

	INDIANA DEPARTMENT OF CHILD SERVICES CHILD WELFARE POLICY	
	Chapter 4: Assessment	Effective Date: August 1, 2019
	Section 42: Plan of Safe Care	Version: 2

STATEMENTS OF PURPOSE

The Indiana Department of Child Services (DCS) will complete a [Plan of Safe Care \(SF56565\)](#) or review and update an existing [Plan of Safe Care \(SF56565\)](#) for each infant under the age of one (1) year who is identified as being born affected by or exposed in utero to substance use (the drugs may be legal or illegal), experiencing symptoms of withdrawal, diagnosed with Neonatal Abstinence Syndrome, and/or diagnosed with Fetal Alcohol Spectrum Disorder (FASD). The plan will address the mental and physical health and substance use treatment needs of the infant, parent(s), household members, and the infant’s caregiver(s).

Note: A [Plan of Safe Care \(SF56565\)](#) will be completed regardless of the decision to substantiate or unsubstantiate the assessment. See policy [4.22 Making an Assessment Finding](#) for further guidance.

Code References

1. [PL 114-198 Comprehensive Addiction and Recovery Act of 2016](#)
2. [42 USC 67 Child Abuse Prevention and Treatment and Adoption Reform](#)

PROCEDURE

The Family Case Manager (FCM) will:

1. Observe and assess the needs of each parent, household member, or caregiver;
2. Collaborate with each parent, household member, caregiver, Child and Family Team (CFT) member, and other professional partners and agencies involved in providing services for the infant, parent(s), household member(s), and caregiver(s) to develop a [Plan of Safe Care \(SF56565\)](#);
3. Speak with the parents, guardians, and caregivers about [safe sleep](#) and document the discussion in the case management system.
4. Ensure the plan addresses the mental and physical health and substance use treatment needs of the infant and each parent, household member and/or caregiver;
5. Create a [Safety Plan \(SF53243\)](#), if needed, to address immediate safety needs of the child. See policy, [4.19 Safety Planning](#) for additional guidance;
6. Have each participating parent, adult household member, and caregiver who is listed on the [Plan of Safe Care \(SF56565\)](#) sign the [Plan of Safe Care \(SF56565\)](#) and provide them with a copy of the plan;

Note: If a parent refuses or is unable to sign the [Plan of Safe Care \(SF56565\)](#) information regarding that parent may not be shared with other individuals, professionals, or agencies. A separate [Plan of Safe Care \(SF56565\)](#) should be created for the other parent.

7. Review the [Plan of Safe Care \(SF56565\)](#) with the FCM Supervisor during regular [clinical supervision](#);
8. Provide a copy of the plan to each individual, professional, or agency included in the plan and authorized by the parents to receive a copy;

Note: When there is court involvement, the [Plan of Safe Care \(SF56565\)](#) should also be provided to the court.

9. Upload the [Plan of Safe Care \(SF56565\)](#) to the case management system;
10. Adjust the [Plan of Safe Care \(SF56565\)](#), as needed, due to changes in the household; identified needs of the child, parent, household member, or caregiver; or a change in risk or [protective factors](#); and
11. Ensure the [Plan of Safe Care \(SF56565\)](#) is provided to the permanency FCM, if further DCS involvement is planned.

The FCM Supervisor will:

1. Guide the FCM in engaging the parent(s), household member(s), caregiver(s), CFT members, professional partners, and agencies to create or update the [Plan of Safe Care \(SF56565\)](#), as needed; and
2. Ensure the [Plan of Safe Care \(SF56565\)](#):
 - a. Addresses the needs of each individual as required,
 - b. Is uploaded to the case management system and provided to the listed parties, and
 - c. Is provided to the permanency FCM, if further DCS involvement is necessary.

PRACTICE GUIDANCE

Plan of Safe Care

A [Plan of Safe Care \(SF56565\)](#) should include the following:

1. The treatment needs of the parent(s), household member(s), caregiver(s), and infant;
2. Other identified needs that are not determined to be immediate safety concerns;
3. Utilization of community resources and extended family support systems; and
4. A plan for continued family support beyond DCS involvement.

Safe Sleep

FCM will talk with the parents, guardians, and caregivers about safe sleep for infants and will document the discussion in the case management system. Refer to the below information for safe sleep guidelines:

1. Always place babies alone, on their backs, and in a crib (the ABCs) to sleep. The back sleep position is the safest¹. Keep other caregivers informed of these safe sleep guidelines
2. In 2010, the Consumer Product Safety Commission banned the further manufacture of drop-side cribs (i.e., cribs that allow for the sides to be lowered and raised). These types of cribs are not permitted for children under DCS care and supervision. See the following link for a picture of the new crib: <http://onsafety.cpsc.gov/blog/2011/06/14/the-new-crib-standard-questions-and-answers/>;
3. Place babies on a firm sleep surface, such as on a safety-approved crib mattress, covered by a fitted sheet. Never place babies to sleep on couches, car seats, swings, pillows, bean bags, quilts, sheepskins, or other soft surfaces;

¹ Riley Children's Health: <https://www.rileychildrens.org/health-info/sleep-safety>

4. Keep soft objects, toys, and loose bedding, out of the baby's sleep area. Do not use pillows, blankets, quilts, or pillow-like crib bumpers in the sleep area. A sleep sack is appropriate to keep the baby warm;
5. Keep baby's sleep area close to, but separate from, where caregivers and others sleep. Babies should not sleep on any surface with adults or other children. They may sleep in the same room as the caregiver;
6. Consider using a clean, dry pacifier when placing the infant down to sleep, but do not force the baby to take it;
7. Dress babies in light sleep clothing and keep the room at a temperature that is comfortable for an adult;
8. Reduce the chance that flat spots will develop on a baby's head by providing "tummy time" when the baby is awake and someone is watching. Also, change the direction that the baby lies in the crib and avoid excessive time in car seats, carriers, bouncers, and swings. These items should be placed/used on appropriate surfaces and should not be utilized in place of a crib; and
9. There should be no smoking around the baby as babies who are around cigarette smoke have a higher risk of sleep-related deaths.²

Additional information regarding safe sleep is available on the following websites:

1. [The American Academy of Pediatrics](#);
2. [Healthy Children.org](#);
3. [The National Institute of Health](#);
4. [Riley Children's Health](#); and
5. [The DCS Website](#).

FORMS AND TOOLS

1. [Plan of Safe Care \(SF56565\)](#) – Available in the case management system
2. [Safety Plan \(SF53243\)](#) – Available in the case management system

RELATED INFORMATION

Protective Factors

Protective factors are characteristics in families that, when present, increase the safety, stability, permanency, and well-being of children and families. Protective factors are directly connected to the strengths of the family and can be used as a resource to learn new skills and solve problems. The FCM should consider the following protective factors when working with children and families:

1. Nurturing and attachment – A child's early experience of being nurtured and developing a bond with a caring adult affects all aspects of behavior and development. When parents and children have a strong attachment to one another, children develop trust that their parents will provide what they need to thrive, including love, acceptance, positive guidance, and protection.
2. Knowledge of parenting and of child and youth development – Children thrive when parents provide not only affection, but also respectful communication and listening, consistent rules and expectations, and safe opportunities that promote independence. Successful parenting fosters psychological adjustment, helps children succeed in school, encourages curiosity about the world, and motivates children to achieve.

² Riley Children's Health: <https://www.rileychildrens.org/health-info/sleep-safety>

3. Parental resilience – Parents who are able to cope with the stresses of everyday life, as well as an occasional crisis, have resilience; they have the flexibility and inner strength necessary to bounce back when things are not going well. Multiple life stressors, such as a family history of abuse or neglect, health problems, marital conflict, or domestic or community violence and financial stressors, such as unemployment, poverty, and homelessness, may reduce a parent's capacity to cope effectively with the typical day-to-day stresses of raising children.
4. Social connections – Parents with a social network of emotionally supportive friends, family, and neighbors often find that it is easier to care for their children and themselves. Most parents need people they can call on once in a while when they need a sympathetic listener, advice, or concrete support. Research has shown that parents who are isolated, with few social connections, are at higher risk for Child Abuse and/or Neglect (CA/N).
5. Concrete supports for parents – Partnering with parents to identify and access resources in the community may help prevent the stress that sometimes precipitates child maltreatment. Providing concrete supports may also help prevent the unintended neglect that sometimes occurs when parents are unable to provide for their children.
6. Social and emotional competence of the child - A child's social and emotional competence is crucial to sound relationships with family, adults, and peers. Conversely, delayed social-emotional development may obstruct healthy relationships. Early identification of such delays and early assistance for children and parents can provide support for family relationships and sustain positive and appropriate development.

See <https://www.childwelfare.gov/topics/preventing/promoting/protectfactors/> for additional information.

Extended Family Support

Extended family members are often the most resourceful and effective support for the family, and their interventions are often the least disruptive for the child involved. Family support services may consist of childcare, transportation, home management assistance, and teaching of skills, and financial assistance for housing, food, or clothing on a short term basis.

Clinical Supervision

Clinical Supervision is a process in which an individual with specific knowledge, expertise, or skill provides support while overseeing and facilitating the learning of another individual.

Example: The focus of clinical supervision for an FCM is on practice that directly impacts outcomes for families.