I. STATEMENT OF POLICY

It is the policy of the Department of Children and Family Services (DCFS) that families with a drug and/or alcohol affected newborn identified during the DCFS investigation process are referred to *Family Services** (FS) for a further assessment of child safety based on the present/impending danger safety assessment/plan. A decision to complete a case plan and offer ongoing services to the family will be based on the following *components of a Plan of Safe Care**:

a. Comprehensive substance abuse evaluation/assessment of all caretakers in the home by a professional substance abuse clinician
b. Documented verification of the newborn’s medical needs, as it relates to the drug exposure, from a medical professional
c. Completed Assessment of Family Functioning (AFF) to include information from collaterals regarding the mother’s or father’s (if in the home or intends to be an active caretaker for the child), substance use and ability to provide safe care for the newborn (Refer to Section 5-405)
d. Early Steps referral for the newborn

*A “Plan of Safe Care” as required by Comprehensive Addiction and Recovery Act (CARA) legislation is initiated during the Child Protective Services (CPS) investigation and continues in the Family Services Program in the following manner:

* The elements of a Plan of Safe Care are assessed as part of the initial Assessment of Family Functioning (AFF). If all elements of a Plan of Safe Care are in place, and no recommendations for continued services, then the case may be closed without further development of a case plan. (See II D. Services Decision).

* If no additional services are needed, documentation must include details to support the fact that no further monitoring of compliance is necessary. Staff is responsible for ensuring that safety and health needs of the newborn and family have been adequately addressed. Case closing summary should include discussion of family strengths and supports, as well as, community resources and information discussed during aftercare planning. (See II D Services Decision).

* After the Initial AFF has been completed and the family has been assessed for ongoing services, the “Plan of Safe Care” is outlined in the Case Plan developed for the family for implementation and monitoring. The case plan must ensure that the healthcare and treatment needs of the newborn and family will be addressed.

* If the family has a Safety Plan that was developed by the CPS worker or by the FS worker, the elements of the Safety Plan shall be included in the Case Plan developed for the family. **
Court intervention shall be requested when families refuse to participate in completing the substance abuse assessment or FS services and the present/impending danger safety assessment indicates the newborn will be unsafe and an in-home safety plan cannot assure safety. Please refer to Child Protective Services Policy 4-710, II B for Instanter Safety Plan policies and procedures.

II. PROCEDURES

A. CASE ACCEPTANCE STAFFING

During the staffing, the *CPS** worker/supervisor is expected to provide the following:

- Print out of the ACESS investigation case CW Form 5 Safety Assessment (present and impending danger assessments)
- Any present and/or impending danger safety plans (** CW Form 5-SP or *** CW Form 5-CSP) when completed with the family
- *** CW Form 10 or other investigation information for emergency referrals
- Initial Structured Decision Making (SDM) Risk Assessment.

The following information should also be discussed during the staffing and further documented in the Assessment of Family Functioning (AFF) process:

1. The infant’s drug or alcohol exposure as verified by toxicology and meconium reports of infant, toxicology reports on mother, or observable harmful effects as verified by a physician (include the information in the Child’s Needs); specify all drugs (legal and/or illegal) and explore information regarding specific possible physical, developmental and behavioral effects of drug(s); when an infant is born exposed to legal or illegal substances, it is imperative that information is obtained and case record documentation describes the nature of all medical, developmental, and emotional/behavioral health needs of the infant

2. Parental protective capacities (including any diminished protective capacities) of mother and any other adult caregivers both in and out of the home (Day to Day Parenting); include information regarding emotional, cognitive, and behavioral factors influencing quality of care

3. Review of safety assessments (current and impending danger) and safety plan, as applicable (include information about circumstances and diminished parental capacities in Day to Day Parenting and/or Parent’s Substance Use, as applicable); careful consideration should be given when parental substance use, mental health conditions or developmental conditions are present
4. SDM Initial Risk Assessment include information such as previous assessments and reports with valid findings, history of child abuse/neglect, mental illness and substance abuse in applicable domains

5. Status of substance abuse assessment of mother and when indicated, father or other adult caregiver (Parent’s Substance Use); explore past/present substance use including age, frequency, type(s) of drug(s) used, method of use and any legal or criminal involvement resulting from substance use

6. In some instances, the use of suboxone and/or methadone may be recommended and medically supervised; the decision to close the Child Protective Services case without referral to Family Services may be made with approval of the Child Welfare Manager if the following conditions exist:
   - SDM risk level is low,
   - no child safety concerns are present,
   - absence of present and impending danger,
   - there is documentation to support the absence of medical concerns for the newborn,
   - parental/caretaker substance use history has been explored,
   - there is documentation to support the absence of illegal drug use,
   - there is documentation of parental compliance with substance abuse treatment, and
   - caretaker protective capacities are sufficient to meet the needs of the infant.

7. Pre-natal care history and mother’s substance use during this pregnancy and any indication of substance use during any previous pregnancies (include information in Child’s Needs)

8. Post-natal information including the infant’s current condition and/or special needs or disabilities (Child’s Needs); including physical and developmental characteristics requiring specialized care

9. Recommendations for care and any referrals at discharge such as home health (Child's Needs and Parent’s Substance Use); including medical needs recommended assessment services, recommendations, for aftercare and support services

10. Information on Parent’s mental health concerns such as post-partum depression and any co-occurring disorder (Physical and Mental Health of Caregivers)

11. Evidence of preparation for the infant, such as a crib and clothing (Housing/Food/Basic Needs); including plans for physical care and safety of child, and possible support network

12. Presence of other children in the home and their current care and condition (Family Telling Their Story and Child’s Needs)
13. Family system, strengths, involvement of infant’s father and other family members, any history of agency involvement (investigations with valid findings, FS, FC, etc,) and parental ability to use services to improve conditions (Family Telling Their Story)

14. Services and/or referrals, including Early Steps or Maternal, Infant and Early Childhood Home Visiting services, provided during the investigation (Child’s Needs)

15. Assessment of parental attachment (bonding and ability to parent infant and any other siblings) of the mother, and fathers of the infant and other children in the home (Day to Day Parenting)

16. Name and contact information for the father and other relatives of the infant/children in the home (Family Telling Their Story)

B. SAFETY ASSESSMENT, MONITORING AND PLANNING

The safety assessment and any safety plan are reviewed during the initial contact with the family as per Section 5-400, Assessments of Safety and Risk. When there is a safety plan in place, the worker shall meet with every person involved with the plan as soon as possible to determine if the plan is sufficient to assure the safety of the infant and any other children in the home * and to obtain information needed to develop the case plan for the family. **

Safety must also be assessed on an ongoing basis. In addition to the ongoing assessment of all safety threats, it includes regular contact with the following:

- Adult household members other than the client
- Participants in the safety plan
- Collaterals and community, including school personnel and physicians
- Service providers, such as home visitation providers and mental health therapists
- All persons with information on the care of the children, and caregivers’ ability to keep children safe

A safety plan is developed or modified as needed to control the danger threats and allow the children to remain in the home. When one or more parents/caregivers are actively abusing alcohol and/or drugs and it is identified as a safety threat, the safety plan must include safety providers who will supervise/care for the children. The safety plan needs to include the use of safety providers when the threat is active.

As the family is able to achieve progress and parental protective capacities are increased, safety is re-assessed. When children are safe due to increased parental protective capacities and the safety plan is no longer necessary, it is terminated. The changes in safety are documented with case plan progress.
C. ASSESSMENT OF FAMILY FUNCTIONING

The assessment is developed with the family in accordance with policy (Refer to Section 5-405) and includes all persons living in the home, out of home parents who are involved with and/or have contact with their child, and any other out of home caregivers. When fathers are involved in the assessment process it is important that they are given accurate information about the maltreatment of their child.

In addition to the information gathered at the case acceptance staffing, each item listed as an “area of focus” for each domain should be addressed. Information should be included for the following:

- Safety assessment decision and information about any safety plan at the time of the referral to FS (include in Family Telling Their Story)
- The role of all caregivers for the substance exposed infant; include information regarding all caregivers
- Documentation of observations used to assess caregiver bonding with the infant and any other children; include specific information regarding parent/child interactions
- Documentation of observations and information obtained about the day to day parenting of the infant and any other children, including information obtained, with appropriate parental consent, from home visiting programs and other service providers
- Impact of caregiver’s substance use on their capacity to safely care for the children in the home; information may be obtained from others having knowledge of the family’s functioning and child caring capabilities
- Consider the possible presence of Post-Partum Depression and intimate partner violence or other violence when assessing the mental health needs and personal safety of the mother

The rating is determined after all information is compiled and the assessment is considered complete.

D. SERVICE DECISION

Once the information is obtained and the domains are rated, the worker and supervisor discuss the need and benefit of service provision to the family. The supervisor is responsible for reviewing the assessment for completeness. Each domain should include information for the items in the “area of focus” and a rating consistent with the information obtained during the assessment. When all domains are rated as “adequate” or “strength,” the parent’s substance abuse evaluation does not indicate a need for services, and there are no safety concerns for any child in the home, the worker and supervisor may close the case without developing a case plan. * When conducting an assessment of a family that had prior valid reports or prior SEN referrals the worker and supervisor should carefully review all prior valids or prior SEN referral information, specifically, to assess in each domain whether or not the family situation has deteriorated since previous case closure. Collateral information shall be obtained to
document their views of what has transpired since the agency involvement concluded. If no collateral information is available, the worker shall document efforts made to obtain this information in the file. Details shall be discussed in staffing with the supervisor and documented. Therefore, when the worker and supervisor recommend that FS services are not needed, they should consider whether any referrals to community resources are appropriate. The recommendation to close the FS case after the assessment is discussed with the Child Welfare Manager and when approved, the case is closed as services completed. The approval for closure is documented on the staffing form. Any referrals and the staffing are documented in FATS case documentation. **

Families for whom one or more domains are rated as an “area of concern” or “problem,” the substance abuse evaluation indicates a need for services, and/or there are safety threats identified, a case plan shall be developed with the family for ongoing services.

When the worker and supervisor recommend that FS services are not needed, they should consider whether any referrals to community resources are appropriate. The recommendation to close the FS case after the assessment is discussed with the Program Operations Manager and when approved, the case is closed as services completed. The approval for closure is documented on the staffing form. Any referrals and the staffing are documented in FATS case documentation.

E. DEVELOPMENT OF A CASE PLAN

When the safety assessment and/or the assessment of family functioning determine a need for a case plan, it is developed with the family.

1. Service Planning for Parent/Caregiver

FS worker must work closely with the Office of Behavioral Health (OBH) clinician for the assessment of the mother and, if needed, the father or other caregivers and home visiting services in the home. Ongoing coordination and communication between the worker and the treatment provider will be necessary in order to assess the safety of the children and the progress of the case plan. This may include the following:

- Safety Plan (day to day parenting domain)
- Substance abuse assessment
- In patient and/or outpatient substance abuse treatment to address drug/alcohol use/abuse with confirmation of attendance and participation in treatment program; and
- Periodic staffing with treatment counselor and client to assess progress
- Transitioning to other levels of treatment
- Completion of random drug screens
- Referral of other family members to alcohol and drug abuse education programs
- Identification of other services to support caregiver’s attendance at treatment, such as child care or after school program
• Assist caregiver in getting health care, such as family planning or HIV testing
• Mental health treatment services, as needed by a parent to assure safety and reduce risk of future maltreatment
• Referral to the Family Resource Center for a parenting or Family Skill Building program
• Services to address Intimate Partner Violence

2. Services for Infant

Follow-up and regular contact with all service providers is required as this will assist with information essential for the on-going safety assessment. These may include:

• Early Steps
• Medical appointments due to prenatal drug/alcohol exposure, pre-maturity or other health issues
• Home health nursing to assist with medical/developmental concerns
• Protective services day care provider
• Infant Mental Health Assessment as available through the Infant Teams
• Any other services identified during assessments, such as maternal, infant and early childhood home visiting

3. Services for Other Children in the Home

Services to other children in the home are developed as indicated by the AFF. They may include the following:

• Age appropriate educational/treatment services regarding the parent’s substance abuse problem
• Assessment for developmental delays, and when identified, services as needed especially when the mother may have abused substances during previous pregnancies
• Protective services day care
• Services as needed for school age children to assist with regular school attendance, parental involvement in education and any needed educational services
• Medical services as needed for immunizations and/or any other medical needs

4. Services Provided by FS Worker

The FS worker will provide direct services to the family based on the needs identified during the assessment process. These services may include the following:

• Teaching/Modeling appropriate problem solving skills
• Educating the parent on the infant and other children’s stages of development and an understanding of their abilities and needs
• Assisting the parent with the development of daily routines or schedules
• Assessing the safety of the physical environment of the home for all the children, including the sleep environment; and, assisting the parent as needed to assure that the home and the sleep environment, especially for the infant, is safe
• Planning with the parent for care for the infant during stressful times such as when the child is ill, difficult to console and/or the parent is feeling overwhelmed by her own difficulties
• Educating the parent on the effects of substance use on the infant (short and long term affects on health, behavior and development) as well as strategies to handle the effects
• Educating the parent on the importance of early intervention services for the infant
• Assisting the parents/caregivers to identify goals for themselves and their children; and, eliciting their ideas about achieving those goals

F. HOME VISITS

The FS worker’s contacts with the parents and children should be planned with a purposeful outcome and occur within the frequency required by any safety plan and the SDM level of risk. All children from infancy to age five years who are not in day care or an educational setting shall be seen at each home visit. The purpose of each visit is determined by the case work process based on the Assessment of Family Functioning, an objective of the case plan or re-assessment to be completed with the family. The contacts along with observations and work with the family are documented in FATS case documentation.

1. Mother and Other Caregivers

The worker should observe the home to determine its ongoing adequacy and safety for the children and for any indication of substance use that impacts the safety of the children. Safety plans must be reviewed with the family to determine its ongoing sufficiency to assure the safety of all the children in the home.

The worker will assess the family’s progress with the case plan during the home visit. Information from all involved parties will be considered in assessing progress. The caregiver and the worker should problem solve any identified barriers to case plan progress with the family (refer to Section 4 for direct services provided by the worker).

2. Drug Affected Infant

The worker should carefully observe the physical care and condition of the infant during each home visit. The parent should be asked about the infant’s eating, sleeping, sleeping arrangement, and daily routine. The worker should provide information to the caregiver on safe sleeping for the infant and assistance to the family as needed to obtain a crib or other safe bed. It is important to observe the interaction between the mother and infant in order to assess safety and the development of the maternal infant bond. The mother’s description of the infant in positive or negative terms, while being sensitive to cultural and
linguistic variances, will provide important information to the worker in assessing the infant’s safety.

The * case ** plan for the infant should be reviewed and the infant’s progress and ongoing needs discussed with the family. The worker should determine if the mother has been able to access any recommended services for the child, or if worker assistance is needed. Once services are initiated, the worker should determine whether the caregiver has implemented the recommendations of medical and service providers.

3. Other Children in the Home

The worker should observe the care and condition of other children in the home along with the interaction with the mother, other caregivers and each other during the home visit. Their safety must also be assessed during each home visit.

The children’s adjustment to the infant should be considered in working with them. The worker may assist the children to understand their feelings about the infant and the changes in their family. If there are older children, the worker should assess the child’s involvement in the care of the infant and whether it is age appropriate.

The children’s progress with any identified educational, health or mental health needs should be discussed with the mother and caregivers. The worker should also engage in age appropriate conversations with the children about their school and service experiences, their feelings and any questions they have about the services they are receiving.

The FS worker may engage in age appropriate conversations about substance use and elicit the children’s feelings toward the effects of substance abuse on themselves, the infant, the family and friends that they have witnessed.

G. * RELAPSE PLAN FOR THE SAFETY OF THE CHILD

A relapse plan for the safety of the child provides for alternative care for the infant and any other children in the home in the event the parent has a relapse. The parent with the assistance of the worker or substance abuse counselor should develop a relapse plan. The following are the elements of a relapse plan: **

- A designated person(s) who will check on the safety and wellbeing of the children on a regular basis (i.e., family, friends, neighbors) and should include specifics, such as time and duration
- Caregivers or locations agreed upon ahead of time where the infant and children can stay if unable to provide a safe environment due to relapse
H. ONGOING ASSESSMENT OF RISK AND CASE PROGRESS

Case progress is assessed through the following:

- SDM risk re-assessment
- Assessment of Family Functioning
- Collaboration and coordination with service providers (include formal and informal supports)
- Coordination with the Office of Behavioral Health (OBH)
- * Coordination with Family Resource Center staff **
- Contacts with collaterals, including school and community
- Ongoing work with the family.

If the assessment indicates a lack of progress or a new safety concern, the following should be considered.

Modification of the Safety Plan
- Changing the case plan
- Referral to MDT
- * Homebuilders ** referral
- Court Intervention

When a family has made progress with the case plan and improved family functioning, current and/or anticipated stressors must also be considered with the decision to consider case closure or continued services. Example of significant stressors are:

- Unemployment,
- A separation or divorce
- Loss of a significant relationship
- Anticipation of an eviction
- Death
- New Pregnancy
- Presence or history of intimate partner violence or violence in general

I. CASE CLOSURE

The following criteria are indicators consistent with case closure:

a. Information/indications that caregiver’s use of alcohol or other drugs is not impacting their capacity to safely care for the children as evidenced by:
   1. Caregiver’s ability to interact with the infant and other children in a nurturing and appropriate manner
   2. Condition of the home constitutes a safe environment
3. Caregiver’s establishment and use of a safe sleeping environment for the infant
4. Caregiver’s ability to meet infants and other children nutritional needs
5. Information from service providers, family members and/or others consistent with improved caregiver functioning

b. Absence of substance related consequences (risky behaviors, DUI, incarceration, Domestic Violence, and HIV exposure).
c. Positive parenting behavior changes and increased parental protective capacities identified on the case plan have occurred as verified by follow-up.
d. Report from the substance abuse provider that indicates progress made in treatment when the client participated in treatment.
e. Caregiver demonstrates improvement with healthy problem-solving and coping skills.
f. SDM indicates low or moderate risk level indicative of worker’s ongoing assessment with no safety concerns and no additional valid *CPS** reports during services.
g. A safe plan of care, when safety threats related to substance abuse was identified, that includes the following:
   1. Community support, family and friends
   2. Participation in AA/NA or other aftercare program supportive if sobriety resulting in positive behavioral changes
   3. Access to mental health or other services, if needed; mental health treatment has resulted in successful or effective management of condition(s)
h. One or more children in the home are removed and placed in the custody of the department and the case is transferred to FC.

III. FORMS AND INSTRUCTIONS

*** CW Family Assessment Tracking System Instructions
*** CW Form 5, Safety Assessment, Instructions
*** CW Form 5-CSP, Court Ordered Safety Plan, Instructions
*** CW Form 5-SP, CW Safety Plan, Instructions
*** CW Form 10, Investigation Report, Instructions

IV. REFERENCES

42 USC §622 et seq.
42 USC §629a
42 USC §5106
45 CFR §1356.21
45 CFR §1357.10
LA Ch. C Art. 615 C