Information for DPH Bureau of Substance Addiction Services' Licensed and/or Contracted Providers, to Support the Implementation Plans of Safe Care

In 2016, the Federal Government amended the Child Abuse Prevention and Treatment Act (CAPTA) with the Comprehensive Addiction and Recovery Act (CARA). This amendment included, among other changes, a new requirement for the creation of "***plans of safe care*** *for infants born and identified as being affected by substance abuse or withdrawal symptoms or Fetal Alcohol Spectrum Disorder*". [1] These Plans of Safe Care (POSC) are intended to help the state "ensure the safety and well-being of infants following the release from the care of health care providers, by (1) addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver; and (2) monitoring these plans to determine whether and how local entities are making referrals and delivering appropriate services to the infant and affected family or caregiver (in accordance with state requirements)".

In response to this legislation, Massachusetts Departments of Children and Families (DCF) and of Public Health (DPH) are reviewing protocols related to substance-affected families, and offering additional tools and resources to contracted service providers to enable compliance with this Federal legislation. DCF screeners and response workers will now be asking those who file a 51-A report[2] of a substance-affected birth or infant whether a POSC has been created with that family. DCF screeners and response workers will take all information regarding a POSC into account when making their decision whether or not to open a case with a family. For this reason, providers contracted to offer substance use treatment and recovery services through the Department of Public Health's Bureau of Substance Addiction Services (BSAS) have a unique responsibility to prepare pregnant and parenting clients[3] for potential DCF contact through the use of the POSC tool. This memo is designed to explain the POSC coordination process and set forth ideal methods of communication to maximize the usefulness of the POSC for families with substance-exposed pregnancies or children.

Plan of Safe Care (POSC)

The Plan of Safe Care (POSC) is a family-led tool designed to organize access to coordinated, multidisciplinary family care and support where there are parental substance use-related health or environmental concerns for the pregnant woman, caregiver, or child during pregnancy or after birth. The POSC is a private document belonging to the family, and its existence does not necessarily indicate the need to file a 51-A report. There is also no requirement to share the content of the POSC with DCF, although if a pregnant individual/parent/caregiver does share information about her recovery work and other preparation to parent, it may help inform DCF's decision-making process.

[1] https://www.acf.hhs.gov/sites/default/files/cb/pi1702.pdf
[2] https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter119/Section51a
[3] For the purpose of this legislation, "parenting clients" refers to clients who have physical custody and are actively parenting a child younger than 12 months of age. Clients without custody may also benefit from the creation of a POSC.

A POSC documents areas of need and progress for the mother/caregiver and/or child. The POSC should be completed jointly with a pregnant client or parent/caregiver and a provider. Ideally, coordination of a POSC occurs across multiple sessions, perhaps in weekly case management or peer recovery support sessions. Duration and frequency of coordination sessions should be determined on an individual basis, with client need/preference as the foremost deciding factor.

In addition to identifying areas of need, the POSC organizes referrals to services such as addiction treatment, recovery supports, medical/behavioral healthcare, material/financial support, vocational/educational services, and other resources required to meet those needs. The POSC is designed with three related purposes in mind: (1) to help a pregnant woman, parent, or other caregiver identify and access needed services and support; (2) to help document an individual's or family's progress in addressing areas of need, which can be particularly helpful if, or when, DCF becomes involved; and (3) to help coordinate care and services among providers by emphasizing the role of a single POSC coordinator who facilitates transitions between services and providers. These three purposes underlie a systemic shift in how our state addresses the needs of substance-affected families: DCF, DPH, and service providers across the Commonwealth are forming a more integrated partnership to share responsibility for the safety, recovery, and well-being of these families.

Implementation of POSC in the Commonwealth

POSC implementation, whether prenatally or with families who are not involved currently with DCF relies on a four-step process: Screening, Coordination, Referrals, and Communication. BSAS-licensed and/or -contracted providers have responsibilities to implement POSC at each step.

1. **Screening:** Many types of providers might screen a parent/caregiver to identify the need for a POSC. These include: prenatal, neonatal, pediatric, and family medicine providers; substance use treatment providers at all levels of care; Early Intervention (EI), and Home Visiting (HV) providers; mental health providers; and others.

   DPH strongly recommends that prenatal providers screen all pregnant patients for substance use in accordance with recommendations of the American College of Obstetricians and Gynecologists.[4] Providers may follow the screening guidelines already established by their agencies, practices, or hospitals. Providers should use a validated screening tool, such as the NIDA Quick Screen. In the event of a positive screen by one of these providers, the provider will offer the creation of a POSC to the pregnant woman or parent/caregiver. Screening and offering of the Plan should be standard practice, and the client/patient has the choice whether or not to engage in the creation of a Plan. Providers should clarify the purposes of the POSC, and that engagement with a POSC may facilitate interactions with DCF. If the client accepts

[4] https://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co711.pdf?dmc=1; https://www.acog.org/-/media/Committee-Opinions/Committee-on-Ethics/co633.pdf?dmc=1

the offer of a POSC, the screening provider must then either initiate a POSC or provide a warm hand-off referral to a provider who is more suited to initiating and coordinating a POSC.

DPH-licensed and/or -contracted treatment providers can assume eligibility of all pregnant and infant-parenting clients[3].

2. **Coordination:** A health care or service provider treating or otherwise working directly with the parent/caregiver or family can initiate and coordinate a POSC or they can refer the parent/caregiver to an identified POSC coordinator. Appropriate types of POSC coordinators might include: hospital/medical practice social workers; substance use treatment providers; peer recovery coaches and recovery support navigators; insurance-affiliated care navigators; EI providers; HV providers; and others. The key factor distinguishing a potential POSC coordinator is whether they have a supportive and preferably on-going relationship with the parent/caregiver or family.

   DPH-licensed and/or -contracted substance use disorder treatment providers who provide services that can last longer than 30 days are obligated to offer coordination of a POSC with all pregnant and parenting clients[3], making clear the potential benefits of creating such a plan should DCF become involved with that family. If DCF is already involved, the provider can still offer to create a POSC.

   The provider who initiates the POSC should act as the coordinator for the Plan unless another provider is identified as more equipped (e.g., has more capacity to meet regularly with the parent/caregiver or preferred by the parent/caregiver). In this case, the initiating provider should make a warm hand-off to the appropriate coordinator. Ideally, a coordinator will continue to coordinate the POSC from the prenatal through the postnatal stage. When that is impractical, the initial coordinator will make a warm hand-off to a provider who would be better suited to coordinate care in a subsequent stage. At all times, participation in the POSC process is voluntary, and a parent/caregiver should determine the duration and frequency of the coordination work.

   Coordination services include identification of needed supports and services for the parent/caregiver and child(ren), and the facilitation of warm referrals to specific available resources in the parent/caregiver's community. The coordinator will also educate the parent/caregiver on the DCF screening and assessment process, help the parent/caregiver prepare for DCF contact at or after birth, and educate the parent/caregiver on the importance of consent and releases of information.

There is no mandatory format or style for a POSC, though DPH has created the attached POSC template to assist providers who are unfamiliar with this process. Providers may use this template, titled the *Family Support Plan/Plan of Safe Care*, modify it, or use their existing service planning and referral forms modified to include information relative to the health and treatment needs of baby and caregiver. Necessary elements of any POSC include contact information for the family and key providers, and a list of the referrals that were offered or made for the client/family. If and when a 51-A is filed with DCF, the reporter should inform the DCF Screener that a POSC does exist for that client/family and that appropriate referrals to needed services were made.

3. **Referrals:** One primary purpose of a POSC is to facilitate access by a family with a substance-affected pregnancy or child to needed services and supports in their community. To that end, the POSC coordinator will be responsible for identifying with the parent/caregiver what services they are interested in accessing and what delivery systems or styles they will be most receptive to. The coordinator should be well-informed about available resources and services in their catchment area, and able to provide warm referrals. A warm referral is one that is client-centered (detailed information about location of service, hours of operation, eligibility requirements, cost/insurance acceptance, services offered, etc.) and direct. By direct, it is meant that the referral should be made over the phone, if possible, where the client and POSC coordinator together call the provider and an appointment is set up immediately.

   To facilitate this work of POSC coordinators, DPH is supporting the development of a statewide resource repository for perinatal services across the Commonwealth, searchable by zip code. This list, while not comprehensive, strives to include resources in every part of the state that address behavioral health needs, provision of material resources and supplies, and parenting and child developmental supports. This searchable resource list will posted online, with open and anonymous access. The webpage will also contain a downloadable version of the *Family Support Plan/Plan of Safe Care*, a copy of this memo, and a release of information form that is compliant with applicable law. Additional information about POSC implementation, training, and guidance will also be housed on that site, as those resources are developed. Providers should contact the Institute for Health and Recovery, which is the agency hosting the resource repository, to suggest the addition of a resource not currently listed.

4. **Communication:** If a POSC is created prenatally, communication about the POSC should be conveyed to the hospital social worker at the time of delivery if not before. If a POSC has not been developed prenatally, hospital staff should create one before a 51A is filed.

If a POSC is created prenatally or prior to DCF contact with a family, confirmation that the Plan was created and that referrals to services were made should be reported to DCF at the time of a 51-A filing. If DCF is involved with a family prior to the creation of a POSC, the creation of the Plan should be communicated to DCF. POSC coordinators will encourage their clients to consider signing releases of information so that their POSC can be shared with DCF, along with other supporting documents. The parent/caregiver can choose to continue a relationship with the POSC coordinator past the point of DCF opening a case with the family, and collaboration between these providers is strongly encouraged.

If a 51-A is filed, the responding DCF worker will ask the individual making the report whether a POSC is in place for that client/family. If that person does not know, or if there is no POSC in place, they will be asked by DCF if they can identify an involved provider to coordinate a POSC, should DCF decide not to open a case with that client/family. In this situation, the reporting provider will be directed to the informational website, where they can download a POSC template and either work with the client/family, or refer them to a provider better positioned to coordinate a POSC.

All BSAS-licensed and/or -contracted providers who may have a service relationship with the client/family longer than 30 days will be obligated to confirm to DCF that they will offer to coordinate a POSC with the client/family and, should they decline, offer to make a warm referral to a POSC coordinator of their choosing.

Any questions on this procedure should be directed to Julia Reddy, Women and Families Service Coordinator at the Massachusetts Department of Public Health's Bureau of Substance Addiction Services (Julia.reddy@state.ma.us).