



Minnesota's Best Practice Guide for Responding to Prenatal Exposure to Substance Use

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Introduction

The purpose of Minnesota's Best Practice Guide for Responding to Prenatal Exposure to Substance Use is to provide direction, policy, protocols, and statewide consistency for local child welfare agency staff.

The effects of prenatal substance exposure on a child begin before they are born. Maternal drug and alcohol use during pregnancy have been associated with premature birth, still birth, low birth weight, slowed growth, Sudden Infant Death Syndrome, and a variety of physical, emotional, behavioral and cognitive problems. The full impact of prenatal substance exposure depends on a number of factors. These include the frequency, timing, and type of substances used; co-occurring environmental deficiencies; social determinants of health and the extent of prenatal care.¹

Factors resulting in healthier infants include:

- Access to early prenatal care
- Consistent prenatal medical visits
- Access to chemical health services and treatment
- Receiving medication assisted treatment (MAT) and counseling
- Planned pregnancies
- Completion of at least one prenatal and neonatal visit.

Factors resulting in less healthy infants:

- Missed prenatal and neonatal medical appointments
- Continued use of illicit opiates and other substances
- Life problems such as domestic violence, lack of stable housing, poverty, and mental health issues that are not addressed
- Discontinuing counseling (even if women continue to receive medication assisted treatment).²

When providing services to families where substance use is identified, a multi-disciplinary approach is needed that draws on trauma-informed professional expertise across agencies, including medical providers; public health, such as home visiting; chemical dependency programs; social services; mental health; and early intervention services.

These guidelines were developed in collaboration with the Minnesota Prenatal Substance Exposure work group. The work group was comprised of diverse participants representing health care, alcohol and drug treatment, child welfare, child development, parent leadership, tribal services, community agencies serving communities of color, housing, legal, judicial and law enforcement. Members demonstrated a commitment to children's safety by developing guidance that addresses prenatal exposure to substance use by women. This guide provides direction for coordinated, systemic responses for women and their infants, both before and after birth, and draws on evidence-based best practices.

¹ AIA, 2012. National Institute on Drug Abuse (NIDA, 2911)

² Children and Recovering Mothers (CHARM) in Burlington, Vermont: A case Study, Vermont Department of Children and Families, August 2014.

The focus is on the safety and well-being of infants, and services and supports to mothers and fathers during pregnancy and after birth. All protocols required by law include a statutory reference.

Definitions

Chemically dependent person is defined in Minn. Stat. 253B.02, subd. 2 and includes a pregnant woman who has engaged during the pregnancy in habitual or excessive use, for a nonmedical purpose, of any of the following substances or their derivatives: Opium, cocaine, heroin, phencyclidine, methamphetamine, amphetamine, tetrahydrocannabinol or alcohol.

Continuum of alcohol and drug use is defined as follows:

- Substance use: The consumption of low or infrequent doses of alcohol or drugs such that damaging consequences are rare or minor.
- Substance abuse: A pattern of substance use that leads to significant impairment or distress in life to fulfill major role obligations at work, school or home; continued use in spite of physical hazards, trouble with the law, interpersonal or social problems. A diagnosis of substance use disorder is not necessary for the purpose of these policies.
- Substance dependence or addiction: The progressive need for alcohol or drugs that results from the use of that substance. This need creates psychological and physical changes that make it difficult for a user to control when they will use or how much.³

Controlled substance is listed in Minn. Stat., section 253B.02, subd. 2, including any of the following substances or their derivatives: Opium, cocaine, heroin, phencyclidine, methamphetamine, amphetamine and tetrahydrocannabinol.

Imminent danger is defined in Minn. Admin. Rule 9560.0214, subp. 12, and means a situation in which a child is threatened with immediate and present maltreatment that is life threatening, or likely to result in abandonment, sexual abuse, or serious physical injury.

Medical practitioner is any individual licensed to practice medical care, e.g., medical doctors, physician's assistants, licensed midwives, nurse practitioners or pediatric nurse practitioners.⁴

Medication assisted treatment (MAT) is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders, including opioid addiction. MAT operates to normalize brain chemistry, block the euphoric effects of opioids, relieve physiological cravings, and stabilize body functions without the negative effects of the short-acting drugs of abuse. Research has shown that MAT reduces drug use, disease rates, overdose deaths and criminal activity among opioid addicted persons.⁵ The three medications approved by the Federal Drug Administration to treat addiction to short-acting opioids are methadone, buprenorphine and naltrexone.

³ Protecting Children in Families Affected by Substance Use Disorders: U.S. Dept. of Health and Human Services, Administration for Children and Families, Children's Bureau, Office of Child Abuse and Neglect. 2009.

⁴ Washington State Department of Social and Health Services, Children's Administration, Prenatal Substance Abuse fact sheet, October 2007.

⁵ Medication-assisted Treatment in Drug Courts, Recommended Strategies. Center for Court Innovation, Legal Action Center, New York, N.Y., 2015.

Prenatal care means the comprehensive package of medical and psychological support provided throughout pregnancy.

Prenatal exposure is the ingestion of a controlled substance for non-medical purposes by a woman during pregnancy which includes the use of opium, cocaine, heroin, phencyclidine, methamphetamine, amphetamine, tetrahydrocannabinol or habitual and excessive use of alcohol.

Substance-affected newborn is one who has withdrawal symptoms resulting from prenatal substance exposure and is identified by a medical practitioner as affected.

Substance-exposed newborn is one who tests positive for substances at birth, or the mother tests positive for substances at the time of delivery, or newborn is identified by a medical practitioner as having been prenatally exposed to substances.

Reporting

The reporting of prenatal exposure to controlled substances in Minn. Stat., section 626.5561, subd. 1, states a person mandated to report shall immediately report to the local welfare agency if they know or have reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during pregnancy, including but not limited to tetrahydrocannabinol, or has consumed alcoholic beverages during pregnancy in any way that is habitual or excessive. Health care and social service professionals are exempt from reporting a woman's use of tetrahydrocannabinol or alcoholic beverages during pregnancy if a professional is providing a woman with prenatal care or other health care services.⁶

The Reporting of Maltreatment of Minors Act, Minn. Stat., section 626.556, subd. 2(g)(6), defines a type of neglect as prenatal exposure to a controlled substance used by a mother for nonmedical purposes, as evidenced by withdrawal symptoms in a child at birth, results of toxicology test performed on the mother at delivery or child at birth, medical effects or developmental delays during a child's first year of life that medically indicate prenatal exposure to a controlled substance, or presence of a Fetal Alcohol Spectrum Disorder.⁷

A child must be born before the local social service agency initiates a child protection response. In cases where there is a report involving a pregnant mother who is using substances, the report is screened out for child protection, but it must be opened for child welfare assessment, and services offered. Once a child is born and there is evidence of substance use by a mother while pregnant, the report is screened in for a child protection assessment or investigation. Later in this guide, more information will be given about how to determine which response is required, and what is best practice within each response type (see Determining a Response). The following section provides information about what is best practice for both responses.

⁶ Minn. Stat. 626.5561, subs. 1 and 2, 2016.

⁷ Minn. Stat. 626.556, subd. 2 (6), 2016.

Child Welfare and Child Protection Response

Comprehensive coordination and cohesive collaboration throughout assessment and case planning is needed to strengthen and support a family, and ensure safety of children. The ideal components of any effective response to an allegation of prenatal exposure should include:

- Team collaboration across all disciplines that are family-focused
- Trauma-informed services
- Culturally responsive services
- Plan of safe care for infants.

Multi-disciplinary team (MDT): Collaboration with other agencies

Families who have substance use disorders have multiple and complex needs, as well as strengths. Women with substance use disorders (SUD) often have co-occurring issues that must be addressed in addition to their substance use. Common co-occurring issues include mental and physical illness, domestic violence, criminal activity, economic difficulties, employment challenges, poverty, historical trauma, housing instability or living in a dangerous environment. Any one of these situations can cause trauma. All of the above challenges can become barriers to successfully engaging in services and remaining substance free. When the above issues are addressed, a woman will have more success in attaining long-term abstinence.⁸ This tendency towards co-occurring issues means that a pregnant mother abusing substances frequently has needs that cross over to many disciplines; no one agency has the capacity to address all of the issues.

Collaborative and integrated strategies have shown positive results in many areas. Women remain in treatment longer, are more likely to reduce substance use, and are more likely to remain or be reunited with their children.⁹ Collaboration builds on the strengths of each area and offers a comprehensive array of services to families that will be more effective than any one agency response.¹⁰

In addition to being collaborative and integrative, a family-focused response is essential for a comprehensive assessment of safety and risk for children, and identifying resources, strengths and supports for parents. For parents to make positive changes in their lives, it is vital for them to move toward full responsibility for their substance use, its consequences and the need to stop using. When parents address their substance use and other issues, positive changes in family functioning can be achieved. Recommendations made by the Governor's Task Force for the Protection of Children encourage and support the use of multi-disciplinary teams, as well. For all of these reasons, it is highly recommended that local social service agencies develop a collaborative approach when working with women and substance use disorders during pregnancy, both prenatally and post-natally.

⁸ Protecting Children in Families Affected by Substance Use Disorders: U.S. Dept. of Health and Human Services, Administration for Children and Families, Children's Bureau, Office of Child Abuse and Neglect, 2009.

⁹ HHHs; 2014; Marsh & Smith, Integrated substance abuse and child welfare services for women: A progress review. *Children and Youth Services Review*, 33 (3): 466-72 2011.

¹⁰ U.S. Dept. of Health and Human Services, Administration for Children and Families, Children's Bureau, Child Abuse and Neglect User Manual Series, Protecting Children in Families Affected by Substance Use Disorders, pps. 55-63: 2009.

A comprehensive and systemic response will support safety for infants and provide support for mothers and their families. Community partners may include:

- Tribal representatives (whenever a case of a tribal child is reviewed¹¹)
- Trauma-informed providers
- Mental health services
- Chemical health services
- Public nursing services
- Medical providers: Doctors, physician’s assistants, licensed midwives, nurse practitioners and pediatric nurse practitioners
- County and city attorneys
- Legal aid, private attorney
- Courts
- Law enforcement
- Community corrections
- Neighborhood community centers
- Faith-based organizations
- Cultural centers
- Schools



¹¹ Governor’s Task Force for the Protection of Children Final Report and Recommendations, March 2015, Rec. 34, 59, page 27.

Developing a successful and sustainable collaborative requires commitment and coordination from multiple agencies over a period of time. Values, principles and goals, and how to achieve them, need to be discussed and agreed upon by all disciplines to guide collaborative efforts. Child welfare, chemical health services and treatment, physician and medical services, corrections and court services, need to work together to make informed decisions for children and families affected by substance use disorders.¹² Although there are federal and state laws that prevent sharing of data without a person's consent, many collaborative programs (MDTs) across the nation have been effective and successful by participants giving their consent.

Having a multi-disciplinary team engages community partners and builds enduring safety for children. When these teams are used to assess risk and protective capacity, there is group decision making; this leads to more comprehensive and consistent assessments and cooperative working relationships. By using multi-disciplinary teams, expertise and decision making are shared, there is more transparency, and shared accountability, resulting in improved safety and better outcomes for children.¹³

To be effective, collaborative relationships ideally need to include the following:

- Trust that enables people to share information, and respect for each other's points of view
- Shared values by all members
- Focus on common goals, despite different philosophies
- Respect for knowledge, competency, and experience of all members of a team
- A collective commitment to working through conflict with all members participating
- A desire to share decision making, risk taking, and accountability for the outcomes of group decisions
- Joint mission statements among all collaborative areas and disciplines
- Develop integrated funding to support programming
- Cross-training of staff
- Co-located staff in various agencies
- Interagency agreements, such as memorandums of understanding (MOUs).

Trauma-informed child welfare practice

Childhood trauma

Children in the child welfare system may have experienced trauma in their family, such as abuse, neglect, exposure to domestic violence, substance use, homelessness and other family stressors. There are also system-imposed stressors such as removal from home and/or multiple foster care placements. For parents who grew up under similar circumstances, it may be difficult for them to provide for the safety and well-being of their children if their own trauma remains unaddressed. If parents do not feel safe, they will be less able to keep their children safe. The entire child welfare system needs to be a trauma-informed system, as described above, to enhance child and family safety, well-being and resiliency.¹⁴

¹² <https://www.ncsacw.samhsa.gov/resources/SAFERR.aspx>.

¹³ Multi-disciplinary Teams, Brenda Mahoney, Stearns County Human Services, and Jodi Wentland, Olmsted County Community Services, PowerPoint, November 2016.

¹⁴ "Trauma-informed Child Welfare Practice, Winter 2013; Center for Advanced Studies in Child Welfare, School of Social Work, University of Minnesota.

Historical trauma

Native American

Historical trauma is defined as “cumulative emotional and psychological wounding across generations, including the lifespan, which emanates from massive group trauma.”¹⁵ For American Indian communities, this massive group trauma began when European people first came to this land, and continued with federal policies and actions focused on the removal of Indian children from their homes and into boarding schools. From the beginning, white culture focused on assimilation, frequently barring Native Americans from speaking their own language, wearing traditional clothing, and engaging in their spiritual and cultural practices.

When working with Native American families, it is critical to understand tribal sovereignty to be effective in supporting culturally appropriate practices. Tribal sovereignty is the right, responsibility, and authority to self-govern. Historical trauma is evidence of the adverse effect and multi-generational trauma resulting from colonization and assimilation policies of the U.S. government. This historical trauma has lasting impacts on children and families today. Child welfare workers need to be aware of, and sensitive to, historical trauma experienced by Native Americans.¹⁶

African-American

African-Americans have experienced historical and cultural trauma, beginning with slavery. The term Post Traumatic Slave Syndrome (PTSS) which is a “condition that exists when a population has experienced multi-generational trauma resulting from centuries of slavery and continues to experience oppression and institutionalized racism today that benefits the society in which they live are not accessible to them.” In addition to slavery, other federal and state policies and actions have contributed to multi-generational trauma, including forced labor, medical experimentation and Jim Crow Laws.¹⁷ African-Americans continue to experience racism and discriminatory practices in their everyday life by individuals and systems. Child welfare workers need to be cognizant and sensitive to the fear and mistrust African-Americans may have towards the child welfare system.

Latino

There are life experiences that have been traumatic for Latino/Hispanic children and families. Many unaccompanied minor children have been caught trying to cross the southern U.S. border. Further, many native born children live with the knowledge that their undocumented immigrant parents may be deported through immigration enforcement. Child welfare practices need to build capacity to provide culturally specific services for Latino/Hispanic families.¹⁸ Having an interpreter who speaks their primary language is needed if parents have limited English proficiency.

¹⁵ Brave Heart, Chase, Elkins, & Altschul (2011).

¹⁶ Center for Advanced Studies in Child Welfare, School of Social Work, University of Minnesota, Culturally Responsive Child Welfare Practice, Winter 2015.

¹⁷ Center for Advanced Studies in Child Welfare, School of Social Work, University of Minnesota, Culturally Responsive Child Welfare Practices, Winter 2015, DeGruy, 2005.

¹⁸ Center for Advanced Studies in Child Welfare, School of Social Work, University of Minnesota, Culturally Responsive Child Welfare Practice, Winter 2015.

Immigrant and refugee populations

Many immigrants or refugees may have experienced life threatening trauma in their home country and may have deep-seated fears of government authorities. They may not have a basic understanding of federal, state or county social service and legal systems. There may be ongoing fear of deportation and break-up of a family if a government agency is involved. Obtaining an interpreter is essential if parents have limited English proficiency. Whenever possible, specific cultural services and supports need to be sought for these families.¹⁹

For all of the above reasons, providing trauma-informed practice to families that are part of the child welfare system is critical. Trauma-informed practice refers to the process of engagement with parents, children or families in a way that ensures that no intentional action is taken that further causes harm. Trauma-informed child welfare practice creates an environment that enables children and their families to feel safe, and promotes the ability of victims to cope and increase resiliency. There are seven essential elements for trauma-informed child welfare practice, including:²⁰

- Physical and psychological safety of child: Psychological safety is the ability to feel safe within one's self, and safe from external harm
- Identify trauma-related needs of family members: Universal screening for traumatic history and stress responses
- Enhance child well-being and resiliency: Evidence-informed and evidence-based services to help child reduce emotions related to trauma, cope with trauma triggers, and redefine the meaning of trauma history
- Enhance family well-being and provide education and services to parents that enhances their protective capacities and increases resiliency
- Enhance family well-being and resiliency of child welfare workers: The child welfare system must acknowledge the impact of primary and secondary trauma on child welfare workers, and develop organizational strategies to enhance resiliency
- Partnering with families: Provide families with choices and an opinion regarding their plan of care that taps into their resiliency.
- Partnering with system agencies: Coordinate, collaborate and develop cross-training with other systems so one entity of the system supports the work of others, with everyone working together on common goals that promotes safety and well-being of children and families.

Cultural responsiveness

Cultural responsiveness remains an important aspect of child welfare, from decision making at the time of assessment/investigation and planning, to engaging a family, developing a case plan, providing support services, making decisions regarding placement and permanency, to closing a case. At all levels, child welfare practices need to have a commitment to cultural competence. Organizations and practitioners need to recognize that attaining cultural knowledge and understanding is a continuous

¹⁹ Minn. Dept. of Human Services. Minn. Best Practices for the Co-occurrence of Child Maltreatment and Domestic Violence Response Path. 2017.

²⁰ Center for Advanced Studies in Child Welfare, School of Social Work, University of Minnesota, *Trauma-informed Child Welfare Practice*, winter 2013.

journey.²¹ A trauma-informed approach includes use of a cultural lens which includes cultural considerations, beliefs, values, and practices relevant to their family and within their community. Historical mistrust and/or recent war trauma may also be present, and a fear of a governmental agency's involvement in their family.²²

Plan of safe care

The Comprehensive Addiction and Treatment Act of 2016 (part of CAPTA), requires the plan of safe care to address the needs of infants and parents, and increasing state's accountability and monitoring by the U.S. Department of Health and Human Services.²³ A plan of safe care must address the health and substance use disorder treatment needs of an infant and affected family or caregiver. Consistent with good casework practice, the plan should be developed with input from parents or other caregivers, as well as any collaborating professional partners and agencies involved in caring for an infant and family. The team working with a family should be involved in the development, implementation and monitoring of the plan of safe care. Family group conferencing can also be used as a tool in development of the plan of safe care. The plan of safe care can be part of the existing case plan for a family as long as it is identified as the plan of safe care and includes the necessary components.

A plan of safe care is required in the following circumstances:

- Prior to an infant's birth: Mothers with positive results of a screening tool (administered by a health care provider), or positive toxicology test during prenatal care. The plan should be developed 30 days prior to the expected delivery date, whenever possible. The purpose is to support a family and ensure communication among health providers, substance use disorder treatment agency staff, child welfare and other community support agencies.
- At the time of birth: Infants or a mother with a positive toxicology at birth or other signs of prenatal exposure. The plan should be developed at the time of birth, prior to discharge, whenever possible. If an infant is discharged prior to child protection receiving the report, the plan of safe care should be developed as soon as possible.
- After discharge (not detected at birth): An infant under age 1 who may not have been detected at birth as experiencing prenatal substance exposure, but later identified and reported to a local welfare agency, must also have a safe plan of care. The plan should be developed within 30 days of receipt of report.

The plan of safe care is based on the results of a comprehensive and coordinated multi-disciplinary assessment to determine an infant's and mother's physical, social-emotional health and safety needs, as well as a mother's strengths and parenting capacity. Concerted efforts to locate and engage fathers in

²¹ Center for Advanced Studies in Child Welfare, School of Social Work, University of Minnesota, *Culturally Responsive Child Welfare Practice*, winter 2015.

²² Minnesota's Best Practices for Family Assessment and Family Investigation, Minn. Department of Human Services, page 8, September 2016.

²³ P.L. 111-320, CAPTA Reauthorization Act of 2010; Title V, section 503, S.524, Comprehensive Addiction and Treatment Act of 2016.

the creation of the plan of safe care should be made. The plan needs to be focused on both the child and parents.²⁴

Plan of safe care development

Development of the plan of safe care for each infant and family must assess immediate safety factors to decide if a child is in danger of being hurt. Along with factors in the Structured Decision Making Safety Assessment, particular safety factors to consider in these cases include:

- Parents' child welfare-related history that indicates unresolved substance use disorders related to a prior case of child abuse or neglect.
- Prior abuse and/or neglect reports related to substance use.
- A child's siblings' substance exposure prenatally or in the family environment.
- Evidence of co-occurring mental health concerns that may affect immediate parenting capacity, such as post-partum depression and substance use.
- Mother's willingness to seek treatment and parenting support.
- Assess strengths, including a family's positive qualities and resources to care for their child.
- Assess family's protective capacities to determine if parent has the ability or support system to provide an environment that keeps children free from harm.
- Assess family environmental challenges related to parental substance use disorders.
- Assess family's access to sufficient income and resources, employment history, and access to health care. It is clear that poverty alone does not connote an immediate safety concern, rather, it is a family's access to sufficient resources in combination with substance use disorders that may place an infant at higher risk.
- Be both child- and parent-focused, recognizing parents' ability to do their part in carrying out such a plan will be as equally important as any role of public or private services.
- Specify with whom child will be discharged, and ensure protective capacity of parents and/or other family members are sufficient to care for an infant.
- Include provisions for frequency and entity responsible for follow up with families.
- Specify a timeline for follow-up and monitoring.
- Specify details of referral of child to developmental intervention.
- Include provision of services and supports that address infant's and mother's physical, social-emotional health and safety needs, and foster parents' and family's capacity to nurture and safely care for an infant.
- Include details for communication among health providers, substance use disorder treatment agencies, child welfare and other community supportive agencies.
- Incorporates mother's (and potentially father's) need for treatment for substance use and mental disorders.
- Appropriate care for an infant who may be experiencing neurodevelopmental or physical effects or withdrawal symptoms from prenatal substance exposure.

²⁴ Children and Family Futures, Lake Forest, Calif. The Role of Plans of Safe Care in Ensuring the Safety and Well-Being of Infants with Prenatal Exposure, their Mothers and Families; March 2016.

- Infant’s care needs, including their general functioning, development, and the effects of illegal substances or alcohol on them.
- Sleep-related safety.
- Services and supports that strengthen parents’ capacity to nurture and care for their infant, and ensure continued safety and well-being.
- Ensures a process for continued monitoring of family, and accountability of responsible agencies such as substance use disorder treatment, home visiting, public health and health care providers, for infant and mother.
- Team meetings are encouraged, whenever possible.
- Be updated as needed, if circumstances change, or every 90 days, whichever comes first.

Many of the factors to be included in the plan are identified by various professionals throughout a woman’s pregnancy, at the time of birth, and at discharge from the hospital. For example, a woman’s post-partum care would typically be included in the hospital discharge plan. It is clear that many of the factors included in assessments, case planning and treatment plans are included in a plan of safe care, and are included in services provided in communities.

Plan of safe care format

The plan of safe care consists of both a written safety plan and a services plan. A safety plan template is in the Social Service Information System (SSIS). Alternatively, a local child welfare agency may use its own format. In a child welfare assessment, the social services plan or Parent Support Outreach Program plan (PSOP cases) is used as the service plan template. In child protection, one of three service plans can meet requirements for the service plan portion of the safe plan of care, including:

- Family Assessment service plan (Family Assessment cases)
- Child protection service plan (in-home family investigation cases)
- Out-of-home placement plan (out-of-home placement cases).

Documenting the safe care plan

A future Social Service Information System release will include documentation to indicate completion of the plan of safe care.

Determining a Response

The type of response required for any allegation of prenatal exposure begins with gathering comprehensive information at the time of a report. Using that information, decisions regarding screening and response path follow.

Intake: Gathering information

Intake is the first point of contact for a report of prenatal exposure made to a local child welfare agency. An intake worker obtains as much information as possible to best respond to a report.

The following information is obtained by child welfare intake workers:

- Reporter’s contact information, relationship to mother and source of information

- Mother's name, birth date, address and phone number
- Father's name, birth date, address and phone number, if known
- Medical clinic where mother receives care, if known
- Other children in the home
- Other adults in the home
- Substance used by mother, history, frequency and verification of use (drug test)
- Gestational age, primary physician and mother's clinic
- Statewide SSIS search to determine previous social service involvement: Past reports, assessments/investigations, ongoing services
- Ethnicity/cultural heritage, primary language spoken in the home
- Current service providers, if known
- Prior services parent(s) have been involved in
- Mother's and father's willingness to engage in services
- Presence of domestic violence, criminal activity, weapons or other activities in the home
- Whether mother has a relationship with healthy individuals, or people in recovery
- Tribal affiliation and notification.

Screening and response path

When receiving reports of prenatal substance exposure, the decision to screen in or screen out a report depends on whether a child has been born. Unborn children are accepted for a child welfare (or similar) response rather than child protection. If a parent has other minor children, and a report includes allegations for those children that meets criteria, a report shall be assigned for a child protection response.

Once a child is born, reports including allegations of prenatal exposure are accepted for a child protection response, either Family Assessment or Family Investigation. When screening in for child protection response, both statutory and discretionary reasons are involved in selecting the response track. Family Assessment and Family Investigation are not voluntary responses. They are both involuntary, serious child protection service responses focused on child safety as the paramount concern.

Family Assessment overview

Family Assessment involves gathering facts to thoroughly evaluate child safety, the risk for subsequent child maltreatment, and a family's strengths that demonstrate protection of a child over time. The focus of Family Assessment is to engage a family's protective capacities and offer services that address immediate and ongoing safety concerns of a child. Family Assessment uses strength-based interventions and involves families in planning for and selecting services.

No determinations of maltreatment are made in Family Assessment response. Two decisions are made at the conclusion of a Family Assessment, whether:

- Child protective services are needed
- Family support services are jointly agreed upon by agency and parents.

Family Investigation overview

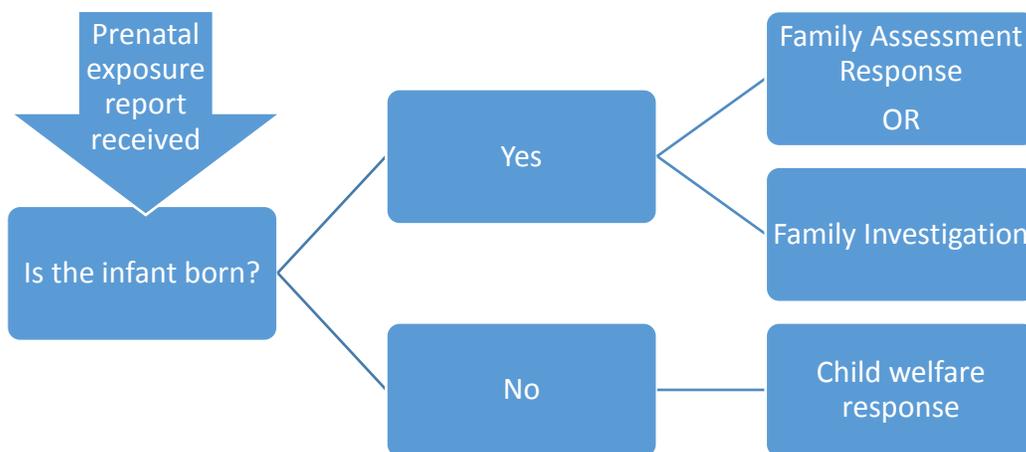
Family Investigations respond to the most serious reports of harm and neglect to children. Family Investigation may also include situations in which there is not a serious report of harm or neglect, but additional considerations or vulnerabilities indicate a need for an investigative response.

Investigations are sometimes conducted with law enforcement as part of a criminal investigation. The focus of a Family Investigation response centers on gathering facts, assessing/evaluating risk of subsequent child maltreatment, and assessing family protective capacities related to child safety. Two decisions are made at the conclusion of a Family Investigation, including:²⁵

- A determination of whether child maltreatment occurred
- Whether child protection services are needed.

[The Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines](#) provide in-depth information.

Prenatal Exposure Reports, Screening and Response Path



Child Welfare Response – Prenatal

Minn. Stat. 626.5561, subd. 2, states that “the local welfare agency shall immediately conduct an appropriate assessment and offer services indicated under the circumstances. Services offered may include, but are not limited to, referral for chemical dependency assessment, chemical dependency treatment, if recommended, and a referral for prenatal care.” If a pregnant woman refuses recommended voluntary services or fails recommended treatment, and is engaged in habitual or excessive substance use, a local agency shall pursue chemical health commitment.²⁶

²⁵ Minn. Dept. of Human Services, Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines, December 2016, pages 58-59.

²⁶ Minn. Stat. 626.5561, subd. 2, 2016.

Prior to birth, when a report is received regarding prenatal exposure to substance use, it is screened out for child protection, but a case is opened for assessment. An assessment may be under child welfare, adult services, chemical dependency or Parent Support Outreach Program. Acceptance of services is voluntary, however, when services are declined, consulting with the county/tribal attorney, or tribal ICWA advocate/case manager, regarding civil commitment is required.

Ideally, a child welfare assessment is done in collaboration with other services such as health care, other social services and chemical health. A mother may be in need of other services, including mental health, housing, child care, or economic needs.

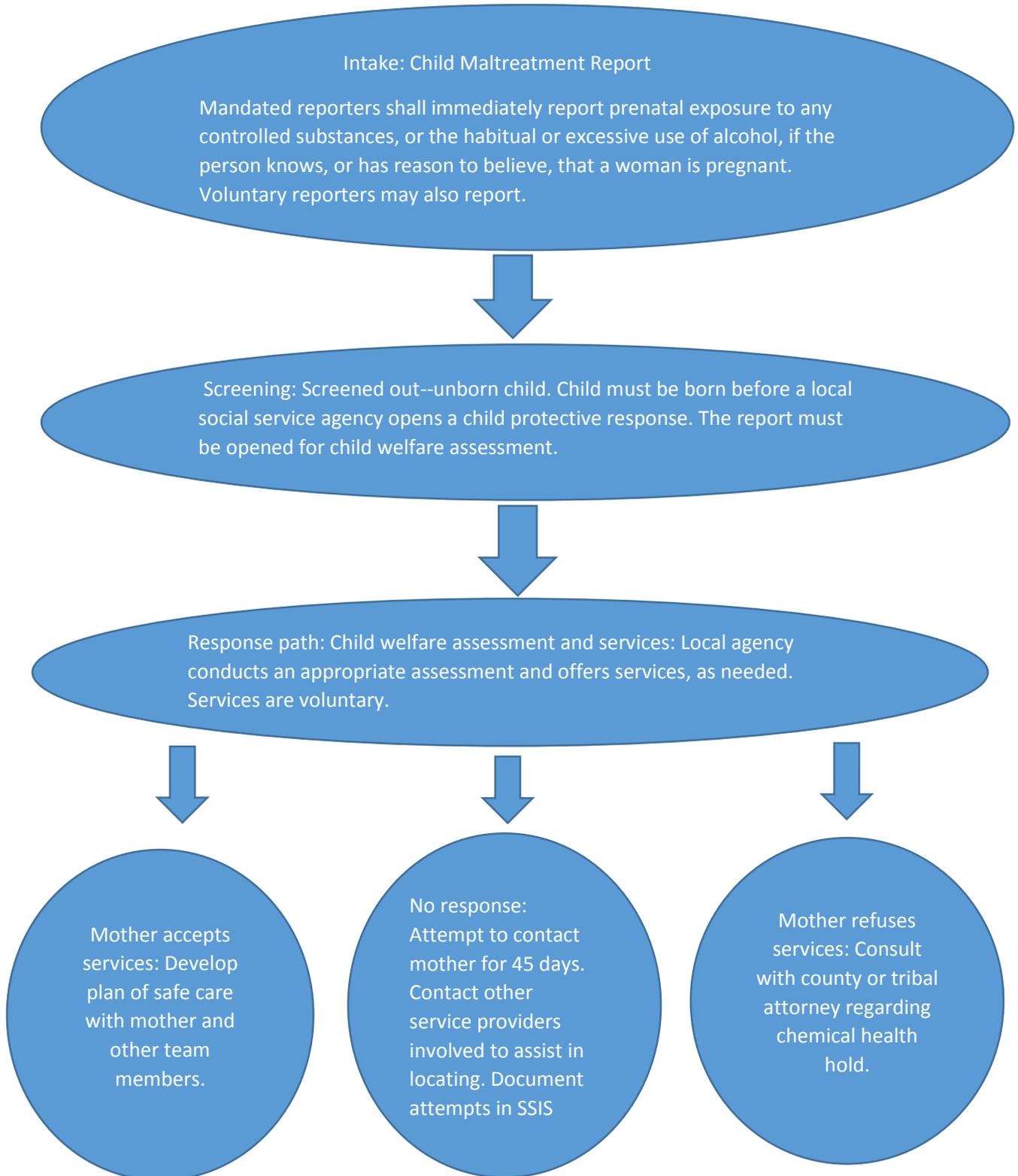
When a report is received regarding a pregnant woman using substances, an assessment worker is strongly encouraged to conduct face-to-face contact with the woman within five calendar days upon receipt of a report. A minimum of two attempts to contact a mother should be made. Ideally, contacts should be face to face, but if that is not possible, phone calls or letters should be attempted. If an outside agency is a mother's primary service provider, a release of information should be sought to make contact with that program. A plan of safe care for an infant should be developed and implemented 30 days prior to birth, whenever possible (see Plan of Safe care section).

Given the dangers associated with substance use during pregnancy, women who abuse substances during pregnancy should receive treatment as early as possible. Research shows that women often are more agreeable to entering treatment and addressing their substance use when they are pregnant. Most women want what is best for their baby, and want their baby to be born healthy. Once babies are born, significant changes can occur in the lives of women who abused alcohol or drugs during pregnancy. A mother may admit to using substances to explain a positive drug test, but not to an addiction due to fear of losing custody of her children.

A woman may also experience remorse and sadness over the actual or potential consequences of her substance use, which can also be a motivating factor to seek treatment. Even if a mother acknowledges and accepts the need for treatment to stop her substance use, some practical barriers may need to be resolved before treatment can occur, such as:

- Lack of available treatment spaces or medication assisted treatment programs
- Not knowing where to go for treatment
- Stigma and shame of substance use
- Relationships with partners, friends, and family members who still may be using and do not support an individual's efforts to change
- A perception of giving in when treatment is mandated by an outside source, such as child protection or the court
- Lack of transportation to treatment
- Economic difficulties in which the need to work takes priority over being in treatment
- Lack of available child care during treatment
- Fear of not being able to use substances and how that may affect their behavior
- Parental separation from child/children.

Child welfare: Prenatal response diagram



No response

If no response is received from phone messages or attempted home visits, a letter should be sent to pregnant woman's last known address within 14 days of receipt of report. When there is indication that a woman has moved to another location, a report should be made to the county or tribal agency where mother is residing.

A case should remain open for 45 days with continued attempts made to contact mother or extended family members, or community members, to help locate her. A final attempt to contact mother should be made prior to closing. Documentation of all efforts should be entered in SSIS.

Pre-petition screening consultation

Local welfare agencies may take action under Chapter 253B.05 if a mother refuses recommended services, fails recommended treatment, or cannot be found. Local agency workers shall consult with the county/tribal attorney, or tribal ICWA advocate, regarding a chemical health emergency admission hold.²⁷

Accepts services

A plan of safe care should be developed at the time of service delivery and, whenever possible, no later than 30 days prior to delivery. System-level collaboration and service integration are essential in providing child welfare services to pregnant women. At minimum, services need to be coordinated among child welfare, chemical health, medical and mental health. Partner with pregnant women to develop plans that address individual needs.

Services that pregnant women may need include:

- Chemical dependency assessment
- Substance abuse treatment and/or counseling
- Medication assisted treatment (MAT) for opioid use
- Family preservation services
- Referral for prenatal care
- Mental health services
- Referrals to preventative services that are culturally specific to a pregnant woman
- Identify sponsors and or peer recovery coaches to help with abstaining, skills training, job searches, child care and transportation in collaboration with pregnant women
- Medical and/or nursing services
- Nutrition services.

Interviewing and engaging pregnant mothers

The focus of interviewing pregnant women should be on assessing risk and planning for the safety and health of their baby. Being supportive of women and jointly engaging in safety planning for their babies are priorities. Caseworkers need to assess if a pregnant woman can successfully and safely care for their infant, and what service referrals a woman will need to support her in providing for the safety and well-being of her baby.

²⁷ Minn. Stat., 2016, 253B.05: Emergency Admission Holds; Office of the Revisor of Statutes: <http://www.revisor.mn.gov/statutes/?id=253B.05>.

Prospective father's involvement

Information regarding identity of prospective fathers should be sought. When identified, a father should be engaged in services to support a healthy pregnancy, whenever possible. In instances of domestic violence, careful consideration should be made as to the level of participation of a father.

When working with fathers, identify services they may need, willingness to engage in services, and their substance use and need for intervention. Assess willingness of father to accept child welfare services, and barriers that might prevent him from receiving these services.

Supports and protective factors for parents

Multiple life stressors can reduce a parent's capacity to cope effectively with day-to-day stressors of caring for children. All parents have inner strengths or resources that can serve as a foundation for building their resilience to parent effectively. Protective factors are the conditions in families and communities that, when present, work to increase the health and well-being of children and families. These factors can aid in helping families find resources, supports and coping strategies that allow them to parent effectively. Protective factors are found within families or communities that a family identifies or engages in. Sources to consider are:

- Family
- Community
- Churches
- Tribal organizations
- Urban/native organization

Protective factors, along with other capacities specific to a family and their culture, are important in initial and ongoing assessments of a child's safety and well-being. The six research-informed protective factors are:²⁸

- Nurturing and attachment
- Knowledge of parenting and child development
- Parental resilience
- Social connections
- Concrete supports for parents
- Social and emotional competence of children.

Partnering with parents to identify and access resources to build and/or support protective factors may provide support, information, and help parents to enhance their capacity to parent and provide for the health, protection and well-being of their children.

Case planning with parents using strength-based family-centered practice

During an assessment, behaviors and conditions are identified that may contribute to risk of maltreatment to an unborn child. During an assessment, caseworkers acknowledge and gain understanding of family strengths, needs and resources that will enable an unborn child to be safe. Case plans need to be holistic, comprehensive and culturally responsive. Case planning should be in collaboration with other team members and include the mother, father, family and all primary service

²⁸ <http://www.childwelfare.gov/preventing>: Making Meaningful Connections.

providers involved with a family. A family-focused response is essential to having an effective case plan. When parents address their substance use and other issues affecting their capacity to effectively parent, positive changes in a family can be achieved.²⁹ The following is a list of positive approaches that may be beneficial in case planning with parents:

- Focus on what is strong, not just on what is wrong
- Encourage parents and their families to do their best within the framework of a family's culture
- Reframe deficits as opportunities for growth
- Acknowledge and build on success
- Presume a desire that a pregnant woman wants her baby born healthy
- Believe that families can and do change with support and services
- Offer support and model empathy
- Ask questions to find their strengths
- Learn what parents want, and have them identify their best hope
- Focus on small changes and acknowledge them
- Don't confuse details with judgments
- Offer choices
- Treat each contact with a parent as an opportunity for change.

²⁹ Protecting Children in Families Affected by Substance Use Disorders, Chapter 6, pages 45 -50. "The Role of Child Protective Services when Substance Use Disorders are Identified." Child Welfare Information Gateway at: www.chldwelfare.gov/pubs/usermanual.cfm.

Child Protection Response – Post-natal

After a child is born, a child protection assessment or investigation is required when a report is made regarding an infant with prenatal exposure to substances identified by:

- A positive toxicology test performed on mother or child at delivery
- Medical effects or developmental delays during a child's first year that medically indicate prenatal exposure to a controlled substance
- Detectable physical, developmental, cognitive or emotional delays, or harm that is associated with parental action involving substance use or abuse
- Presence of Fetal Alcohol Spectrum Disorder during a child's first year.

Possible signs of prenatal exposure detectable at birth and early infancy that require an assessment include:

- Facial characteristics of Fetal Alcohol Syndrome
- Withdrawal as defined by Neonatal Abstinence Syndrome
- Irritability
- Irregular and rapid changes in state of arousal
- Low birth weight
- Prematurity
- Difficulties with feeding due to poor suck
- Irregular sleep-wake cycles
- Decreased or increased muscle tone
- Seizures or tremors
- Developmental delays during the first year.

During an initial Family Assessment or Investigation, caseworkers should identify behaviors and conditions, including substance use by the parent and other members in the family household, which may contribute to risk of maltreatment. Each family is unique; during a Family Assessment or Investigation, caseworkers should engage a family in a process designed to gain a greater understanding of family strengths, needs and resources so that children are safe and risk of maltreatment is reduced. The assessment or investigation of prenatal exposure reports are not unlike other child maltreatment reports, and have the same requirements with the exception of the plan of safe care.

Informing tribes of American Indian children involved in a Family Assessment or Investigation

Local welfare agencies shall provide immediate notice to an Indian child's tribe, including tribes located outside of Minnesota, when an agency has reason to believe a Family Assessment or Investigation may involve an Indian child as an alleged victim. Immediate notice means within 24 hours. The notice must be by telephone, email or FAX, and must request participation in evaluating a family's circumstances, identifying family and tribal community resources, and, if case planning is necessary, help in developing a case plan. This immediate notice is required by the Minnesota Indian Family Preservation Act (MIFPA). [Minn. Stat. 260.761, subd. 2]

Child protection: Post-natal response diagram

Intake

Mandated reporters shall immediately report prenatal exposure to any controlled substances or alcohol evidenced by withdrawal symptoms in an infant at birth, or by results of a positive toxicology test performed on a mother or child at birth, or by medical effects or developmental delays during an infant's first year that indicate prenatal exposure to a controlled substance. [Minn. Stat. 626.556, subd. 2 (g)(6)]



Screening: Screened in

Open for child protection assessment or investigation. Both are non-voluntary responses and involve a comprehensive evaluation of safety, risk, protective factors, strengths, needs, and a determination of whether services are necessary.



Child protection assessment or investigation

Assess safety of infant and develop plan of safe care if not previously done. Develop comprehensive service plan with parents and other team members. Make referrals for services that family and infant need.



When necessary, consult with county or tribal attorney regarding a CHIPS petition. If immediate safety is needed, contact law enforcement regarding placing infant on 72-hour hold.

Child protection response time frames

Child maltreatment reports assigned for investigation that do not allege substantial child endangerment or sexual abuse, and reports assigned for a Family Assessment response, require face-to-face contact within five calendar days of receipt of report, according to Minn. Stat. 626.556, subd. 10 ((j)). When a report is received for an infant born prenatally exposed to substance use, it is always best practice to make contact as soon as possible, regardless of the response path, because face-to-face contact with children and their primary caregivers is the first way to assess child safety. When an infant is in the hospital, it is also important to make contact and begin planning prior to infant's discharge. Child protection assessments and investigations must be completed within 45 days of receipt of a report.³⁰ For information on response time frames, see [Minnesota's Best Practices for Family Assessment and Family Investigation](#).

Safety planning and developing a safety net

Safety planning should begin immediately, and may occur at any time during an assessment or investigation, depending on safety threats. A safety plan is required for all children assessed to be unsafe or conditionally safe. The Structured Decision Making (SDM) safety assessment tool must be completed during the first face-to-face contact and documented in SSIS within three days of contact. Caseworkers should seek supervisory consultation when dealing with critical safety issues of children being assessed for child maltreatment.

The safety plan is a course of actions, steps, or procedures put in place immediately to control risk of parental factors, and amplify protective factors.

A safety plan outlines the following:

- Immediate family conditions that threaten child safety
- Action steps or procedures that will mitigate risk and maintain safety of children
- Identifies how each family condition that threatens a child's safety is being controlled by the safety plan
- Identifies a family's capacity and willingness to support the safety plan
- Identifies arrangements made with family, extended family, kin, friends, informal networks, cultural and spiritual groups, and other service providers to carry out a safety plan
- Identifies protective factors and capacity (or lack thereof) of persons to protect a child that can be drawn on to create safety.

A plan of safe care is required for an infant that has been prenatally exposed to substance use. Ideally, a plan of safe care is developed prior to an infant's birth. However, if an agency becomes aware of an infant's exposure to substance use only after birth, a plan of safe care needs to be developed and implemented prior to discharge, whenever possible. See Plan of safe care section on pages 11-13.

Law enforcement and 72-hour holds

When a child is found in surroundings or conditions that endangers their health or welfare, law enforcement has the authority to remove them from the home and place them in foster care. For a child

³⁰ Minnesota Best Practices for Family Assessment and Family Investigation, Minn. Dept. of Human Services, page 3, September 2016.

to remain in care longer than 72 hours, child welfare agencies must have the court approve placement, or a parent must sign a voluntary placement agreement for a child to remain in care.³¹ It is possible that an infant that has been prenatally exposed to substance use by the mother could be placed on a 72-hour hold at birth by law enforcement, if it is determined that an infant would be in imminent danger remaining with their parents. In these situations, every effort (and active efforts with an Indian child) is made to work with a parent during this time to develop a safe plan for infant to return to their care within 72 hours, if possible.

Court considerations and out-of-home placement

At the time of a report, assessing risk to determine if an infant can go home, or can remain in their home safely, is paramount, and a critical component of the comprehensive assessment process. Reasons for placing an infant in protective custody are based on immediate safety threats not mitigated by sufficient familial protective factors to provide for an infant's safety. If a mother and infant are residing in, or enter a residential treatment program, which can mitigate immediate safety concerns, removal of an infant from a mother's care can be avoided.

If it is determined that immediate safety factors are present, and protective capacity is not clear to provide for an infant, they must be placed in out-of-home care. In such instances, it is imperative that an infant's caregivers (e.g., kin, foster parents) also be involved in discharge planning and caring for them, especially if they have medical concerns, as is likely for infants with Neonatal Abstinence Syndrome or Fetal Alcohol Syndrome. This should be included in the plan of safe care.

It is imperative that other caregivers receive medical information, training, and support to appropriately care for infants with prenatal exposure when these infants will not be released to the care of their parent.

Regardless of immediate placement decisions, the plan of safe care must be completed.

Minn. Stat. 260.C007, subd. 18, defines out-of-home care or foster care as any 24-hour substitute care for children placed away from their parents or guardian, and for whom a responsible social services agency has placement and care responsibility. Foster care includes, but is not limited to, placement in foster family homes (relative and non-relative), group homes, emergency shelters, residential facilities, child care institutions and pre-adoptive homes. There may be times in which additional oversight or court involvement may be necessary to achieve child safety and temporary out-of-home placement is needed. Consultation with county/tribal attorney's office should be made when conditions exist that may necessitate an infant's removal from their parents. A Child in Need of Protection or Services (CHIPS) petition may need to be filed when unresolved safety threats exist, efforts have been made to provide

³¹Minn. Out-of-home Care and Permanency Report, Minn. Dept. of Human Services, Children and Family Services, January 2017.

safety but have not been successful, or other conditions meeting the legal threshold for court intervention.

If a child is to be removed from their parents' care, diligent efforts must be made to place infants with safe family/kin or known supportive people to minimize trauma of removal, and who can provide a safe, temporary home for them.³²

Placement of American Indian children

For American Indian children, active efforts must be made to prevent placement of an Indian child, and placement preferences must be followed according to the Indian Child Welfare Act (ICWA) and Minn. Stat. 260.762, subd. 7. Active efforts under ICWA requires placing agencies to notify designated tribal representatives of a child's tribe to seek guidance and advice in case planning, determining available family and tribal resources, and working with a child's tribe and family to develop an alternative placement.³³

High risk families

A SDM risk assessment is required in Family Assessment and Family Investigation. The risk assessment identifies the level of risk of future maltreatment and guides decisions about the need for child protective services. High risk families should be opened for case management services, unless protective factors or capacities exist. If a family is rated high risk, and a child cannot be kept safe, the county or tribal child welfare agency staff should consult with the county or tribal attorney about court action to protect a child. This consultation should take place as early in the involvement of an agency as necessary to provide needed protection for a child. Agency staff should document pertinent factors considered when determining the need for court involvement, which can occur in either a Family Assessment or Family Investigation response. It is encouraged that agency staff and county or tribal attorney agree there is a basis for court action to protect a child.

County or tribal attorney consultation

Local welfare agency staff shall consult with the county or tribal attorney to decide if it is appropriate to file a petition alleging a child is in need of protection or services if:

- A family does not accept or comply with a plan for child protective services
- Voluntary child protective services may not provide sufficient protection for a child
- A family is not cooperating with an investigation or assessment.³⁴

Child protection services determinations³⁵

In both Family Investigations and Family Assessments, determinations are made of whether child protection services are needed. According to Minn. Stat. 626.556, subd. 10e(g), "a determination that child protective services are needed means that the local welfare agency has documented conditions

³² Minn. Department of Human Services, Best Practice in the Co-occurrence of Child Maltreatment and Domestic Violence Response Path, July 2017.

³³ Minn. Department of Human Services, bulletin 15-68-05; Relative Notice Requirements for Children in Foster Care. May 1, 2015.

³⁴ Minn. Stat. 626.556, subd. 10m (b)

³⁵ Minnesota's Best Practices for Family Assessment and Family Investigation, Minn. Department of Human Services, page 14, September 2016.

during the assessment or investigation sufficient to cause a child protection worker to conclude that a child is at significant risk of maltreatment if protective intervention is not provided, and the individuals responsible for the child's care have not taken or are not likely to take actions to protect the child from maltreatment, or risk of maltreatment." This determination is also made based on a preponderance of evidence.

When a Family Assessment or Investigation is closed or opened for services, local welfare agency staff shall document the outcome, including a description of services provided and the removal or reduction of risk to a child, if it existed.³⁶

Child Protection Case Planning

If a case is opened for ongoing services, the plan of safe care is the case plan for a prenatal-exposed infant, other children in a family and the parents. The plan should be developed in collaboration with a family and all service providers involved with a family. A family-focused response to address family functioning issues is essential to an effective case plan. (See Safe care plan section.) Services a mother may need and included in the plan of safe care include:

- Chemical health assessment
- Substance abuse treatment, including MAT
- Aftercare services
- Mental health services
- Child care, transportation
- Housing/basic needs
- Economic needs
- Counseling services
- Parenting support and education
- Domestic violence prevention
- Education
- Sexually exploited youth service referrals
- Healthy family planning (long-acting reversible contraception – LARK)
- Parenting support or education.

Services for an infant may include:

- Medical: Well-baby checks, in-home nursing services, public health nurse, doula, care coordinators, medications
- Safe sleep practices
- Referral for developmental screening
- Referral for early intervention services.

Services a father may need include:

- Chemical health assessment
- Substance abuse treatment, including MAT

³⁶ Minn. Stat. 626.556, subd. 10I.

- Aftercare services
- Mental health services
- Transportation
- Housing/basic needs
- Economic needs
- Counseling services
- Parenting support and education
- Education
- Domestic violence prevention.

The SDM risk assessment and reassessment tools help determine the number of monthly face-to-face contacts a worker will have with a family. The face-to-face contact with a family helps to assess protective factors ongoing, and monitor effectiveness of the plan of safe care for an infant and the need to revise it, if needed.

If a parent is in need of chemical dependency treatment, every effort should be made to have the mother in a treatment program where her children can reside with her. If a program is not available that enables her to have her children, the program should be in close proximity so she is able to see her children often, and they can visit her, whenever possible.

Planning for relapse

Relapse can occur because substance use disorder is a chronic disorder. There is no cure and there is always the potential for relapse. The chronic nature of the disease means that relapsing to substance abuse at some point is not only possible but likely. Treatment of substance use disorder involves changing deeply imbedded behaviors, and relapse does not mean treatment has failed. For a person recovering from substance use disorder, lapsing back to substance use indicates that treatment needs to be reinstated or adjusted, or that another treatment should be tried.³⁷

The risk of relapse depends on the substance used. The rate for relapse for opiate addiction after one year is 85 percent. With alcohol, the range for relapse is 30 to 70 percent after one year. There can be internal risk factors such as a persistent negative mood, feeling stressed, genetic predisposition, family history or co-existing psychiatric problems. There are also external triggers, such as losing a job, problems with family or friends, housing needs, child care needs, loss of a loved one, health-related or academic problems. Risk factors are very individualized, and even happy events can be a risk factor for relapse. Drug and alcohol treatment is critical to learning coping skills that can help manage relapses. Treatment plans need to be reviewed often and modified to fit a person's changing needs. The best way to prevent relapse is to understand the warning signs and risk factors, and planning a relapse prevention program with other people and/or a treatment program is critical to maintaining sobriety.³⁸

³⁷ National Institute on Drug Abuse (NIDA), Treatment and Recovery: <https://drugabuse.gov/publications/drugs-brain-behavior-science-addiction/treatment>, March 2017

³⁸ Understanding Addiction Relapse: Addiction Center Everyday Health.com: <http://everydayhealth.com/addictin/understanding-addiction-relapse.aspx>, March 2017.

Working with clients struggling with a substance use disorder

People with a substance use disorder are victims of their disease and working with them can be a challenge for caseworkers. People struggling with a substance use disorder tend to blame their problems on those around them, and may go to great lengths to deny their addiction is the reason for their current situation. Most people with substance use disorder believe they have no problem and that others do not understand their situation. An important aspect of substance use disorder denial is the ability to excuse, rationalize, minimize, lie or blame others for their behavior. In addition, a pregnant woman may fear she will lose her infant if she acknowledges her substance use. By the nature of the illness, people with substance use disorders are not able to control use by practicing self-control; they use denial to maintain using substances. Until a person receives treatment for their substance use, they may not be willing or open to changing their behavior. They may suffer many consequences because of their addiction, or be forced to go to treatment through family or court intervention before they are willing to acknowledge they have a problem and need help to remain free from using substances.

Caseworkers need to have patience and understanding of the multiple facets of this chronic disease when working with people with this disorder. Believing in a person's ability to change and wanting a sober life is imperative. Once a person with a substance use disorder receives treatment and remains sober, they will no longer need addictive defenses. When they view themselves in a positive way, their behavior will also change in that direction. Caseworkers can aid in this change by acknowledging and building on a person's successes, offering support, being non-judgmental, and treating each contact as an opportunity for growth.³⁹

Family Group Decision Making

Family Group Decision Making (FGDM) is a family-centered, culturally appropriate process that allows families to take responsibility for planning and caring for their members. This process can be initiated by child welfare agencies whenever a critical decision about a parent or their child is needed. The FGDM process is a specialized facilitated meeting where the decision making primarily rests with the family, and is useful for safety planning, case planning, placement prevention and reunification. FGDM seeks to have collaboration and leadership of family members in making and implementing plans that support the safety, permanency and well-being of their children.⁴⁰ FGDM can be a resource and help to a family in developing or reviewing the plan of safe care.

Services for Children and Families

Help Me Grow

Infant and toddler interventions are special services and supports for children birth through age 2 and their families. Preschool special education is for eligible children ages 3 to 5. Minnesota children eligible for Help Me Grow can receive services in their home, child care setting or school. Help Me Grow services are free to eligible families regardless of income or immigrant status.

³⁹ "The Problem of Addiction," Modern Drummer, February 1991.

⁴⁰ Minnesota Best Practices for Family Assessment and Family Investigation, Minn. Department of Human Services, pg. 20, September 2016.

Infant and toddler intervention

Once an infant or toddler has been identified as being eligible for early intervention services, an Individual Family Service Plan (IFSP) is developed that describes a family's long- and short-term goals for their child. School teams work with a family to develop intervention strategies that can be integrated into their everyday routines and activities.

Services are typically provided in a child's home or daycare setting. Visits occur weekly to every few months, depending on a child's needs. Several professionals may be on a child's team to help develop and implement an Individual Family Service Plan. One primary service provider will be responsible for working with a family. Service areas may include:

- Early Childhood Special Education teacher
- Speech and language
- Occupational therapist
- School psychologist
- Physical therapist
- Teacher of the deaf and hard of hearing
- Teacher of the visually impaired
- Autism resource specialist

Pre-school special education (ages 3-5)

Early Childhood Special Education (ECSE) services are provided for children ages 3-5 with disabilities or developmental delays. Eligibility is determined after an evaluation is completed.

A child is eligible for Early Childhood Special Education services if they meet criteria for any one of the following disability categories:

- Autism Spectrum Disorder
- Emotional behavioral disorder
- Deaf/hard of hearing
- Other health impairment
- Speech/language impairment
- Visual impairment
- Deaf-blindness
- Developmental cognitive disability
- Physical impairment
- Specific learning disability
- Traumatic Brain Injury
- Developmental delay

Early Childhood Special Education services

When a child is identified as eligible for Early Childhood Special Education services, an Individual Education Plan (IEP) is developed. The IEP identifies long- and short-term goals for a child, the type of services that will be provided, and where the services will be located.

Services are provided by one or several professionals, depending on a child's educational needs. One team member is assigned as the primary contact person for parents. Team members may include:

- Early Childhood Special Education teacher
- Speech and language pathologist
- School psychologist
- Physical therapist
- Teacher of the deaf and hard of hearing
- Teacher of the visually impaired
- Autism resource specialist
- Pre-school teacher
- School nurse

Fetal Alcohol Spectrum Disorder

Fetal Alcohol Spectrum Disorder (FASD) is a range of effects that can occur when a developing baby is prenatally exposed to alcohol. FASD can include physical disabilities as well as difficulties with behavior and learning. These conditions are lifelong and irreversible, and there is no cure.

The effects of FASD vary widely from person to person. They may be physical, mental, social, behavioral and/or learning disabilities. A child with FASD might have:

- Abnormal facial features
- Poor coordination
- Hyperactive behavior
- Difficulty paying attention
- Learning disabilities
- Poor reasoning and judgment skills

Research is clear that early intervention can help identify problems or potential problems that may threaten a child's developmental foundation and lead to additional delays and deficits later in childhood. Learning the full extent of a child's disabilities can help parents and teachers prepare for challenges ahead, open doors to social services, and provide greater understanding and acceptance that can lead to more realistic expectations, and contribute significantly to positive long-term outcomes.

Organizations, such as the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS), are also a resource. The vision of MOFAS is to eliminate disability caused by alcohol consumption during pregnancy, and to improve the quality of life for those living with Fetal Alcohol Spectrum Disorders throughout Minnesota. The organization is committed to ensuring individuals living with Fetal Alcohol Spectrum Disorders are identified, recognized and valued. MOFAS is a nonprofit funded mainly through the Minnesota Department of Health. It is a statewide organization serving as the leading voice and resource on Fetal Alcohol Spectrum Disorders in Minnesota and on a national level. MOFAS provides education and training so that FASD is better understood, and creates an awareness so women know that there is no safe level of alcohol use during pregnancy. MOFAS provides FASD diagnostic assessment services, youth and young adult services and caregiver services. MOFAS serves individuals and organizations throughout Minnesota. Its website is www.mofas.org, and contact at info@mofas.org.

Case closing

Cases can be closed when a family no longer needs child protection intervention to ensure the safety of their child. The team working with a family meets to determine when child protection services are no longer needed. A SDM risk reassessment must be completed prior to closing a case; a case can be closed if risk is low or moderate. Many of the resources and services in place for a family may continue. A meeting should be held with service providers and family to discuss closing a case, and what community services and supports will continue on a voluntary basis. The case closing summary should address the following:

- Initial reason a case was opened in child protection services
- Services that were provided
- Family's involvement with services and supports
- Identified issues that were resolved, and why a child is no longer at risk and in need of child protection intervention
- Address safety of infant and SDM risk level
- Identify services and supports family will continue to be involved in once a case is closed
- Describe relapse prevention plan, and steps to take if there is a relapse
- Identify family or support services that will ensure continuation of the safe plan of care.

