

Pennsylvania Plan of Safe Care Guidance

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Part I - Background

Chapter 1

Introduction:

Each year, thousands of infants born in Pennsylvania are identified as having been prenatally exposed to substances, including alcohol (OpenDataPA, 2018). The short-and long-term effects for the infant will vary impacted by the type of prenatal substance exposure, including co-exposure (e.g., opioids and benzodiazepines), interventions immediately utilized to promote attachment between the mother and infant, postnatal environmental factors and the infant's connection to stable caregivers in infancy and early childhood. The current research remains too limited to draw any conclusions about the full and long-term consequences prenatal substance exposure has during infancy and throughout childhood. It is widely understood that prenatal exposure to substances has the potential to cause a wide spectrum of physical and developmental challenges for these infants. Ongoing stability and well-being challenges may arise for infants who have been prenatally exposed to substances if the caregiver's substance use has not been addressed with appropriate treatment, including long-term recovery support (National Center for Substance Abuse and Child Welfare (NCSACW), n.d.).

A child's early experiences affect brain development (Centers for Disease Control and Prevention (CDC), 2018). Adverse Childhood Experiences (ACEs), like being separated from a parent or living in a home where drugs and alcohol are misused, are linked to risky health behaviors, chronic health conditions, low life potential and early death (CDC, 2016). As the number of ACEs increases, so does the risk for these outcomes (CDC, 2016).

Early identification of infants with prenatal substance and alcohol exposure combined with the infant being connected to supported caregivers and appropriate developmental interventions can improve outcomes. Universal screening of pregnant women for drug or alcohol use and engaging women identified as having a substance use disorder (SUD) into clinically appropriate treatment and other services is an essential element of prenatal care and has demonstrated strong benefits by mitigating or preventing negative birth outcomes (American College of Obstetricians and Gynecologists (ACOG), 2018).

The federal Child Abuse Prevention and Treatment Act (CAPTA) authorizes funding for state grants when a state has "policies and procedures" ensuring that health care providers refer infants that are identified as affected by substance abuse, experience withdrawal symptoms or have Fetal Alcohol Spectrum Disorders (FASD) in order for a multidisciplinary team of professionals to develop a Plan of Safe Care addressing "the health and substance use disorder treatment needs of the infant and affected family or caregiver."

On June 28, 2018, Governor Tom Wolf signed Act 54 of 2018 updating Pennsylvania law, consistent with CAPTA, to require health care professionals, including those involved in the delivery or care of an affected infant or encountering an infant up to age one outside a hospital setting, notify the Pennsylvania Department of Human Services (DHS) so that a Plan of Safe Care can be developed. State law stipulates that this notification by health care providers "shall not constitute a child abuse report."

Act 54 directed the Pennsylvania Departments of Drug and Alcohol Programs (DDAP), Health (DOH) and Human Services (DHS) to prepare “interagency protocols” to support local multidisciplinary teams (MDT) that will identify, assess and develop a Plan of Safe Care for infants born affected by substance use or withdrawal symptoms resulting from prenatal drug exposure or FASD. This is a notable shift from the previous law which limited notification to DHS to only those cases including illegal substance use and included an exception to reporting if the pregnant woman was receiving active treatment for a substance use disorder.

Chapter 2

Impact of Substance Exposure and Commonwealth Responses:

Impact of Substance Exposure on Prenatal and Postnatal Outcomes

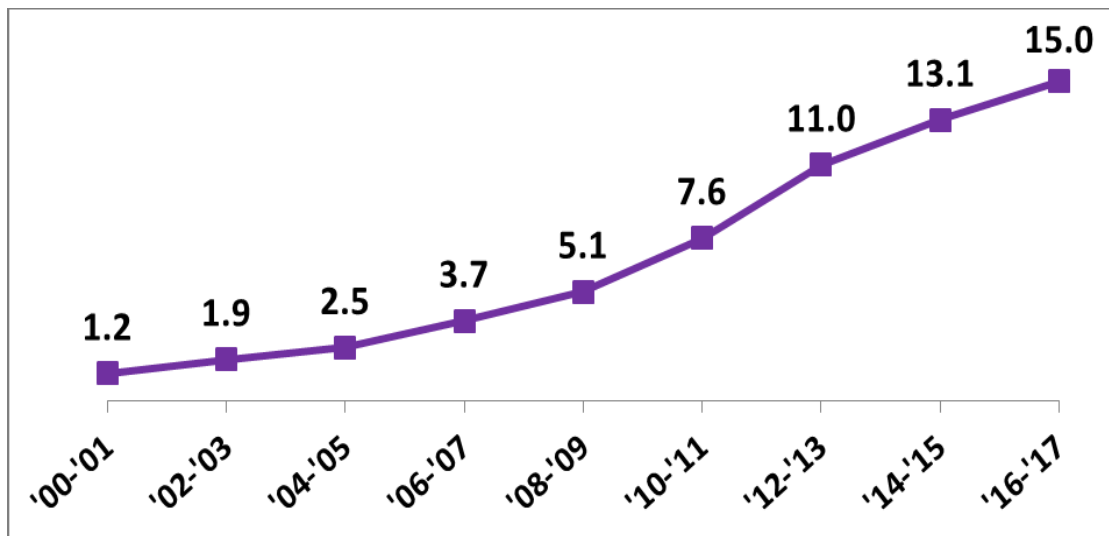
Prenatal exposure to substances, including alcohol, has the potential to cause a wide spectrum of physical, emotional and developmental problems for infants. The effects can be significant and long-lasting, especially if the exposure is not detected and the effects are not treated immediately. Ongoing challenges can exist in the stability and well-being of infants who have been prenatally exposed if parental substance use disorders are not addressed with appropriate treatment and long-term recovery support.

Substance exposure in utero has been associated with physical birth defects in some instances as well as increased risk of regulatory and neuropsychological difficulties. It is a critical public health issue that leads to several harmful maternal and neonatal outcomes, including consequences to the mother-infant dyad. A review of the Pennsylvania-specific data below regarding Neonatal Abstinence Syndrome (NAS) suggests that without effective interventions NAS will continue to grow at alarming rates.

Neonatal Abstinence Syndrome

Each year, an estimated 15% of infants are affected by prenatal alcohol or substance exposure (NCSACW, n.d.). In Pennsylvania, the rate of newborns with NAS was 15.0 per 1,000 newborn hospitalizations in FY 2016-2017, an increase of 1,096% from FY 2000-2001 at a rate of 1.2 (Pennsylvania Health Care Cost Containment Council (PHC4), 2018).

Table 1. Rate of NAS



Rate of Neonatal Abstinence Syndrome per 1,000 Newborn Stays, FYs 2000-2001 to FY 2016-2017. Each data point represents two years of data (PHC4, 2018).

Neonatal and Maternal Hospital Stays

Neonatal and maternal hospital stays for Pennsylvania residents where a substance-related condition was present has increased by 250% since FFY 2000 (PHC4, n.d.). Between FFY 2000 and FFY 2015, the rate increased from 5.6 to 19.5 per 1,000 neonatal stays, largely driven by a rise in opioid use (PHC4, n.d.). A substance-related condition was present in nearly 1 in 50 neonatal hospital stays in FFY 2015, which equated to 2,691 neonatal stays out of 138,149 total neonatal stays (PHC4, n.d.). In FFY 2000, there were 788 neonatal stays where a substance-related condition was present out of 141,540 total neonatal stays (PHC4, n.d.).

NAS was present in about 82% of neonatal substance-related stays in FFY 2015 (PHC4, n.d.). The rate of NAS increased from 1.6 to 16.0 per 1,000 neonatal stays from FFY 2000 to FFY 2015 (PHC4, n.d.). In State FY 2017, there were 1,912 NAS-related newborn stays in Pennsylvania (PHC4, 2018). Through the opioid disaster declaration, 1,986 cases of infants diagnosed with NAS were reported to the Department of Health by 88% of birthing hospitals and birthing centers in 2018 (OpenDataPA, 2018). There was evidence of maternal substance use in 3,289 newborn stays, however not all of these newborns developed withdrawal signs (PHC4, 2018). NAS was diagnosed in 58% of the newborn stays involving maternal substance use in State FY 2017 (PHC4, 2018). Withdrawal signs develop due to the newborn no longer being exposed to the substance for which they have become physically dependent.

Newborns with NAS typically require more days in the hospital and are much more likely to suffer from complications compared to all other newborns. The average hospital stay for newborns with NAS was 17.1 days compared to 3.5 days for all other newborn stays (PHC4, 2018). NAS babies are more likely to have low birth weight, prematurity, difficulty feeding and respiratory distress compared to all other newborns.

Complication	NAS Newborn Stays	All Other Newborn Stays
Low birth weight	15.7%	6.6%
Prematurity	14.8%	8.1%
Difficulty feeding	14.9%	3.5%
Respiratory distress	24.0%	9.3%

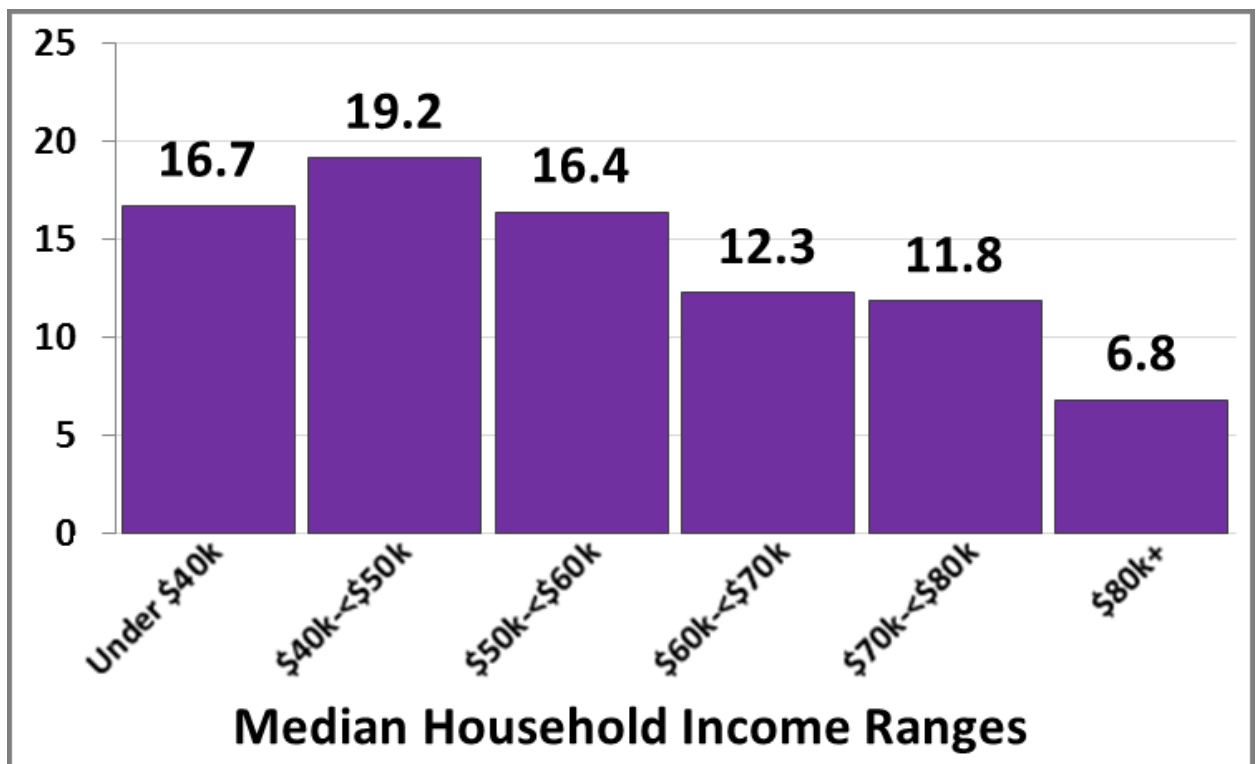
(PHC4, 2018)

Maternal stays related to substance use have also increased. The rate of these maternal hospital stays increased from 14.8 to 32.4 per 1,000; this is an increase of 119% from FFY 2000 to FFY 2015 (PHC4, n.d.). A substance-related condition was present in nearly 1 in 30 maternal hospital stays in FFY 2015, which equated to 4,615 maternal stays out of 142,502 total maternal stays (PHC4, n.d.). In FFY 2000, there were 2,293 maternal stays where a substance-related condition was present out of 154,971 total maternal stays (PHC4, n.d.).

Of the 4,615 maternal stays in FFY 2015, 51.9% involved opioids. Between FFY 2000 and FFY 2015, maternal hospital stays involving opioids increased from 2.8 to 16.8 per 1,000, which includes stays for pregnant women receiving medication-assisted treatment (MAT) (PHC4, n.d.). There was a decrease in maternal stays involving alcohol and cocaine between FFY 2000 and FFY 2015, at 36% (2.7 to 1.8 per 1,000) and 61% (7.4 to 2.9 per 1,000) respectively (PHC4, n.d.).

NAS rates are highest among white, non-Hispanic newborns, occurring at a rate of 19.5 per 1,000 newborn hospitalizations (PHC4, 2018). The rate for black, non-Hispanic newborns was 7.2. NAS rates varied by income. Rates were highest (at 19.2 per 1,000 hospitalizations) for newborns from neighborhoods with median household incomes in the range of \$40,000 to <\$50,000 and lowest (6.8 per 1,000) for newborns from areas with the highest incomes of \$80,000 and above (PHC4, 2018).

Table 2. Median Household Income of babies born with NAS



Rate of Neonatal Abstinence Syndrome per 1,000 Newborn Stays by Income Category, FY 2017 (PHC4, n.d.).

Women with substance use disorder and their infants face barriers to care and/or legal consequences. The goal of optimal care is to protect against prenatal substance exposure. The stigma associated with substance use disorder during pregnancy and after birth, along with the lack of understanding among healthcare professionals and systems about how to treat women with substance use disorder, results in the reluctance to provide care for such women. These barriers can prevent women from receiving essential prenatal care or treatment for their substance use disorder until they are close to delivery or in labor. Without preventative

treatment, pregnant women with substance use disorder face increased risks of preterm delivery and delivering an infant with low birth weight.

Effective prenatal interventions for substance use disorder exist and healthy outcomes can occur for both the mother and the infant when healthcare professionals recognize and treat the woman's substance use disorder as part of her comprehensive prenatal care. No single agency, organization or professional can meet the unique needs of a mother, caregiver or infant alone. Successful physical and behavioral health care treatment is grounded in a multi-disciplinary approach that uses the clinical expertise of team members to ensure that the level of service is consistent with family needs.

Creation of Multi-Disciplinary Workgroup on Infants with Substance Exposure (MDWISE)

Federal changes to the CAPTA legislation became effective in July 2016. As a result of these changes, the MDWISE work group was created to discuss and formulate implementation of the updated requirements. The mission of the group is to minimize prenatal exposure to substances and improve infant, child and family outcomes through a public health approach. The group consists of 30-40 individuals across various disciplines, including DDAP, DOH and DHS, along with system partners who are committed to the mission of the workgroup and are engaged in the treatment of impacted women and infants. These partners include experts from the medical field, including neonatologists, obstetricians, pediatric and family physicians, and nurses, representatives from the child welfare field, courts, law enforcement officials, substance use disorder specialists, child advocates and legislative staff.

Overview of Centers of Excellence

Governor Wolf's budget included funding for 45 Opioid Use Disorder (OUD) Centers of Excellence (COEs) to increase access to OUD services and improve engagement in the continuum of care necessary for recovery. In 2016, the legislature appropriated funds to implement these programs. COEs became operational in early 2017 and have helped nearly 15,700 individuals in Pennsylvania get treatment for their OUD. The COEs are re-imagining what the care delivery system looks like for people with OUD. COEs have been charged with achieving three goals:

1. Integrating and coordinating physical health care with behavioral health care to treat the whole person;
2. Engaging individuals across the continuum of care by using community-based care management teams; and
3. Increasing access to Medication Assisted Treatment (MAT).

COEs are important members of the communities they serve and they reach out to patients in a variety of ways. Some COEs have well-defined "warm handoff" protocols established with local emergency departments. When someone comes to the emergency department experiencing a drug overdose, COE staff will meet that individual in the hospital to talk to them about how important it is to get help. Other COEs partner closely with primary care providers. When a primary care provider suspects that his or her patient is struggling with dependency on opioids, they might refer that patient to a COE. Still other COEs work closely with law enforcement to

re-direct individuals who have been involved in criminal activity as a result of their OUD to help them seek a life of recovery. Several of the COEs focus exclusively on pregnant women.

The hallmark of a COE is the way that COE clients receive full recovery support and assistance in navigating the continuum of care. COEs serve as a hub in a hub-and-spoke model, where they build partnerships with referral resources so that they can connect clients to community services, both clinical and non-clinical. COEs provide recovery support services either directly or through these referral pathways. They can help clients with needs such as education and training, housing, employment or transportation. By focusing on these recovery support services and by providing clients with help to navigate the various resources, services and treatment options available to them, COEs meet the multiple, complex needs of their clients, giving them the best chance of attaining successful recovery.

There are 45 COEs across the commonwealth, serving communities throughout Pennsylvania in rural, urban and suburban settings. They were carefully selected to cover the state's geography, while focusing resources where they are most needed. The COEs are very diverse: some are methadone clinics; some are large health systems; some are counseling services and some are small medical clinics. The variety of provider types allows COEs to provide services in whatever model best supports their communities. Some COEs even choose to focus on serving certain populations. For example, some COEs serve clients experiencing homelessness, clients who are newly released from incarceration or clients who are pregnant or postpartum.

For more information on the Centers of Excellence, please follow this link:

<http://www.dhs.pa.gov/citizens/substanceabuseservices/centersofexcellence/>

Disaster Declaration

On January 10, 2018, Pennsylvania took another step forward in the fight against the heroin and opioid epidemic by implementing a statewide disaster declaration that identified the heroin and opioid epidemic a public health emergency. The heroin and opioid epidemic has contributed to addiction, overdose emergencies and deaths across the Commonwealth. In August 2018, the Drug Enforcement Administration's (DEA) Philadelphia Field Division announced that 5,456 drug-related overdose deaths were reported by coroners and medical examiners in Pennsylvania for 2017 (United States Drug Enforcement Administration (USDEA), 2018). This number represents a rate of 42 deaths per 100,000 people and a 64% increase in overdose deaths from 2015 to 2017 (USDEA Philadelphia Field Division & the University of Pittsburgh, 2017).

The opioid disaster declaration was originally established for 90 days and is periodically reviewed and renewed. The declaration can be found at the following link:

<https://www.pema.pa.gov/Proclamations/Documents/01.10.18%20-%20Disaster%20Proclamation.pdf>

Chapter 3

Overview of Federal Child Abuse and Prevention Treatment Act (CAPTA):

The federal Child Abuse Prevention and Treatment Act (CAPTA) was originally enacted on January 31, 1974 (P.L. 93-247) and is the United States' foremost legislation addressing child abuse and neglect. CAPTA has been amended several times, with the most recent changes made through **the Comprehensive Addiction and Recovery Act (CARA) of 2016**. CARA went into effect July 22, 2016, including Title V, Section 503, "Infant Plan of Safe Care." The legislation (P.L. 114-198) makes several changes to CAPTA:

- Removes the term "illegal" in regard to substance abuse;
- Requires that Plans of Safe Care address the needs of both the infant and the affected family or caregiver;
- Specifies that data on affected infants and Plans of Safe Care be reported by states to the maximum extent practicable. Such data includes:
 - The number of infants identified as being affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or FASD;
 - The number of infants for whom a plan of safe care was developed; and
 - The number of infants for whom referrals were made for appropriate services-including services for the affected family or caregiver.
- Requires that states develop and implement monitoring systems regarding the implementation of such plans 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 Children's Bureau also directs the state to provide qualitative information in their State Annual Progress and Services Report (APSR) with details of updates to state laws, policies, procedures and systems to address the needs of infants born and identified as being affected by substance use or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder.

The 2016 changes were made in the context of attention generated by the nation's prescription drug and opioid epidemic, which has focused state agencies on the requirement to implement a Plan of Safe Care for these infants.

In order to comply with federal statute, the state Child Protective Services Law was amended to require notification to DHS when a health care professional identifies that a child under age one was born affected by substance use or withdrawal from prenatal drug exposure or FASD. This

notification triggers the completion of an assessment that will guide the development of a Plan of Safe Care to address the needs of the child, parents and caregivers.

Chapter 4

Know Your State Systems:

Department of Human Services (DHS)

The Department of Human Services' (DHS) mission is to improve the quality of life for Pennsylvania's individuals and families. The Office of Children Youth and Families (OCYF) serves children and families through child support enforcement, oversees adoption and foster care services, and works with counties on child abuse prevention and juvenile justice issues.

As a state supervised, county-administered child welfare system, each county is responsible for the provision of direct services to children and families, with DHS providing statewide oversight and technical assistance. County children and youth administrators submit yearly plans that describe how the county will meet the needs of the children and families served by the agency. In practice, this gives each of Pennsylvania's 67 counties flexibility in determining which services and interventions are most critical to meet the needs of their populations.

Mental health services in Pennsylvania are overseen by the Office of Mental Health and Substance Abuse Services (OMHSAS) and are administered through county Mental Health and Intellectual Disability (MH/ID) offices. These services are delivered by county or local provider agencies who contract with the county MH/ID office or behavioral health managed care organizations.

Through a collaboration between the Pennsylvania Departments of Education (PDE) and DHS, the Office of Child Development and Early Learning (OCDEL) administers the commonwealth's Early Intervention (EI) program for eligible infants, toddlers and preschoolers. The EI program provides services and supports to eligible children, from birth to school age, with developmental delays and disabilities to improve a child's development, so they are successful in any early childhood education setting. The Bureau of Early Intervention Services and Family Supports within OCDEL contracts with local administrators including 48 county Infant/Toddler EI programs and 34 entities for Preschool EI services which include Intermediate Units (IUs), school districts and a private organization to provide EI services and supports.

OCDEL Programs also include Family Support programs, such as Evidence-Based Home Visiting, Family Centers, Promoting Responsible Fatherhood and Positive Parenting programs. OCDEL has designed an interactive map to help those that support families/caregivers locate the OCDEL funded Early Intervention and Family Support programs and services available in their local communities. The interactive map can be found at the following link: <http://www.eita-pa.org/uploads/presentations/pafamilysupport/index.html#/>

OCDEL also oversees the Early Learning Resource Centers (ELRCs). ELRCs provide a single point-of-contact for families, early learning service providers and communities to gain information and access services that support high-quality child care and early learning programs. There is a map of the ELRCs, so families/caregivers and providers can locate the ELRC that supports their local community. This map can be found at the following link:

<http://dhs.pa.gov/citizens/childcarearlylearning/earlylearningresourcecenter/index.htm>

Department of Drug and Alcohol Programs (DDAP)

DDAP's mission is to engage, coordinate and lead the Commonwealth of Pennsylvania's effort to prevent and reduce drug, alcohol and gambling addiction and abuse; and to promote recovery, thereby reducing the human and economic impact of the disease. DDAP has a primary role in setting drug and alcohol treatment policy and providing regulatory oversight to drug and alcohol treatment programs.

DDAP is designated as the Single State Authority (SSA) to plan and allocate the Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant and does so by allocating state and federal funds to administrative units called Single County Authorities (SCAs). The SCAs are awarded grants based on population statistics, competitive awards and other factors. SCAs serve as local administrative entities for a catchment area that includes one or more counties. Currently, there are 47 SCAs serving the 67 counties in the commonwealth. It is the SCAs' responsibility to determine the needs of their catchment area and provide needed services directly or contract with providers to deliver the appropriate services.

Department of Health (DOH)

DOH's mission is to promote healthy lifestyles, prevent injury and disease and to assure the safe delivery of quality health care for all commonwealth citizens.

DOH works collaboratively with public and private community partners to facilitate the development of an effective public health system that promotes the optimal health of its citizens while reducing the need for health care.

DOH is responsible for planning and coordinating health resources throughout the commonwealth. It licenses and regulates a variety of health facilities, such as hospitals, nursing homes, ambulatory surgical facilities and other in-patient and out-patient facilities. In addition, DOH supports outreach, education, prevention and treatment services across a variety of program areas. Grants and subsidies to community-based groups are used to provide essential services to the commonwealth's citizens including programs for women and children, nutrition, immunization, diagnosis and treatment of certain blood and communicable diseases, cancer control and prevention and the prevention and treatment of substance abuse.

DOH works in close collaboration with DHS, DDAP and other state departments to realize these efforts. Examples include continuous communication at the executive level, shared administrative services and a coordinated effort to address numerous programs and initiatives, the opioid epidemic among them.

It is important for local planning teams and MDTs to understand how partnering systems are administered when developing plans of safe care as each systems' unique policies and procedures will affect the team's ability to translate statewide guidance into practice. Development of each Plan of Safe Care must take into consideration how hospital and healthcare systems are administered, organized and connected to county children and youth agencies, substance use treatment and other relevant agencies.

Part II - Preparing to Develop Plans of Safe Care

Chapter 5

Identify Partners for a Comprehensive Plan of Safe Care Approach:

As we move toward development of plans of safe care for children and families, we must recognize that multiple agencies and organizations play a role in plan development. The commonwealth has worked with system partners to provide this guidance to local communities that will assist in the development of overarching system policy and protocols. These system protocols will provide assistance in establishing a common set of operating standards that will lead to the identification of the entity that will serve as the lead in the development of each individualized Plan of Safe Care for an infant and their family members. What follows is a high-level description of each team and their role in implementation of these standards.

Role of State Implementation Team

The Multi-Disciplinary Workgroup on Infants with Substance Exposure (MDWISE) has met over the past few years to develop policies, protocols and procedures that will help to translate state guidance into local practice. A common theme throughout member discussions has been that all policies, protocols and procedures must ensure the coordination and collaboration of prevention, EI and an array of community-based treatment and support services for infants, children and their families for local teams to be successful.

Role of Local County Planning Teams

The creation of county specific policies and procedures that guide the development of a Plan of Safe Care require the input and resources of multiple local entities. The local county planning team should develop a comprehensive response to infants with prenatal substance exposure, their families and their caregivers that draws on the expertise of staff across various local agencies. Local protocols should build on the guidance provided through this document and must adhere to the requirements of Act 54. The local county planning team should encourage the development of collaborative partnerships for coordinating and supporting a family-focused system that delivers prevention, EI, public health and community-based treatment services. The local county planning teams should regularly assess their membership to identify any potential gaps in agencies and organizations that provide services to impacted mothers and infants. Local policies and procedures should include guidance on how the MDT will be individualized to each specific case based upon the needs of the infants, families and/or caregivers.

Role of Multi-Disciplinary Teams (MDTs)

The main purpose of the MDTs is for multiple agencies to coordinate services to address the unique needs, situations and experiences of each family member in order to best serve infants with substance exposure and their family/caregiver. One of the main benefits of bringing together multiple agencies, instead of relying on one entity to provide all services, is bring different agencies with unique expertise and resources together to provide the needed services and supports. County children and youth agencies, substance use disorder and mental health

treatment agencies, health care providers, judicial officers and attorneys, public health agencies and community partners benefit from their involvement in this collaborative effort through enhancements in training, resources, shared information and improved outcomes for the individual served and the community at large.

Ideally, partners who are working with or needed by the family will collaboratively develop and implement the individual Plans of Safe Care as part of the MDT. Partners may include obstetrician/gynecologist, pediatrician, neonatologist or other hospital provider; professional home visitor; substance use treatment clinician and medication-assisted treatment clinician; mental health clinician; county children and youth caseworker; representatives from local community-based organizations; and the family or caregiver. Counties implementing a collaborative approach will benefit from clear communication procedures and data reporting roles to ensure that data and policies are shared.

Table 3. Potential Members of Multi-Disciplinary Teams

Multi-Disciplinary Teams may include representatives from:
<ul style="list-style-type: none">• Public Health• Maternal and Child Health• Home Visitation Programs• Substance Use Disorder Prevention and Treatment Providers• Mental Health Providers• Public and Private Children and Youth Agencies• Early Intervention and Developmental Services• Court System• Local Education Agencies• Managed Care Organizations and Private Insurers (e.g. Care Coordinators)• Hospitals and Medical Providers (e.g. Hospital Social Workers)

Chapter 6

Screening for Alcohol, Tobacco and Drug Use in Pregnancy and for Newborns:

Background

Prevention, identification and reduction of perinatal opioid and other substance use during pregnancy and the postpartum period is critical to support the health and well-being of women and their infants (World Health Organization, 2014). Perinatal substance use exists across all socioeconomic groups and geographic areas (Substance Abuse and Mental Health Services Administration Center for Behavioral Health Statistics and Quality, 2016).

Universal screening for alcohol and other drug use is an essential first step in identifying women with substance use disorders and linking them with services at the appropriate level of care. Universal screening reduces the potential for bias and stigma and normalizes the screening process in the same way one would ask all pregnant or postpartum women about the availability of a car seat or a crib for the newborn.

Screening vs. Testing – Screening vs. Assessment

DDAP defines screening as the determination of need for emergent care in the areas of withdrawal management, prenatal or psychiatric care. It is a short series of questions to identify the need for services and determine if further assessment is necessary.

It is imperative that pregnant women who screen at risk for alcohol or substance use be referred for a follow up Drug and Alcohol Assessment. This allows for more timely interventions and entry into the treatment system, including medication assisted treatment, to reduce harms for both women and newborns.

Screening is differentiated from *testing* in that testing involves biological samples such as blood, urine, meconium or umbilical cord.

Screening is differentiated from *assessment* in that screening is a short series of questions designed to determine risk, not to generate a formal diagnosis as per the Diagnostic and Statistical Manual of Mental Disorders (DSM), which is the standard classification of mental disorders used by mental health professionals in the United States, or to determine need for treatment. A Drug and Alcohol Assessment is completed by a Licensed Professional Counselor or a drug and alcohol professional working in a treatment facility or the Single County Authority. The assessment is completed to determine if treatment is warranted, at what level of care and what support services are needed.

Screening During Pregnancy

Screening should be inclusive of illicit drug, prescription drug, alcohol and tobacco use. All of these are risk factors which may impact infant and maternal health outcomes.

DOH recommends a public health, population-based approach, consistent with the American College of Obstetrics and Gynecologist (ACOG) recommendations, in which all pregnant women are screened for substance use.

According to the ACOG, screening for substance use is part of complete obstetric care and should be done in partnership with the pregnant woman. Further, ACOG recommends that both before pregnancy and in early pregnancy, all women should be routinely asked about their use of alcohol and drugs, including prescription opioids and other medications used for nonmedical reasons (ACOG, 2016). To begin the conversation, the patient should be informed that these questions are asked of all pregnant women to ensure they receive the care they require for themselves and their fetuses. To foster a trusting and nonjudgmental relationship, patients should be informed about what information will be and what cannot be kept confidential pursuant to state and institutional regulations and policies for mandated notification of prenatal substance use.

Screening may be completed by a healthcare practitioner or a human services professional. Having staff trained to use motivational interviewing (MI) techniques to assist with the screening of pregnant women can be key to a successful transition into appropriate follow-up services. MI techniques have been proven to be effective in instilling behavior change (Rollnick & Miller, 1995). MI is a goal-oriented, client-centered counseling style for eliciting behavior change by helping clients to understand the need for change (Rollnick & Miller, 1995).

Screening Instruments for Use During Pregnancy

Several screening instruments for alcohol and other drug use have been validated for use during pregnancy. There are other screening instruments that have been validated for screening of adult women, but not specifically for prenatal or antenatal screening. Table 4 outlines selected instruments with the target population and specific areas of inquiry. There is no consensus regarding which tool is best.

Both DOH and DDAP recommend that providers utilize an evidence-based (validated) tool that meets the needs of the provider and the population served. There are many considerations for providers when choosing and implementing a screening tool in practice including: cost, availability and where on the evidence-based continuum the tool is rated. Additional considerations should be given to staff training needs; administration responsibility; integration with or change from current tools and methods for screening; timing and frequency of screening; and referrals and handoffs resulting from the screening.

The Institute for Health and Recovery's Integrated 5 P's Screening Tool or NTI Upstream's 4P's Plus© were designed for pregnant women to be a quick, easy and non-threatening means to identify a pregnant woman's risk for use and current use of substances. These tools expand upon Dr. Hope Ewing's 4Ps tool to include tobacco use and interpersonal violence. The inclusion of these additional risk factors, which are frequently intertwined with substance use factors, are a part of the 5P's Screening Tool and the 4P's Plus© for use throughout the prenatal period. Both the 5P's Screening Tool and the 4P's Plus© require little training and can be administered by a wide range of individuals who are trained in the use and administration of the selected tool. These individuals may be healthcare practitioners, allied professionals or social service staff. Of note, the 4P's Plus© tool is available from NTI Upstream and there are fees associated with training and use of the tool. The 5P's tool is free to use and a copy of the tool can be found in the Attachments section that accompanies this document.

Other evidence-based tools for use with pregnant women are ASSIST V3.0 (Alcohol, Smoking and Substance Involvement Screening Test) and CAGE-AID (Cut Down, Annoyed, Guilty, Eye Opener Adapted to Include Drugs), which are targeted to the general population, as well as CRAFFT (Car, Relax, Alone, Forget, Family or Friends, Trouble), which is targeted towards teens. All of these tools are available in the public domain.

ASSIST V3.0 can be found at the following link:

https://www.who.int/substance_abuse/activities/assist_v3_english.pdf.

CAGE-AID can be found at the following link:

<https://www.integration.samhsa.gov/images/res/CAGEAID.pdf>.

CRAFFT Screening Tool can be found at the following link:

https://www.integration.samhsa.gov/clinical-practice/sbirt/CRAFFT_Screening_interview.pdf.

Additional evidence-based screening tools are available on the Substance Abuse and Mental Health Services Administration website at <https://www.integration.samhsa.gov/clinical-practice/screening-tools>

Table 4. Selected Screening Instruments

	4Ps Plus ©	5Ps	Assist V3.0	CAGE-AID	CRAFFT Screening Test
Adult			X	X	
Adolescent	X	X			X
Pregnant/Female	X	X			
Alcohol	X	X	X	X	X
Substances	X	X	X	X	X
Tobacco	X	X	X		
Interpersonal Violence	X	X			
Depression	X	X			
Available in the public domain		X	X	X	X

Screening Newborns

The DOH recommends a public health, population-based approach, consistent with the current practice of screening all newborns in Pennsylvania for metabolic, endocrine, hemoglobin, heart disease and hearing loss. Universal substance screening for newborns compared to targeted screening removes potential bias from practitioners and places the identification of withdrawal symptoms in the context of a medical condition.

Universal substance screening for newborns involves monitoring and assessing for signs consistent with withdrawal and scoring each newborn with specialized tools. The Modified

Finnegan's Neonatal Abstinence Scoring Tool is the most widely used tool due to its comprehensive nature and use for a wide range of substance withdrawal. The Lipsitz Tool was previously recommended by the American Academy of Pediatrics (AAP) due to its relatively simple metric and good sensitivity. Both tools are available in the public domain with versions modified to practice needs. It is important to note that both tools were developed for use in full-term infants. Currently, the AAP does not recommend a specific tool, but stresses that a chosen tool be used correctly by properly trained staff.

Finnegan's Neonatal Abstinence Scoring Tool can be found at the following link:

<http://www.academyofneonatalnursing.org/NAS/FinneganNASTool.pdf>

A version of the Lipsitz Tool can be found at the following link:

https://opqc.net/sites/bmidrupalpopqc.chmcrec.cchmc.org/files/Webinar%20Series/Lipsitz_tool_OPQC_09302014_FINAL.pdf

Instructions for using the Lipsitz Tool can be found at the following link:

https://opqc.net/sites/bmidrupalpopqc.chmcrec.cchmc.org/files/Webinar%20Series/Lipsitz%20Tool-directions%20for%20use_09302014_FINAL.pdf

Chapter 7

Create a Notification System and Protocol for Plans of Safe Care:

Pennsylvania's Child Protective Services Law requires that a notification be made to DHS via ChildLine when a health care provider has been involved in the delivery or care of a child under one year of age and the health care provider has determined, based on standards of professional practice, the child was born affected by substance use or withdrawal symptoms resulting from prenatal drug exposure or FASD.

Ensuring that infants born affected by substances and their mothers and caregivers receive needed treatment begins with early identification through appropriate screening and assessment by a health care professional.

Upon determination that an infant has been affected by substances, whether prenatally, at birth, or in the infant's first year, the provider is required to notify ChildLine, Pennsylvania's statewide hotline that accepts reports of suspected child abuse and general protective services (GPS). It is important to note that this report does not need to be made by the child's specific health care provider, such as a pediatrician or other physician; the provider may identify a designated staff person to do so, such as a medical social worker, registered nurse or patient care coordinator. Healthcare professionals/providers are encouraged to submit the required notification electronically to DHS via the self-service portal at:

<http://www.compass.state.pa.us/cwis>, but ChildLine can also be contacted by calling 1-800-932-0313.

Trained staff at ChildLine receive the information and transmit the information to the appropriate county children and youth agency for review. These notifications may be considered information only referrals or GPS referrals, depending on the circumstances, and, by state law, "shall not" constitute an allegation of child abuse on the sole basis of the infant being identified as affected by substance use. The information only notification may be later re-categorized as a higher priority GPS or child protective services (CPS) referral if additional concerns are identified during the initial meeting or after the county children and youth agency reviews the initial notification.

Simultaneously with the initial notification, the initial multidisciplinary team (MDT) of professionals who will meet to develop a Plan of Safe Care for the infant should be convened by the health care provider making the required notification.

- For infants identified as substance exposed at birth, the hospital social worker or other appropriate staff person, such as a patient care representative or discharge coordinator, should convene the initial MDT meeting.
- For infants identified as affected by substance use after their discharge from the hospital, such as through a well-child visit with their pediatrician or an appointment with the mother's OB/GYN, the healthcare provider or appropriate staff will make the notification and a county children and youth caseworker will be assigned to convene the initial MDT meeting.

For pregnant women identified as using substances prior to the birth of their infant, the healthcare provider or other appropriate staff person treating the woman, such as a pain management specialist or patient care coordinator, is encouraged to immediately begin the process of convening all parties for the initial MDT that may provide assistance in developing and implementing a plan to address the need of the pregnant woman. However, it is important to remember that a notification to DHS is not required in the prenatal period.

While considering who the MDT may include, refer to Chapter 5 Table 3., Potential Members of Multi-Disciplinary Teams.

Within this initial meeting, the MDT should also determine who to designate as the lead for the development, implementation and monitoring of the Plan of Safe Care, based on the circumstances of the infant, mother and family. All partners at the meeting will work together to ensure potential risks of harm are mitigated, such as immediate housing needs, health insurance or other community services.

As part of the plan development, the MDT should determine how often they must meet to ensure that the Plan of Safe Care is being implemented consistent with the needs of the infant, family and caregivers. These meetings should confirm that needed referrals have been made and that services are being provided as identified in the plan. At times, it may be necessary to revise the plan as circumstances change. If at any time team members believe there is any concern for the child's safety and the county children and youth agency is not currently involved, the team is required to report to ChildLine.

Chapter 8

Define Plans of Safe Care:

A Plan of Safe Care is defined as a document that lists and directs services and supports to provide for the safety and well-being of an infant affected by substance abuse, withdrawal, or FASD, including services for the infant and their family/caregiver. A Plan of Safe Care should specify the agencies that provide specific services, outline communication procedures among the family and provider team and guide the coordination of services across various agencies with the family.

In their January 17, 2017 Program Instruction (ACYF-CB-PI-17-02), the federal Administration on Children and Families (ACF) states:

“while CAPTA does not specifically define a “Plan of Safe Care,” CARA amended the CAPTA state plan requirement at 106(b)(2)(B)(iii)(1) to require that a Plan of Safe Care address the health and substance use disorder treatment needs of the infant and affected family or caregiver. We want to highlight that this change means that a Plan of Safe Care must now address not only the immediate safety needs of the affected infant, but also the health and substance use disorder treatment needs of the affected family or caregiver. Consistent with good casework practice, the plan should be developed with input from the parents or other caregivers, as well as, any collaborating professional partners and agencies involved in caring for the infant and family” (United States Department of Health & Human Services Administration on Children, Youth and Families, 2017).

Plans of safe care go beyond the immediate safety factors of an infant and address their ongoing health, development and well-being as well as the treatment and other service needs of their family/caregiver. Plans of safe care may incorporate services and supports for diverse, longer-term needs, including physical and mental health, substance use treatment, parenting education, infant developmental screening and other family needs.

A list of elements to consider when creating a Plan of Safe Care can be found in Appendix A. An example of a Plan of Safe Care template can be found in Appendix B.

Table 5. Effective Plans of Safe Care

Effective Plans of Safe Care are:
<ul style="list-style-type: none">• Interdisciplinary across health and social service agencies• Based on the results of a comprehensive, multi-disciplinary assessment of physical, social-emotional, health and safety needs of the infant and the parents or caregivers• Family-focused to assess and meet the needs of each family member, as well as overall family functioning and well-being by building on each family member's strengths, challenges and, for the mother and father, parenting capacity• Completed, when possible, in the prenatal period to facilitate early engagement of parents and communication among providers or, when not possible, before the infant's discharge from the hospital• Easily accessible to relevant agencies with the appropriate confidentiality safeguards to facilitate information sharing• Collaborative in identifying appropriate lead agencies to be accountable for the care management and for plan development, implementation, management, communication and data submission• Grounded in evidence-informed practices, such as a preference that infants, mothers and families remain together whenever possible

Comparisons Between Plans of Safe Care and Other Types of Plans

While plans of safe care may differ from standard CPS safety plans, substance use treatment plans and hospital discharge plans in a number of ways, these plans can help to strengthen any Plan of Safe Care put into place. Many of the domains in the Plan of Safe Care come from these three documents.

Table 6. Plan Comparisons

CPS Safety Plans	Plan of Safe Care
Focuses on the immediate safety of a child	Focuses on the safety and well-being of infants by addressing the health of the infant and the substance use disorder treatment needs of the affected family/caregiver
Substance Use Treatment Plans	Plan of Safe Care
Focuses on the treatment of adults	Includes the treatment and broad services of the whole family, including the infant and parent-child dyad
Hospital Discharge Plans	Plan of Safe Care
Focuses on the health and well-being of the infant	Includes the ongoing health and development of the infant, as well as the educational and substance use disorder treatment needs of the family/caregiver who will be caring for the infant

Three Populations

When determining who should receive a Plan of Safe Care, there are three populations that have been identified:

- Population 1: Women who are using legally prescribed medications, including opioids, for chronic pain or on medication that can result in withdrawal symptoms and do not have a substance use disorder;
- Population 2: Women who are receiving medication assisted treatment for an opioid use disorder and/or are actively engaged in treatment for a substance use disorder;
- Population 3: Women who are misusing prescription drugs or are using other legal or illegal substances, may meet criteria for a substance use disorder, and are not actively engaged in a treatment program.

For the first two populations, the MDTs should determine who will be responsible for the creation and implementation of the Plan of Safe Care. Women who are identified to be in the second population may need involvement from the county children and youth agency. If the use of MAT or engagement in treatment is relatively new, the county children and youth agency may need to be involved to help support the mother’s continued engagement in substance use treatment and that she is receiving the support she needs. For the third population, the county children and youth agency should be responsible for the creation and implementation of the Plan of Safe Care.

The table below can assist in determining the potential lead agency for developing the Plan of Safe Care for each of the three populations, whether in the prenatal period or at/after birth.

Table 7. Three Populations and Potential Lead Entities (NCSACW, 2018)

Population of Pregnant and Postpartum Women	Potential Entity to Oversee Plan of Safe Care	
	Developers of Plans of Safe Care in the Prenatal Period	Developers of Plans of Safe Care at/after Birth
Using opioid medications for chronic pain or other legal medications (e.g. benzodiazepines) that can produce withdrawal symptoms and has no substance use disorder	Prenatal care provider with pain specialist or another physician	Maternal and child health postpartum service providers (e.g. home visiting and Head Start providers) and community-based child welfare agencies that provide prevention services
Receiving medication-assisted treatment (buprenorphine or methadone) for an opioid use disorder or engaged in treatment for a substance use disorder	Prenatal care provider with opioid treatment program or waived buprenorphine prescriber and/or therapeutic treatment provider	Opioid treatment or therapeutic substance use disorder treatment providers with maternal and child health partners or child welfare
Misusing prescription drugs or using legal or illegal drugs, or meets criteria for a substance use disorder and is not engaged in a treatment program	Prenatal care provider or high-risk pregnancy clinic with substance use disorder treatment agency	Child protective services and other child welfare service agencies

Chapter 9

Assess Needs to Guide Individual Plans of Safe Care:

In assessing needs for the development of a Plan of Safe Care, a multidisciplinary approach is vital to help families access needed services that will help to mitigate risks to both the child and the family. Identifying social service needs through the initial assessment should be the first step MDTs take when developing and implementing individual Plans of Safe Care for infants affected by substance use and their families. Paired with the knowledge of the county's own community service array as well as input from the family itself, this initial assessment will help more accurately identify families' needs and identify the most appropriate and available services to meet those identified needs.

Factors MDTs may consider in assessing needs may include:

- Child abuse and neglect risk and protective factors,
- Infant health and development,
- Mother's medical history,
- Mother's co-occurring treatment history and symptoms,
- Family members' and caregivers' need for substance use disorder treatment,
- Education and employment history,
- Family and social relationships,
- Current legal issues and history, and
- Other health and social service supports in place or needed.

This multidisciplinary approach differs from other typical plans such as CPS safety plans, substance use treatment plans and hospital discharge plans in that it may include such partners as birthing hospitals, substance use disorder treatment providers, primary care providers, home visiting professionals, public health agencies and other community partners as needed.

For infants identified as exposed to substances at birth, it may be difficult for the MDT to gather all of the information needed to complete a comprehensive assessment to inform the individual Plan of Safe Care before the mother and child are ready for discharge from the hospital, as required. Therefore, system partners should continue to work together to share the necessary information quickly. Those present at the first MDT meeting should immediately determine what additional information is needed to inform the Plan of Safe Care and make arrangements for information sharing moving forward.

For infants identified as exposed to substances following discharge from the hospital, the identification of needed information should take place at the first MDT convening as well.

For plans developed prenatally, preparation to address any anticipated needed information and services for the infant and family prior to delivery will help to alleviate stress both on the family and service providers working with the family, as well as improve overall service coordination.

Such an intentional depth of coordination between system partners requires trust between agencies in addition to clear communication and procedures to address confidentiality concerns.

Part III - Multidisciplinary Teams (MDTs): Individual Plans of Safe Care Guidance

Chapter 10

Develop, Implement and Manage the Plan of Safe Care:

The overall well-being of infants with substance exposure improves with early detection and intervention. There are multiple points at which interventions can occur. Universal screening practices of all pregnant patients can identify substance use long before the birth of the infant. This early detection provides the first intervention point where a Plan of Safe Care can be created through an assessment and comprehensive plan to provide linkages to supports and services. A Plan of Safe Care can be developed at any time that substance use is identified both during pregnancy and following the birth of the baby up to age one.

The process by which a Plan of Safe Care is developed and implemented involves:

- Screening, identification and reporting
- Engagement of the family system
- Assessment of strengths needs and barriers
- System coordination and collaboration
- Resource identification and linkage
- Monitoring

An individualized approach should be given to the development of each Plan of Safe Care utilizing a combination of any of these four systems: family, medical, treatment and child welfare. The family should be a partner in every Plan of Safe Care. The establishment of common goals like safety and well-being for the infant and a supportive recovery system for the parent provide a framework on which the Plan of Safe Care should be built and its efficacy determined.

An MDT, including medical professionals from the health system, drug and alcohol and mental health treatment providers and the county children and youth representatives, is responsible for convening and determining the lead entity in the development of each Plan of Safe Care. These teams maintain an equal stake in the development and implementation of each Plan of Safe Care. Each of these systems comes with its own mandates and protocols, as well as a rich network of services and collaboration. As a result, cross-systems training is imperative.

Education and training opportunities at the local level for all members of the MDT must emphasize the identification of substance use, the establishment of partnerships among entities and strategies for linkage to beneficial community resources. Specialized education and training should be made available for the team members on the identification of Substance Use Disorder (SUD), treatment options for SUD, including MAT, reducing stigma, relapse

management, confidentiality, accessing community resources, EI, risks to the infant, family engagement, discharge planning, home visitation programs, mandatory reporting laws and child welfare mandates. Information sharing among the entities is needed to provide a continuous assessment of the appropriateness of the Plan of Safe Care and to adequately monitor it. Specialized confidentiality agreements should be developed to account for the laws that pertain to the sharing of information in each system.

The lead entity in the development of the Plan of Safe Care should be determined by the MDT members during the initial team meeting with considerations for the identification of substance use, the impact this use has on the mother and infant and the safety and well-being of the baby and/or other children in the mother's care. Not every system will be involved in each Plan of Safe Care and consideration should be made for the variety of services available through each system. Through education and collaboration, the medical, treatment and child welfare systems will be able to identify which one takes the lead.

A Plan of Safe Care builds on the inherent strengths of a parent, family and support system. It should develop strategies for promoting the safety and well-being of the infant, while supporting the treatment needs of the mother. It should seek to augment current functioning with the linkage to services, such as treatment and recovery support, behavioral health, medical care, rapid response models of family engagement and teaming, EI, education, transportation, housing, income support and child care.

System collaboration and coordination are essential in the success of the development, implementation and overall effectiveness of each plan. Careful consideration should be given to avoid duplication of services and to reduce overwhelming a family.

The medical provider can take the lead in the development of a prenatal Plan of Safe Care soon after identification occurs through universal screening. An assessment of the patient's support network identifies others who can be of assistance to the patient in navigating a community's supports and services designed to improve maternal and child well-being and the mother's recovery. This Plan of Safe Care likely includes:

- A release of information to allow for the collaboration among entities;
- Referrals to treatment programs, mobile engagement and peer recovery specialists;
- Education on NAS, effects of substance use during pregnancy and reporting requirements for substance exposed infants;
- A relapse plan that includes child safety considerations and identified family supports;
- Coordination between the obstetrician and the prescribing practitioner(s);
- Development of a birth plan, including pain management options;
- Education and guidance on breastfeeding and substance use;

- Stigma reducing practices designed to engage the patient in consistent prenatal care;
- Referrals to Family Strengthening, Early Head Start, Family Check Up for Children, Healthy Families America, Nurse-Family Partnership, Parents as Teachers, Family Group Decision Making (FGDM), Women Infant Children (WIC), public assistance, transportation assistance, counseling, housing assistance, domestic violence programs and/or food banks;
- Referral to ChildLine if there are concerns with mother's ability to be a caretaker for other children.

Modifications to a Plan of Safe Care are completed at any time an increase or decrease in intervention is determined to be appropriate. If developed during pregnancy, the plan should be modified at the time of the infant's birth to account for the infant's safety and well-being and to further address a mother's treatment needs as it relates to caring for the infant. The frequency at which the MDTs come together to develop and monitor these Plans of Safe Care will differ based on the identified needs, risk factors and current situations of each family.

Careful assessment of a mother's substance use is essential in determining how to implement a Plan of Safe Care. When a mother has been under the consistent care of a prescribing practitioner and has no history of prescription misuse or substance use disorder, her physician may consider developing a Plan of Safe Care independent of drug and alcohol treatment and child welfare, in addition to making a notification to ChildLine. Considerations for this assessment include diagnosis, type and dosage of medication, side effects and interactions of medication(s), family supports and their history of substance use, coordination among the prescribing and treating practitioners, discussion of safe sleep practices, breast feeding considerations and a secure location for the storage of medication.

With universal screening protocols in place, mother and infant are screened at the time of the birth. This is a second point of intervention. The identification of substance use at the time of birth necessitates a notification to Childline and a needs assessment of the infant and caregivers to determine which systems of the MDT should take the lead. That initial MDT meeting must be held prior to the discharge of the infant from the hospital. For infants identified as substance exposed after their discharge from the hospital, such as at a well-visit with the child's pediatrician, ChildLine must be notified immediately and the MDT must be convened within 72 hours of that notification. The convening of the initial MDT meeting will be the start of a Plan of Safe Care (or initial modification for those developed prenatally) and should include:

- Engagement of family supports;
- Identification of family strengths;
- Signing of releases for mother's and caregiver's providers;

- Identification of type of substance use, duration, prescribing practices, treatment history, considerations for maternal impairment;
- Relapse plan for mother and infant;
- Considerations for breastfeeding;
- Medical conditions of mother and post-partum follow up, including options for birth control;
- Medical considerations for infant and follow up plan;
- Education on safe sleep practices;
- Assessment of housing needs;
- Assessment of household support system;
- Determination of lead entity in developing the Plan of Safe Care.

County children and youth involvement is warranted when a woman is found to be misusing prescription drugs, or is using legal or illegal drugs, meets criteria for a substance use disorder and/or is not actively engaged in a treatment program. If, during the initial MDT meeting there are safety concerns identified for the child, that may also warrant an investigation or safety assessment.

When the county children and youth agency takes the lead, a thorough assessment of the infant, mother, father and other identified caregivers and household members will be conducted. Arrangements for a follow up MDT meeting following the initial convening are made based upon factors identified in the assessment.

Upon discharge from the hospital, the Plan of Safe Care is the continuation of what was initiated upon the infant's birth or prenatally. At this interval, the Plan of Safe Care may contain the following:

- Arrangements for face to face contact with the infant, parents and all caregivers and household members;
- Identification of involved support system, both personal and community based and a discussion of Family Finding efforts, a proven strategy within the child welfare field to locate and engage relatives of children living in out-of-home care;
- Execution of releases to allow the county children and youth agency worker to contact all involved providers: medical, mental health, D&A treatment, probation, etc.;

- Identification of infant’s medical needs and plans for follow up, including the name of medical provider and plan for transportation;
- Plans for a visit to or an assessment of the family home to determine its appropriateness/stability;
- Breastfeeding supports if breastfeeding;
- Discussion on safe sleep practices and the presence of a safe infant sleeping environment, in accordance with the American Academy of Pediatrics recommendations;
- Post-partum follow-up including depression screening and discussion of family planning/birth control access;
- Assessment of the safety and well-being of older children including medical, dental, educational, developmental and mental health;
- Relapse plan, including family support for recovery, identification of triggers, signs and symptoms of relapse, increasing level of care and appropriate caregivers for infant;
- Identification of supports: mobile engagement, treatment, peer recovery support, Family Group Decision Making (FGDM), Family Engagement, Family Strengthening, Healthy Families America, Nurturing Parents, evidence-based home visitation programs, WIC, housing, public assistance, Early Intervention, Family Preservation, medical providers, transportation, Planned Parenthood, educational and employment;
- Identification of barriers to accessing services: transportation, financial and/or language along with strategies to overcome these;
- The identification of safety plan supervisors and a schedule of 24/7 supervision if Safety Plan implementation is necessary.

Each component in a Plan of Safe Care should indicate which entity is responsible for monitoring it and at what intervals. The plan is ongoing and should be provided in writing to each entity. Parts of the Plan of Safe Care are easier to measure than others. Each person’s journey to recovery is unique and thus, measurement may be different. A Plan of Safe Care creates an opportunity for a rich network of supports and strategies that can continue to promote the safety and well-being of children and family systems long after a county children and youth agency and other service providers are involved.

Considerations for assessing compliance with the objectives is based on a number of variables:

- The history of substance use, including drug testing results;
- Screening or assessment of SUD;

- Follow through with treatment recommendations;
- The age and needs of the child(ren);
- Familial support system;
- Announced and unannounced home visits;
- Collateral calls to doctors and/or service providers;
- Barriers to compliance with objectives.

Consensus among the involved entities is needed when determining that changes should be made to a plan or that a plan is no longer needed. There are no statutory requirements surrounding timeframes for monitoring plans of safe care. Each MDT should determine the appropriate intervals at which the team should meet to review the plan and the infant and family's continued need for services and supports. The regular pattern for meetings should be determined based on each individual case but should be at least monthly. These intervals will likely be more frequent at the onset of a plan and become less frequent as the plan is implemented. Further, the amount of monitoring required for a plan that includes an infant whose mother has been in recovery for many years will differ from a plan for an infant identified as substance exposed at birth whose mother received no prenatal care and was not involved in any treatment at the time of birth. Consistent with the individualized nature of plans of safe care, the MDT lead will continuously assess each individual situation in order to ensure all of the needs of the family are being met.

Appendix A

Considerations for Plans of Safe Care

Considerations for Plans of Safe Care		
Infant		
Domain	Provider	Types of Services/Supports
Safety	County children and youth agency providers, in partnership with Family Physician, Primary Care Provider, or Pediatrician or early childhood services agency, as needed	<ul style="list-style-type: none"> • Child welfare safety and/or risk assessment • In-home services such as parenting education • Supervision as needed • Linkage to community services and supports, such as housing or utility assistance, transportation assistance, etc. • Referrals to evidence-based home visiting services, Early Intervention programming, mental and behavioral health care services and other services as needed and appropriate for all persons in the home • Linkage to parenting education and skills-based learning opportunities • Inclusion in family support groups, as appropriate • Health care coverage for children • Substance use and mental health treatment for other family members or caregivers
Health	Family Physician; Pediatrician or Primary Care Provider in partnership with county children and youth agency providers, as needed	<ul style="list-style-type: none"> • Linkage to medical home, pediatrician or primary care provider • High-risk infant follow-up care • Referral to specialty health care

		<ul style="list-style-type: none"> • Health care coverage
Development	Early Intervention Specialist; Developmental Pediatrician or early childhood services agency in partnership with county children and youth agency providers, as needed	<ul style="list-style-type: none"> • Coordination of early care, developmental and education programming with county children and youth agency and other partners, as needed • Developmental interventions and supports provided by staff with knowledge of and expertise in, young children and working with infants with prenatal substance exposure • Developmental screening and assessment and re-assessments for services for infants and toddlers with developmental delays or who have physical or mental conditions likely to result in developmental delays
Mother		
Domain	Provider	Types of Services/Supports
Primary, obstetric and gynecologic care	Prenatal Care Physicians, Nurses and/or Healthcare Agencies	<ul style="list-style-type: none"> • Pre-pregnancy and prenatal screening • Primary health care management • Pregnancy and postpartum obstetrical, gynecological and family planning • Prenatal education and support • Pain management • Breastfeeding coaching and support for enhanced bonding and attachment • Health care coverage

Parents/Caregivers		
Domain	Provider	Types of Services/Supports
Substance use prevention and treatment, especially if required for postpartum depression	Mental Health Clinician; Substance Use Treatment Counselors or Community Treatment Agencies in partnership with county children and youth agency providers as needed	<ul style="list-style-type: none"> • Substance use disorder treatment, including medication-assisted treatment • Care for co-occurring mental health conditions, particularly maternal depression • Substance use disorder care management to enhance treatment access and retention via outreach services and ongoing recovery supports • Designated treatment provider who is, to the extent possible, knowledgeable about child welfare, delivers gender-specific programming, is family focused, is trauma informed and provides trauma-specific treatment • Mental health services, including for symptoms of depression and anxiety and trauma-specific treatment • Substance use and mental health treatment for other family members or caregivers
Parenting/Family Support	Social Worker; Case Manager; Home Visitor; Perinatal Nurse or community agencies designated to provide family focused services in partnership with county children and youth agency providers, as needed	<ul style="list-style-type: none"> • Education on appropriate care for the infant experiencing neurodevelopment effects, physical effects or withdrawal symptoms • Coordinated care management for parents and family in conjunction

		<p>with the county children and youth agency and other partners</p> <ul style="list-style-type: none">• Follow-up services, such as infant care, parent/infant bonding support, nurturing parenting coaching and skill development, safe sleep practice support and parental support with appropriate intensity based on individual family needs through such methods as on-site education, classes, and short-term in-home and longer-term home visits• Education on potential county children and youth agency involvement and Plans of Safe Care• Evidence-based home visiting services and parent-child therapy• Interventions for intimate partner and family violence• Child care in developmentally appropriate setting• Education/employment support• Safety net benefits eligibility determination• Recovery support, including safe and stable housing and transportation assistance• Life/social skills• Assistance with legal status
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Appendix B

Plan of Safe Care Template (Example)

Plan of Safe Care Template		
Infant		
<input type="checkbox"/> Need	Area of Assistance	Date Complete
	Health <ul style="list-style-type: none"> • Linkage to medical home, pediatrician, or primary care provider • High-risk infant follow-up care • Referral to specialty health care • Health insurance 	
Action Steps:		
Person(s) Responsible:		
Target Date:		
30 Day Update:		
60 Day Update:		
<input type="checkbox"/> Need	Area of Assistance	Date Complete
	Development <ul style="list-style-type: none"> • Coordination of early care, developmental and education programming with county children and youth agency and other partners, as needed • Developmental interventions and supports provided by staff with knowledge of and expertise in, young children and working with infants with prenatal substance exposure • Developmental screening and assessment and re-assessments for services for infants and toddlers with developmental delays or who have physical or mental conditions likely to result in developmental delays • Developmental Pediatrician 	
Action Steps:		
Person(s) Responsible:		

Target Date:		
30 Day Update:		
60 Day Update:		
☐ Need		
	Area of Assistance	Date Complete
	Safety <ul style="list-style-type: none"> • Focuses on the immediate safety and well-being of the infant • Child abuse and neglect risk and protective factors • The health of the infant • The safety of the environment 	
Action Steps:		
Person(s) Responsible:		
Target Date:		
30 Day Update:		
60 Day Update:		
Mother		
☐ Need		
	Area of Assistance	Date Complete
	Primary and obstetric and gynecologic care <ul style="list-style-type: none"> • Pre-pregnancy and prenatal screening • Primary care provider for primary health care management • Pregnancy and postpartum obstetrical, gynecological and family planning • Prenatal education and support • Pain management • Breastfeeding coaching and support for enhanced bonding and attachment • Health insurance 	
Action Steps:		
Person(s) Responsible:		
Target Date:		
30 Day Update:		
60 Day Update:		

Parents/Caregivers		
<input type="checkbox"/> Need	Area of Assistance	Date Complete
	Substance use and mental disorders prevention and treatment, especially if required for postpartum depression <ul style="list-style-type: none"> • Substance use disorder treatment, including medication-assisted treatment • Care for co-occurring mental health conditions, particularly maternal depression • Substance use disorder care management to enhance treatment access and retention via outreach services and ongoing recovery supports • Designated treatment provider who is, to the extent possible, knowledgeable about child welfare, delivers gender-specific programming, is family focused, is trauma informed and provides trauma-specific treatment • Mental health services, including for symptoms of depression and anxiety and trauma-specific treatment • Substance use and mental health treatment for other family members or caregivers 	
Action Steps:		
Person(s) Responsible:		
Target Date:		
30 Day Update:		
60 Day Update:		
<input type="checkbox"/> Need	Area of Assistance	Date Complete
	Parenting/Family Support <ul style="list-style-type: none"> • Education on appropriate care for the infant experiencing neurodevelopment effects, 	

	<p>physical effects or withdrawal symptoms</p> <ul style="list-style-type: none"> • Coordinated care management for parents and family in conjunction with the child welfare and other partners • Follow-up services, such as infant care, parent/infant bonding support, nurturing parenting coaching and skill development, safe sleep practice support and parental support with appropriate intensity based on individual family needs through such methods as on-site education, classes and short-term in-home and longer-term home visits • Education on potential county children and youth agency involvement and Plans of Safe Care • Evidence-based home visiting services and parent-child therapy • Interventions for intimate partner and family violence • Child care in developmentally appropriate setting • Education/employment support • Safety net benefits eligibility determination • Recovery support, including safe and stable housing and transportation assistance • Life/social Skills • Assistance with legal status 	
Action Steps:		
Person(s) Responsible:		
Target Date:		
30 Day Update:		
60 Day Update:		

Appendix C

Pennsylvania Definitions

Pennsylvania Definitions	
'Affected by'	Infant with detectable physical, developmental, cognitive, or emotional delay or harm that is associated with maternal substance use or withdrawal, as assessed by a health care provider.
Alcohol Use	Any consumption of alcohol in one of its various forms. This individual may or may not meet criteria for Alcohol Use Disorder and may or may not experience adverse impacts.
Child Protective Services Law mandatory reporting §6386	<p>Notification to DHS and development of Plan of Safe Care for children under one year of age.</p> <p>(a) Notification to DHS for the purpose of assessing a child and the child's family for a plan of safe care-- A health care provider shall immediately give notice or cause notice to be given to DHS if the provider is involved in the delivery or care of a child under one year of age and the health care provider has determined, based on standards of professional practice, the child was born affected by:</p> <p>(1) Substance use or withdrawal symptoms resulting from prenatal drug exposure; Or (2) A Fetal Alcohol Spectrum Disorder.</p>
Drug and Alcohol Addiction	Addiction is a chronic, relapsing brain disease that is characterized by compulsive drug and alcohol seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain; they change its structure and how it works. These brain changes can be long lasting and can lead to many harmful, often self-destructive, behaviors.
Drug and Alcohol Assessment	<p>The process of gathering information to ascertain the degree and severity of alcohol or other drug (AOD) use, the social, physical and psychological effects of that use, as well as the strengths and needs of the individual.</p> <p>Assessments are comprehensive and may require an hour or more to complete. These are completed by licensed SUD programs.</p>
Drug and Alcohol Screening	The first step in identifying the presence or absence of alcohol or other drug (AOD) use, whereby data is

	collected on an individual in order to make an initial determination if an alcohol or other drug problem exists and/or to determine if emergency services are warranted. Screenings are typically brief, requiring 10 minutes or less and assist in identifying those who are at risk and in need of a complete assessment. These may be completed by a range of professional disciplines.
Drug and Alcohol Testing	Chemical analysis of a biological specimen to determine the presence of substances or their metabolites. Specimens may include urine, blood, breath, or other biological samples. Notably these procedures only detect the specific substances included in the testing panel and depend on biological factors such as specimen type, drug class, amount and frequency of substance use, metabolic rate, body mass and age.
Fetal Alcohol Spectrum Disorders (FASD)	Fetal alcohol spectrum disorders (FASDs) are a group of conditions that can occur in a person whose mother drank alcohol during pregnancy. These effects can include physical problems and problems with behavior and learning.
'Health care practitioner'	An individual who is authorized to practice some component of the healing arts by a license, permit, certificate or registration issued by a Commonwealth licensing agency or board. (<i>Health Care Facilities Act definition</i>)
'Health care provider' or 'provider'	A licensed hospital or health care facility or person who is licensed, certified or otherwise regulated to provide health care services under the laws of this Commonwealth, including a physician, podiatrist, optometrist, psychologist, physical therapist, certified nurse practitioner, registered nurse, nurse midwife, physician's assistant, chiropractor, dentist, pharmacist or an individual accredited or certified to provide behavioral health services. (<i>CPSL definition</i>)
Local Planning Team	A group of designated individuals at the county level that are responsible for the development of policies and procedures that guide the Plans of Safe Care.
Medication-Assisted Treatment (MAT)	Medication-assisted treatment (MAT) is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.

Multidisciplinary Team (MDT)	A group of designated individuals at the local level that are responsible for the development and implementation of the Plans of Safe Care.
Neonatal Abstinence Syndrome (NAS)	Neonatal abstinence syndrome (NAS) is a group of problems that occur in a newborn who was exposed to opiate drugs prenatally.
Non-Neonatal Abstinence Syndrome (Non-NAS) Diagnosis	Non-NAS newborns may suffer from a group of problems that occur in children that are exposed to substances, other than opioids, prenatally. This may include alcohol and/or prescription medications.
Plan of Safe Care	Document that may: 1) be developed prior to birth or discharge of infant; 2) be a comprehensive multi-disciplinary assessment; 3) address multiple intervention points: pregnancy, birth and beyond; 4) address the needs of both the infant and the family/immediate caregivers; 5) put structure in place to ensure coordination of, access to and engagement in services.
Prenatal Drug Exposure	Use of drugs, alcohol, or prescription medication during pregnancy. This may cause a spectrum of physical and developmental challenges as a result of the drug or alcohol use and/or as a result of withdrawal upon birth.
Public Health	Promoting physical and mental health and preventing disease, injury and disability.
Substance Misuse	The use of over the counter or prescribed medication when taken in excess of prescription or medical standards of care. This would also include use of illegal substances. This individual may or may not meet criteria for SUD and may or may not experience adverse impacts.
Substance Use	The use of over the counter medication, prescribed medication, drugs, alcohol and/or illicit substances. Typically connotes beneficial or recreational use.
Substance Use Disorder (SUD)	A problematic pattern of use of an intoxicating substance leading to clinically significant impairment or distress.
Universal Screening	The process of asking all pregnant women questions to identify those who are at risk of using or currently using substances such as drugs or alcohol and monitoring newborns for signs consistent with withdrawal and scoring each newborn with specialized tools. Universal substance screening is not testing of biological samples such as blood, urine, meconium, or umbilical cord.
Withdrawal Symptoms	“Withdrawal symptoms” shall mean a group of behavioral and physiological features in the infant that follow the

	<p>abrupt discontinuation of a substance that has the capability of producing physical dependence. No clinical signs of withdrawal in the neonate should be attributed to in utero exposure to alcohol or other drugs without appropriate assessment and diagnostic testing to rule out other causes. <i>(American Academy of Pediatrics definition)</i></p>
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Appendix D

Local Emerging Practices: County Specific

DDAP County Example

Blair Drug and Alcohol Program (BDAP), the Single County Authority in Blair County, is collaborating with the University of Pittsburgh Medical Center Pregnancy Care Center (PCC) in Altoona, PA to provide Screening, Brief Intervention and Referral to Treatment (SBIRT) to pregnant women. BDAP employs a case manager/SBIRT care coordinator as part of a grant initiative in conjunction with DDAP. The grant allows the case manager/SBIRT care coordinator to be located at the Pregnancy Care Clinic and ensures patients identified by the medical staff as needing a referral to treatment have access to the case manager/SBIRT care coordinator. The University of Pittsburgh's Program Evaluation and Research Unit (PERU) provides training on the SBIRT Model, Motivational Interviewing and the workflow process. PCC patients are screened by a RN care coordinator utilizing the 5Ps, Audit/DAST and the Edinburgh Postnatal Depression Scale (EPDS). Based on the SBIRT score and using clinical judgment, the provider (Physicians, Physician Assistants, Certified Registered Nurse Practitioner, etc.) selects the appropriate intervention for a patient which may be screening and feedback where positive reinforcement, education and risk are reviewed; brief intervention where the provider conducts a brief intervention; or Early Intervention or referral to treatment where the provider conducts a brief intervention and connects the patient to the case manager/SBIRT care coordinator for further discussion immediately. The case manager/SBIRT care coordinator would meet with the patient regarding their needs and if necessary, complete a drug and alcohol assessment to determine the most appropriate treatment for the patient. The case manager/SBIRT care coordinator can collaborate with the social worker and also provide referrals to other services as deemed appropriate.

If a pregnant patient presents to PCC and is currently using substances, PCC engages the pregnant patient and begins the referral process if the patient agrees to services. In addition, PCC passes the information to Labor and Delivery at UPMC Altoona.

Embedding the case manager/SBIRT care coordinator into the primary health care site allows case management to occur at the time of the patient's appointment with the medical provider and brings together primary health and behavioral health/substance use disorder treatment.

The ability to provide SBIRT services to pregnant patients may be a way to engage pregnant patients prior to delivery in a non-threatening manner and begin the process for a Plan of Safe Care.

Opioid Use Disorder Center of Excellence (OUD COE) Example

Reading Hospital has a long history of being part of a professional community that collaboratively works with pregnant and parenting women with substance use disorder.

Hospital policy for reporting is based on the Child Protective Services Law section 6386; however, the county children and youth agency has requested that such reports get directed to

ChildLine. These reports are generally made electronically immediately following the birth of a child which meets the criteria under statute.

Obstetric providers within the hospital system utilize an electronic medical record which prompts providers to ask questions relating to the use of illicit substances, alcohol and tobacco use. The electronic medical record also prompts providers to review medications prescribed by other providers within the hospital system and to ask about medications prescribed by providers outside of the hospital system.

Urine drug screens are recommended at each initial prenatal visit and whenever substance use is suspected. Several services are available for obstetric providers to refer their patients when illicit substance use is detected or disclosed or the pregnant patient is taking a medication that could result in withdrawal symptoms if she would stop use which should indicate likewise to the infant after birth. These include a referral to the OUD COE when an opioid or medication assisted treatment for opioid use disorder exists, a referral to the maternal child health nurse navigators or to community-based case management services for pregnant women with substance use issues. The Department of Obstetrics and Gynecology has offered routine education to providers on these topics. Additionally, pregnant women who indicate they are using opioids and would like to stop using opioids are offered hospital-based induction onto MAT.

Two MAT options are offered to pregnant women using opioids: buprenorphine and methadone. Assessment in conjunction with Addiction Medication is used to determine the best option for the patient which is then offered to the patient. Patients inducted onto methadone will receive follow up at New Directions Treatment Services. They may choose to continue to receive care coordination services through the Reading Hospital COE or may choose to receive case management services through the COE at New Directions.

The Women's Health Center offers a Patient Centered Medical Home for pregnant women with OUD by offering buprenorphine. Patients choosing this option will receive the following:

- MAT at the Women's Health Center in a step-down manner which allows more face-to-face contact during the initial period following hospital induction
- Obstetric care at a provider within the hospital system
- Care coordination through the COE which includes drug and alcohol treatment
- Social services at the Women's Health Center
- Services from the Maternal Child Health Nurse Navigators
- Referral for pain management for applicable patients
- Education session about Neonatal Abstinence Syndrome prior to the birth of their child

- Referral for Family Group Decision Making (FGDM) at 28 weeks gestation in order to develop a Plan of Safe Care for the child
- Referral to Nurse-Family Partnership extension program when applicable
- Referral for evidence-based parenting education at Maternal Recovery Services
- Access to breastfeeding nurses and lactation consultants, as all mothers on MAT are encouraged to breastfeed as long as urine drug screens are only positive for the MAT prescribed
- A warm hand-off after a minimum of six months postpartum to another buprenorphine provider.

The care coordination services through the COE provide direction to the pregnant woman on MAT for parenting their child and understanding the roles and responsibilities of various entities including the medical team, Early Intervention and county children and youth agency. Additionally, all service providers participate in the FGDM planning process which establishes safe plans of care for the child prior to birth. There is an emphasis on plans always taking into consideration the potential for relapse of the child's parent. The use of FGDM prenatally has significantly decreased the number of children who enter non-relative foster care compared to those families who do not participate in the process. The use of buprenorphine to treat pregnant women with OUD, focus on non-pharmacologic interventions for NAS and changes in pharmacologic interventions in the care to infants with NAS has significantly decreased the length of treatment and length of stay for these infants. The development of a Plan of Safe Care prior to birth has become paramount in preventing foster home placements. Many women who are also receiving care coordination services may not have cases opened for general protective services after the initial assessment period by children and youth services.

In addition to support for the continued recovery of the parents, a focus has been placed on services for the infant. Early Intervention has a presence in the Neonatal Intensive Care Unit where all children being observed and treated for neonatal abstinence syndrome are admitted. This allows for early parental engagement and has increased the compliance of these services after the infant is discharged from the hospital for infants going home to parents or family members.

Women who receive MAT outside of the PCMH but receive services through the COE, the Women's Health Center or the Maternal Child Health Nurse Navigators are also offered the NAS education sessions which are held on odd numbered months, referral for FGDM and Early Intervention Services.

Having a collaborative community response is essential in understanding each other's roles and then implementing a system that supports pregnant and parenting women who suffer from OUD. The Pregnant and Parenting Substance Use Disorder Community Consortium as met on a monthly basis for several decades. Members include representatives from the following:

- Early childhood education including the Intermediate Unit and Head Start
- Recovery and case management services for pregnant and parenting women
- Early Intervention
- OUD COE
- Hospital staff including inpatient and outpatient social services, nurses, physicians and nurse navigators
- Housing programs for women with substance use disorders
- The Single County Authority
- County Children & Youth Services
- Private Children & Youth Social Service Agencies
- Obstetric providers
- Pediatric providers
- Nursing education programs
- Home visiting programs including Nurse-Family Partnership and Parents as Teachers
- Federally qualified health care providers
- MAT providers

Project LAUNCH Example

In October 2014, the Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) was awarded a Project LAUNCH grant – Linking Actions for Unmet Needs in Children’s Health. The purpose of LAUNCH is to help all children reach social, emotional, behavioral, physical and cognitive milestones and to thrive in school and in life. It focuses on children birth to 8 years of age and their families and pregnant women at risk for mental health concerns and living at or under 200% of the federal poverty level. Prevention and promotion strategies focus on 1) screening and assessment in a range of child-serving settings, 2) integration of behavioral health into primary care, 3) mental health consultation in early care and education, 4) home visiting focusing on social and emotional well-being and 5) family strengthening and parent skills training. Cross-cutting issues include racial/ethnic disparities in access to services, cultural and linguistically appropriate services, workforce development and public awareness.

PA Project LAUNCH is an alliance among partners that have a shared vision for the wellness of young children and a history of working together on their behalf. OMHSAS partnered with Allegheny County Department of Human Services as the local pilot community because of its 1) commitment to early childhood and evidence-based practices, 2) unique but representative population and 3) access to networks of providers dedicated to improving the lives of young children and their families. Allegheny County's Department of Human Services is leading a partnership that includes the Allegheny County Health Department, the University of Pittsburgh Office of Child Development, a network of parents and numerous providers of services that have a commitment to promoting the social, emotional, behavioral and physical health and cognitive development of young children from birth to eight years of age.

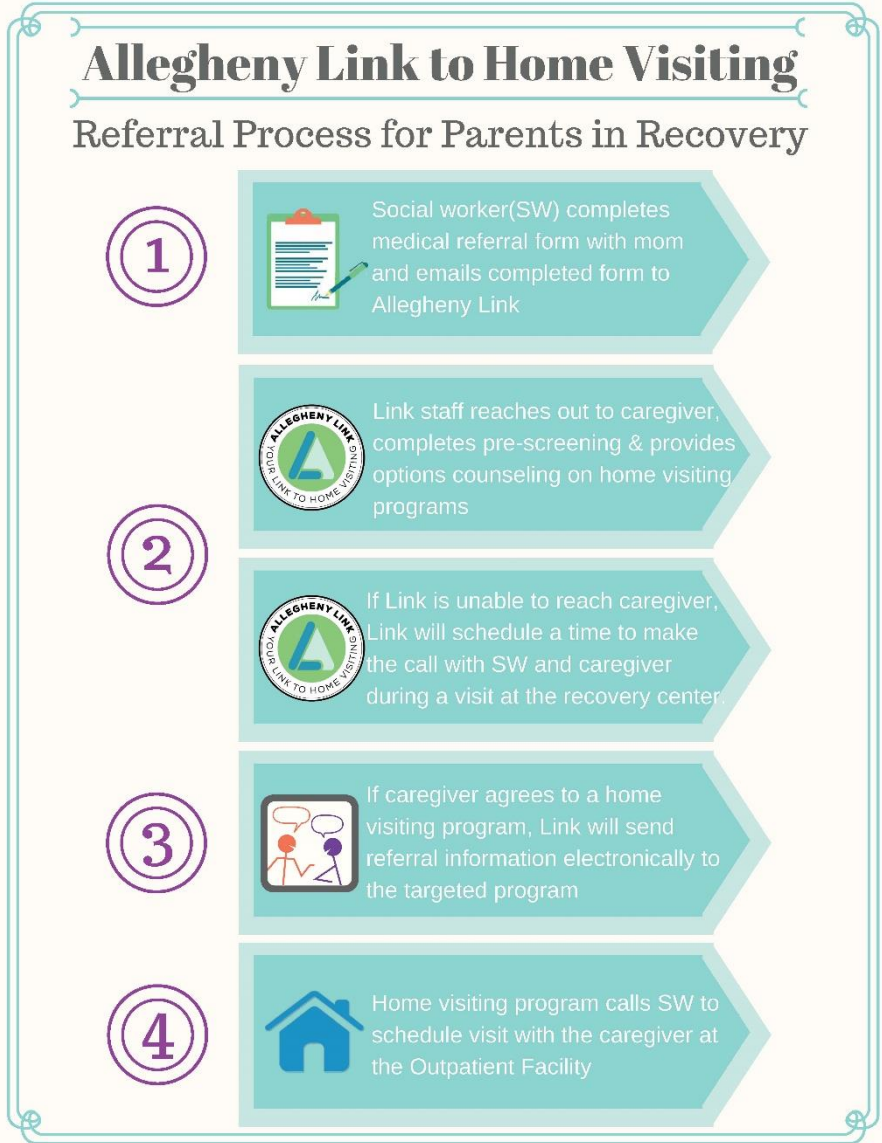
The general purpose of PA Project LAUNCH is to enhance local and state infrastructure to support services for children birth to eight years of age, their families and pregnant women. Broadly speaking, this involves services that aim to support the social-emotional development, behavioral health and overall wellness of children who reside in these areas. This purpose was informed by the completion of an Environmental Scan in Year One. Scan results identified a variety of exemplary services and programs across the core Project LAUNCH goal areas but indicated that the primary challenge was to coordinate and expand such model programs to meet the needs of families with young children who are facing multiple risk factors. Given its purpose of enhancing local and state infrastructure, PA Project LAUNCH has taken a broad approach and focuses these efforts across all five of the Project LAUNCH prevention and promotion goal areas identified above. These, coupled with local and state infrastructure, represent the key domains of PA Project LAUNCH:

- Screening and Assessment
- Family Strengthening
- Behavioral Health and Physical Health Integration
- Early Childhood Mental Health
- Home Visiting

Engagement of substance use prevention and substance use treatment systems partners has been a key requirement for PA Project LAUNCH, set forth by SAMHSA. However, in support of our goal to create a coordinated and comprehensive system, all supports must address the health and wellness of young children and the family context that they are growing up in. The PA Project LAUNCH Partnership is aware that opioid use has reached epidemic proportions both nationally and in Pennsylvania. The Project LAUNCH team connected with their local

Centers to coordinate and collaborate on behalf of young children and families served. One way in which the PA Project LAUNCH Partnership has begun to coordinate support services for pregnant women with a substance use disorder, primarily opioids, is the creation of a process in which a referral to an appropriate home visitation program (using the coordinated referral line, Allegheny Link) will occur as part of the treatment and care coordination for a woman during her prenatal engagement in a recovery program. By engaging women during pregnancy and in collaboration with recovery staff, home visitors will have the opportunity to develop a trusting relationship with a mother prior to the birth of her baby and be better positioned to support ongoing recovery post-partum.

In connecting families who are impacted by substance use disorders to community home visiting programs, it has been imperative to ensure that the workforce feels prepared to support families who are struggling with this risk factor. The PA Project LAUNCH partners engaged home visitors to understand their fears and anxieties about working with this population and created a full-day training to address these issues through the perspectives of behavioral health clinicians, a pediatrician and a peer navigator in one of the County’s pregnancy recover centers who could share the lived experience and needs of a recovering mother with a new baby. This training came one year after another conference which focused on substance use and its impact on parent-child attachment.



Appendix E

Local Emerging Practices: OCYF County Examples

Montgomery County Office of Children and Youth Example - Infant and Preschool Children Drug and Alcohol Exposure Practice

Snapshot:

Public awareness, legislative changes and a county-wide focus on the opioid epidemic has continued to impact the number of at-risk newborns and preschool-age children reported to the Office of Children and Youth (OCY) due to parental/caregiver addiction. From the onset of a family's involvement with OCY, every effort is made to engage a parent/caregiver in treatment so that caregiving capacities are strengthened without jeopardizing the child's safety. While over the past couple of years OCY has seen increases in newborns and preschool-age (0-5) children referred due to parental substance use, inconsistent screening by hospitals and healthcare professionals do not provide a true picture of the number of children affected. Newborns identified as affected by maternal substance use referred by hospital have increased by roughly 40%. Pre-school-age children (0-5) referred by healthcare providers and other community-based organizations as a result of parent/caregiver substance use has increased 55%. Several local hospitals test parents and newborns for the presence of illegal or detrimental substances, while others test if circumstances create concern. The number of reports by hospitals and healthcare professionals vary widely and likely are largely under reported. These issues underscore the need for the policy changes described in this document.

Policy:

Children that come to the attention of OCY due to concerns of parent/caregiver substance use are assessed using a triage approach to determine level of services and needs. Depending on individual family factors, various agency practices are employed. Infants and preschool-age children cases are handled in a specialized manner due to the vulnerability of the children. In all cases where there is a child under the age of five years old, a drug and alcohol risk assessment and an administrative review are completed. Other practices and services such as intensive family finding, family team meetings, substance use education and home visiting are implemented routinely.

Procedures:

Upon receiving a report of drug exposed infant:

1. Caseworker makes initial contact with parent(s) within 24 hours, sees infant within 48 hours. All household members are interviewed.
2. Caseworker and Supervisor complete drug and alcohol risk assessment.
3. Caseworker contacts D&A review Administrator within two days of receiving case to schedule a meeting.

4. Caseworker and D&A review Administrator decide on case approach:
 - Case may be closed at that time, if no concerns
 - Case may be opened for a 60-day intake assessment to determine if there is a need for an open OCY case. Safety plan will be implemented, if necessary.
 - If case is opened, file is flagged to mark as a preschool D/A case
 - Case must be reviewed with an administrator before closure and D&A survey completed
5. For any case opening for a 60-day intake assessment, a Mobile Engagement Services (MES) referral is initiated.

Drug and Alcohol (D&A) Risk Assessment:

Twenty-one (21) factors are used on the drug and alcohol risk assessment. The purpose of the risk assessment is to determine level of response and child/family needs.

D&A Administrative Review:

Reviews are held before opening, closing and for any pertinent updates where a preschool-age child is present. The purpose of D&A review is to provide a higher level of case direction and service recommendations. The timeframe for reviews is within 3 business days of the request.

Mobile Engagement Services:

This service is delivered by Penn Foundation and funded by Montgomery County Drug and Alcohol Office. An MES worker has been dedicated to serving only OCY families. Mobile Engagement Service is a community-based addiction intervention service for individuals and families who fail to access or respond to traditional drug and alcohol treatment.

Collaborative Partnerships:

To effectively address infants and young children affected by parental/caregiver substance use, development of several collaborative partnerships is ongoing.

- Montgomery County Maternal and Early Childhood Consortium: In 2017 one of the priorities set for the consortium was to focus on mitigating maternal substance use effects on infants and young children. While this work is ongoing, there has been increase awareness brought to this issue through two actionable items, 1) Collaboration between organizations for funding and service provision purposes, as well as building effective service delivery relationships; 2) Understanding and foundational development of creating a Montgomery County Plan of Safe Care best practice protocol.
- Nurse-Family Partnership: OCY and Montgomery County Office of Public Health (OPH) have a long-standing shared vision of supporting families in their communities through

the use of evidence-based practices. Since FY 2016/17 OCY has supported NFP using Child Welfare Special Grants Initiatives. NFP's preventative properties have demonstrated positive outcomes in a number of maternal and child health indicators, including reducing maternal substance use and child abuse and neglect.

- Montgomery County Office of Public Health: OCY and OPH are currently exploring existing opportunities to embed an OPH nurse in OCY to enhance development of plans of safe care.
- Family Group Decision Making (FGDM): Over the past couple of years, OCY has expanded the use of FGDM to include a prevention and diversionary approach to child welfare involvement. In 2018, initial steps have been taken with a few local hospitals healthcare groups to utilize FGDM as an aid in the development of a Plan of Safe Care, prior to or at the time of child's birth.

Bucks County Office of Children and Youth Example

SEI Referral Assessment Guidelines

- Face to face contact with the newborn (per mandated response time) and any other case children or household member children
- Face to face contact with all caregivers and household members
- JNETs on all caregivers and household members
- Collaterals to all treatment providers for all parents, caregivers and household members: medical, mental health, drug & alcohol, probation/parole officers, etc.
- What supports does the family have in place: MES, Family Strengthening, MOMS, Treatment Providers, Parenting, Early Intervention, Maternity Care Coalition, etc.? Do they all understand the safety plan? If no safety plan, do they understand what to do if there is a relapse?
- Thorough home visits with a discussion about who lives in the home and where everyone sleeps, as well as any evident safety issues
- Safe sleep discussion at each home visit that is clearly documented
- Safety Assessments and Risk Assessments must include every household member and caregiver. Case notes must reflect everyone was seen and assessed.
- Safety Plan must be signed and distributed to all stakeholders (parents, safety plan supervisors, doctor, daycare, school, etc.)

- Collateral calls for follow up on case children:
 - to pediatrician and dentist for follow up appointments
 - to specialists for follow up appointments
 - to Early Intervention to make a referral or follow up on one
 - to school for older siblings/school aged household members
- Agency Drug Testing for parents and caregivers: both parents, safety plan supervisors, significant others
- Everything must be clearly documented in case notes
- Determinations must be accurate. The allegations are:
 - Child < 1 who has withdrawal symptoms as a result of prenatal drug exposure
 - Child <1 who was born and identified as being affected by illegal substance use by mother
 - Child <1 who is identified as having Fetal Alcohol Syndrome (FAS)

These are not screen outs or invalid referrals. They can be determined as valid and not accepted for service, or they can be determined as valid and accepted for service.

Allegheny County Office of Children, Youth and Family Example

Challenges:

- Identification of infants born substance exposed absent of universal screening
- Racial disproportionality around reporting
 - Ex. One local hospital's birth data of all referrals received by CYA showed of 227 infants - 88 White to 160 African American. This is in stark contrast to the ethnic picture of the population of Allegheny County
- Universal implementation of Plans of Safe Care: beyond child welfare to prevention and community
- Accuracy of data collection related to reporting category/reporting source

Child Welfare Response:

For those youth brought to the attention of Allegheny County OCYF, we have created (and are still developing) service delivery paths and strategies to address the needs of these infants and families and our system, when they are referred to the CYA.

***Formal standards of practice and guidance, beyond CYA response/regulatory standard, are in development*

Service paths & strategic initiatives:

The Children's Institute Care Coordination Program 2016

DHS initiated collaboration with The Children's Institute (TCI) to serve families with infants born NAS and/or medically complex. TCI serves the family via a team to ensure their babies born with NAS receive the services they need when they need them in concert with supporting access to services for the parent/caregiver, such as MAT. The team includes a medical director, care coordinator and health coach. The care coordinator creates the child's plan of care which consists of goals for the family and the health coach to work on together. Participation in the program is voluntary, however upon receipt of a referral for an infant, OCYF staff are required to refer to the family to TCI for service.

Home Based Family Recovery 2018 Connecticut Model

Holy Family provides recovery-oriented trauma informed in home substance use disorder treatment. This is an intensive and comprehensive in-home program with the goal of helping to reduce the risk of removal and help children develop in a drug-free, safe and stable home with their parents. The parent or caregiver has an assessment completed by POWER staff and/or licensed DDAP facility staff and if the level of care is for outpatient service the family can be referred for participation in this program. The target population served are families with a child under 36 months who is at home with the parent; if they are in out of home care, there is a plan for reunification.

In Home Family Recovery 2019

Family Residential treats 'the whole family' by providing a residential/home setting for the entire family under a residential support model. Evidenced-based recovery supports are provided with anticipated outcomes of: reduction or elimination of referred parent's substance use; recovery maintenance; improved child safety and parent-child relationship; and out of home placement prevention or reduction.

ARIA: Family Links 2018

ARIA is a rental assistance program supporting individuals and families being served by OCYF with locating and securing housing where homelessness is an identified barrier to the client receiving treatment. The client must have a goal of reunification or preservation with regards to their child or children's placement. Once stable in housing, *Family Links* staff then assists with connecting the client, through case management, with drug and alcohol treatment,

employment and any necessary community resources. Financial support for rent is provided and the program clearly illustrates concurrent work of intervention and prevention.

Addressing housing needs is a concrete intervention layered with preventative measures.

Strategies to address challenges in Allegheny County:

- Education, education and more education
- Introduction of a Substance Use Consultant in 2017
- Liaison for program office staff to support family's navigation of respective systems
- Staff education: 8 series training developed and delivered by POWER
- Substance Use Disorder Training Day September 2018 for all court partners: judges, hearing officers, JPO & CYF leadership, public defenders, District Attorney, parent advocates, Kids Voice, county solicitors, CASA and conflict consul
- Collaboration with the ACHD to identify most effective screening tool
- Education for OCYF regional office leadership around the use of urine screens to inform critical decisions versus understanding the use of screen results to inform conversations with the family and service identification
- Introduction of a Diversity Officer to OCYF in 2016
 - Racial Equity Summit in 2018
 - Racial Equity Training for all OCYF staff from 2016-2018

Greene County Office of Children and Youth Example

Greene County has implemented new positions and processes to ensure not only the safety of the substance exposed infants, but also offer support to parents/caregivers. Greene County will utilize a newly implemented Caseworker III position to specifically manage notifications for substance exposed infants. This current caseworker has prior CYS experience and subsequently worked as a certified drug and alcohol evaluator before returning to child welfare. The caseworker is not only experienced in risk and safety regarding children, but also possesses specialized knowledge regarding addiction, resources to assist parents and families and outside referrals, as needed. The Caseworker III will be the primary point of contact for all of the substance exposed infant notifications, will assess the needed response time within the guidelines of the updated CPSL and schedule/coordinate the MDIT meeting. The Caseworker III will then assist and/or lead the development of the response plan based on the information obtained as part of the MDIT. This process will allow for a single and consistent point of contact, the development of strong and positive relationships with the local birthing hospitals and the development of a consistent process by which all members of the MDIT can cooperatively address the needs of the child and family.

Appendix F

Brief Description of State Entities:

OCDEL Resources

Early Learning Resource Centers (ELRC's) - (Young Children and their Families/Caregivers)

ELRCs provide a single point-of-contact for families, early learning service providers and communities to gain information and access services that support high-quality child care and early learning programs. ELRCs administer child care subsidy and supports. This state and federal investment in Pennsylvania's working families enables parents to maintain employment while creating opportunities for the commonwealth's children to develop and learn to their fullest potential.

Through the ELRC, child care professionals can obtain support in building quality outcomes for children by working with quality coaches, building connections with community partners and supporting children and families in accessing additional services, such as PA Pre-K Counts, Head Start, evidence-based home visiting and Early Intervention.

All ELRCs will have a primary location in their designated region and most will have satellite offices. ELRCs will also partner with community organizations to meet families' needs where they naturally congregate. You can use this link in order to locate the ELRC that supports your local community:

<http://dhs.pa.gov/citizens/childcareearlylearning/earlylearningresourcecenter/index.htm>

Early Intervention (EI) - (Birth to entrance into kindergarten)

EI in Pennsylvania consists of services and supports designed to help families with children who have developmental delays or disabilities. EI services can include: information about how children develop, parent or caregiver education, family supports and developmental and instructional therapies that assist in child development. Early Intervention builds upon the natural learning that occurs in the first few years. It is a process that promotes collaboration among parents, service providers and others who are involved with the child.

Early Intervention At-Risk Tracking - (Birth-3 years old)

Developmental screening and tracking services include a process to regularly assess the development of a child who is at risk for developing a delay.

An infant or toddler may be eligible for tracking services through Pennsylvania's Early Intervention program if they are at risk for a developmental delay based on one of the following categories:

- Low birth weight

- Cared for in a hospital's neonatal intensive care unit (NICU)
- Prenatal substance exposure, including alcohol exposure
- Referred by a county children and youth agency
- Exposed to lead
- Experiencing homelessness

To reach EI, please contact the statewide CONNECT Line at: 1-800-692-7288

The Help Me Grow tracking brochure can be found here:

<http://www.pattan.net/publications/help-me-grow>

Family Support Programs

Evidence-Based Home Visiting: Voluntary, family-focused homebased supports and services to expectant parents and families with infants and young children. Trained professionals meet regularly in the homes to support families by teaching positive parenting skills and parent-child interactions, promote early learning, provide information and guidance on topics such as breastfeeding, safe sleep practices, injury prevention and nutrition, conduct screenings and provide referrals and follow up to address issues such as depression, substance use disorders and family violence, screen children for developmental delays and refer to Early Intervention, and connect families to other resources.

Family Centers: There are 47 state and federally funded community-based Family Centers serving 31 counties across Pennsylvania that provide integrated community services to help families become healthier, better educated and self-sufficient by helping them: learn about child development, positive parenting, access health care information, access education, training and employment information and other community resources, such as WIC and immunizations. Each Family Center takes a unique approach to meeting their community's needs, therefore not all services are available in every center; however, every center offers an evidence-based home visiting program.

Promoting Responsible Fatherhood programs: There are 24 agencies across Pennsylvania that receive federal funding to provide supports and services to fathers of young children to strengthen positive father-child engagement, improve employment and economic mobility opportunities and improve healthy relationships.

Positive Parenting programs: Local agencies are able to apply for Children's Trust Fund (CTF) grants to provide positive parenting programs known to prevent child abuse and neglect and can include individual and/or group-based parent education programs such as Triple P, the Incredible Years, STEP and Nurturing Parenting as well as evidence-based home visiting programs. For more information on the CTF go to: <http://www.pa-ctf.org/>

In addition, the Strengthening Families Leadership Team (SFLT) is an initiative of the CTF supported by OCDEL working to ensure the Strengthening Families Protective Factors

Framework is being used in family-serving systems across Pennsylvania. The Strengthening Families Protective Factors Framework is a research-based approach to give parents what they need to parent effectively. When these 5 protective factors (parental resilience, social connections, knowledge of parenting and child development, concrete supports in times of need, and social and emotional competence of children) are robust in families, the likelihood of child abuse and neglect is reduced. This approach benefits all families, not just those experiencing stress. For more information on Strengthening Families: <http://www.pa-strengthening-families.org/>

Parent to Parent: In Pennsylvania, the Parent to Parent (P2P) model is a one-to-one match between an experienced, mentor parent, called a peer support parent, and a parent seeking individualized support from another parent who has been there. To date it has primarily been for families of children and adults with disabilities or special needs but is expanding to support families who participate in the family support programs. For more information on Parent to Parent: <http://www.parenttoparent.org/>

An interactive map listing all of the above OCDEL Family Support programs as well as local EI programs and community partners can be found at: <http://www.eita-pa.org/uploads/presentations/pafamilysupport/index.html#/>

DDAP Overview

DDAP is designated as the Single State Authority (SSA) to plan and allocate the Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant. DDAP, in administering the SAPT Block Grant, allocates state and federal funds to forty-seven administrative units called Single County Authorities (SCAs) that are awarded grants based on population statistics, competitive awards and other factors. Additional funds are generated via other state dollars, county funds, fees, private sources, or third-party insurance coverage, etc. Given the dollars available to the SCAs for administration, prevention, intervention, treatment and treatment-related services, SCAs routinely partner with private and public organizations to support the continued development and implementation of new and innovative strategies for addressing drug and alcohol problems.

SCAs administratively plan and fund drug and alcohol prevention, intervention, treatment and treatment-related services in their communities. The organizational structure of the SCAs may be operated by county government, be contracted by the county, or be a non-profit entity that represents the geographical location and is contracted directly by the state. SCAs serve as local administrative entities for a catchment area that includes one or more counties. Currently, there are 47 SCAs serving the 67 counties in the commonwealth. It is the SCAs' responsibility to determine the needs of their catchment area and provide needed services directly or contract with providers to deliver the appropriate services. Services provided by the SCAs either directly or through contractual agreements with providers include prevention, intervention, treatment and treatment-related services. Treatment-related services includes but is not limited to case management, coordination of services and recovery support services. SCAs and their contracted providers have the ability to screen and assess an individual for substance use disorder treatment and the need for services.

DDAP is also responsible for the licensing of drug and alcohol abuse treatment facilities which is done through its Bureau of Quality Assurance for Prevention and Treatment, Program Licensure Division. This responsibility is carried out under the power and duties contained in Articles IX and X of the Public Welfare Code (62 P.S. § 901-922, 1001-1059), as transferred to the Governor's Council on Drug and Alcohol Abuse by Reorganization Plans 1977-2 (71 P.S. § 751-25) and then by 1981-4 (71 P.S. § 751-31) to DOH. Standards for licensing treatment facilities are provided in 28 Pa. Code §§701-715.

As the SSA, DDAP works to engage, coordinate and lead the commonwealth's effort to prevent and reduce substance use and abuse and to promote recovery thereby reducing the human and economic impact of the disease. DDAP works in collaboration with the SCAs, stakeholders and other commonwealth departments to ensure the needs of individuals are met and the right services are provided at the right time.

DDAP Resource list:

DDAP website <https://www.ddap.pa.gov/>

SAMHSA: <https://www.samhsa.gov/>

Get Help Now: <https://apps.ddap.pa.gov/gethelpnow/> or 1-800-6624357

Opioid Data Dashboard: <https://data.pa.gov/stories/s/Pennsylvania-Opioids/9q45-nckt/>

FASD: <https://www.cdc.gov/ncbddd/fasd/index.html>

<http://www.dhs.pa.gov/parecovery/childrenadolescents/fetalalcoholspectrumdis/index.htm>

Neonatal Abstinence Syndrome:

https://www.cdc.gov/mmwr/volumes/66/wr/mm6609a2.htm?s_cid=mm6609a2_w

<https://blog.samhsa.gov/2016/08/02/a-healthier-start-addressing-neonatal-abstinence-syndrome-and-opioid-misuse-during-pregnancy/#.W2ncg3mWyUk>

Single County Authorities: <https://apps.ddap.pa.gov/gethelpnow/CountyServices.aspx>

Evidence Based Screening Tools: <https://www.integration.samhsa.gov/clinical-practice/screening-tools>

DHS's Office of Mental Health and Substance Abuse Services (OMHSAS) Overview

Mental Health services in Pennsylvania are administered through county Mental Health and Developmental Services/Intellectual Disabilities (MH/ID) program offices and the actual mental health services are delivered by the county or local provider agencies under contract with the county MH/ISDS office. The county MH/ID office determines a person's eligibility for service funding, assesses the need for treatment or other services and makes referrals to appropriate programs to fit service needs.

The current public children's behavioral health system in Pennsylvania is based on the principles and framework developed more than 20 years ago through the Child and Adolescent

Service System Program (CASSP). This Introduction to CASSP describes the origins of CASSP in Pennsylvania, highlights current initiatives and services and lists some basic children's behavioral health services.

CASSP Coordinators

When the Child and Adolescent Service System Program (CASSP) began in Pennsylvania more than 20 years ago, funding was provided for each county to hire a CASSP coordinator to help develop an infrastructure for an effective children's mental health system at the county level. Over time, the roles of CASSP and Children's Mental Health Coordinators have evolved and many of them serve a variety of functions in their counties. In general, however, the individuals in the following list understand how the children's behavioral health system works in their counties and can serve as a resource to family members, providers and others who need assistance with services.

A list of county CASSP and Children's Mental Health Coordinators can be found at the following link: http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_260461.pdf

Behavioral Health Choices

Mental health and drug and alcohol services provided via the HealthChoices program differ from the physical health component of the HealthChoices program. For mental health and drug and alcohol services, each county contracts with a Managed Care Organization (MCO). Once you are enrolled with the MCO, you continue to have choices as to who provides your services. The MCO will send you a handbook outlining how to access services and outlining the benefits available to you. If a practitioner is a HealthChoices participating provider and is accepting new clients, you have the right to see that doctor.

Under the behavioral health component of the HealthChoices program, County Mental Health programs are required to ensure high quality care and timely access to appropriate mental health and drug and alcohol services and to facilitate effective coordination with other needed services. Each HealthChoices consumer is assigned a Behavioral Health Managed Care Organization (BH-MCO) based on his or her county of residence. Members, then, have a choice of Behavioral Health Care providers within the BH-MCO's network. You can use the following chart to determine the BH-MCO that operates in your county and click the corresponding link provided to access their webpage.

COUNTY	BH-MCO
Philadelphia	Community Behavioral Health (CBH)
Adams, Allegheny, Bradford, Berks, Blair, Cameron, Carbon, Centre, Chester, Clarion, Clearfield, Clinton, Columbia, Elk, Erie, Forest, Huntingdon, Jefferson, Juniata, Lackawanna, Luzerne, Lycoming, McKean, Mifflin, Montour, Monroe, Northumberland, Pike, Potter, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Warren, Wayne, Wyoming, York	Community Care Behavioral Health Organization (CCBHO)
Bucks, Delaware, Lehigh, Montgomery, Northampton, Cambria	Magellan Behavioral Health of Pennsylvania (MBH)
Bedford, Cumberland, Dauphin, Franklin, Fulton, Lancaster, Lebanon, Perry, Somerset	PerformCare
Armstrong, Beaver, Butler, Crawford, Fayette, Greene, Indiana, Lawrence, Mercer, Washington, Westmoreland, Venango	Value Behavioral Health

To search for mental health treatment providers, please use the following link: <http://www.dhs.pa.gov/citizens/searchforprovider/humanservicesproviderdirectory/index.htm>

To search for drug and alcohol treatment providers by county, please use the following link: <https://apps.ddap.pa.gov/gethelpnow/CareProvider.aspx>

Appendix G

Publicly Available Data:

Pennsylvanians can find public data related to infants born and identified as being affected by substance use or withdrawal symptoms resulting from prenatal drug exposure in the following places:

Annual Child Protective Services Report:

<http://www.dhs.pa.gov/publications/childabuserereports/index.htm>

Pennsylvania Opioid Data Dashboard:

<https://data.pa.gov/stories/s/Pennsylvania-Opioids/9q45-nckt/>

Department of Health:

<https://www.health.pa.gov/topics/HealthStatistics/VitalStatistics/MaternalChildHealth/Pages/maternal-child-health.aspx>

PA Health Care Cost Containment Council:

http://www.phc4.org/reports/researchbriefs/neonatal/17/docs/researchbrief_neonatal2017.pdf

http://www.phc4.org/reports/researchbriefs/neonatal/092716/docs/researchbrief_neonatal_2000-2015.pdf

Appendix H

Statewide Monitoring and Evaluation Plan:

Section 106(b)(2)(B)(iii)(II) of CAPTA requires that the state have policies and procedures for “the development and implementation by the State of monitoring systems regarding the implementation of such 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”.

There is no definition of “monitoring” in federal law and CAPTA does not specify of what the state level monitoring system must consist. In guidance provided to states, the Administration for Children and Families has confirmed that a “state agency” is required to monitor the implementation of Plans of Safe Care. As a state-supervised, county-administered system, the county child welfare agency is considered a “state agency” and may both develop and monitor Plans of Safe Care. Other state agencies, such as the Department of Health and Department of Drug and Alcohol Program, may also monitor Plans of Safe Care.

As discussed in Chapter 10 of this Guidance Document, multidisciplinary teams (MDTs) are responsible for monitoring the implementation of individual Plans of Safe Care. In particular, the designated lead for each MDT, as discussed on pages 24 and 25 of this Guidance Document, is tasked with ensuring the Plan of Safe Care is appropriately updated, edited as needed and closed when necessary.

Statewide monitoring of Plans of Safe Care in Pennsylvania will occur as follows:

- For Plans of Safe Care in which the local children and youth agency is the designated lead:
 - County children and youth caseworkers and supervisors should keep record in the family’s case file that includes the Plan of Safe Care; a list of the members of the MDT; proof of referrals to recommended services and supports, including contact information for the appropriate agencies; notes from regular MDT meetings; confirmation of notification to ChildLine that the child was born and identified as affected by substances; and any other documentation related to the Plan of Safe Care, including, but not limited to, release of information agreements and confidentiality agreements.
 - The county agency is responsible for monitoring the implementation of Plans of Safe Care on an ongoing-basis. This may take place during regular quality assurance activities such as case file reviews, supervision, peer reviews, etc.
 - During annual licensing inspections by the Department of Human Services, random sampling will be employed to assess overall agency compliance with these Guidelines. Ten percent of case files pulled for review must include those for whom a Plan of Safe Care was created. The plan will be reviewed for compliance based on this Guidance Document. If agencies do not have the appropriate documentation regarding Plans of Safe Care in the case file for

infants and families for whom a notification was made under section 6386 of the CPSL, a plan of correction will be required that outlines the agency's planned steps to remedy the violation and ensure future compliance.

- For Plans of Safe Care in which a healthcare provider is the designated lead:
 - In the event that a licensed hospital staff or health care facility staff is designated as the lead for a Plan of Safe Care, the Department of Health will monitor for compliance with these Guidelines.
 - The Department recommends that the licensed hospital or health care facility maintain a copy of the Plan of Safe Care and documentation of notification to the Department of Human Services per section 6386 of the CPSL in the patient's medical record.
 - With potential updates to the Pennsylvania hospital regulations, a licensed hospital or health care facility would be required to comply with all aspects of the CPSL. As such, hospital licensure surveys may include review of the licensed hospital's or health care facility's policies, protocols and/or records to ensure compliance related to the notification to the Department of Human Services as stated in section 6386 of the CPSL.
- For Plans of Safe Care in which a drug and alcohol counselor or other appropriate staff person is the lead:
 - The Department of Drug and Alcohol Programs' executive team is in the process of developing monitoring requirements for Plans of Safe Care which is inclusive of discussions with the 47 single county authorities (SCAs) and contracted treatment providers.

Institute for Health an Recovery

Integrated Screening Tool

Women's health can be affected by emotional problems, alcohol, tobacco, other drug use, and domestic violence. Women's health is also affected when those same problems are present in people close to us. By "alcohol," we mean beer, wine, wine coolers, or liquor.

Parents Did any of your parents have a problem with alcohol or other drug use?	Yes <input type="checkbox"/>		No <input type="checkbox"/>
Peers Do any of your friends have a problem with alcohol or other drug use?	Yes <input type="checkbox"/>		No <input type="checkbox"/>
Partner Does your partner have a problem with alcohol or other drug use?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Violence Are you feeling at all unsafe in any way in your relationship with your current partner?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Emotional Health Over the last few weeks, has worry, anxiety, depression, or sadness made it difficult for you to do your work, get along with people, or take care of things at home?			Yes <input type="checkbox"/> No <input type="checkbox"/>
Past In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?			Yes <input type="checkbox"/> No <input type="checkbox"/>
Present In the past month, have you drunk any alcohol or used other drugs? How many days per month do you drink? _____ How many drinks on any given day ? _____ How often did you have 4 or more drinks per day in the last month? _____			Yes <input type="checkbox"/> No <input type="checkbox"/>
Smoking Have you smoked any cigarettes in the past three months?			Yes <input type="checkbox"/> No <input type="checkbox"/>

Review Risk

Review Domestic Violence Resources

Review Substance Use, Set Healthy Goals

Consider Mental Health Evaluation

Advise for Brief Intervention

	Y	N	NA
Did you State your medical concern?			
Did you Advise to abstain or reduce use?			
Did you Check patient's reaction?			
Did you Refer for further assessment?			

At Risk Drinking	
Non-Pregnant	Pregnant/ Planning Pregnancy
> 7 drinks / week > 3 drinks / day	Any Use is Risky Drinking

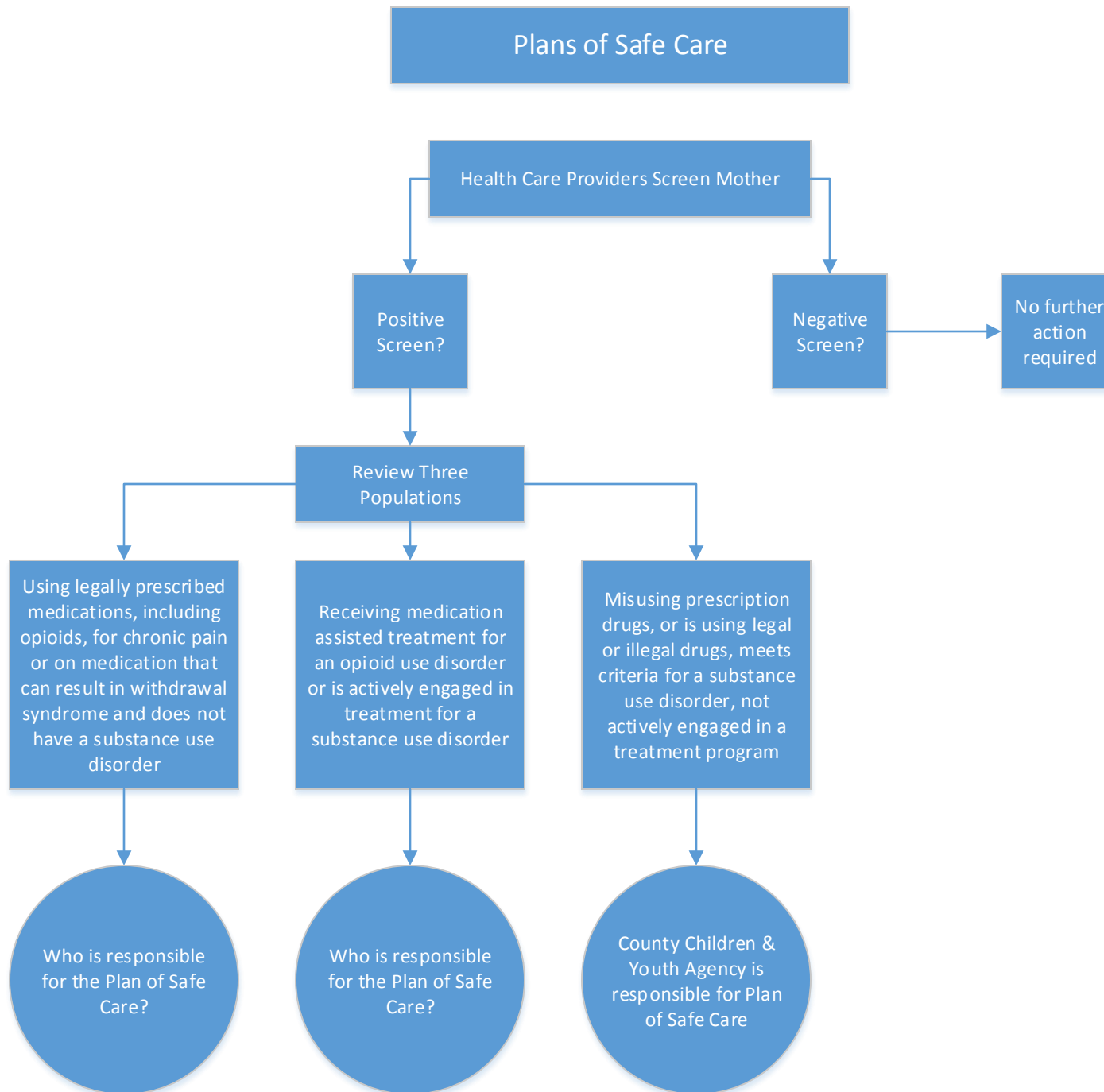
Date: _____

Language: _____

Race: _____

Ethnicity: _____

For the best health of mothers and babies, we strongly recommend that pregnant women, or those planning to become pregnant, do not use alcohol, illegal drugs or tobacco. Safe levels of usage have not been determined.



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