



STATE OF DELAWARE
PLAN OF SAFE CARE
IMPLEMENTATION GUIDE

For Infants with Prenatal Substance Exposure and their Families

I. PURPOSE

The purpose of this manual is to provide guidance to child welfare social workers, hospital and medical personnel, community health nurses, substance use treatment providers, and other professionals involved with a family in executing an effective Plan of Safe Care (POSC) for infants with prenatal substance exposure and their families.

II. LEGAL AUTHORITY

The Child Abuse Prevention and Treatment Act (CAPTA), Comprehensive Addiction and Recovery Act of 2016 (CARA), and Aiden's Law¹, requires the development of a Plan of Safe Care for an infant born with and identified as being affected by substance abuse, withdrawal symptoms or Fetal Alcohol Spectrum Disorder. The Plan of Safe Care should address the needs of the infant and those of the parent(s) so that appropriate services are provided to the family to ensure the infant's safety and well-being.

III. GUIDING PRINCIPLES

- A. All pregnant women and their families affected by substance use disorders should have access to affordable prevention and treatment services. Ideally, substance use by pregnant women will be identified early, prompt referrals for substance use disorder treatment will be made, and the development of the POSC will be initiated prenatally prior to the birth event.

¹ CAPTA (42 USC 5104(b)), as amended by CARA (2016); 16 Del.C. §901B et al.

- B. The safety and well-being of children and families is a responsibility shared by the entire community. As such, systems of care communities must join together in holding one another accountable for ensuring positive outcomes, regardless of where the child and family seek help.²
- C. Delaware has adopted the “Five-Point Intervention Framework” developed by the National Center on Substance Abuse and Child Welfare which serves as a comprehensive model that identifies five major time frames when intervention in the life of an infant can help reduce the potential harm of prenatal substance exposure.³
- D. Interventions should be provided to pregnant and breastfeeding women in ways that prevent stigmatization, discrimination, criminalization, and marginalization of women seeking treatment to benefit themselves and their infants.⁴
- E. A Plan of Safe Care (POSC) will be developed for an infant born with and identified as being affected by substance abuse or withdrawal symptoms or Fetal Alcohol Spectrum Disorder (FASD) to ensure the safety and well-being of such infant following release from the healthcare providers. This will be effectuated by addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver, including monitoring these plans to ensure appropriate referrals are made and services are delivered to the family.⁵ The focus of the POSC is promoting the safety of an infant while developing a strategy to address the well-being of the family.
- F. Services for families with substance use disorders are different than services for other populations. A thorough assessment done by a certified substance abuse counselor will typically be the first step in providing services for the family. Assessment is a process for defining the nature of the substance use problem, determining a diagnosis, and

² <https://www.childwelfare.gov/topics/management/reform/soc/history/accountability/>

³ Young et al. (2009). *Substance Exposed Infants: State Responses to the Problem*. HHS Pub.No. (SMA) 09-4369. Rockville, MD; <https://www.youtube.com/watch?v=nEaTjxydGp4&feature=youtu.be>

⁴ World Health Organization Guidelines for the Identification and Management of Substance Use and Substance Use Disorders in Pregnancy (2014).

⁵ CAPTA (42 USC 5104(b)), as amended by CARA (2016).

developing specific treatment recommendations for addressing the problem or diagnosis.⁶ Special consideration should be given to the following:

- Is outpatient treatment needed and available?
- Is in-patient treatment needed and available?
- Is detoxification required?
- Does the individual need a program for dual diagnosis patients?
- Does the individual need a program that specializes in a particular addiction?
- Is peer support needed and available?
- Does the treatment facility address the special needs of women and their children?

IV. DEFINITIONS

A. Adherence is a term that refers to how closely clients cooperate with, follow, and take personal responsibility for the implementation of their substance use disorder treatment plans, including how well clients accomplish the goal of persistently taking medications. The client's efforts to accomplish the goals of a treatment plan occur along a complex spectrum from independent proactive commitment, to mentored collaboration, to passive cooperation, to reluctant partial agreement, to active resistance, and to full refusal. Attempts to understand factors that promote or inhibit adherence must take into account behaviors, attitudes, willingness, and varying degrees of capacity and autonomy. The term "adherence" emphasizes the client's collaboration and participation in treatment. It contributes to a greater focus on motivational enhancement approaches that engage and empower clients.⁷

B. Infant with prenatal substance exposure (IPSE) or substance exposed infant (SEI) means a child not more than 1 year of age who is born with and identified as being affected by substance abuse or withdrawal symptoms or a Fetal Alcohol Spectrum Disorder. The

⁶ Virginia Dept. of Social Services, Child and Family Services Manual, July 2017, section 10.6: CPS On-going services to families with SEI.

⁷ <https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf>

healthcare provider involved in the delivery or care of the infant shall determine whether the infant is “affected by” the substance exposure.

- C. **Medication Assisted Treatment (MAT)** is the use of FDA- approved medications, in combination with counseling and behavioral therapies, for treatment of opioid related substance use disorders.⁸
- D. **Misuse of a legal/prescription/MAT drug** means taking a medication in a manner or dose other than prescribed; taking someone else’s prescription, even if for a legitimate medical complaint such as pain; or taking a medication to feel euphoria (i.e., to get high).⁹
- E. **Plan of safe care (POSC)** means a written or electronic plan to ensure the safety and well-being of an infant with prenatal substance exposure following the release from the care of a healthcare provider by addressing the immediate safety needs of the affected infant, the health and substance use treatment needs of the infant and affected family or caregiver, and monitoring these plans to ensure appropriate referrals are made and services are delivered to the infant and affected family or caregiver.¹⁰ The plan of safe care is effective when it reflects the input of the family and professionals and provides relevant resources to address the family’s needs. The plan of safe care should include referrals to appropriate services that support the affected infant and family or caregivers. Plans of safe care may require modification post hospital discharge, as the implementation of the plan moves forward. Any modifications to the plan should occur in cooperation with the family and service providers, and where necessary, be documented in an amended plan of safe care form.
- F. **Prenatal substance exposure** means either the mother or infant test positive for a substance (alcohol, illegal drugs or misuse of legal/prescription/MAT drugs) at the time of birth requiring a notification to DFS; or the mother or infant test negative at the time of birth but mother had a positive test for a substance (alcohol, illegal drugs or misuse of legal/prescription/MAT drugs) during the 60 days prior to the birth event, as evidenced in prenatal care records; or the mother or infant test negative at the time of birth but the

⁸ <https://www.samhsa.gov/medication-assisted-treatment>

⁹ <https://www.drugabuse.gov/publications/research-reports/misuse-prescription-drugs/summary>.

¹⁰ 16 Del.C. §901B et al.

infant is experiencing withdrawal symptoms including Neonatal Abstinence Syndrome (NAS), requiring a notification to DFS; or the mother or infant test negative at the time of birth but the mother discloses/admits to substance use during the 60 days prior to the birth event.

- G. Substance use disorders** occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.¹¹
- H. Withdrawal symptoms** means a group of behavioral and physiological features in the infant that follow the discontinuation of a drug that has the capability of producing physical dependence.¹² Varying withdrawal symptoms can occur following the discontinuation or reduction of use of opioids, benzodiazepine, stimulants, alcohol, inhalants or marijuana.¹³

¹¹ <https://www.samhsa.gov/disorders/substance-use>

¹² 16 Del.C. §901B et al.

¹³ Clinical Guidelines for Withdrawal Management and Treatment of Drug Dependence in Closed Settings. Geneva: World Health Organization; 2009. 5, Psychosocial interventions. <https://www.ncbi.nlm.nih.gov/books/NBK310657/>

**V. NOTIFICATIONS TO THE DIVISION OF FAMILY SERVICES OF INFANTS WITH PRENATAL
SUBSTANCE EXPOSURE**

A. Why must healthcare providers notify DFS?

Healthcare providers must notify DFS of an infant born with and affected by substance abuse, withdrawal symptoms or FASD because it is required by federal law, known as CAPTA and CARA, as well as state law, known as Aiden’s Law.¹⁴

B. How is prenatal substance exposure identified by healthcare providers?

1. When the mother or infant tests positive at the time of birth for a substance (alcohol, illegal drugs or misuse of legal/prescription/MAT drugs), a notification to DFS is required; or,
2. When the mother or infant tests negative at the time of birth for a substance (alcohol, illegal drugs or misuse of legal/prescription/MAT drugs), but the mother had a positive test at any time during the 60 days prior to the birth event, as evidenced in prenatal care records, a notification to DFS is required; or,
3. When the mother or infant tests negative at the time of birth for a substance (alcohol, illegal drugs or misuse of legal/prescription/MAT drugs), but the mother discloses/admits to substance use during the 60 days prior to the birth event, a notification to DFS is required; or,
4. When the mother or infant tests negative at the time of birth for a substance (alcohol, illegal drugs or misuse of legal/prescription/MAT drugs), but the infant is experiencing withdrawal symptoms, a notification to DFS is required.

C. How do healthcare providers make a notification to DFS?

A notification is made when the healthcare provider involved in the delivery or care of the infant, usually the hospital social worker, contacts the DFS hotline and provides pertinent information about the infant, mother and other caregivers. (See Attachment A – Information Necessary for an IPSE Notification to DFS).

¹⁴ CAPTA (42 USC 5104(b)), as amended by CARA (2016); 16 Del.C. §901B et al.

D. When must healthcare providers make a notification to DFS?

A notification must be made at the time of the infant's **birth** when the substance exposure involves:

- 1) **Alcohol**: the infant is prenatally exposed to alcohol; or,
- 2) **Illegal Drugs**: the infant is prenatally exposed as a result of mother's use of illegal substances including but not limited to heroin, cocaine, marijuana/cannabis¹⁵, PCP, LSD, MDMA (Ecstasy), fentanyl (synthetic opioids) or methamphetamines; or,
- 3) **Misuse of Legal Prescription Drugs or MAT Drugs**: the infant is prenatally exposed as a result of mother's misuse of prescription drugs or Medication Assisted Treatment drugs, including but not limited to opioids¹⁶, benzodiazepines¹⁷, amphetamines¹⁸, methadone, or buprenorphine, that are likely to cause withdrawal symptoms or Neonatal Abstinence Syndrome (NAS)¹⁹ in the infant.

E. When are healthcare providers NOT required to make a notification to DFS?

- 1) **Negative drug test**: The mother or infant test negative for substances (alcohol, illegal drugs or misuse of legal/prescription/MAT drugs) at the time of birth AND during the 60 days prior to the birth event; or,
- 2) **Proper use of legal/prescription drugs or medication assisted treatment drugs and adherence to treatment plan**: a notification does NOT need to be made to DFS at the birth event when the infant is prenatally exposed as a result of:
 - a) Mother's proper use of a prescription drug or a MAT drug;²⁰and,

¹⁵ The FDA and DEA have concluded that marijuana has no federally approved medical use for treatment in the U.S. and thus it remains as a Schedule I controlled substance under federal law (www.dea.gov)

¹⁶ Oxycodone (OxyContin, Percocet), Hydrocodone (Vicodin), Morphine (Kadian, Avinza), Codeine, Tramadol (www.marchofdimes.org), Hydromorphone (www.dea.gov)

¹⁷ Common brand names include Alprazolam, Diazepam, Xanax, Klonopin, Valium, Ativan (www.dea.gov)

¹⁸ Common brand names include Adderall and Ritalin (www.dea.gov)

¹⁹ Neonatal abstinence syndrome (also called NAS) is a group of conditions caused when a baby withdraws from certain drugs he or she is exposed to in the womb before birth. (www.marchofdimes.org)

²⁰ SAMSHA certified Opioid Treatment Programs in Delaware include: Addiction Medical Facility, AMS, ARS, ATS of DE, Brandywine Community Counseling Services, Connections Community Support Services, Kent Sussex Community Services, NorthEast Treatment Center, and Recovery Centers of America. (<https://dpt2.samhsa.gov/directory.aspx> updated 2/7/18).

- b) The healthcare provider verifies that mother has been actively engaged in substance use disorder treatment for at least 60 days prior to the birth event; and,
 - c) The healthcare provider verifies that Mother is adhering to the requirements of her treatment plan, including but not limited to taking the prescribed dose of medication at the prescribed schedule for the prescribed duration of therapy, and is refraining from using other substances (illegal drugs or misuse of prescription/MAT drugs);²¹ and,
 - d) The healthcare provider does not perceive any risk factors or safety concerns after interviewing mother and her family; and,
 - e) The MAT provider or prescribing physician agrees to assume the responsibility of preparing, implementing and monitoring the POSC for the family (see Section IV, A below).
- If the above criteria are met, the MAT provider or prescribing physician assume the responsibilities of preparing, implementing and monitoring the POSC and will provide a notification to DFS²² on a quarterly basis of the number of POSC prepared, the number of the referrals made for services for the family and the outcome of the family's case.
 - If the MAT provider or prescribing physician does not agree to assume the responsibilities of the POSC, the hospital will make an immediate notification to DFS, at which time DFS will assume responsibilities of the POSC.
 - If at any time during the POSC process the MAT provider or prescribing physician becomes aware of or perceives any risk or safety concerns for the infant, an immediate call to the DFS hotline will be made. (See Attachment B – DFS Substance Exposed Infants Risk Factors).

²¹ <https://pubs.niaaa.nih.gov/publications/projectmatch/match06.pdf>

²² Notification is to be made in the form of aggregate data to the DFS Intake and Investigation Program Manager.

VI. PLANS OF SAFE CARE (POSC)

A. PRENATAL POSC

1. All pregnant women should be universally screened by their primary care physician/OBGYN using an evidence based screening tool during each trimester of pregnancy. (See Attachment C - “How to Screen Pregnant Patients for Substance Use Disorders and Alcohol Use” by the DE Division of Public Health)
2. If a pregnant woman is identified as needing substance use disorder treatment, or is using alcohol or a substance that will likely cause withdrawal or NAS symptoms in the infant at birth, the primary care physician/OBGYN will provide an immediate referral and “warm hand-off” to a substance use treatment provider with access to evidence based treatment, including Medication Assisted Treatment (MAT), and psycho-social therapy services. (See Attachment D –“Fact Sheet for Medical Providers: Substance Use During Pregnancy” by the DE Division of Public Health; www.helpisherede.com)
3. A referral by the primary care physician/OBGYN for a Peer Recovery Coach will help link pregnant women struggling with a substance use disorder to appropriate services and support.
4. For those pregnant women who choose MAT, such as methadone or buprenorphine, the MAT provider will begin the POSC during the prenatal period. (See Attachment E – State of Delaware Plan of Safe Care Family Assessment).
5. For those pregnant women who are taking valid prescription medications, such as opiates, benzodiazepines or amphetamines, that will likely result in withdrawal symptoms or Neonatal Abstinence Syndrome (NAS) in the infant at birth, the prescribing physician should begin the POSC during the prenatal period.
6. The MAT provider, prescribing physician or the pregnant woman will provide the prenatal POSC to the hospital social worker upon admission at labor and delivery. (See Attachment F – State of Delaware Plan of Safe Care template).
7. When the infant with prenatal substance exposure is born, the hospital social worker will contact the mother’s identified MAT provider or prescribing physician

to verify mother's compliance with her substance use treatment, MAT or other prescription drug. If the hospital verifies mother is adhering to her treatment plan for at least 60 days prior to the birth event, she is taking the prescribed medication as directed with no positive tests for illegal drugs during the 60 days prior to the birth event, and there are no other risk factors present, the hospital is not required to notify DFS at the time of birth. (See Notification Section D (a) above; See Attachment G – Notification Flow Chart).

8. The MAT provider or prescribing physician will then assume finalizing the POSC with the hospital social worker and scheduling the **“POSC Discharge Meeting”** which will take place at the birthing hospital.
9. At the POSC Discharge Meeting, the Plan will be reviewed, discussed and signed by mother, father or other caregiver and the Plan Participants, who will receive a copy of the plan.
10. The POSC may be modified at any time after the discharge meeting by the POSC Coordinator as needed for the benefit of the family.
11. If the MAT provider or prescribing physician does not agree to assume the responsibilities of the POSC, the hospital will make a notification to DFS to assume the preparation of the POSC.
12. If the hospital verifies that the mother is *not* in adherence with treatment, or is not taking the prescribed medication as directed or has tested positive for illegal drugs within 60 days prior to the birth event, the hospital is required to notify DFS at the time of birth and the case will be screened in by DFS and assigned to a POSC Coordinator. The “Birth Event POSC” protocol below shall be followed.
13. If a pregnant woman identified as needing substance use disorder treatment by her primary care physician/OBGYN does not engage in prenatal substance use treatment or MAT and tests positive at labor and delivery, the “Birth Event POSC” protocol below shall be followed.

14. If a pregnant woman is not identified as needing substance use disorder treatment by her primary care physician/OBGYN but tests positive for substances at labor and delivery, the “Birth Event POSC” protocol below shall be followed.

B. BIRTH EVENT POSC

1. All Delaware birthing hospitals²³ universally test pregnant women at labor and delivery for substances with informed consent. The specific substances that are typically included on the test panel are: alcohol, amphetamines/MDMA, barbiturates, benzodiazepine, buprenorphine, cocaine, marijuana, methadone, opiates, and PCP.
2. If a pregnant woman tests positive for a substance at labor and delivery, or she does not consent to testing, the hospital may choose to test the infant’s urine, blood or meconium.
3. If either mother or infant test positive for a substance as outlined below, the hospital social worker will call the DFS hotline to make a notification. The notification must include specific information so that DFS may conduct a risk assessment utilizing the Structured Decision Making Tool. (See Attachment A – Information Needed for SEI Notification to DFS).
4. Depending on the extent and type of substance exposure, whether the mother is adhering to her substance use treatment plan and MAT/prescription, and whether any risk factors are identified through the Structured Decision Making Tool, DFS will pursue one of the following Pathways:

1. Pathway 1: if the exposure involves alcohol, illegal drugs, misuse of a legal/prescription drug, misuse of a MAT drug, or any substance use coupled with high risk factors, the case will be accepted by DFS for investigation. A DFS investigation worker will be assigned the role of POSC Coordinator and will assume

²³ Bayhealth Kent Campus, Bayhealth Sussex Campus, Beebe Healthcare, Christiana Care, Nanticoke Hospital, and St. Francis Hospital.

the responsibilities of preparing, implementing and monitoring the Plan of Safe Care; or,

2. **Pathway 2**: if the exposure involves marijuana only and there are no other risk factors identified by the hospital social worker, the case is referred to a Contracted Agency who will assume the responsibilities of preparing, implementing, and monitoring the Plan of Safe Care; or

3. **Pathway 3**: if the exposure involves a valid MAT or prescription drug and the healthcare provider has verified mother's adherence to her substance use treatment and MAT/prescription, and there are no other risk factors identified, the hospital is not required to notify DFS at the time of birth. However, if the hospital does make the notification to DFS, the case will be screened out and referred to the MAT provider or prescribing physician who will assume the responsibilities of preparing, implementing and monitoring the Plan of Safe Care, if one has not already been initiated in the prenatal period. If the MAT provider or prescribing physician does not agree to assume the responsibilities of the POSC, DFS will screen in the case under Pathway 1.

5. Once the case is screened in by DFS under Pathway 1, the DFS worker assigned to the case will assume the role of Plan of Safe Care Coordinator who will prepare the Plan of Safe Care, gathering information from the mother, her family, the hospital social worker, substance use treatment provider, MAT provider, and/or other community partners.
6. Once the case is referred to a Contracted Agency under Pathway 2, a POSC Coordinator will be assigned by the agency and will assume the preparation of the POSC by gathering information from the mother, her family, the hospital social worker, substance use treatment provider, MAT provider, and/or other community partners. If at any time during the POSC process the Contracted Agency POSC Coordinator perceives any risk or safety concerns for the infant, an immediate call to the DFS hotline will be made.

7. The Plan of Safe Care Coordinator will coordinate with the hospital to schedule a **“POSC Discharge Meeting”** which will take place at the birthing hospital. The POSC will be reviewed, discussed and signed by mother, father or other caregiver and the Plan Participants, who will receive a copy of the plan at the conclusion of the POSC Discharge Meeting.
8. The POSC may be modified at any time after the discharge meeting by the POSC Coordinator as needed for the benefit of the family.
9. If the Contracted Agency POSC Coordinator and his/her supervisor determines that the family needs ongoing services, the case will be referred back to DFS. If the DFS POSC Coordinator and his/her supervisor determines that the family needs ongoing services, the case may be transferred to the Treatment Unit. The treatment worker will then assume the responsibilities of the POSC for the family.

VII. SERVICE REFERRALS AND MONITORING OF THE POSC

- A. **Legal Authority:** The Child Abuse Prevention and Treatment Act (CAPTA) Reauthorization (2010) and P.L. 114-198, Comprehensive Addiction and Recovery Act of 2016, Title V, Section 503, authorizes states to develop monitoring systems regarding the implementation of plans to determine how effectively local entities are providing referrals to and delivery of appropriate services.
- B. **Goals:** Monitoring of the POSC will ensure that POSC Coordinators are initiating timely and appropriate referrals to service providers who have developed a culturally sensitive, multidisciplinary approach to working with mothers and infants with prenatal substance exposure. Monitoring of the POSC will ensure that families are being provided appropriate referrals for services that meet the identified needs of affected infants, mothers, fathers and family members.
- C. **Referral Process:** Depending on the needs of the family, some referrals for services may be made during the prenatal period by the pregnant woman's treating physician(s) or substance use disorder provider. In addition, the birthing hospital social worker or nursing staff may also make referrals for services after the infant is born. Furthermore, when the POSC Coordinator is conducting the family assessment, he/she may also make referrals for services. In any event, all referrals must be documented in the POSC by the POSC Coordinator regardless of who made the initial referral.
- D. **Delivery of Services:** The POSC Coordinator is responsible for routinely following up with each service provider to confirm delivery of services to the family. The POSC Coordinator is required to document in the POSC if the family engaged in and completed the services, or whether the family did not comply.
- E. **Contact with the Family:** The POSC Coordinator will review the POSC with the family at least bi-weekly within the first 30 days after the discharge meeting with a minimum contact schedule (frequency of contact) of bi-weekly within the first 30 days and an assessment process thereafter to determine the contact schedule

- F. **Contact with the Plan Participants:** In addition to the POSC Coordinator providing a copy of the POSC to the Plan Participants within 48 hours after the POSC Discharge Meeting, the POSC Coordinator will have monthly contact, via in person or telephonically, with the Plan Participants to discuss any issues or concerns with the infant or family, until the POSC is terminated.
- G. **Information Sharing:** The POSC requires consistent and timely information sharing, with informed consent, of client progress and challenges with the Plan Participants. Information sharing allows for the POSC Coordinator to ensure that appropriate referrals for services are made and effectively delivered to the family. Information sharing also ensures the safety and well-being of the affected infant.
- H. **Termination of the POSC:** The POSC Coordinator will determine when the POSC will be terminated after consulting with the service providers and Plan Participants and determining that the family is stable and there are no safety risks present in the home. If the POSC is terminated, the following is best practice:
- A POSC team meeting prior to termination of the POSC;
 - A copy of the POSC to be left with the family;
 - Contact numbers to be left with the family;
 - A notification to the POSC plan participants;
 - Completion of any closure referrals on behalf of the family.