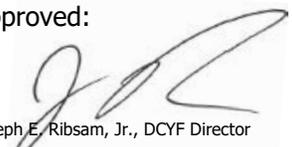


1184 ENHANCED ASSESSMENT PRACTICE	
Chapter: Child Protective Field Services	Section: CPS Family Assessments
 <p>New Hampshire Division for Children, Youth and Families Policy Manual Policy Directive: 20-14 Effective Date: March 2020 Scheduled Review Date:</p>	<p>Approved:</p>  Joseph E. Ribsam, Jr., DCYF Director
Related Statute(s): RSA 132:10-e , RSA 132:10-f , and RSA 169-C Related Admin Rule(s): Related Federal Regulation(s): 42 USC 5106a (b)(2)(B)	Related Form(s): FORM 1192 and FORM 1520 Bridges' Screen(s) and Attachment(s):

This policy defines differential response practices for Child Protection Service Workers (CPSWs) assessing reports relative to parental substance use as it impacts alleged victims who are at highest risk.

Definitions

- "Action Plan"** means a document to be used with the families to identify specific actions and strategies to avoid, disrupt, or escape high-risk situations. It is a fluid document that may change with the family's progress and enhances the case plan. An Action Plan may be used when a concern does not rise to the level of a "Safety Plan," or as a transitional strategy after completing a "Safety Plan" to continue implementing certain tasks.
- "Enhanced Response"** means a differential response requiring Child Protective Services staff to utilize systematic practices including increased contacts with family and providers to mitigate potential danger.
- "Infant"** means a child between the ages of zero (0) and 12 months.
- "NAS"** means Neonatal Abstinence Syndrome, the withdrawal syndrome of infants, caused by the cessation of the administration of licit or illicit drugs.
- "NHIA"** means New Hampshire Integrated Assessment, which is the process and tools that assist the CPSW in assessing the families' safety and capacity utilizing a standardized, systematic approach to manage Child Protection Services.
- "POSC" or "Plan of Safe Care"** means a formalized plan established by the medical care provider with the primary caregiver of an infant born with, and identified as being affected by, substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder to address the immediate needs of the affected infant as well as the ongoing treatment needs of the affected infant and the health and substance use disorder treatment needs of the affected family or caregiver.
- "Rebuttable Presumption of Harm"** means an assumption of facts that can be overturned only if the evidence contradicting it is true and if a reasonable person of average intelligence could logically conclude from the evidence that the presumption is no longer valid.

“Safe Sleep” means practices aimed to reduce the risk of sudden infant death syndrome (SIDS) and other sleep related causes if infant death that could occur when an infant is in a crib or in other sleeping arrangements.

“Safety Plan” means a document developed by DCYF with a family that is used to address immediate danger by identifying interventions to be implemented to mitigate the danger.

“Substance-Exposed Infant” means infants exposed to alcohol, prescription drugs, misuse of over the counter medications, inhalants, and illicit drugs (cannabis, hallucinogens, opioids, stimulants, sedative hypnotics) while the infant is in utero, whether prescribed or not which result in the infant exhibiting withdrawal symptoms at birth by a medical professional. (See Practice Guidance for definitions from the NIDA Drugs of Abuse and DSM-V for the [specific identified substances](#).)

“Substance Use” means the ingestion of alcohol, misused prescription/over the counter medications, inhalants, and illicit drugs (cannabis, hallucinogens, opioids, stimulants, sedative hypnotics). See Practice Guidance for definitions from the NIDA Drugs of Abuse and DSM-V for the [specific identified substances](#).

Policy

- I. A Child Protective Services Supervisor will ensure an Enhanced Response Assessment is initiated by a CPSW when an accepted report alleges that an infant was born with, and is identified as being affected by, substance use or withdrawal symptoms resulting from prenatal drug exposure (except as identified below), or a Fetal Alcohol Spectrum Disorder as determined by a medical professional.
 - A. This policy does not apply when exposure occurred as the result of a mother’s use of a substance, as prescribed, under the supervision of a physician.
- II. All Assessments identified for Enhanced Response must follow standard Assessment practices in addition to the following:
 - A. All Enhanced Response Assessments will have a minimum number of face-to-face visits;
 1. Any report for a substance-exposed infant who has not yet been discharged from the hospital will have a minimum of 4 face-to-face visits, inclusive of an initial visit at the hospital, a home visit within 5 days of discharge, a visit 2 weeks after the initial home visit, and a final visit within 10 days prior to the Assessment closing; or
 2. Any report for a substance-exposed infant who has already been discharged will have a minimum of 3 face-to face visits. The first home visit shall be within identified time frames, followed by a visit 2 weeks after the initial home visit, and a final visit within 10 days prior to closure;
 - B. Enhanced Response Assessments with identified danger will have a safety plan, developed by the CPSW with the parent(s) and an additional safe and sober caregiver. These safety plans should also incorporate any supports or referrals identified in the Plan of Safe Care (POSC) if one has been created;
 1. All safety plans must be documented in the NHIA “24-hour Safety Assessment” screen and all safety review screens;

2. If an additional safe and sober caregiver cannot be identified or the parent(s) refuse(s) to engage in developing a safety plan, the CPSW must consult with a Supervisor immediately to determine what, if any, additional steps will be taken;
 - (a) Consideration should be made when opioid abuse or dependence are a factor as to whether petitions should be filed, in alignment with RSA 169-C: 12-e Rebuttable Presumption of Harm;
 - (b) If petitions are filed, a case must be opened pursuant to policy 1217 Transition of Assessment to Family Services;
- C. The CPSW will gather the following information as circumstances allow:
1. A history of the parent(s) substance use/abuse and any familial use/abuse history;
 2. The Plan of Safe Care (if a POSC was not created with the family, then the CPSW should remind the medical provider of the statutory obligation for a POSC and note this in their documentation);
 3. Information from the infant's Primary Care Physician; and
 4. Information from professional collateral contacts which may include, but are not limited to:
 - (a) Visiting Nurse Association (VNA);
 - (b) Parent(s)' and/or child(ren)'s treatment provider(s); and
 - (c) Early Supports and Services (ESS).
- III. Within 10 business days of when the CPSW anticipates closing the Assessment, the CPSW will conduct a final home visit with the infant and family. During this home visit, the CPSW should review the Plan of Safe Care with the family and create an action plan that will assist the family with services, supports, and new referrals as outlined on the POSC.
- A. If the Assessment is not submitted to the Supervisor for closure within the 10 business days of the required final home visit, another home visit should be completed, unless otherwise agreed upon with the Supervisor.

Procedure

- I. If the infant is currently admitted to a hospital:
 - A. The CPSW shall visit the infant at the hospital (prior to discharge when possible) pursuant to the response level assigned by Central Intake, and document all information gathered. The CPSW will:
 1. Make an effort to obtain releases in order to gather information regarding concerns for potential danger and discharge planning;
 2. Seek to obtain and understand through consultation with the medical provider the NAS scores, drug screen results, withdrawal symptoms, and

documentation/information regarding any medically prescribed treatment being administered;

- (a) If the medical provider is not available, the CPSW may consult with the DCYF Public Health Nurse Consultant or LADC (Licensed Alcohol and Drug Counselor);
 3. Obtain medical information regarding the harm or future impact to the child;
 4. Inquire if hospital staff have educated the parent(s) on safe sleep;
 5. Obtain a copy of the Plan of Safe Care developed with the family to meet health and substance use treatment needs of the infant and affected family members, including appropriate referrals for services. If a POSC was not created, the CPSW should remind the medical provider of their statutory obligation to create one and document this;
 - (a) Discuss the POSC with the family to determine what supports and services the family may need assistance connecting with;
 6. Gather observations of the parent(s)' behavior(s) from the hospital staff and observe the parent(s) interacting with the infant; and
 7. Request a copy of the Discharge Orders and Discharge Summary (if these are not available, ask to be provided copies as soon as they are available);
- B. The CPSW shall then complete a home visit, when possible, before the infant is discharged. If danger is identified, a safety plan is created with the parent(s) and another safe and sober caregiver for when the infant will be discharged. The CPSW shall:
1. Utilize the family's strengths and support system to develop a safety plan that speaks to specific actions to be taken to avoid situations that lead to potential danger and defuse situations as the need arises;
 2. Review the POSC (if established), safe sleep, and the infant's sleeping arrangements, regardless of if there is a safety plan or not; and
 3. Discuss actions identified in the POSC and Discharge Orders and what supports the family may need in completing these; and
- C. Post discharge, the CPSW must see the infant and the family in the home environment within 5 business days. At this visit the CPSW shall:
1. Ensure that the Early Supports and Services (ESS) referral has been made, and if it has not been made, make the referral (ensuring it is documented in Bridges as soon as possible);
 2. Review the family's POSC, if established, and the family's ability to access services, supports, and new referrals as outlined;
 3. Discuss referrals to community resources that the family may benefit from, including but not limited to financial, housing, parenting, treatment supports, or referrals made

as documented in the POSC (assist in the referral process as applicable and document in Bridges as soon as possible);

4. Discuss safe sleep and review the infant's sleeping arrangements; and
5. If a Safety Plan is in place and the CPSW has been able to confirm that the danger has been mitigated, the Safety Plan can be discontinued and an Action Plan may be established.

II. If the infant has already been discharged and is at home, the CPSW shall:

- A. Visit the infant at their home pursuant to the response level assigned by Central Intake. During the first face-to-face visit the CPSW will:
 1. Make an effort to obtain releases in order to gather information regarding concerns for potential danger and discharge planning;
 2. Ask the family to review the Plan of Safe Care, discuss how they have utilized this plan for ongoing services, supports and new referrals and what assistance DCYF may be able to offer. If a POSC has not been created, the CPSW should document this;
 3. Create a safety plan (if danger is identified) with the parent(s) and a safe and sober caregiver that utilizes the family's strengths and support system and includes any actions identified in the Discharge Orders, if available; and
 4. Review safe sleep and the infant's sleeping arrangements; and
- B. Obtain information from the hospital as outlined in procedure I. A. directly above.

III. The CPSW will see the infant and the family in the home environment within 2 weeks of the initial face-to-face. At this visit, the CPSW shall:

- A. Follow-up on needs and services and make a referral to Early Supports and Services (ESS) if it has not been (ensuring it is documented in Bridges as soon as possible);
- B. Review prior safety/action plans and document progress;
- C. Review the POSC and identify any supports the family may need in accessing services, supports, or new referrals outlined in this plan; and
- D. Discuss referrals to community resources that the family may benefit from, including but not limited to financial, housing, parenting, treatment supports or referrals made as documented in the POSC (assist in the referral process as applicable and document in Bridges as soon as possible).

IV. The CPSW will make a final visit to the home within 10 days prior to closing the Assessment to:

- A. Determine the family's ability to access the services, supports and new referrals as outlined in the POSC and any supports DCYF can offer to assist in accessing these;

- B. Create an Action Plans to help the family access or follow through with supports, services, or new referrals outlined in the POSC that will assist them in reducing risk due to parental substance use; and
- C. Ensure the family has appropriate information regarding community supports and services.

Practice Guidance

A child born exposed to marijuana experiences no withdrawal. If the child's health has not suffered nor is it likely to suffer, the circumstances do not rise to an allegation of neglect. If there are no other concerns, do I still need to keep the Assessment open for the 60 days?

- If the CPSW is able to confirm and document within 10 days of receipt of the Assessment that completed safety and risk assessments do not indicate danger or very high/high risk, the family is receptive to community referral,; and the family is following through with their POSC from the hospital, the CPSW may consult with their Supervisor on the appropriateness of a Second Level Screening.
- It is important to remember that pursuant to the Child Abuse Prevention and Treatment Act, the child must have a Plan of Safe Care. Confirm with medical providers that the family does have a POSC before closing the Assessment. If the family does not, inquire of the medical provider why there is not a plan in place, document this in Bridges, and seek consultation with your supervisor as to how to proceed.

What are the differences between the types of substances and how are they defined?

- Alcohol means ethyl alcohol (ethanol), an intoxicating ingredient found in beer, wine, and liquor.
- Cannabis means the scientific name for marijuana. It is a dry, shredded green and brown mix of leaves, flowers, stems, and seeds from the hemp plant Cannabis sativa. Synthetic cannabinoid compounds such as Spice or K2 are included in this category.
- Hallucinogens means drugs are dissociative anesthetics and can include Phencyclidine (PCP/Angel Dust), Ketamine, LSD (acid), MDMA (Ecstasy) and Bath Salts.
- Inhalant means any drug administered by breathing in its vapors. Inhalants are commonly organic solvents, such as glue and paint thinner, or anesthetic gases such as nitrous oxide.
- Opioids means natural or synthetic chemicals that mimic the actions of endogenous opioids or pain-relieving chemicals produced in the body. These drugs can include heroin, opium, synthetic fentanyl, and pain medications available legally by prescription, such as oxycodone (OxyContin), hydrocodone (Vicodin), codeine, morphine, fentanyl, methadone and buprenorphine (Subutex/Suboxonne).
- Stimulant means a class of drugs that elevates mood, increases feelings of well-being, and increases energy and alertness. Some stimulants, such as cocaine and methamphetamine, produce euphoria and are powerfully rewarding. Other stimulants, such as Ritalin, Concerta, and Adderall are prescribed to treat ADHD.
- Sedatives (or Tranquilizers) means a class of drugs that slow CNS function; some are used to treat anxiety and sleep disorders. Examples of these drugs include barbiturates and benzodiazepines such as Valium (Diazepam), Clonipin (Clonazepam), Xanax (Alprazolam), and Ativan (Lorazepam).

Do we have to visit the home prior to the infant being discharged from the hospital?

- Whenever possible the CPSW shall visit the family home prior to the infant being discharged from the hospital in an effort to ensure that all the needs of the infant can be met safely in the home (e.g. Ensuring that the family has established a safe sleep environment for their infant by not using baby bumpers on their cribs and using safety approved portable cribs for naps and bedtimes).

- If the CPSW is unable to visit the home prior to the infant's discharge, the CPSW shall discuss the items mentioned above with the parent(s) prior to discharge or as soon as possible after discharge.

If the initial report was received by an On-Call CPSW, how many face-to-face visits do I complete?

- If the initial report was responded to by an On-Call CPSW then the face-to-face visits made by the On-Call CPSW count as part of the Enhanced Response. For example, if the On-Call CPSW responded to the hospital to see a drug-exposed infant then the On-Call CPSW completed the first face-to-face and the assigned CPSW is responsible to complete a visit within 5 days, a visit at 2 weeks, and a final visit before closure.
- A CPSW should consider the initial face-to-face made by the On-Call CPSW and may in some circumstances determine that another face-to-face at that time would be appropriate (e.g. If an On-Call CPSW responded to a home and the child was asleep, the CPSW assigned the Assessment may determine it is appropriate to complete another face-to-face the following day).

What are the expectations related to seeing siblings during an Enhanced Response?

- Efforts shall be made to see the non-victim siblings at the first home visit whenever possible. If all non-victims cannot be seen at the first home visit a plan will be made to see them at subsequent home visits to ensure their safety. All children in the home must be seen, and when age appropriate, interviewed, prior to the Assessment being closed.
- If a family declines to allow the CPSW to see the other children in the home, the CPSW must consult with their Supervisor as to next steps prior to closing the Assessment.

When should "Action Plans" be used during the Enhanced Response process?

- All Enhanced Response Assessments will have a safety plan when danger is identified. However, if the CPSW is able to confirm that a parent is in engaging in treatment or that danger is not present, an action plan can be created to provide the family with a tangible document containing clear and concise action steps that align with the treatment they are already participating in, to help maintain a danger-free environment.

What should we include in a referral to Early Supports and Services?

- The ESS referral should include the infant's history of exposure to substances, what those substances were, and any known implications for monitoring the infant's development over time.
- The CPSW should also request the provider teach the parents basic child development and what signs or symptoms they should watch for over time, as well as educate the parent(s) as to available resources in regards to their child's development at all stages and how to create a nurturing environment specific to their child's developmental needs, particularly potential developmental interruption due to exposure.
- The CPSW should also encourage the provider to check with the parents during home visits about where the baby sleeps, including when not at home, and educate the parents about the importance of providing safe sleep environments for their infant at all times.

What are the key discussions that should be had and documented with the family during the Enhanced Response process?

- When conducting an Enhanced Response, or any Assessment for that matter, some of the topics of discussion should be based on the concerns outlined in the protective report. These should include, but are not limited to:
 - Alcohol and tobacco use during pregnancy and current;
 - Education about NAS and other drug withdrawal effects on the infant and potential long-term effects on development to watch for;
 - Drug related activity in the home;

- Risk of on-going substance use;
- Safe sleep and safe sleep environments;
- [Period of purple crying](#), a trademarked phrase used to describe the time in an infant's life when they cry more than any other time;
- Shaken Baby Syndrome;
- Post-Partum Depression;
- Managing everyday tasks;
- Co-parenting and partner support;
- Utilization of natural supports and other resources that can support the parent(s)' recovery;
- Access to treatment; and
- Other community-based supports available to the family, including help lines, transportations assistance to reach supports, available food supplements, etc.

What do I do if a Plan of Safe Care (POSC) was not created?

- The medical provider is required, pursuant to [RSA 132:10-e](#) to create a Plan of Safe Care (POSC) with the parent(s)/guardian(s) of an infant born with, and identified as being affected by, substance abuse or withdrawal symptoms resulting from prenatal drug exposure or fetal alcohol spectrum disorder. The medical provider is required, under [RSA 132:10-f](#) to submit POSC when making a referral to Central Intake.
- If the provider has failed to develop and/or provide the POSC, the CPSW should inquire as to why the plan was not created and request that one be created with the family as soon as possible in accordance with RSA 132:10-e.
- If the medical provider declines to create a POSC, the CPSW should remind them of their statutory obligation and document this in Bridges.