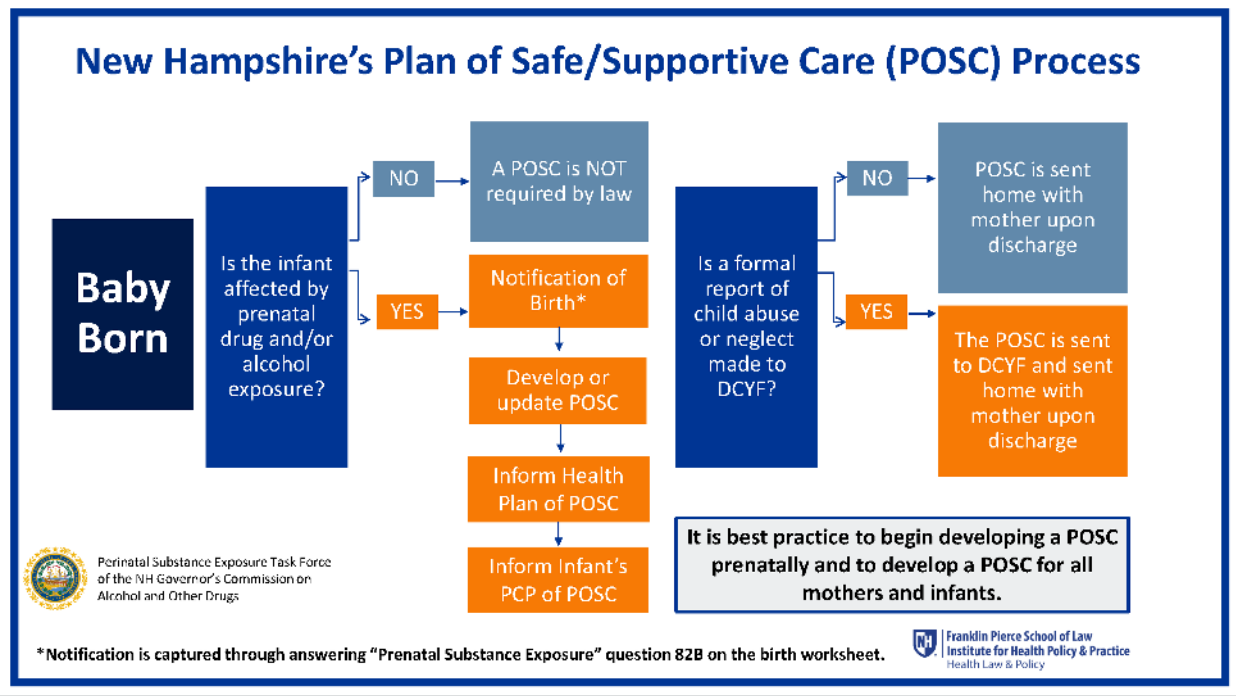
New Hampshire Plans of Safe and Supportive Care — a Legal Primer

Fostering Services and Supports for Families when a Baby is Born Exposed to Substances

Judges, attorneys, GALs, CASA volunteers, and other advocates and staff involved in the family courts will find it helpful to understand prenatal opioid exposure, the state's approach to Plans of Safe Care, NH hospitals' best practice treatment of exposed newborns, and relevant state and federal laws, as a means to inform family engagement, shape referral to services and supports, and improve outcomes for both infants and mothers.

Plans of Safe Care

Consistent with related federal law requirements, New Hampshire law requires the development of a Plan of Safe Care (POSC), sometimes also called a Plan of Supportive Care by care providers, "[w]hen an infant is born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder."[1] A POSC fosters coordination of services and supports to help mothers and their infants stay safe and connected to services when they leave the hospital. The POSC is developed collaboratively with the mother and other caregivers to identify and reinforce existing strengths and supports, and to coordinate referrals to new services. Ideally the POSC is developed prenatally, and should continue to support the mother, baby and family after hospital discharge and during the early period of the baby's life. New Hampshire POSC tools and resources were developed by a multi-disciplinary Perinatal Substance Exposure Task Force of the Governor's Commission on Alcohol and other Drugs; more details are available on the POSC webpage.



Prenatal Drug Exposure and NAS

When pregnant women use drugs, their infants may be affected and may display withdrawal symptoms. Neonatal abstinence syndrome (NAS) is a common term used to refer to a cluster of symptoms typically associated with opioid withdrawal in newborns. Although some babies born exposed may not demonstrate these symptoms, NAS can include tremors, problems eating and/or sleeping, diarrhea, inconsolability, fussiness, poor weight gain, and vomiting. Onset of symptoms usually begins within one to two days of birth. Without medication, these symptoms typically resolve within 1-2 weeks, and can usually be managed in a non-intensive care setting. The practice now followed by most NH hospitals calls for nonpharmacological interventions as the best approach for most of these infants, including supporting the mother or other caregiver in providing skin-to-skin contact, swaddling, gentle rocking, and a low stimulation environment.

Several important notes:

- It is never correct to say that a baby is "born addicted," as addiction refers to "a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences,"[2] as distinct from physical dependence and withdrawal, which is what infants experience.
- The existence, severity and duration of NAS symptoms are clinical indicators that inform hospital care decisions, but do not alone indicate parental abuse, neglect or unfitness; indeed, NAS symptoms may occur because a pregnant woman is taking prescribed medication as directed to address chronic pain, or is in recovery from opioid use disorder and maintained on buprenorphine or methadone, as well as from using illicit substances such as heroin or fentanyl.
- Unlike alcohol, which is known to cause permanent physical, cognitive and behavioral disabilities in infants exposed in utero, there is little conclusive evidence regarding long-term health effects as a result of opioid exposure. Referral for early intervention and supports, as well as parental supports, can help to ensure that these babies grow up without long term deficits.

Reducing Stigma[3]

"Research has identified the stigma around NAS and substance use disorders in general as a significant barrier to treatment for pregnant women. Many mothers do not self-disclose their drug use during pregnancy due to stigma, complicating the treatment process. In addition, when they do reach out for help, 'they often encounter misinformation, denial, inaction, and even judgmental and punitive attitudes toward their substance use.' In some cases, policies that initiate punitive responses to pregnant women with substance use disorders may also create barriers to treatment.

In 2013, 40 leading medical experts sent a letter to several prominent news outlets describing how sensationalized terminology commonly used in the media to describe NAS is medically inaccurate and reinforces stigma. Drug-addicted babies, for example, is not an accurate description of babies born with NAS. These newborns may exhibit physiologic dependence, but they cannot exhibit the compulsive behaviors associated with addictive disorders. This language is successful at eliciting a strong emotional response, but may also help to reinforce many of the negative attitudes that discourage women from accessing the treatment they need."

Federal and State Laws

The Child Abuse Prevention and Treatment Act (CAPTA) is the primary federal statute addressing child abuse and neglect. For many years, CAPTA has required that states address the needs of infants born with prenatal substance exposure.[4] In 2016, the Comprehensive Addiction and Recovery Act (CARA) amended several provisions of CAPTA pertaining to the development of Plans of Safe Care (POSC). In response to these amendments, the New Hampshire legislature enacted RSA 132:10-e and 132:10-f to establish the requirements for POSCs in this state, including a process for notification of births, aggregated reporting, development of POSCs and referrals for services.

New Hampshire law requires a health care provider develop a POSC "[w]hen an infant is born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder."[5] Although a POSC is not legally required for all infants, all mothers deserve a plan of safe care, and developing one with all mothers reduces stigma associated with the POSC and helps all infants and families stay safe and supported.

Developing and Sharing of Plans of Safe Care

All NH birthing hospitals are working to train staff and implement the POSC process, with the goal of adopting more consistent practices to ensure that each mother who delivers a baby prenatally exposed to substances leaves the hospital with a POSC for her newborn. The POSC must be given to the mother or infant's other caregiver upon discharge from the hospital or birth center.[6] Providers may encourage the mother to share the POSC with partners or close family or friends, as well as the professionals who will be supporting her and her infant. This may include not only the mother's and infant's other healthcare providers, but also, as relevant, home visiting services, family resource centers, or other community agencies. Best practices call for the hospital to share the POSC with the infant's pediatrician. The POSC includes private health information that may, absent patient consent, be protected from disclosure by health and substance use disorder record confidentiality laws.

To the extent the mother or caregiver is involved in a Drug Court program or is otherwise interacting with the judicial system, the court may want to ask about the POSC, as a means to understand what strengths and supports, as well as needs and gaps, have been identified for the family. Knowledge of the POSC process and purposes may be important for those involved in assisting mothers and families.

Reporting to DCYF

The POSC is not shared with DCYF unless a report of child abuse and/or neglect is made.[7] The fact that an infant is born with withdrawal symptoms, or prenatal exposure to drugs and/or alcohol more broadly, does not itself constitute abuse or neglect of an infant nor require a mandatory report. Furthermore, the fact that a provider develops a POSC with a mother does not necessarily mean the provider has a reason to suspect child abuse or neglect. For example, an infant exposed prenatally to drugs due to medication prescribed to the mother under a clinician's direction and without any child safety concerns does not need to be reported to DCYF. Some providers may adopt the recommended practice of developing POSCs with all new mothers, not just those for whom substance exposure is present. When a provider makes a mandated report to DCYF based on concerns for risk of child abuse and/or neglect, the POSC must be shared with DCYF.[8]

Distinguishing Plans of Safe Care and a DCYF Plan of Care

The federally required "Plan of Safe Care" created by providers with the mother and family is not to be confused with a Safety, Case or Action Plan developed by DCYF for open abuse/neglect cases. The name "Plan of Safe Care" comes from federal and state statute. The POSC document is designed to support mothers as crucial partners in their babies' care. A mother's adherence to a POSC is voluntary. The POSC is intended to be developed collaboratively and is not presented to the mother by her care providers as a plan that must be followed to retain custody.

Endnotes

1. RSA 132:10-e & 10-f
2. This section is quoted from NASADAD, Neonatal Abstinence Syndrome (June 2015).
3. American Society of Addiction Medicine, Definition of Addiction
4. 42 U.S.C. § 5105 et seq.
5. RSA 132:10-e
6. *Id.*
7. *Id.*
8. RSA 132:10-f

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