has worked intensively with states on developing Infant Plans for Safe Care,⁹ and recommends jurisdictions consider and address the following components:

1. **Cross-system partnerships:** The successful development and implementation of Plans of Safe Care requires the active **engagement of multiple service systems in collaboration with child welfare**, such as obstetricians and pediatricians; substance use, mental health and medication-assisted treatment; public health and maternal health; and, early intervention providers and others.
2. **Governor's office support:** Since there are many systems involved and no single entity is

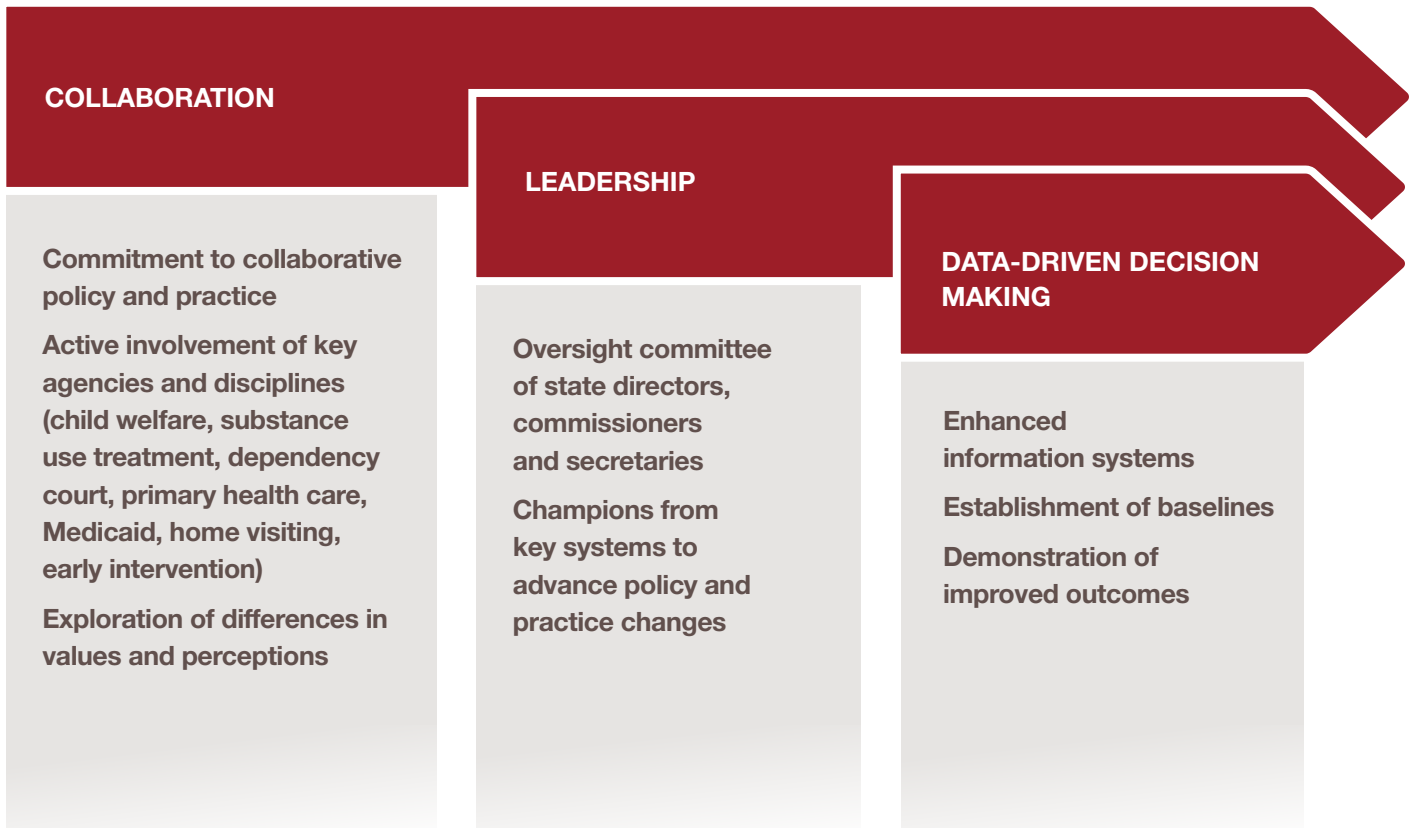
ultimately responsible, the governor's office has a critical role to play in leading and driving the state collaboration and ensuring that infants and families' needs are being met, often through the creation of a **state-level task force**.

- 3. **Clear guidance:** Plans of Safe Care are often confused with child welfare safety plans. In addition, the notification requirements are not the same as a report to the child hotline. **Clarification on the purpose and extent** of each of these documents is necessary for successful use and implementation, as is the distinction between notification and a report of child abuse or neglect. CAPTA requires health care providers notify child protective services of all infants born and identified as affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, but it is ultimately the child protection agency's responsibility to assess level of risk and determine

whether the circumstance constitutes child abuse or neglect under state law.¹⁰

- 4. **Local implementation teams:**
Community-based teams are effective vehicles for the implementation of a task force's recommendations and selected strategies.

A single system does not have sufficient resources, information, or influence to adequately serve pregnant women with opioid use disorders and their infants and families. Strong leadership, however, can facilitate the coordination and collaboration of multiple systems, however, and create cross-system linkages that coordinate services from prevention to intervention to treatment. The NCSACW contends that jurisdictional leaders can improve services that address needs created by opioid disorders by focusing on three key elements: (1) strong leadership, (2) interagency and interdisciplinary collaboration, and (3) conscientious reliance on data.



Jurisdictional initiatives: examples from the field

Some jurisdictions have begun to find modest improvements resulting from their implementation of new and enhanced interventions that support families affected by substance use disorders. These interventions include building collaborative teams and developing programs and services that address various points of intervention.

Building collaborative teams

Cross-system collaboration presents challenges that can be effectively addressed by building and fostering a collaborative team that includes a steering committee, core team, and work groups. The Substance Abuse and Mental Health Services Administration (SAMHSA) provides guidance and tools for building a collaborative team¹¹ that reflect the four basic planning steps and related questions to aid the development of the team:

1. Set the stage for collaboration

- What practices and policies are in place in each team member's service system and in the other service systems?
- What partner mandates and priorities are likely to affect, and possibly limit, their level of involvement?
- What is the terminology that each team member's organization uses most frequently and how do the organizations define these terms (e.g., "treatment")?
- What are the baseline resources, resource gaps, and barriers in each system?
- What needs to be addressed and improved, particularly from the perspective of mothers, children, and family members, to provide the necessary care?

2. Engage key stakeholders and establish work groups

- Who is currently working on the issue being tackled?

- What do each of these individuals or organizations contribute?
- Which key stakeholders are missing from the conversation?

3. Define shared goals

- What is each represented agency's role in achieving shared priorities and outcomes? (e.g., How does child welfare services support parent recovery? How do treatment providers for parents support child safety and permanency and family well-being?)
- What does each team member believe about the nature of substance use and substance use disorders?
- Do team members agree on the markers of effective practice and service delivery? What are those markers?
- How is "best interest" defined for infants? For mothers? For families? Do mothers have sufficient input in determining this?
- What do team members or policy leaders believe about the use of medication-assisted treatment (MAT) for women who are pregnant or breastfeeding?
- What do team members believe constitutes recovery?

4. Identify strategies and jointly monitor outcomes

- What are the desired outcomes for each system and how is success defined and measured? What are baseline levels for clients, and are there better (or additional) indicators available to demonstrate progress?
- What are the metrics (e.g., number of pregnant women treated with MAT) that need to be developed and tracked to effectively measure success over time?
- What is the preferred method for communicating progress related to key indicators (e.g., a report

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card or dashboard) to ensure transparency and promote accountability for results?

- What is the plan for sustaining change and how will the team document, maintain, and build on the collaboration's institutional knowledge?

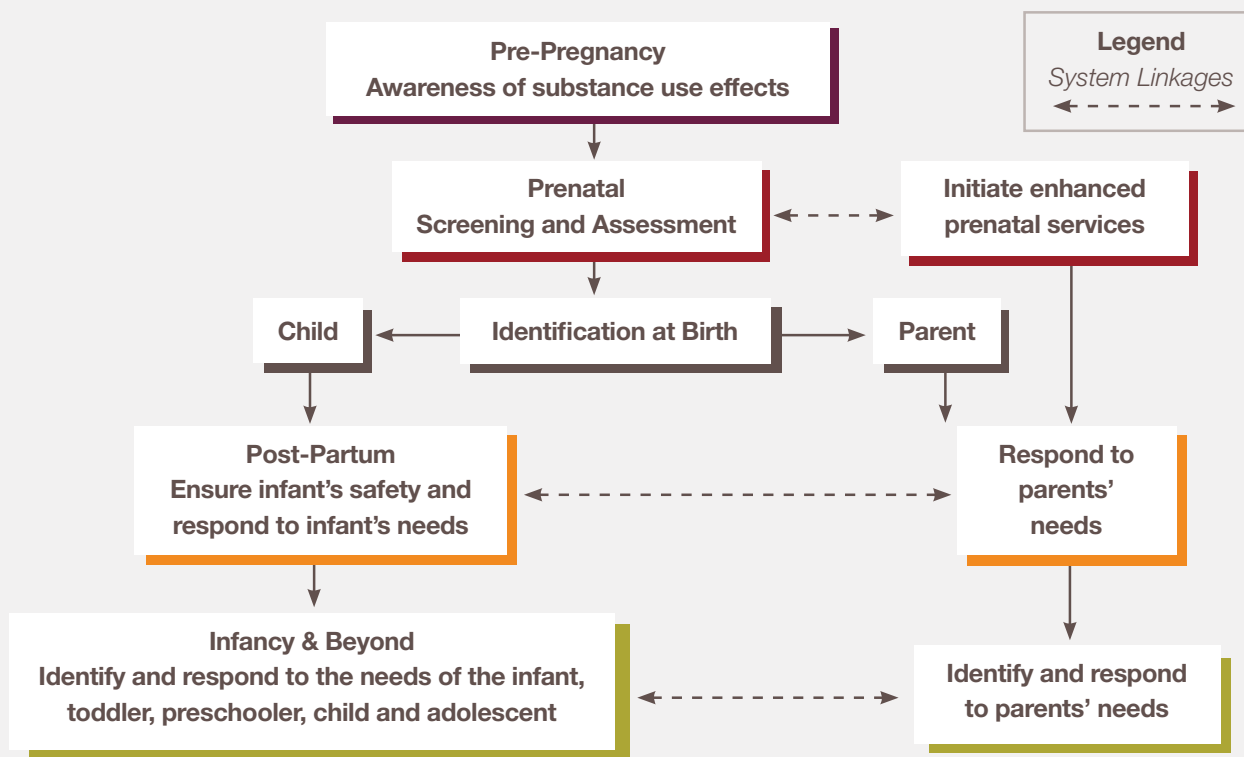
Additional suggestions for strengthening collaboration between systems working with pregnant women with opioid and other substance use disorders

can be found in the September 2017 webinar, [Supporting Families Affected by Opioids and Other Substance Use Disorders](#).

Points of intervention

Jurisdictions are updating their policies and practices to include evidence-informed services that address various points of intervention: pre-pregnancy, prenatal, at birth, post-partum, and at infancy and beyond (see flow chart¹² provided below).

Policy and Practice Framework: 5 Points of Intervention



Carpenter, L., Gresham, J., Green, M., Terplan, M. (2016) *Developing a Plan of Safe Care for Infants with Prenatal Substance Exposure, their Mothers and Caregivers: Collaborative Approaches Learned in a Six Site Initiative*. Presented August 1, 2016, for the CWLA 2016 National Conference Advancing Excellence in Practice & Policy: What Works For Families Affected by Substance Use. Orange County, CA

Jurisdictional examples

Jurisdictional initiatives have focused on four core areas:

1. Screening, identification, and referral of pregnant women with Substance Use Disorders (SUDs)
2. Developing guidelines for working with pregnant women and their infants
3. Establishing hospital standards and discharge plans for infants and mothers
4. Creating state strategies for CAPTA compliance and Plans of Safe Care

The following table provides examples of these strategies, including sample Plan of Safe Care and CAPTA implementation protocols, forms gathered from publicly available documents or shared by jurisdictional partners,¹³ and projects implemented by six states recipients of NCSACW's In-Depth Technical Assistance.¹⁴

JURISDICTIONAL EXAMPLES

Jurisdiction	Source	Description
Connecticut	https://www.ncsacw.samhsa.gov/technical/sei-idta.aspx?id=145	<p>This NCSACW project marked Connecticut's first attempt to coordinate an inter-agency effort to address substance exposure among infants related to FASD and Neonatal Abstinence Syndrome (NAS), implementing a statewide infrastructure development program to address FASD/NAS that includes a financial mapping component to identify opportunities for financial support for workforce development, policy, and practices recommended by the inter-agency collaboration during the planning process. Connecticut seeks to strengthen the existing Recovery Specialist Voluntary Program (RSVP) collaboration and its linkages across child welfare, addiction treatment, and family courts to improve outcomes for substance exposed infants and their families. The program focuses on the following goals:</p> <p>Goal 1: Assessing the state's capacities and needs related to FASD/NAS to: 1) Identify data infrastructure strengths and challenges; 2) Establish policy and develop infrastructure for prevention and intervention services including workforce development; 3) Develop recommendations for improving the state's data infrastructure to collect data on prenatal exposure.</p> <p>Goal 2: Developing a statewide plan to address FASD and NAS in a coordinated fashion and to offer a continuum of services to vulnerable families, including prevention, education about services and supports, early intervention, and intensive intervention.</p> <p>Goal 3: Conducting financial and asset mapping to identify, coordinate, and maximize fiscal resources to support ongoing FASD/NAS efforts.</p>

JURISDICTIONAL EXAMPLES

Jurisdiction	Source	Description
Delaware	http://dhss.delaware.gov/dhss/pressreleases/2017/mecadv_09082017.html	Delaware's Child Protection Accountability Commission has a sub-committee on Substance Exposed Infants working to develop a template for Plans of Safe Care. The template borrows information used by other states and is under review by the team that is providing Delaware with in-depth technical assistance through the NCSACW. The template's first part is an assessment of the mother, father, and other affected caregivers, while the second part outlines services that will be in place for the infant and family, such as home visiting, substance abuse treatment, etc. Delaware plans to pilot this process in two of six birthing hospitals before rolling it out statewide by the beginning of 2018. Delaware is currently in the process of transitioning to a new SACWIS, so there will be some additional challenges with the necessary reporting elements.
Georgia	http://odis.dhs.ga.gov/ViewDocument.aspx?docid=3007123&verId=1	Georgia has had a Plan of Safe Care (POSC) process in place since 2013 that it updated in 2017 to include the provisions enacted by the Comprehensive Addiction and Recovery Act (CARA).
Kentucky	https://www.ncsacw.samhsa.gov/technical/sei-idta.aspx?id=144	<p>Kentucky is moving toward a "system of care" to address the concerns surrounding substance use prior to pregnancy through post-delivery and beyond by developing policies and implementing coordinated services that intervene at any of the five stages of intervention: pre-pregnancy, prenatal, birth, neonatal, and during child development. Kentucky has a two-pronged approach: providing expanded prevention services to women of child bearing age, both prior to and during pregnancy; expanding treatment services to include universal screening, brief intervention, and referral to treatment services (SBIRT) as a routine part of pre-natal care; and expanding the availability of treatment, including MAT, and support services to women at any of the five stages of intervention. Kentucky's NCSACW project is focusing on the following goals:</p> <p>Goal 1: Developing a comprehensive system to address needs of infants experiencing NAS while providing an integration of supportive services for pregnant and parenting mothers and their babies.</p> <p>Goal 2: Developing and implementing a statewide protocol for ensuring comprehensive assessment and Infant Plans for Safe Care.</p> <p>Goal 3: Establishing guidelines for hospital protocol.</p>

JURISDICTIONAL EXAMPLES

Jurisdiction	Source	Description
Maryland	http://dhr.maryland.gov/documents/SSA%20Policy%20Directives/Child%20Welfare/SSA%2012-17%20Substance%20Exposed%20Infants%20Care%20Plan.pdf	<p>Maryland’s 2011 Policy Directive requires local departments of social services (LDSS) to identify a coordinator who will implement the Substance Exposed Infant Care Plan within their agency. Coordinators will form teams of staff who have experience working with families with alcohol and drug abuse problems and who have a working knowledge of child protective services, including investigation, continuing services, and foster care services.</p> <p>At the same time, coordinators will form teams with partnering agencies, including hospital(s), the health department’s divisions of maternal and child health and of addictions and mental health, treatment providers, and other agencies who share these clients. This team will meet regularly to coordinate services for substance exposed infants, their mothers, and families, and to identify resources, barriers to care, and gaps in services. The team’s goal is to streamline services so that agencies do not duplicate services or work at cross purposes.</p>
Minnesota	https://www.ncsacw.samhsa.gov/technical/sei-idta.aspx?id=143	<p>Minnesota is working with tribal nations to improve communication across systems and employ a unified response to the opioid crisis, which has resulted in a significant increase of babies being born with NAS. Minnesota’s NCSACW project has focused on the following goals:</p> <p>Goal 1: Screening and assessing pregnant women, substance exposed infants, and their families to ensure that they are identified in a consistent, uniform, and timely manner across all systems.</p> <p>Goal 2: Improving joint accountability and shared outcomes by working with partners to develop a collaborative approach to serving substance exposed infants and their families.</p> <p>Goal 3: Providing services for pregnant women, substance exposed infants, and their family using evidence-based practices and programs that meet the needs of the target populations and have processes in place for monitoring use and effectiveness of these programs.</p>

JURISDICTIONAL EXAMPLES

Jurisdiction	Source	Description
New Jersey	https://www.ncsacw.samhsa.gov/technical/sei-idta.aspx?id=142	<p>New Jersey participated in SAMHSA’s Prescription Drug Abuse Policy Academy and is receiving technical assistance to align and coordinate the numerous initiatives that are underway to address prescription drug abuse. To that end, the state is developing a comprehensive, unified plan where each initiative supports and enhances the other and that will include a focus on NAS and Substance Exposed Infants (SEI), with an emphasis on addressing the entire spectrum of SEI needs and improve collaboration to address the multiple SEI intervention opportunities. New Jersey’s NCSACW project has focused on the following goals:</p> <p>Goal 1: Increasing perinatal SEI screening at multiple intervention points (health system, SUD/MH system).</p> <p>Goal 2: Leveraging existing programs and policy mechanisms to collaboratively increase the rate at which women screening positive on the 4p’s Plus get connected for a comprehensive assessment such as through establishing formal warm-handoffs and other safety net measures.</p> <p>Goal 3: Leveraging existing programs and policy mechanisms to collaboratively increase the rate at which women delivering SEIs and their babies and any other eligible children receive early support services for which they are eligible.</p>
Virginia	https://law.lis.virginia.gov/vacodeup-dates/title63.2/section63.2-1509/ https://www.ncsacw.samhsa.gov/technical/sei-idta.aspx?id=141	<p>Virginia passed legislation in 2017 to bring it into alignment with the CARA and CAPTA changes from 2016. A part of that legislation addressed Substance Exposed Infants, requiring a Plan of Safe Care to be developed for any substance exposed infant Virginia works with. Virginia has developed a sample Plan of Safe Care that it is providing as part of the CPS guidance manual along with training and education about Plans of Safe Care. The NCSACW project focuses on evaluating current efforts, developing strategies to better respond as a system to substance exposed infants, and implementing recommendations from the interagency workgroup plan. Virginia focused on the following goals:</p> <p>Goal 1: State agencies will adopt a shared vision and coordinated systems approach that includes outreach, referral, medical care, behavioral health, and child welfare treatment services.</p> <p>Goal 2: Virginia will evaluate the implementation and effectiveness of state laws that address perinatal substance use, and identify needed updates and changes as well as strategies to improve their implementation.</p> <p>Goal 3: Virginia will develop a system of care, e.g., medical, home visiting, behavioral health and child welfare, that ensures that all women of childbearing age receive screening, brief intervention, and referral to treatment services for behavioral health risks.</p>

JURISDICTIONAL EXAMPLES

Jurisdiction	Source	Description
Washington	https://www.dshs.wa.gov/sites/default/files/FSA/forms/pdf/15-491.pdf	<p>Washington’s Department of Children and Families Services Policy requires all DCFS staff to: Complete a Plan of Safe Care DSHS 15-491 with the family as required by the Child Abuse Prevention and Treatment Act (CAPTA) when a newborn:</p> <ol style="list-style-type: none"> 1. Is identified as substance affected by a medical practitioner. Substances are defined as alcohol, marijuana, and any drug with abuse potential, including prescription medications. 2. Is born to a dependent youth. <p>The form includes a plan and person responsible for medical care, safe housing, safe sleep, routine child care, emergency child care, parenting support, crisis planning, service referrals, and referrals to resources.</p>
West Virginia	https://www.ncsacw.samhsa.gov/technical/sei-idta.aspx?id=140	<p>The overarching goals of this NCSACW project are to achieve healthy, drug-free beginnings for newborns, improved health and recovery outcomes for mothers and children, and fewer future substance-exposed births. Partners are working together to integrate multiple systems of care for pregnant women and their families across the state, with the goal of improving pregnancy and birth outcomes and enhancing the long-term health and development of children.</p> <p>West Virginia focused on the following goals:</p> <p>Goal 1: Decrease the negative effects of prenatal substance exposure on neonates.</p> <p>Goal 2: Reduce stigma associated with receiving behavioral health and recovery-related supportive services.</p> <p>Goal 3: Promote consistent screening and interventions among physicians and other health providers.</p> <p>West Virginia seeks to develop the following strategies, policies and practices which, when implemented, will strengthen the system of care for moms and babies throughout the state: (1) Provide prevention, intervention of FASD and NAS training for physicians, educators, criminal justice system, and social service providers; (2) Partner with key stakeholders to coordinate all related programs statewide; (3) Fund “moms and babies programs” that achieve proven health and recovery outcomes for mothers and children and prevent future substance-exposed pregnancies; and (4) Block legislation or other state policies that might increase service barriers or offer punitive responses for women seeking services.</p>

What Are Infant Plans of Safe Care and Some Examples of State Responses to Infants Affected by Substance Abuse?

- 1 U.S. Department of Health and Human Services, Administration for Children and Families. (2016). *Information memorandum: NEW LEGISLATION- Public Law 114-198, the Comprehensive Addiction and Recovery Act of 2016*. Retrieved from <https://www.acf.hhs.gov/sites/default/files/cb/im1605.pdf>
 - 2 Carpenter, L., Gresham, J., Green, M., & Terplan, M. (2016). Developing a plan of safe care for infants with prenatal substance exposure, their mothers and caregivers: Collaborative approaches learned in a six site initiative. http://www.cwla.org/wp-content/uploads/2016/09/SuperSession_SEI_Part1_Final.pdf
 - 3 National Center on Substance Abuse and Child Welfare. (2017). *Child welfare and treatment statistics*. Retrieved from <https://www.ncsacw.samhsa.gov/resources/child-welfare-and-treatment-statistics.aspx>
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 - 6 U.S. Department of Health and Human Services, Administration for Children and Families. (2016). *Program Instruction 1603*. Retrieved from: <https://www.acf.hhs.gov/sites/default/files/cb/pi1603.pdf>
 - 7 U.S. Department of Health and Human Services, Administration for Children and Families. (2016). *Information memorandum: NEW LEGISLATION- Public Law 114-198, the Comprehensive Addiction and Recovery Act of 2016*. Retrieved from <https://www.acf.hhs.gov/sites/default/files/cb/im1605.pdf>
 - 8 U.S. Department of Health and Human Services, Administration for Children and Families. (2017). *Program Instruction 1702*. Retrieved from: <https://www.acf.hhs.gov/sites/default/files/cb/pi1702.pdf>
 - 9 Carpenter, L., Gresham, J., Green, M., & Terplan, M. (2016). *Developing a Plan of Safe Care for Infants with Prenatal Substance Exposure, their Mothers and Caregivers: Collaborative Approaches Learned in a Six Site Initiative*. CWLA 2016 National Conference, August 1, 2016. Retrieved from http://www.cwla.org/wp-content/uploads/2016/09/SuperSession_SEI_Part1_Final.pdf
 - 10 Carpenter, L., Gresham, J., Green, M., & Terplan, M. (2016). *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*. CWLA 2016 National Conference, August 1, 2016. Retrieved from http://www.cwla.org/wp-content/uploads/2016/09/SuperSession_SEI_Part2_Final.pdf
 - 11 National Center on Substance Abuse & Child Welfare. (2017). *Substance Exposed Infants In-Depth Technical Assistance (SEI-IDTA)*. Retrieved from <https://www.ncsacw.samhsa.gov/technical/sei-idta.aspx>
 - 12 National Center on Substance Abuse & Child Welfare. (2017). *Summary 2017 Policy Academy: Improving Outcomes for Pregnant and Postpartum Women with Opioid Use Disorders and Their Infants, Families and Caregivers*. Retrieved from https://www.ncsacw.samhsa.gov/files/Policy_Academy_Dissemination_Brief.pdf
 - 13 U.S. Department of Health and Human Services, Administration for Children and Families, Administration for Children, Youth and Families, Children's Bureau. *Child Welfare Policy Manual*. Retrieved from https://www.acf.hhs.gov/cwpm/public_html/programs/cb/laws_policies/laws/cwpm/index.jsp
 - 14 Substance Abuse and Mental Health Services Administration. (2016). *A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders*. HHS Publication No. (SMA) 16-4978. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf
- For a national overview of state efforts to develop Infant Plans of Safe Care and their associated challenges, please review the January 2018 GAO report, [SUBSTANCE AFFECTED INFANTS: Additional Guidance Would Help States Better Implement Protections for Children](#).
- 15 Slide from: http://www.cwla.org/wp-content/uploads/2016/09/SuperSession_SEI_Part1_Final.pdf
 - 16 AR, DE, MD and WA were created prior to the 2016 changes in federal legislation.
 - 17 The National Center on Substance Abuse and Child Welfare (NCSACW) is providing in-depth technical assistance to strengthen the capacity of states and local jurisdictions to improve the safety, health, and well-being of substance exposed infants, and the recovery of pregnant and parenting women and their families. The 18-month initiative, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), supports six state efforts to strengthen collaboration and linkages across child welfare, addiction treatment, medical providers, early child care and education systems. For more information, please see: <https://www.ncsacw.samhsa.gov/technical/sei-idta.aspx>

P 800.228.3559

P 206.282.7300

F 206.282.3555

casey.org | KMResources@casey.org

