Resources

Federal Administration for Children and Families program instructions to states:
https://www.acf.hhs.gov/sites/default/files/cb/pi1702.pdf

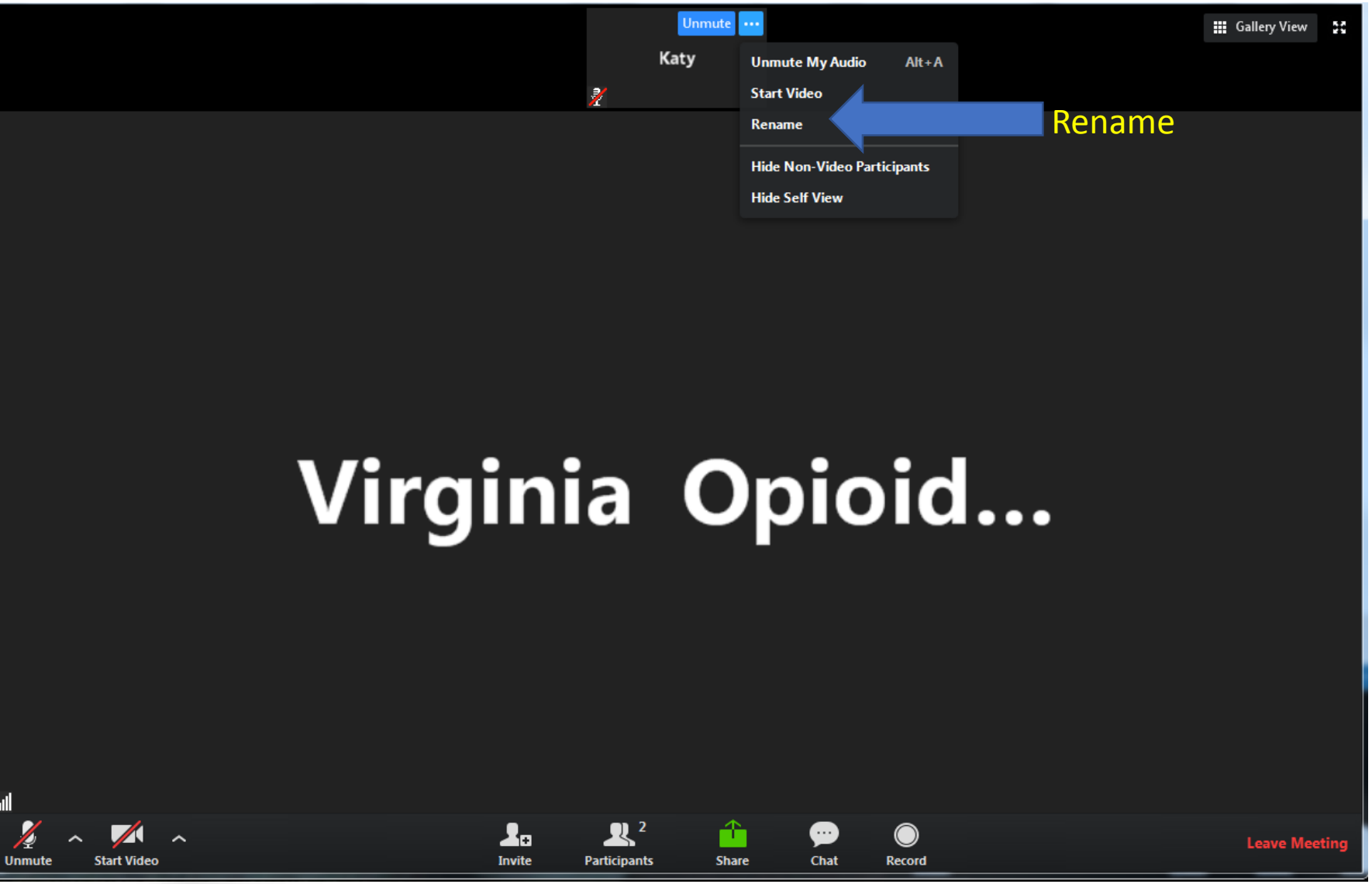
https://www.dss.virginia.gov/files/division/dfs/cps/intro_page/manuals/07-2017/section_10_substance_exposed_infants.pdf

Virginia Opioid Addiction ECHO* Clinic

March 15, 2019

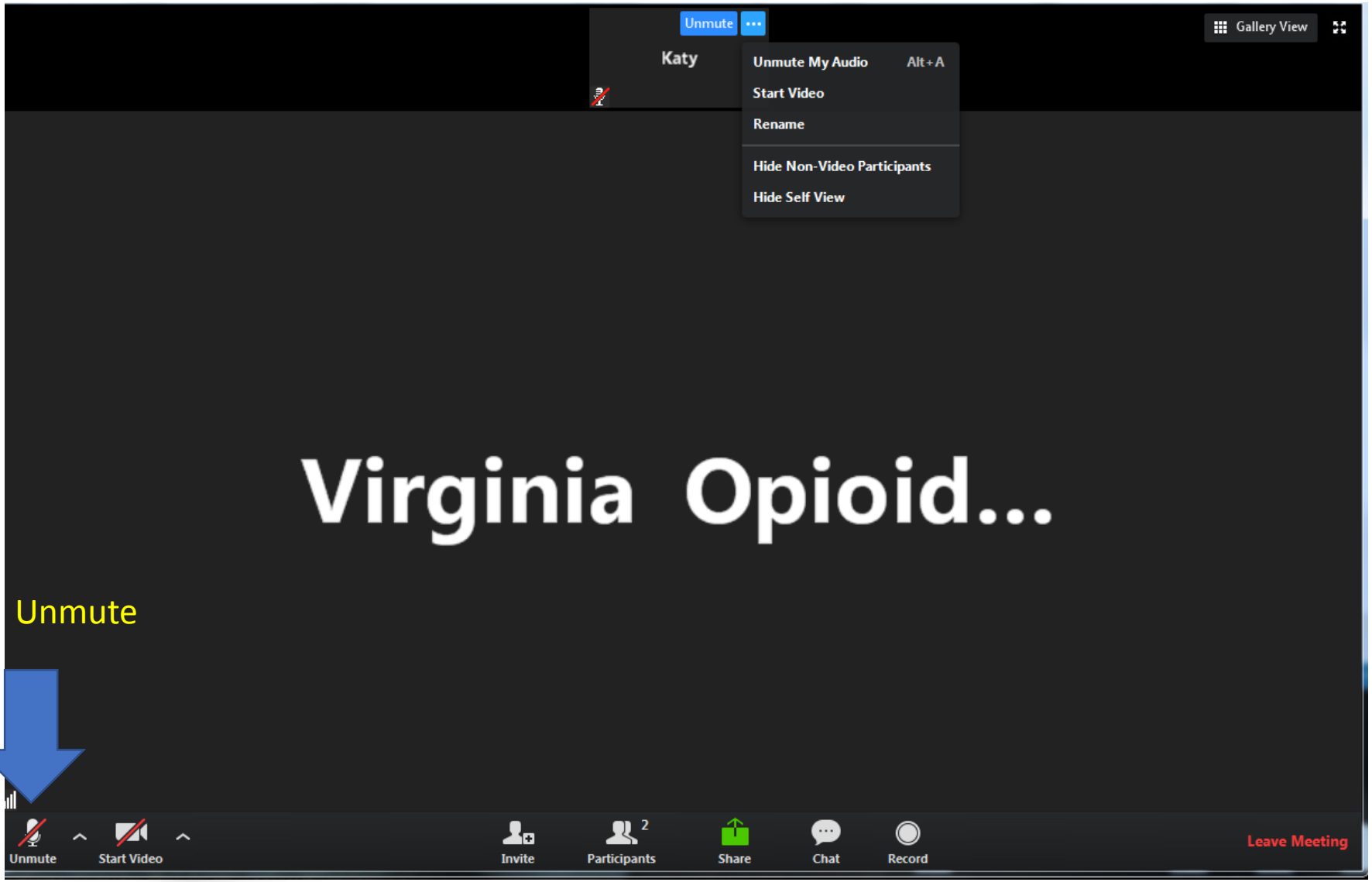
*ECHO: Extension of Community Healthcare Outcomes

Helpful Reminders



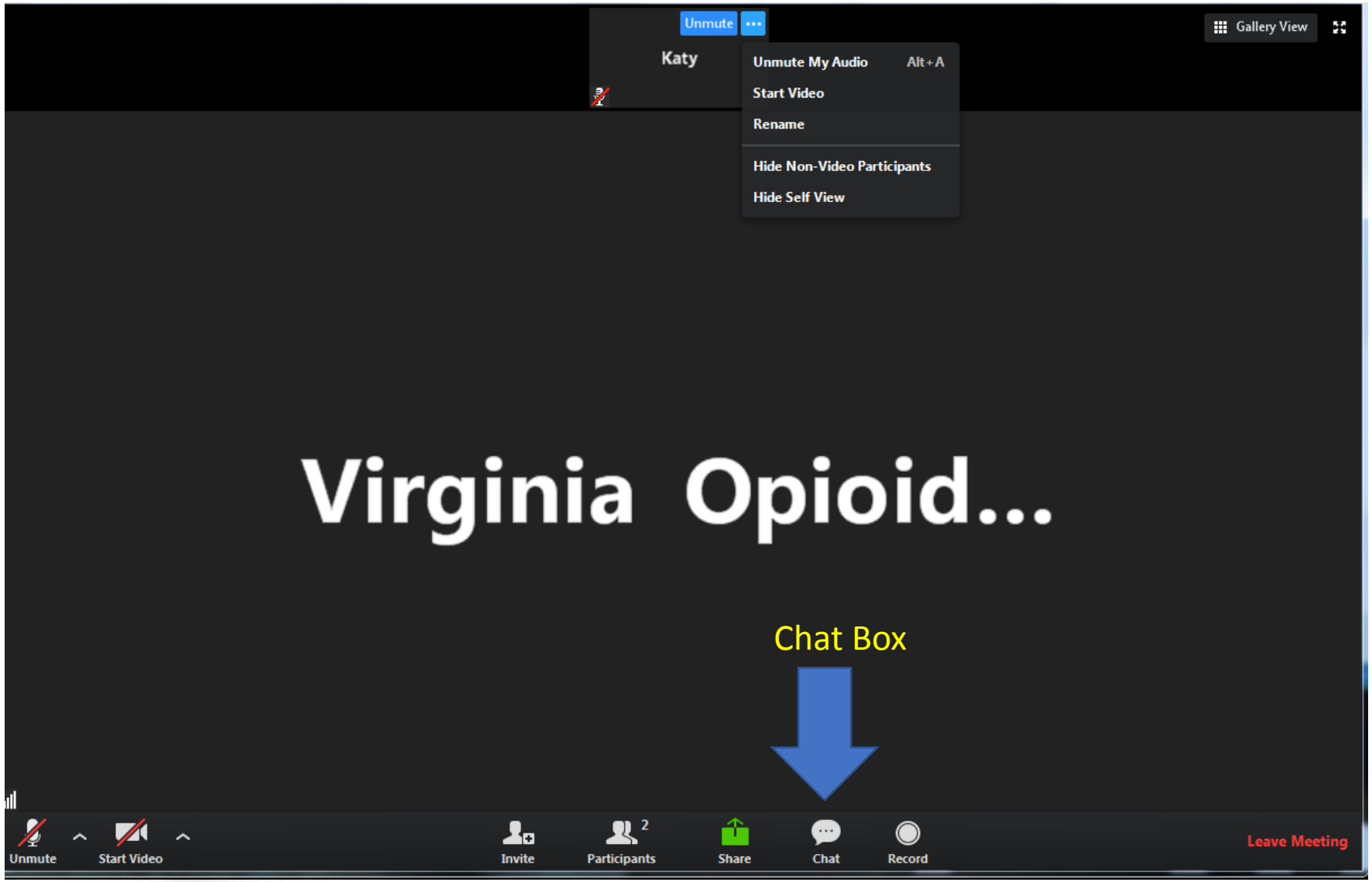
- Rename your Zoom screen, with your name and organization

Helpful Reminders



- You are all on mute please unmute to talk
- If joining by telephone audio only, *6 to mute and unmute

Helpful Reminders



- Please type your full name and organization into the chat box
- Use the chat function to speak with IT or ask questions

VCU Opioid Addiction ECHO Clinics

VCU Health
VCU School of Medicine

VDH Virginia Department of Health | VDHLiveWell.com | Virginia Department of Behavioral Health & Developmental Services

- Bi-Weekly 1.5 hour tele-ECHO Clinics
- Every tele-ECHO clinic includes a 30 minute didactic presentation followed by case discussions
  - Didactic presentations are developed and delivered by inter-professional experts in substance use disorder
- Website Link: www.vcuhealth.org/echo

VCU

Hub Introductions

VCU Team	
Clinical Director	Mishka Terplan, MD, MPH, FACOG, FASAM
Administrative Medical Director ECHO Hub and Principal Investigator	Vimal Mishra, MD, MMCi
Clinical Expert	Lori Keyser-Marcus, PhD Courtney Holmes, PhD
Didactic Presentation	Valerie L'Herrou, JD, Margaret Rockwell
Program Manager	Bhakti Dave, MPH
Practice Administrator	David Collins, MHA
IT Support	Vladimir Lavrentyev, MBA

Introductions:

- Name
- Organization

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for Introduction

What to Expect

I. Didactic Presentation
   I. **Virginia Mandatory CPS Reporting: substance-affected infants**
   II. **Valerie L'Herrou, JD**

II. Case presentations
   I. Case 1
      I. Case summary
      II. Clarifying questions
      III. Recommendations

   II. Case 2
      I. Case summary
      II. Clarifying questions
      III. Recommendations

III. Closing and questions

Lets get started!

Didactic Presentation

VIRGINIA MANDATORY CPS REPORTING: *substance-affected infants*

A PRESENTATION BY THE
VIRGINIA POVERTY LAW CENTER

VALERIE L'HERROU
STAFF ATTORNEY, CENTER FOR FAMILY ADVOCACY

919 E Main St. Suite 610, Richmond, VA 23219 | T: 804-782-9430 | F: 804-649-0974

VPLC

The statewide support center for legal aid in Virginia providing support in

ADVOCACY

TRAINING

LITIGATION

on the civil justice issues faced by

low-income Virginians

State responses to prenatal substance use

- **23 states** and the District of Columbia consider substance use during pregnancy to be child abuse under civil child-welfare statutes
- **3 states** consider it grounds for civil commitment during pregnancy.
- **25 states** and DC require health care professionals to report suspected prenatal drug use, and 8 states require them to test for prenatal drug exposure if they suspect drug use.
- **19 states** have either created or funded drug treatment programs specifically targeted to pregnant women, and 17 states and the District of Columbia provide pregnant women with priority access to state-funded drug treatment programs.
- **10 states** prohibit publicly funded drug treatment programs from discriminating against pregnant women.

Source: Guttmacher Institute: https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy

Treating in-utero substance exposure as child abuse

Twelve states: positive results from a toxicology test performed on a newborn, or signs of prenatal drug exposure in newborns, is considered evidence of child abuse or neglect.

- In these states, evidence of substance exposure provides grounds for removing the infant from the mother's custody and qualifies as a factor in determining whether to terminate parental rights.
- *Example*: Under South Carolina law, a newborn is presumed to be neglected and "cannot be protected from further harm without being removed from the custody of the mother" if there is a positive drug test on either the mother or the child at birth.

Source: Guttmacher Institute: https://www.guttmacher.org/gpr/2000/12/state-responses-substance-abuse-among-pregnant-women

Treating in-utero substance exposure as child abuse

Virginia:

- While the *CPS* response to infants born affected by maternal substance use is to treat it as a red flag for risk of neonatal neglect and abuse, and thus local CPS workers are to assign a reported case to the assessment track, *police* and *prosecutors* sometimes treat such a case as criminal, even though prenatal substance exposure is not part of the criminal code; they argue that §63.2-1509(B) (civil child abuse) is evidence to prove § 18.2-371.1 (criminal child abuse).
- Women may come to the attention of law enforcement if they are arrested for possession of an illicit substance while pregnant, for example.
- It is not known how many women may have been prosecuted for criminal child abuse for prenatal substance use, as many may have pled guilty to lesser charges. While some cases have been prosecuted as felonies, these have been dismissed based on the fact that Virginia law does not classify fetuses as children.

Sources: http://advocatesforpregnantwomen.org/file/1992%20State-by-State%20Case%20Summary.pdf; personal communication with Gail Deady, Women's Rights Advocacy Counsel, ACLU-VA

Federal law re: substance-affected infants

- **Federal laws regarding states' response:**
  CARA (Comprehensive Addiction & Recovery Act)
  PHSA (Public Health Service Act)
  CAPTA (Child Abuse Prevention and Treatment Act)

  - 2016: CARA amended CAPTA and PHSA
    - Addresses state responses to substance use by pregnant women
  - PHSA:
    - Federal funds for prenatal *family-based* treatment
  - CAPTA (1988; including 2016 amendments from CARA):
    - Requires states to track/report data on infants born "affected by" substance abuse or withdrawal symptoms
    - Requires states to report such infants to CPS
    - Remove the term "illegal" as applied to maternal substance abuse affecting infants
    - Requires providing "plan of safe care" for *both* mother and infant
    - State monitoring system of referrals and delivery of appropriate treatment

Federal Administration for Children and Families program instructions to states:
https://www.acf.hhs.gov/sites/default/files/cb/pi1702.pdf

Federal law re: substance-affected infants

What does CAPTA require of states?

- "policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to **address the needs of infants** born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder...."

Federal Administration for Children and Families program instructions to states:
https://www.acf.hhs.gov/sites/default/files/cb/pi1702.pdf

Current Virginia law (through June 30)

- **Virginia's Tracking and Reporting Law:***
  - In 2017, in response to CARA, language was changed: added prescription substances, and removed reporting exception for women receiving treatment.
  - Located in the Virginia Code section detailing required reporting of suspected child abuse and neglect to Child Protective Services (CPS)
  - Does not align with 22 VAC 40-705-40(A)(6)(h): *"Facts solely indicating that the infant may have been exposed to controlled substances prior to birth are not sufficient to render a founded disposition of abuse or neglect..."*
  - Does *not* mention continuing care related to Plan of Safe Care.
  - *Does* mandate CPS assessment track (vs investigation track)

- **Virginia's prenatal and neonatal treatment:**
  - **Prenatal**: Doctors required to advise women of potential for poor birth outcomes.**
  - **Prenatal**: No requirement to connect women with treatment options.
  - **Neonatal**: Requires doctors to discuss discharge with patient and make appropriate referrals .
  - **Neonatal**: Requires hospitals to notify, subject to federal law restrictions, the community services board of the jurisdiction in which the woman resides to appoint a discharge plan manager.***

* §63.2-1509(B); ** §54.1-2403.1; ***§32.1-127(B)(6)

Typology of Affected Women

§63.2-1509(B) does not distinguish between different types of circumstances when infants may be exposed to substances in utero:

Group A

- Responsibly using prescribed medications while pregnant.
- Medications for seizure disorders
- Opioids for Pain Management
- Anxiety/Depression Medication
- Anesthesia administered for surgery while pregnant
- Anesthesia during labor (i.e. as part of epidural)

Group B

- Receiving Medically Assisted Treatment for Opioid-use Disorder
- Methadone
- Suboxone

Group C

- Using Prescription substances without the supervision of a doctor or not as prescribed
- Recreational, Illicit Drugs
- Alcohol
- Cigarettes

Virginia's CPS Manual provides differentiation in its recommended Plans of Safe Care for each group, as well as who is responsible for creating/monitory a Plan depending on typology, and whether pre- or post-natal.

Source: Rockwell & Siddall, 2018

Mandatory Reporting to CPS

Inconsistency / confusion for health and CPS workers?

- The Virginia Department of Social Services July 2017 Child and Family Services Manual Section C: Child Protective Services, at 10.3.1 states:

  "The Code of Virginia requires health care providers to make a report of abuse or neglect ***when there is a reason to suspect that a mother exposed a newborn infant to controlled substances during the pregnancy"*** [emphasis added].

- However, this is not entirely true. The language of the law is:

  - **Statute:** §63.2-1509(B): *"For purposes of subsection A, 'reason to suspect that a child is abused or neglected' shall include (i) a finding made by a health care provider within six weeks of the birth of a child that the* ***child was born affected by substance abuse or experiencing withdrawal symptoms resulting from in utero drug exposure****; (ii) a diagnosis made by a health care provider within four years following a child's birth that the child has an illness, disease, or condition that, to a reasonable degree of medical certainty, is attributable to maternal abuse of a controlled substance during pregnancy; or (iii) a diagnosis made by a health care provider within four years following a child's birth that the child has a fetal alcohol spectrum disorder attributable to in utero exposure to alcohol."* [emphasis added]

https://www.dss.virginia.gov/files/division/dfs/cps/intro_page/manuals/07-2017/section_10_substance_exposed_infants.pdf

Mandatory Reporting to CPS

- **The manual goes on to provide more clarity, outlining the three circumstances that require reporting:**
  - **CPS Manual: 10.3.2 Health care provider responsibilities**
    - **10.3.2.1 Report to CPS** (22 VAC 40-705-40 A6). Pursuant to § 63.2-1509 B of the Code of Virginia, whenever a health care provider makes a **finding or diagnosis**, then the health care provider or his designee **must make a report to child protective services immediately**.
    - Whenever a health care provider makes a finding or diagnosis of one (1) of the three (3) circumstances… the health care provider shall make a report to CPS **as soon as possible, but no longer than 24 hours after having reason to suspect a reportable situation**.
    - When reporting SEI, health care providers are required to release, upon request, medical records that document the basis of the report. Disclosure of child abuse or neglect information is also permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and federal Confidentiality of Alcohol and Drug Abuse Patient Information Regulations. (CFR 42 Part 2)

    [emphasis added]

https://www.dss.virginia.gov/files/division/dfs/cps/intro_page/manuals/07-2017/section_10_substance_exposed_infants.pdf

Mandatory Reporting to CPS

- **CPS Manual: 10.3.1.1 First circumstance**
  - The first circumstance is a finding is made by a health care provider **within six(6) weeks of birth** that the child **is born affected by substance abuse or is experiencing withdrawal symptoms** resulting from in utero drug exposure. This includes dependency on **controlled substances prescribed for the mother by a physician** or an opioid treatment program (OTP).
    --Including Neonatal Abstinence Syndrome (NAS)

- **CPS Manual: 10.3.1.2 Second circumstance**
  - The second circumstance is within **four (4) years of a child's birth**, a health care provider can **diagnose the child as having an illness, disease or condition** which, to a reasonable degree of medical certainty, is **attributable to in utero exposure** to a controlled substance.

- **CPS Manual: 10.3.1.3 Third circumstance**
  - The third circumstance is **within four (4) years following a child's birth**, a health care provider can make the **diagnosis that the child has a fetal alcohol spectrum disorder (FASD)** attributable to **in utero exposure to alcohol**.

[emphasis added]

https://www.dss.virginia.gov/files/division/dfs/cps/intro_page/manuals/07-2017/section_10_substance_exposed_infants.pdf

Mandatory Reporting to CPS

- **CPS Manual: 10.3.2.2 Report to the Community Services Board**
  - The Code of Virginia (§ 32.1-127 (B)(6)) "requires that **each licensed hospital develop and implement a protocol requiring written discharge plans for identified, substance-abusing, postpartum women and their infants.** The discharge plan should be discussed with the patient and appropriate referrals made and documented. The discharge planning process shall involve, to the extent possible, the father of the infant and any members of the mother's extended family who may participate in the follow-up care for the mother and the infant. Hospitals are required to notify the Community Services Board (CSB) of the jurisdiction in which the woman resides to appoint a discharge plan manager for any identified substance-abusing postpartum woman. The CSB shall implement and manage the discharge plan." [emphasis added].

- **2019 law change**: the above requirement from VA Code § 32.1-127 has been ADDED to the mandatory reporter section.

→ ***Nota bene***: I am not providing legal advice on when/what to report!

https://www.dss.virginia.gov/files/division/dfs/cps/intro_page/manuals/07-2017/section_10_substance_exposed_infants.pdf

Mandatory Reporting to CPS

CPS Manual: 10.3.2.2.1 Hospital discharge plan

- Post-partum women with substance use disorders and their newborns may have multiple health care, treatment, safety and environmental needs. Their hospital discharge plans should include, but are not limited to:
- A referral of the mother to the local CSB for a substance use assessment and implementation of the discharge plan.
- Information and medical directives regarding potential postpartum complications and, as appropriate, indicators of substance use withdrawal and post-partum depression.
- A follow-up appointment for pediatric care for the infant within two-four weeks.
- A referral to early intervention Part C services for a developmental assessment and early intervention services for the infant.
- A follow-up appointment for the mother for postpartum gynecological care and family planning. The CPS worker should obtain a copy of the hospital discharge plan and document the details in the automated data system.

https://www.dss.virginia.gov/files/division/dfs/cps/intro_page/manuals/07-2017/section_10_substance_exposed_infants.pdf

CPS Response: assessment vs investigation

§ 63.2-1504. Child-protective services differential response system.
The Department shall implement a child-protective services differential response system in all local departments. The differential response system allows local departments to respond to valid reports or complaints of child abuse or neglect by conducting **either an investigation or a family assessment**.

- **Regulation** (to CPS, not mandated reporters): **22 VAC 40-705-40(A)(6)(h)**:
  "Facts solely indicating that the infant may have been exposed to controlled substances prior to birth are not sufficient to render a founded disposition of abuse or neglect..."
  - This regulation misstates the law. A founded disposition of child abuse *cannot* be made based *ANY occurrence prior to birth*, since a fetus prior to birth is NOT a child under Virginia law.

- **Family Assessment**
  - Assess child safety
  - Strengthen and support families
  - Assess risk of future maltreatment
  - Prevent further abuse

- **Investigation**
  - Assess child safety
  - Strengthen and support families
  - Assess risk of future maltreatment
  - Prevent further abuse
  - **Determine if abuse or neglect occurred**

Health Care Provider *or* CPS? Plan of Safe Care

CPS Manual: 10.4.1 Who creates a Plan of Safe Care?

- A Plan of Safe Care should **begin when the mother is pregnant** and **be initiated by her health care providers**. Once CPS becomes involved in a SEI referral, the CPS becomes a part of this Plan of Safe Care.

Three populations of pregnant/post-partum women, and who would typically take the lead in creating/monitoring a Plan of Safe Care.

1. Using legal/illegal drugs, on an opioid medication for chronic pain or on a medication that can result in dependency/withdrawal and **does not have a substance use disorder**. *Prenatal: Prenatal care provider in concert with pain specialist or other physician. Postpartum: Maternal and Child Health service providers (e.g. home visiting provider, Healthy Families); CPS or community prevention services*
2. Receiving medication assisted treatment for an opioid use disorder (e.g. Methadone) *or* is **actively engaged in treatment** for a substance use disorder. *Prenatal: Prenatal care provider in concert with OTP or other therapeutic substance use disorder treatment provider/CSB. Postpartum:* OTP or other therapeutic substance use disorder treatment provider/CSB.
3. Misusing prescription drugs, or is using legal or illegal drugs, **meets criteria for a substance use disorder**, ***not*** **actively engaged in a treatment program**. *Prenatal: Prenatal care provider or high-risk pregnancy clinic in concert with substance use disorder treatment agency/CSB Postpartum: Child Protective Services*

https://www.dss.virginia.gov/files/division/dfs/cps/intro_page/manuals/07-2017/section_10_substance_exposed_infants.pdf

What's included: Plan of Safe Care

CPS Manual 10.4.2 What is included in a Plan of Safe Care?

- A Plan of Safe Care should incorporate the mother's (and potentially the other primary caregivers) need for treatment for substance use and mental disorders, appropriate care for the infant who may be experiencing neurodevelopmental or physical effects or withdrawal symptoms from prenatal substance exposure, and services and supports that strengthen the parents' capacity to nurture and care for the infant and to ensure the infant's continued safety and well-being.
- The plan should also ensure a process for continued monitoring of the family and accountability of responsible agencies such as substance use disorder treatment, home visiting, and public health and health care providers for the infant and mother.

CPS Manual 10.11 Appendix D: Sample Plan of Safe Care

https://www.dss.virginia.gov/files/division/dfs/cps/intro_page/manuals/07-2017/section_10_substance_exposed_infants.pdf

2019: Virginia Legislation, SB 1436

SB 1436 (McClellan): Child abuse or neglect; prenatal substance exposure, mandatory reporters.

Effective July 1, 2019

§63.2-1509(B): For purposes of subsection A, "reason to suspect that a child is abused or neglected" shall, *due to the special medical needs of infants affected by substance exposure*, include (i) a finding made by a health care provider within six weeks of the birth of a child that the child was born affected by substance abuse or experiencing withdrawal symptoms resulting from in utero drug exposure; (ii) a diagnosis made by a health care provider within four years following a child's birth that the child has an illness, disease, or condition that, to a reasonable degree of medical certainty, is attributable to maternal abuse of a controlled substance during pregnancy; or (iii) a diagnosis made by a health care provider within four years following a child's birth that the child has a fetal alcohol spectrum disorder attributable to in utero exposure to alcohol. When "reason to suspect" is based upon this subsection, such fact shall be included in the report along with the facts relied upon by the person making the report. *Such reports shall not constitute a per se finding of child abuse or neglect. If a health care provider in a licensed hospital makes any finding or diagnosis set forth in clause (i), (ii), or (iii), the hospital shall require the development of a written discharge plan under protocols established by the hospital pursuant to subdivision B 6 of § 32.1-127.*

Thank You

VALERIE L'HERROU
VALERIE@VPLC.ORG ▪ 804.351.5276
WWW.VPLC.ORG

Questions?

Case Presentation #1
Faisal Mohsin, MD

- 12:35-12:55 [20 min]
  - 5 min: Presentation
  - 2 min: Clarifying questions- Spokes
  - 2 min: Clarifying questions – Hub
  - 2 min: Recommendations – Spokes
  - 2 min: Recommendations – Hub
  - 5 min: Summary - Hub

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions

Case Presentation #1
Faisal Mohsin, MD

QUESTION: How do we re-engage the client back into treatment? Client cancelled his upcoming appointment for medication management and Suboxone.

Background: 33 y.o. Caucasian Male, lives with girlfriend, and 5 children in their own house. He is not very close to his immediate family members. Given events pertaining to his past substance use. Patient had recently reported during one of his group meetings that his girlfriend was on the verge of leaving him. He owns his own landscaping business, but because of seasonal variations, business had slowed down which led him to seek a part time job and he is now working as a welder. He is the main provider for his family.

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions

Case Presentation #1
Faisal Mohsin, MD

Treatment Plan: Plan is to re-engage the client and get him back in the program. This could mean also working with him and weaning him off safely if that is what his present goal is.

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions

Case Presentation #2
Sunny Kim, NP

- 12:55pm-1:25pm [20 min]
  - 5 min: Presentation
  - 2 min: Clarifying questions- Spokes (participants)
  - 2 min: Clarifying questions – Hub
  - 2 min: Recommendations – Spokes (participants)
  - 2 min: Recommendations – Hub
  - 5 min: Summary - Hub

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions

No NBUP

Buprenorphine, Urine	1,922 ng/mL
Norbuprenorphine, Urine	None Detected

“spiked”

03/11/2019 14:35	Buprenorphine, Urine	>5000 ng/mL	Trend
	Norbuprenorphine, Urine	23 ng/mL	Trend

Buprenorphine, Urine	>2000 ng/mL
Norbuprenorphine, Urine	129 ng/mL

Buprenorphine, Urine	>2000 ng/mL
Norbuprenorphine, Urine	353 ng/mL

Normal

03/11/2019 13:15	Buprenorphine, Urine	25 ng/mL	Trend
	Norbuprenorphine, Urine	49 ng/mL	Trend

03/12/2019 09:30	Buprenorphine, Urine	77 ng/mL	Trend
	Norbuprenorphine, Urine	182 ng/mL	Trend

Closed to normal?

03/12/2019 09:05	Buprenorphine, Urine	1,542 ng/mL	Trend
	Norbuprenorphine, Urine	1,202 ng/mL	Trend

Case Studies

- Case studies
  - Submit: www.vcuhealth.org/echo
  - Receive feedback from participants and content experts

https://www.vcuhealth.org/for-providers/education/virginia-opioid-addiction-echo/virginia-opioid-addiction-echo-thank-you

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VCU Health

Our Providers | Our Services | Locations | Patients & Visitors | For Your Health | Our Story

Home > For Providers > Education > Virginia Opioid Addiction ECHO > Thank You

Thank You

The success of our telehealth program depends on our participants and those who submit case studies to be discussed during clinics. We recognize the following providers for their contributions:

- Diane Boyer, DNP from Region Ten CSB
- Michael Fox, DO from VCU Health
- Shannon Garrett, FNP from West Grace Health Center
- Sharon Hardy, BSW, CSAC from Hampton-Newport News CSB
- Sunny Kim, NP from VCU Health
- Thokozeni Lipato, MD from VCU Health
- Faisal Mohsin, MD from Hampton-Newport News CSB
- Jennifer Phelps, BS, LPN from Horizons Behavioral Health
- Jenny Sear-Cockram, NP from Chesterfield County Mental Health Support Services
- Bill Trost, MD from Danville-Pittsylvania Community Service
- Art Van Zee, MD from Stone Mountain Health Services
- Sarah Woodhouse, MD from Chesterfield Mental Health

Telehealth

- About Telehealth at VCU Health
- For Patients
- For Providers

Project ECHO® Virginia Commonwealth University

VCU

Submit Feedback

Opportunity to formally submit feedback

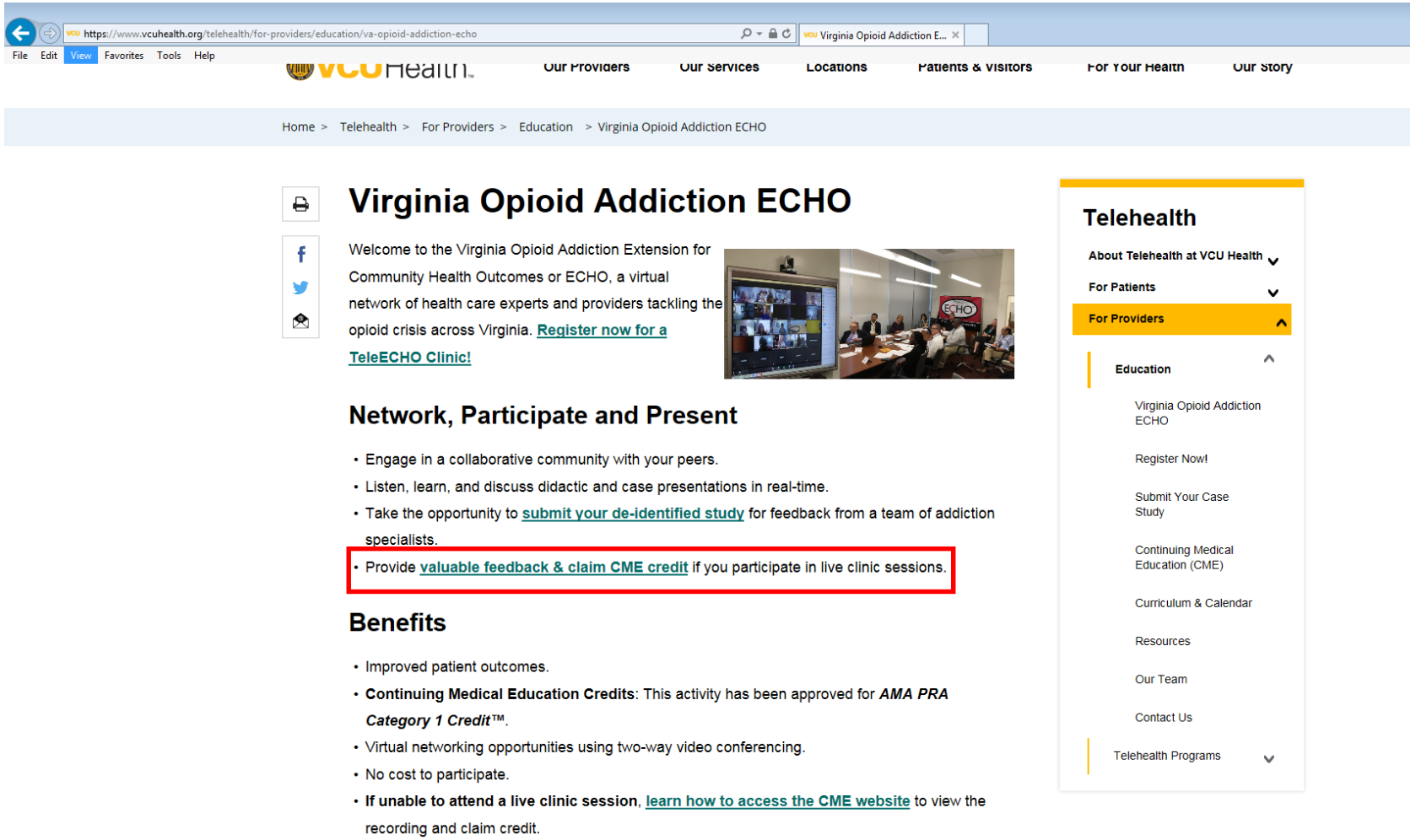
- Survey: www.vcuhealth.org/echo
- Overall feedback related to session content and flow?
- Ideas for guest speakers?

Claim Your CME and Provide Feedback

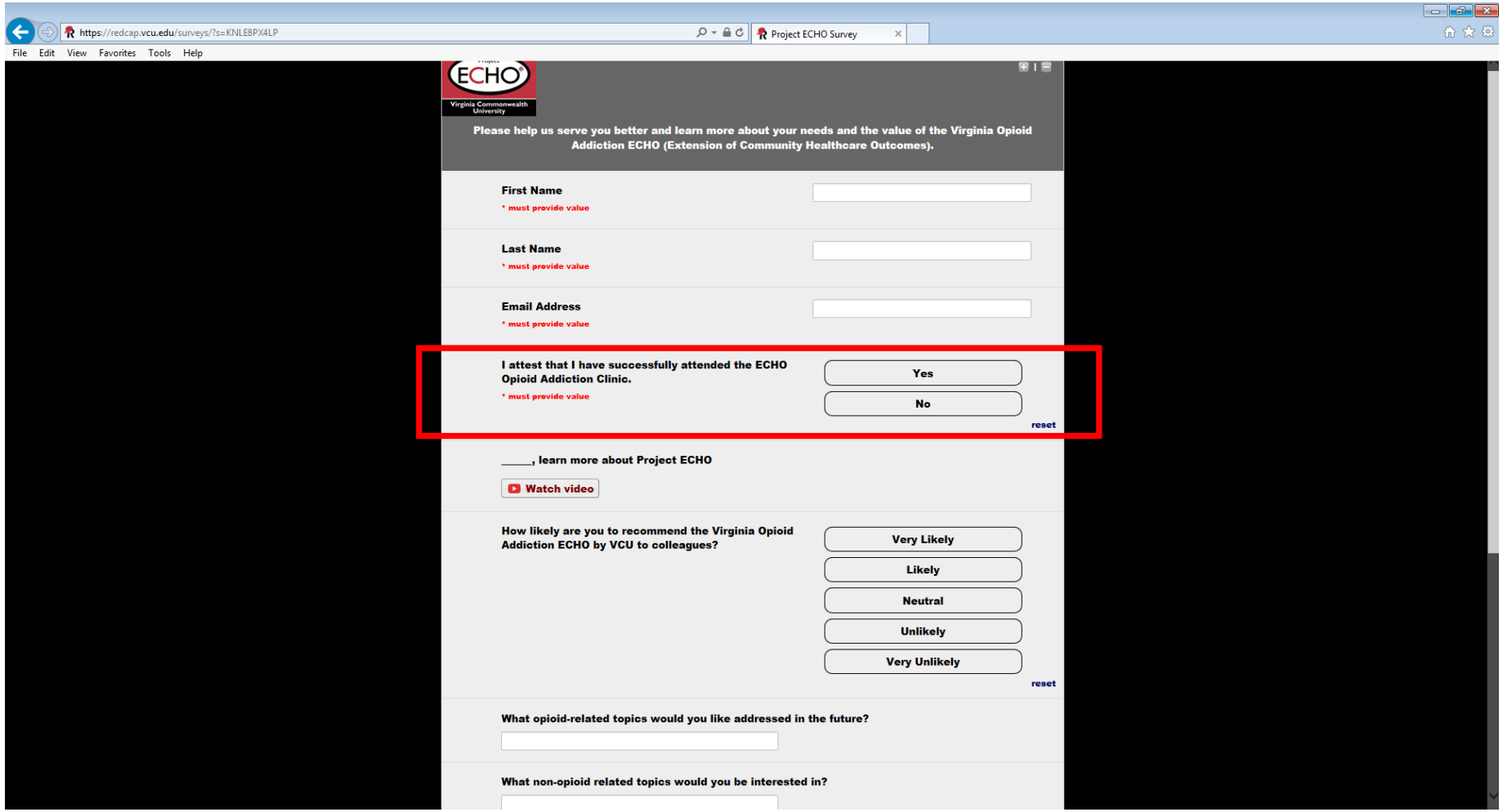
- www.vcuhealth.org/echo

- To claim CME credit for today's session
- Feedback
  - Overall feedback related to session content and flow?
  - Ideas for guest speakers?

Access Your Evaluation and Claim Your CME



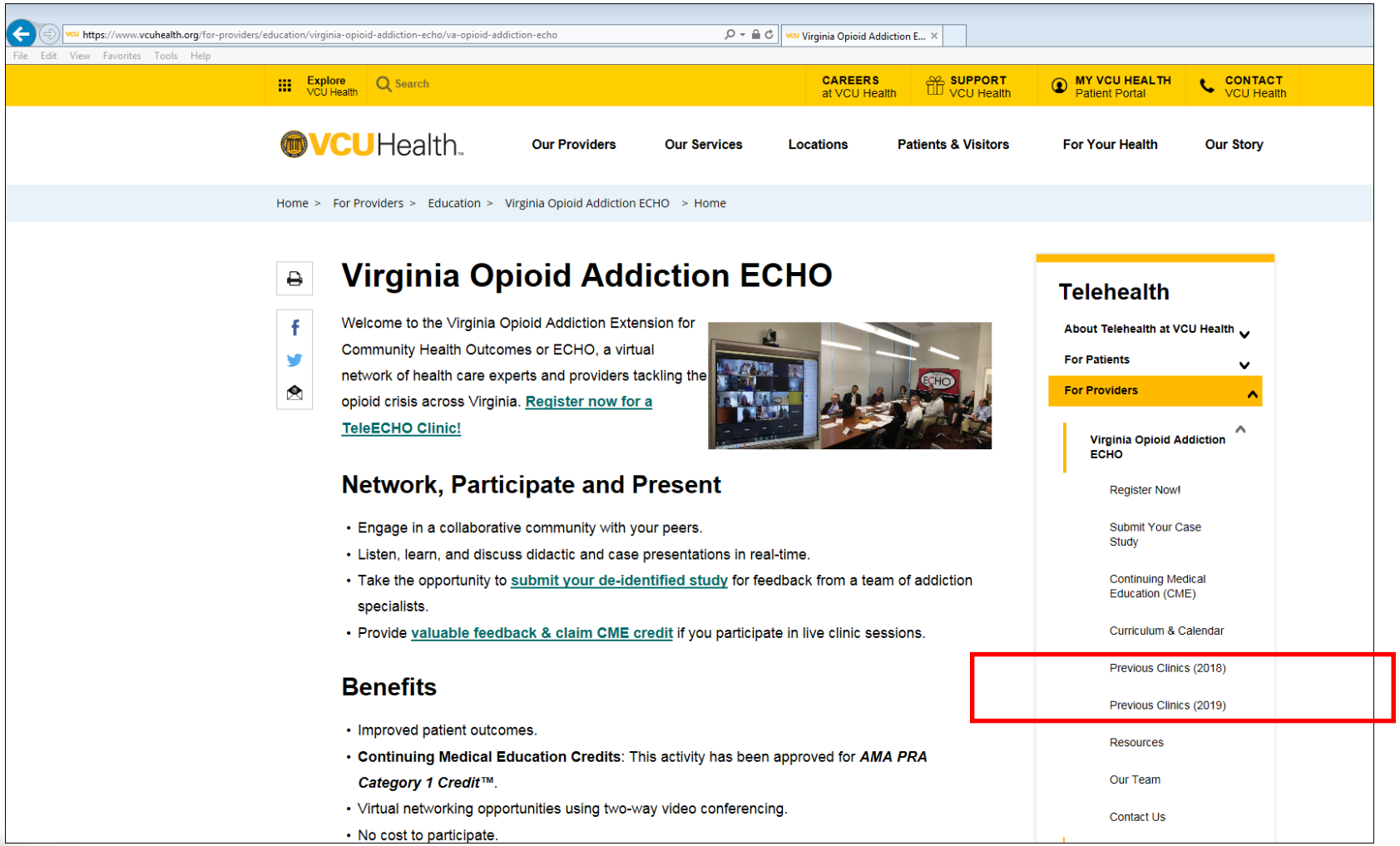
Access Your Evaluation and Claim Your CME



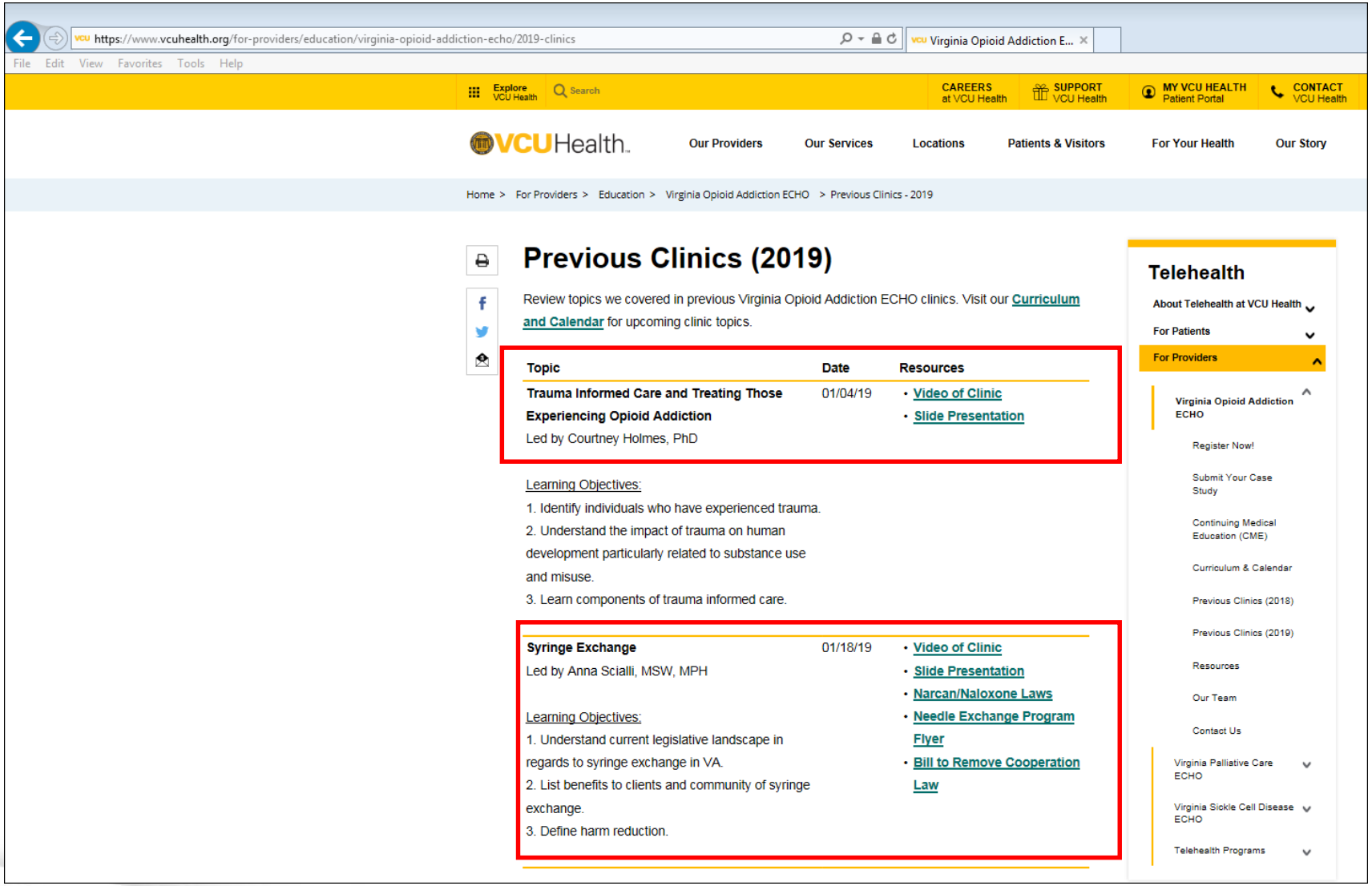
Access Your Evaluation and Claim Your CME

- www.vcuhealth.org/echo
  - To view previously recorded clinics and claim credit

Access Your Evaluation and Claim Your CME



Access Your Evaluation and Claim Your CME



VCU Virginia Opioid Addiction TeleECHO Clinics

Bi-Weekly Fridays - 12-1:30 pm

Mark Your Calendar --- Upcoming Sessions

March 29: Motivational Interviewing - Lori Keyser-Marcus, PhD & Courtney Holmes, PhD

April 5: Medical and Non-Medical Cannabis: An evidence-based review - Mishka Terplan, MD

April 19: Addressing Vocational Needs of People with SUD— Rebecca Farthing & Elizabeth Phillips

Please refer and register at vcuhealth.org/echo

Project ECHO®
Virginia Commonwealth University

THANK YOU!

VCU

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions

Margaret Rockwell
Peyton Siddall

Analysis of Virginia's Tracking and Reporting Law for Substance-Affected Infants

Executive Summary

Congress passed the Comprehensive Addiction and Recovery Act (CARA) in 2016, requiring all states to implement new procedures associated with prenatal substance use. CARA amended two bills: the Child Abuse Prevention and Treatment Act (CAPTA) and the Public Health Service Act (PHSA). CAPTA's new amendments mandated that each state implement a system for tracking infants born affected by substance abuse or withdrawal symptoms. Additionally, it required each state to provide these infants and their mothers with a plan of safe care. Meanwhile, PHSA's new amendments authorized the Director of the Center for Substance Abuse Treatment (CSAT) at the Substance Abuse and Mental Health Services Administration (SAMHSA) to carry out a pilot program broadening federal grants available to states. This new program sought to enhance state use of federal funds for family-based services provided to pregnant and postpartum women with a primary diagnosis of a substance use disorder. CARA's amendments to CAPTA and PHSA thereby mandated a twofold state response to substance use by pregnant women that addressed the overall health of the mother-infant dyad both before and after the infant's birth.

In this report, we examine Virginia's response to CARA's amendments addressing the prenatal and neonatal needs of the mother and infant. Specifically, we look at the state's tracking mechanism of babies born affected by substance use and withdrawal symptoms, promulgated through § 63.2-1509(B) of the Virginia Code. This mechanism was established in 2017 by the state legislature to ensure Virginia's compliance with CAPTA's new amendments and address the needs of the mother-infant dyad after the birth of the infant. Additionally, we assess the actions taken by the state to address the needs of the mother-infant dyad before the birth of the infant. Our examination focuses on the legal framework surrounding Virginia's tracking and reporting mechanism, which has ultimately created an expansion of discretion that lays a foundation for punitive actions against postnatal mothers.

To better comply with CARA's mandate so that both infants and mothers are provided with medical support before and after the baby is born, the Commonwealth should take several key actions. First, the Commonwealth should amend its current tracking and reporting statute, protecting women with substance use disorders from punitive action for child abuse. The statute's language should be updated to align with regulatory standards and ensure there is consistent application of the law. Furthermore, as treatment services and judicial alternatives are lacking, Virginia should explore the option to utilize federal money to expand integrated services available to these families. To ensure access to these services, Virginia should expand the role of doctors so that pregnant women suffering from substance use disorders are referred to treatment services immediately following their prenatal screening. Last, a review of the numerous regulations, statutes, and Department of Social

Services (DSS) guidance sections that interact with the state's tracking mechanism reveals inconsistencies in terms and requisite procedures. A legal audit of the entire statutory and regulatory framework surrounding the state's tracking and reporting law is necessary to amend outdated terms and inconsistent procedures.

Introduction:

While the opioid epidemic continues to sweep through the nation, the United States has seen a significant shift in the law's approach towards pregnant women struggling with substance use disorders. As recently as a quarter century ago, there was a call for "coercive" legislation that "would make it a crime for anyone to abuse alcohol, licit substances, or illicit substances while pregnant."[1] During the height of the early nineties' drug boom in Virginia, women who used substances while pregnant were prosecuted for child abuse.[2] In the past quarter century, however, the government's response has shifted from an emphasis on prosecution and punishment to the "prioritiz[ation], prevention, treatment and recovery" for the mother-infant dyad.[3]

As this perspective has changed, lawmakers have sought to better utilize resources to protect newborns without punishment of the mother. In 2016, Congress passed the Comprehensive Addiction and Recovery Act (CARA), which amended the Child Abuse Prevention and Treatment Act (CAPTA) and the Public Health Service Act (PHSA). CARA's amendments to CAPTA addressed the needs of the mother-infant dyad after the birth of the baby and CARA's amendments to PHSA address the needs of the mother-infant dyad before the birth of the baby. CAPTA requires each state to provide infants and their mothers with a plan of safe

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[1] Janet W. Steverson, *Stopping Fetal Alcohol Abuse with No-Pregnancy and Drug Treatment Probation Conditions*, 34 SANTA CLARA L. REV. 295, 298 (1994).
[2] LYNN M. PALTROW CRIMINAL PROSECUTIONS AGAINST PREGNANT WOMEN 37-38 (Reproductive Freedom Project April 1992), http://advocatesforpregnantwomen.org/file/1992%20State-by-State%20Case%20Summary.pdf.
[3] 162 CONG. REC. H2374 (daily ed. May 13, 2016) (statement of Rep. Esty requesting an instruction to the Conf. Comm.).

care that addresses the continued healthcare needs of the mother-infant dyad. Additionally, it requires each state to implement a system for tracking infants born affected by substance abuse or withdrawal symptoms. Meanwhile, PHSA authorizes the Substance Abuse and Mental Health Services Administration (SAMHSA) to allocate federal funds for family-based services provided to pregnant and postpartum women with substance use disorder. CARA's amendments to CAPTA and PHSA thereby mandated a twofold state response to substance use by pregnant women that addressed the overall health of the mother-infant dyad both before and after the infant's birth.

CAPTA and its amendments aimed to track women and children in these situations. Spurred by the damage wrought from abuse of prescription opioids, CARA amended the law to include all substances, not just illegal substances, in the tracking focus. However, that opened the door for women who take substances responsibly and under the care of a doctor to be pursued under criminal statutes for reporting the infants under CAPTA. Where illegal substances had been the target before CARA, ambiguous State laws, passed to comply with the federal mandate, allow for women following the instructions of their doctors to be caught in a net of criminal liability. The intent of the federal statutes was not to punish pregnant women for their medications, it was to allow for irresponsible use of prescription opioids to receive attention and aid from federal sources.[4]

While national public sentiment has shifted, ambiguous laws in Virginia have allowed for targeted prosecution by Commonwealth's Attorneys (CA) who believe punishment of new mothers with substance use disorder is warranted.[5] Though successful prosecution of these

[4] 162 CONG. REC. S826 (daily ed. Feb. 11, 2016) (statement of Sen. Portman).
[5] *See* Brief of Commonwealth in Response to Motion to Dismiss, *Commonwealth v. Evans*, No. CR 15-93 and CR 15-94 (Cir. Ct. of Shenandoah Cty. Dec. 1, 2016).

women for child abuse may be rare in Virginia, prosecutors who have commented on this project note that subjecting these women to criminal proceedings is possible. Specifically, they can envision the law being used to place women in jail or hold them criminally liable for the effect of their substance use on a baby.[6]

It is notable that numerous stakeholders in the Commonwealth, including prosecutors, medical experts, social services experts, policy experts, and judges, speak to the importance of treatment rather than punishment.[7] The treatment approach ensures that the child will be born healthier, provides the necessary foundation for ongoing recovery, and combats the woman's inclination to avoid care for fear of punishment.[8] Effective prenatal and neonatal treatment in addition to a safe caregiving environment for the child are the most important factors in raising a healthy child.[9] Punishing a woman by incarcerating her for child abuse eliminates her access to family-based neonatal treatment and a safe caregiving environment. Ultimately, this negatively impacts the child's developmental health.[10] Furthermore, programs offering prenatal, neonatal, and substance use treatment provides both the mother and child with a foundation for long-term recovery. There is a lack of providers of services which are integrated in one facility. With every additional step, there is a greater risk that mothers and families will fall through the crack.[11]

Conversely, incarceration of a postpartum woman for punishment purposes fails to address the long-term needs of the mother-infant dyad, instead wasting the state's resources on

[6] Interview with Local Commonwealth's Attorney (Oct. 23, 2018).
[7] Interviews with Local Commonwealth's Attorney (Oct. 23, 2018); Local OB/GYN (Nov. 20, 2018); Telephone Interview Presiding Judge, Family Drug Treatment Court (Oct. 11, 2018).
[8] Interview with Local OB/GYN (Nov. 20, 2018).
[9] Interview with Local Commonwealth's Attorney (Oct. 23, 2018).
[10] Interviews with Local OB/GYN (Nov. 20, 2018); Phone Interview with Local Substance Abuse Specialist (Nov. 15, 2018).
[11] Interview with Local OB/GYN (Nov. 20, 2018).

the costs of judicial proceedings, daily living expenses, medical expenses, and security.[12] While incarcerating a postpartum woman with substance use disorder for child abuse may satisfy those who believe she should be punished, she and her newborn will ultimately lack a secure foundation for recovery, independence, and health. Additionally, the threat of punishment exacerbates the fear of government intervention experienced by pregnant woman with substance use disorder, further discouraging these women from seeking prenatal care. "Prenatal care greatly reduces the negative effects of substance abuse during pregnancy", depriving the fetus of important care in utero that ameliorates harmful exposure.[13] Ultimately, state action involving punishment rather than treatment wastes resources and contributes to a lack of sustainable care, leading to poor birth outcomes and poor recovery.[14]

Despite these negative outcomes of the punishment approach, Virginia law does not explicitly prohibit women from being prosecuted for child abuse upon the finding that her infant was born exposed to a substance. Though these charges have been dismissed in the past upon the finding that they lack valid legal foundation, the fact remains that a woman in Virginia can be subjected to criminal proceedings for child abuse upon the birth of her baby.[15] Additionally, though a national emphasis has been placed on family-based prenatal substance use treatment, Virginia lacks statewide availability to these types of treatment programs. Considering the possibility of criminal repercussions upon the birth of an infant born affected by substance use, and considering the lack of integrated services available to women to better their circumstances

[12] Interview with Local Commonwealth's Attorney (Oct. 23, 2018).
[13] Committee Opinion, The American College of Obstetricians and Gynecologists, Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist (January 2011), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co473.pdf?dmc=1&ts=20151215T1226107964.
[14] Interviews with Local OB/GYN (Nov. 20, 2018); Telephone Interview with Local Substance Abuse Specialist (Nov. 15, 2018).
[15] *See* Brief of Commonwealth, *Evans*, No. CR 15-93 and CR 15-94 (Cir. Ct. of Shenandoah Cty. Dec. 1, 2016).

before the birth of their infants, Virginia is not fully aligned with the nationally-led shift in addressing the needs of mothers with substance use disorder or their infants.

For this reason, advocates in Virginia are seeking increased protection for women from the threat of frivolous child abuse charges, and they are seeking increased access to prenatal treatment options that mothers with substance use disorders can utilize. Their efforts involve a proposed amendment to Virginia's tracking and reporting statute that would align the statute's language with Virginia's statutory and regulatory definition of child abuse. This legislative change would codify that a doctor's report to DSS flagging the birth of a baby born with a positive screening for a substance does not per se indicate that the woman has committed child abuse. The amended language would also ensure that every pregnant woman with a substance use disorder is referred to the local Community Services Board so recovery services at the prenatal stage are more accessible. This legislative change would place the Commonwealth in better compliance with Congress's mandate addressing the needs of the mother-infant dyad before and after the birth of the infant.

PART ONE: VIRGINIA'S COMPLIANCE WITH CAPTA

I. CARA's Amendments to CAPTA and Virginia's 2017 Response

CAPTA seeks to address the health and treatment needs of mothers and infants affected by substance use and ensure that each state tracks the circumstances surrounding these individuals. Since 2003, CAPTA has required states to have policies and procedures relating to "infants born and identified as being affected by *illegal* [emphasis added] substance abuse or withdrawal symptoms resulting from prenatal drug exposure."[16] In 2016, CARA amended

[16] U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ADMINISTRATION ON CHILDREN, YOUTH AND FAMILIES, ACYF-CB-PI-17-02, GUIDANCE ON AMENDMENTS MADE TO THE CHILD ABUSE PREVENTION AND TREATMENT ACT (CAPTA) BY PUBLIC LAW 114-198, THE COMPREHENSIVE ADDICTION AND RECOVERY ACT OF 2016 (JAN. 17, 2017).

CAPTA by removing the term "illegal" as applied to substance use affecting infants, and by specifically requiring that plans of safe care address the needs of both the infant and the infant's mother. By deleting the term "illegal" and including the infant's mother as a recipient of the plan of safe care, the amendment expanded the population of infants and families subject to the provision. As of 2016, infants born to women who either appropriately or inappropriately used legal substances while pregnant must be included in the states' tracking mechanisms, and the needs of these women, in addition to those of the infants, must be addressed once the infant is born.

The text of Sections 106(b)(2)(B)(ii) and (iii) of CAPTA, as amended by CARA, appears below:

> The state must submit an assurance in the form of a certification by the Governor of the State that the State has in effect and is enforcing a State law, or has in effect and is operating a statewide program, relating to child abuse and neglect that includes…
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> (ii) policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition of such infants, except that such notification shall not be construed to:
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> (I) establish a definition under Federal law of what constitutes child abuse or neglect; or
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> (II) require prosecution for any illegal action;
>
> (iii) the development of a plan of safe care for the infant born and identified as being affected by substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder to ensure the safety and well-being of such infant following release from the care of healthcare providers, including through:
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> (I) addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver; and
>
> (II) the development and implementation by the State of monitoring systems regarding the implementation of such plans to determine whether and in what manner local entities are providing, in accordance with State requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver.

CARA also amended the annual data report requirements in section 106(d) of CAPTA. As a result, States must report, to the maximum extent practicable: a) the number of infants

identified under subsection 106(b)(2)(B)(ii); b) the number of such infants for whom a plan of safe care was developed; and c) the number of such infants for whom a referral was made for appropriate services, including services for the affected family or caregiver.[17]

To comply with CAPTA's amended treatment and tracking requirements, Virginia's legislature broadened §63.2-1509 of the Code in 2017.[18] The resulting statute cemented Virginia's reporting and tracking mechanism so the state response to infants born affected by opioids could be better monitored. Under the new tracking and reporting mechanism, designated reporters must report to the local Department of Social Services (LDSS) when an infant is born exhibiting effects of substance abuse or withdrawal symptoms. Per the statute's language, these effects serve as "reason to suspect that a child is abused or neglected." Specifically, the statute requires health care professionals to send a report to LDSS upon "a finding ... within six weeks of the birth of a child that the child was born affected by substance abuse or experiencing withdrawal symptoms resulting from in utero drug exposure."[19]

II. Typology of Affected Women under Virginia's Reporting and Tracking Mechanism

The birth of an infant affected by either substance abuse, withdrawal symptoms, or both can result from three sets of circumstances involving varying types of drug use. While there may be overlap among these three sets of circumstances, it is important to identify the three general ways a woman may find herself subject to Virginia's tracking and reporting mechanism.

- For the purposes of this paper, women falling within these circumstances will be "Group A" mothers: a pregnant woman is properly taking a legally-prescribed medication under the close supervision of her doctor for illnesses such as chronic

[17] *Id.*
[18] 2017 Va. Acts 298-301.
[19] VA. CODE ANN. §§63.2-1509(A)(2017), 63.2-1509(B)(2017).

pain, anxiety, or seizures. As the substances used to treat these disorders can negatively affect the woman's fetus, it is very rare that a doctor will prescribe them. However, it is possible. The woman is likely being treated with benzodiazepines (used to treat insomnia, seizures, anxiety, or panic attacks), barbiturates (used to treat epilepsy), or in extremely rare cases, opioids (used to treat chronic pain).[20] The specific drugs used to treat these illnesses include Fentanyl, Xanax, Klonopin, Ativan, or Valium. Though the doctor involved knows these drugs may cause the woman's infant to exhibit withdrawal symptoms upon birth, treatment using these drugs is a last resort necessary to provide care for the woman. When her child is born, the infant experiences withdrawal symptoms or tests positive for one of these drugs. [21]

- Women falling under the following set of circumstances will be "Group B" mothers: a pregnant woman suffering from substance use disorder is enrolled in a drug treatment program in which she receives medication to treat her disorder. She is likely receiving methadone or buprenorphine while in treatment for opioid use disorder. While the woman's child avoids the effects of substance abuse, the postpartum screening of her infant reveals the presence of a drug prescribed as part of the treatment program. It is unlikely, however, that the infant is suffering

[20] VIRGINIA DEPARTMENT OF SOCIAL SERVICES, CHILD AND FAMILY SERVICES MANUAL, PART C. CHILD PROTECTIVE SERVICES, SECTION 10, SUBSTANCE-EXPOSED INFANTS, §§10.3.1.1, 10.4.1 (July 2017); Joseph Nordqvist, *The Benefits and Risks of Benzodiazepines* (2018) https://www.medicalnewstoday.com/articles/262809.php.
[21] *Id.* §10.4.1 (July 2017).

from extensive withdrawal symptoms from these drugs as they do not cause the same effects in the infant as do other types of opioids.[22]

- Women falling within the following set of circumstances are "Group C" mothers: a pregnant woman is taking prescription medication without a valid prescription, is using illegal drugs, or is using drugs or alcohol unsafe for her fetus. As a result, her infant experiences effects of substance abuse, withdrawal symptoms, or both after birth. Alternatively, a woman may take a drug listed as harmful to a fetus, such as a Valium for sleep, without realizing that it could cause harm to her infant or could appear in the infant's postpartum screening.[23]

III. Virginia's Statutory and Regulatory Framework Involving Groups A through C

Virginia's tracking and treatment system, triggered by a report made under §63.2-1509(B), involves a multitude of actions taken by health care providers, the LDSS, CSBs, and possibly CA. The process comprises four main stages: the report of suspected child abuse or neglect, the LDSS receipt of the report, the LDSS response to the report, and the possible prosecution of the mother as a result of her prenatal drug use.

The Report of Suspected Child Abuse or Neglect

The first step of the process involves the health care provider's submission of a report of suspected child abuse or neglect, hereinafter a "1509(B)" report, to the LDSS upon the determination that a newborn is "affected by substance abuse or experiencing withdrawal

[22] Lauren M. Jansson et al., *Methadone Maintenance and Breastfeeding in the Neonatal Period*, PEDIATRICS. 106, 112 (2008); Hendree E. Jones, *Methadone and Buprenorphine for the Management of Opioid Dependence in Pregnancy*, DRUGS. 747, 750 (2012).
[23] Nina Martin, *Take a Valium, Lose Your Kid, Go to Jail*, PROPUBLICA (Sept. 23, 2015), https://www.propublica.org/article/when-the-womb-is-a-crime-scene.

symptoms resulting from in utero drug exposure."[24] Health care providers identify infants born "affected by substance abuse or experiencing withdrawal symptoms" by using clinical indicators, including maternal and infant presentation at birth, substance use and medical histories, and toxicology results.[25] There is no statutory indication of the standards health care providers should use to define "affected by substance abuse" and "withdrawal symptoms." While the Virginia Department of Social Services (VDSS) provides guidelines, the definitions for these phrases are ultimately determined by the health care providers.

VDSS notes that "affected by substance abuse may be evidenced by impaired growth, preterm labor or subtle neurodevelopmental signs."[26] The agency does not define "withdrawal symptoms," but it does provide common symptoms of Neonatal Abstinence Syndrome (NAS) and defines NAS as "a group of problems that occur in a newborn as a result of sudden discontinuation of addictive opioids … to which the newborn was exposed while in the mother's womb."[27] Some common NAS symptoms VDSS lists include tremors, irritability, sleep problems, high-pitched crying, diarrhea, stuffy nose and sneezing, vomiting, seizures, yawning, and sweating.[28] It is important to note that though a positive toxicology screen was removed from the Virginia Code in 2017 as a valid basis for a 1509(B) report, a number of health care providers continue to submit 1509(B) reports upon a positive toxicology screen.[29]

Once a health care provider determines that a newborn is affected by substance abuse or experiencing withdrawal symptoms, the hospital in which the child was born must take

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[24] VA. CODE ANN. §63.2-1509(B)(2017).
[25] VDSS, CHILD AND FAMILY SERVICES MANUAL, PART C. CPS, SECTION 10, SUBSTANCE-EXPOSED INFANTS, §10.3 (July 2017).
[26] *Id.* at §10.3.1.1.
[27] *Id.* at §10.9.
[28] *Id.* at §10.9.
[29] Interviews with Local Social Services Expert (Nov. 16, 2018); Local OB/GYN (Nov. 20, 2018); Phone Interview with Local Substance Abuse Specialist (Nov. 15, 2018).

numerous actions, regardless of whether the mother falls within Group A, Group B, or Group C.[30] After submitting the 1509(B) report to LDSS,, it must develop written discharge plans for the "identified, substance-abusing, postpartum" mother and her infant, and it must discuss these discharge plans with the mother.[31] Additionally, "appropriate referrals" for the mother and the infant must be made and documented. These referrals may include treatment services, early intervention services, and family-oriented prevention services.[32] Last, the hospital must report the "substance-abusing, postpartum woman" to the local Community Services Board (CSB).[33] The CSB is then required to appoint a discharge plan manager to implement and manage the discharge plan.[34]

The LDSS Receipt of the Report

At the second stage of the process, the LDSS receives the report from the health care provider and enters the woman's name and personal information into its child abuse and neglect information system. [35] The LDSS screens the report of suspected child abuse or neglect for validity before moving forward.[36] Each LDSS has the discretion to determine whether the report meets the required elements of a valid report.[37] It is important to note that no regulation or statute

[30] VA. CODE ANN. §32.1-127(B)(2018); VDSS, CHILD AND FAMILY SERVICES MANUAL, PART C. CPS, SECTION 10, SUBSTANCE-EXPOSED INFANTS, §10.3.1.1-§10.3.3 (2017).
[31] VA. CODE ANN. §32.1-127(B)(6)(2018). The statutory language used to describe the mother should be noted as it is out of date.
[32] *Id.*
[33] *Id.*
[34] *Id.*; VDSS, CHILD AND FAMILY SERVICES MANUAL, PART C. CPS, SECTION 10, SUBSTANCE-EXPOSED INFANTS, §10.3.2.2 (July 2017).
[35] Title 22, VA. ADMIN. CODE §40-705-50 (2017). Note that this regulation requires a record of all reports made to the LDSS to remains in the system for one year, regardless of whether the complaint was found to be a valid complaint of abuse or neglect. It is purged one year after the date of the report unless a subsequent report or complaint is made.
[36] VA. CODE ANN. §63.2-1503(I)(2018).
[37] Title 22, VA. ADMIN. CODE §40-705-50(B)(2017): A valid report of suspected child abuse or neglect must meet the following elements: 1) the alleged victim child is under the age of eighteen; 2) the alleged abuser is the alleged victim child's parent or other caretaker; 3) the local department receiving the complaint or report has jurisdiction; and 4) the circumstances described allege suspected child abuse or neglect as defined in §63.2-100. This Code

clarifies whether a report made solely upon a positive toxicology screening is valid; however, in late 2018, the VDSS disseminated guidance to all LDSSs that such a report should be considered invalid.[38] Within twenty-four hours upon receipt of the a valid report, the LDSS's Child Protection Services (CPS) must conduct an initial safety assessment.[39] Additionally, the LDSS must refer the infant to the local Infant and Toddler Connection of Virginia and develop a plan of safe care for the mother and child.[40]

The initial safety assessment involves multiple steps. First, CPS must immediately determine whether to petition a juvenile and domestic relations district court (JDR) for any necessary services or court orders needed to ensure the safety and health of the child.[41] Next, CPS must develop a safety plan addressing the immediate safety concerns and needs of the infant.[42] CPS considers a number of factors when developing the safety plan, including whether the mother caused serious physical harm to the child and whether the mother's substance use is currently and seriously affecting her ability to supervise, protect, or care for child.[43] CPS then conducts a substance use screening to determine whether a substance abuse assessment is

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Section states that an abused or neglected child means any child whose parents or other person responsible for his care creates or inflicts, threatens to create or inflict, or allows to be created or inflicted upon such a child a physical or mental injury by other than accidental means, or creates a substantial risk of death, disfigurement, or impairment of bodily or mental functions.

[38] Interview with Local Social Services Expert (Nov. 16, 2018).

[39] Title 22, VA. ADMIN. CODE §§40-705-40(A)(6)(b)(2017), 40-705-110(A)(2017); §3.8.8. "Effective July 1, 2017, all valid reports that involve a child victim less than two years of age must receive an R1 response (a response within 24 hours)."

[40] VDSS, CHILD AND FAMILY SERVICES MANUAL, PART C. CPS, SECTION 10, SUBSTANCE-EXPOSED INFANTS, §10.5.6 (July 2017); VA. CODE ANN. §63.2-1506(C)(b)(2018).

[41] Title 22, VA. ADMIN. CODE §40-705-40(A)(6)(c)(2017).

[42] VDSS, CHILD AND FAMILY SERVICES MANUAL, PART C. CPS, SECTION 10, SUBSTANCE-EXPOSED INFANTS, §10.5.2 (July 2017). Note that a safety plan is not the same as a Plan of Safe Care but is considered one critical component of the Plan of Safe Care. A safety plan addresses immediate safety concerns and needs, while the Plan of Safe Care addresses both short and long term needs.

[43] VDSS, CHILD AND FAMILY SERVICES MANUAL, PART C. CPS, SECTION 10, SUBSTANCE-EXPOSED INFANTS, §10.5.2 (July 2017).

needed.[44] If a substance abuse assessment is necessary, CPS identifies the services that would best meet the needs of the mother.[45]

The LDSS Response to the Report

The third stage of the process involves LDSS placement of the report into a "family assessment" track or an "investigation" track.[46] The purpose of a family assessment is to collect information to determine: 1) the immediate safety needs of the child; 2) the protective and rehabilitative services needs of the child and family; 3) risks of future harm to the child; and 4) alternative plans for the child's safety if the family is unable or unwilling to participate in protective and rehabilitative services.[47] Meanwhile, the purpose of an investigation is to determine the above four factors and establish whether abuse or neglect has in fact occurred.[48]

The Virginia Code requires reports of suspected child abuse or neglect to be placed in the family assessment track unless an investigation is required by law or is necessary to protect the safety of the child.[49] The VDSS manual states that a family assessment is usually a more appropriate response because the purpose of a family assessment is to assess the safety, risk, and

[44] VDSS, CHILD AND FAMILY SERVICES MANUAL, PART C. CPS, SECTION 10, SUBSTANCE-EXPOSED INFANTS, §10.5.2.1 (July 2017). A substance use screening should include questions concerning: frequency and amount of alcohol consumption prior to and during pregnancy; frequency and amounts of over-the-counter prescriptions and legal/illegal substances prior to and during pregnancy; effects of substance use on life areas such as relationships, employment, legal, etc.; other parent or partner substance use; previous referrals for substance abuse evaluation or treatment; and previous substance use treatment or efforts to seek treatment. his screening and safety assessment may lead to consideration of court action or a Family Partnership Meeting.

[45] *Id.*

[46] VA. CODE ANN. §63.2-1506 (2018). Note that effective July 1, 2017, there is no longer an exception for an LDSS to respond to valid reports of substance exposed infants.

[47] Title 22, VA. ADMIN. CODE §40-705-10 (2017); VIRGINIA DEPARTMENT OF SOCIAL SERVICES, CHILD AND FAMILY SERVICES MANUAL, PART C. CHILD PROTECTIVE SERVICES, VDSS, SECTION 3 COMPLAINTS AND REPORTS, §3.9.1 (July 2017).

[48] *Id.*

[49] VA. CODE ANN. §63.2-1506 (2018). Note that the phrase "necessary to protect the child" is not defined. Even if an investigation is not required, an LDSS can proceed with investigation if "necessary to protect child."

service needs of the child.[50] It notes that, as a woman using controlled substances prior to the birth of her child is not sufficient evidence for a founded disposition of abuse or neglect in an investigation, the investigation track is not as appropriate as the family assessment track for 1509(B) referrals. To move forward with either track, the circumstances described in the 1509(B) report allege that the child's parent has inflicted physical or mental injury (by non-accidental means) or has created a substantial risk of impairment of bodily or mental functions.[51]

Upon the initiation of a family assessment, CPS must notify the family verbally and in writing that a report of suspected abuse or neglect has been received and that a family assessment will be conducted in response.[52] Next, CPS will apply its Family Risk Assessment tool to determine whether the 1509(B) report warrants further action. CPS will take into consideration whether the infant was exposed to a substance in utero, whether the child has a positive toxicology screen at birth, whether the mother has or had a drug or alcohol problem, and the characteristics of other children in the household.[53] If CPS determines upon its assessment of these factors that there is a low likelihood of future abuse or neglect, it establishes that no further intervention is needed and it closes the case.[54] Upon the determination that there is a moderate likelihood of future abuse or neglect, CPS establishes that minimal intervention may be needed and it may either close the case or continue it.[55] Upon the determination that there is a high or

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[50] VDSS, CHILD AND FAMILY SERVICES MANUAL, PART C. CPS, SECTION 10, SUBSTANCE-EXPOSED INFANTS, §10.5.1 (July 2017).
[51] Title 22, VA. ADMIN. CODE §§40-705-50(C)(2017), 40-705-50(B)(2017); VA. CODE ANN. §63.2-100 (2018). ("The LDSS shall not conduct a family assessment or investigate reports of child abuse or neglect that fail to meet all of the criteria in subsection (B)"). See additional discussion on this topic in Section IV.
[52] VDSS, CHILD AND FAMILY SERVICES MANUAL, PART C. CPS, SECTION 4, FAMILY ASSESSMENT AND INVESTIGATION, §4.4.2 (July 2017); Title 22, VA. ADMIN. CODE §40-705-90(B)(2017).
[53] VDSS, CHILD AND FAMILY SERVICES MANUAL, PART C. CPS, SECTION 10, SUBSTANCE-EXPOSED INFANTS, §10.5.5.3 (July 2017).
[54] *Id.* at §10.5.5.4.
[55] *Id.*

very high likelihood of future abuse or neglect without intervention, CPS will continue the case.[56] Continuing the case involves assessing the on-going services that are necessary for the family. This involves considerations involving whether treatment is required and available, whether there are treatment facilities that can address the needs of the mother and her child or children, and whether other services are needed, like parenting education, job skills training, mental health assistance, and safe housing.[57]

While any 1509(B) report may be placed into the investigation track, the report *must* be investigated if required by statute.[58] According to §63.2-1506(C), an investigation is required if: 1) there are sexual abuse allegations; 2) the infant has died; 3) the mother has caused the child to undergo forced ingestion of dangerous substances or life-threatening internal injuries; or 4) the child has been taken into state custody.[59] It is not clear at this time whether an LDSS has the discretion to find that prenatal substance exposure equates "forced ingestion of dangerous substances." This interpretation of the language is not likely valid as prenatal exposure occurs before the law considers the fetus to be a child. Alternatively, if the infant experiences particularly severe withdrawal symptoms such as seizures, it is unclear whether an LDSS may argue that the mother has caused life-threatening internal injuries to the child, thereby requiring placement of the 1509(B) report into the investigation track.[60]

Once CPS has initiated the investigation, it must notify the family in writing and orally that a report of suspected abuse or neglect has been received and that an investigation will be

[56] *Id.*
[57] *Id.* at §10.6.2.
[58] *Id.* at §10.5.1.1.
[59] VA. CODE ANN. §18.2-371.1(2016).
[60] We suggest further inquiry to determine whether an LDSS make take this route as it lays the foundation for a felony of abuse or neglect.

conducted in response.[61] CPS must then observe the child in person and conduct a face-to-face interview with the mother.[62] Like the procedures required in the family assessment track, CPS must also conduct a family risk assessment at the initiation of the investigation.[63] The family risk assessment in the investigation track requires CPS to consider factors like the mother's history of substance abuse or criminal activity, whether the infant was exposed to substances in utero, whether the infant is medically fragile or shows evidence of a developmental or physical disability, and the relationship between the mother and the infant. Like the family risk assessment process in the family assessment track, the risk level determined guides the CPS's decision to continue the case.

After fully investigating a 1509(B) report, CPS must make a determination of whether or not the child has been abused or neglected.[64] This determination is called a disposition.[65] A founded disposition of child abuse or neglect means that a review of the facts shows by a preponderance of the evidence that child abuse or neglect occurred.[66] Facts indicating or establishing that the infant was exposed to controlled substances prior to birth are not sufficient to render a founded disposition of child abuse or neglect.[67] A founded disposition must be "the

[61] Title 22, VA. ADMIN. CODE §40-705-90B(2017); VDSS, CHILD AND FAMILY SERVICES MANUAL, PART C. CPS, SECTION 4, FAMILY ASSESSMENT AND INVESTIGATION, §4.5.3. (July 2017).
[62] Title 22, VA. ADMIN. CODE §40-705-80(B)(2017); Title 22, VA. ADMIN. CODE §40-705-80(B)(4)(2017); VDSS, CHILD AND FAMILY SERVICES MANUAL, PART C. CPS, SECTION 4, FAMILY ASSESSMENT AND INVESTIGATION, §4.5.8 (July 2017).
[63] Title 22, VA. ADMIN. CODE §40-705-110(B(2017)); VDSS, CHILD AND FAMILY SERVICES MANUAL, PART C. CPS, SECTION 4, FAMILY ASSESSMENT AND INVESTIGATION, §4.5.24 (July 2017).
[64] Title 22, VA. ADMIN. CODE §40-705-110 (2017).
[65] Title 22, VA. ADMIN. CODE §40-705-10 (2017).
[66] *Id.*
[67] Title 22, VA. ADMIN. CODE §40-705-40(A)(6)(h)(2017); VDSS, CHILD AND FAMILY SERVICES MANUAL, PART C. CPS, SECTION 10, SUBSTANCE-EXPOSED INFANTS, §§10.5.5, 10.5.5.2.(July 2017).

result of a preponderance of the evidence that the infant was injured or experienced a threat of harm that meets the statutory and regulatory definitions of another type of abuse or neglect."[68]

Further inquiry is necessary as to whether an LDSS could find prenatal substance use as a form of medical neglect. If so, this would provide the necessary elements for a founded disposition. According the VDSS manual, medical neglect involves a caretaker's failure to provide medical treatment thereby causing harm to the child or placing the child in risk of harm as a result of the failure.[69] It is unclear at this time whether an LDSS could establish that a mother's failure to secure prenatal care, coupled with the mother's prenatal substance use, would be sufficient to find that the mother failed to provide medical treatment for her fetus, thereby causing harm to her child or placing her child in risk of harm for future illnesses.

It is important to note that once the LDSS has placed the §1509(B) referral into a family assessment or investigation track, it may also file a petition with the local JDR court solely because an infant has been exposed to controlled substances prior to his or her birth.[70] The LDSS must state in the petition presented to the court that a CPS investigation or family assessment has been commenced in response to a §63.2-1509(B) report.[71] The purpose of this petition is to lay the foundation for the court to enter an order that the court deems necessary to protect the health and welfare of the child pending final disposition by CPS.[72] It is important to note that the fact

[68] VDSS, CHILD AND FAMILY SERVICES MANUAL, PART C. CPS, SECTION 10, SUBSTANCE-EXPOSED INFANTS, §10.5.5.2.(July 2017).
[69] VDSS, CHILD AND FAMILY SERVICES MANUAL, PART C. CPS, SECTION 4, FAMILY ASSESSMENT AND INVESTIGATION, §4.5.29 (July 2017).
[70] VA. CODE ANN. §16.1-241.3(2012); VDSS, CHILD AND FAMILY SERVICES MANUAL, PART C. CPS, SECTION 10, SUBSTANCE-EXPOSED INFANTS, §10.7.1.1 (July 2017).

[71] VDSS, CHILD AND FAMILY SERVICES MANUAL, PART C. CPS, SECTION 10, SUBSTANCE-EXPOSED INFANTS, §10.7.1.1 (July 2017).
[72] VA. CODE ANN. §16.1-241.3(2012).

that an order was entered is not admissible as evidence in any criminal proceeding.[73] Upon the LDSS's final disposition of the investigation or family assessment, the JDR may enter an emergency removal order or preliminary protective order, or it may limit or prohibit the parent's contact with the child.[74]

Possible Prosecution as a Result of the Report

It is possible for a CA to become involved in the process if the LDSS receives a 1509(B) report involving any injury to the child in which a felony or Class 1 misdemeanor is also suspected.[75] According to §63.2-1503(D)(i), CPS must notify the local Commonwealth's Attorney and the local police department of these circumstances. Per §18.2-371 of the Code, a parent who causes any condition that renders a child in need of services, in need of supervision, or abused or neglected is guilty of a Class 1 Misdemeanor. This statute does not define "services" or "supervision." While it likely that "services" and "supervision" refers to actions associated with a Child in Need of Services (CHINS) petition, the statute does not clarify this fact. As a valid 1509(B) report requires LDSS to conduct a family risk assessment, refer the mother and child to the local Infant and Toddler Connection of Virginia, and initiate a family assessment or investigation, it is not clear whether a CA could successfully argue that these responses amount to "services." If so, the mother's prenatal substance use has rendered her newborn in need of services, and that could lead to criminal liability.

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[73] *Id.*

[74] *See* VA. CODE ANN. §16.1-241.3(2012), 16.1-251(2017), 16.1-253(2014), §16.1-278.2A(2017); VDSS, CHILD AND FAMILY SERVICES MANUAL, PART C. CPS, SECTION 10, SUBSTANCE-EXPOSED INFANTS, §10.7.3 (July 2017). Note the presence of an inconsistency between the statute and the manual. §16.1-241.3 states that a court order is effective pending final disposition of an investigation, however, the VDSS manual states that aa court order is effective pending final disposition of the investigation or *family assessment*."

[75] VA. CODE ANN. §63.2-1503(D)(ii)(2018).

The phrase "abused or neglected" is defined as any child whose parent "creates or inflicts, threatens to create or inflict, or allows to be created or inflicted upon such child a physical or mental injury by other than accidental means, or creates a substantial risk of death, disfigurement or impairment of bodily or mental functions."[76] Further inquiry is necessary to determine whether a CA could succeed in the legal argument that a mother's prenatal substance use created, threatened to create, or allowed to be created upon her newborn physical or mental injury or impairment of bodily or mental functions. Considering the broad nature of the statute's language, it seems that this argument could be possible.

According to §18.2-371.1(A), a parent who (by willful act or willful omission) causes or permits serious injury to the life or health of her child is guilty of a Class 4 felony. "Serious injury" includes disfigurement, a fracture, a severe burn or laceration, mutilation, maiming, forced ingestion of dangerous substances, or life-threatening internal injuries. Further inquiry is necessary to determine whether a CA could succeed in the legal argument that the mother of a substance exposed infant has caused serious injury to the health of her child. It is unclear whether a CA could argue that a mother's prenatal substance use has caused types of disfigurement in her newborn that some studies have attributed to opioid withdrawal. These include torticollis - an abnormal twisting of the neck - or plagiocephaly - a flattening of the head.[77] It is possible that a CA may also argue that a mother's prenatal substance use caused her child to undergo forced ingestion of dangerous substances, though this argument would be unlikely to succeed as the ingestion would have occurred before the child was born. During the course of this project, the prosecutors who were spoken to indicated that they would not pursue

[76] VA. CODE ANN. §16.1-228(1)(2018).

[77] Jim Feuer, *Study Reveals Abnormalities in Infants Born in Withdrawal After Opioid Exposure in Utero*, CINCINNATI CHILDREN'S HOSPITAL, NEWSROOM (2018) https://www.cincinnatichildrens.org/news/release/2018/opioid-exposure-in-utero.

the above arguments, however, they did note that it would be possible for other prosecutors to pursue them.

IV. Gaps in Virginia's Compliance with CAPTA

Section 63.2-1509(B) of the Code appears to place the state in a position of compliance with CAPTA's new amendments. It repeats CAPTA's definition for substance-affected infants ("affected by substance abuse or experiencing withdrawal symptoms resulting from in utero drug exposure"), establishes a reporting mechanism when infants are born affected by substance abuse or withdrawal systems, and initiates a state-led process that oversees the mother-infant dyad. However, the statute falls short of realizing two of CAPTA's objectives: 1) creating an efficient reporting mechanism that is triggered by a defined set of circumstances; and 2) ensuring that the report is used to secure a plan of care for both the mother and the infant rather than a plan involving punitive measures against the mother.

Factors Affecting the Efficiency of Virginia's Reporting Mechanism

According to the federal Department of Health and Human Services (DHHS), CAPTA gives States the flexibility to define the phrase, "infants born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure."[78] The definition of the terms in this phrase are significant as they initiate a process that involves multiple entities and that heavily imposes on the privacy of a family. A defined set of perimeters can ensure that the reporting mechanism is efficient and that it properly identifies the population of women and infants addressed by CAPTA.

[78] U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ADMINISTRATION ON CHILDREN, YOUTH AND FAMILIES, ACYF-CB-PI-17-02, GUIDANCE ON AMENDMENTS MADE TO THE CHILD ABUSE PREVENTION AND TREATMENT ACT (CAPTA) BY PUBLIC LAW 114-198, THE COMPREHENSIVE ADDICTION AND RECOVERY ACT OF 2016 (JAN. 17, 2017).

It is thus important to note that Virginia's tracking and reporting mechanism, promulgated by §63.2-1509(B), fails to indicate the standards reporters should use to define "substance abuse," "withdrawal symptoms," or "affected by substance abuse or withdrawal symptoms." While flexibility in defining these terms may be necessary to avoid constricting the discretion of medical professionals, reporters need to understand how the recipients of these reports, the local Departments of Social Services (LDSS), define these phrases. Because the LDSS initiates the state's response, the agency's definitions for these terms are paramount to the process. If a disparity exists between how reporters define these terms and how the LDSS define them, the danger of over or under reporting arises. Ultimately, reports that interpret these words and phrases differently from the LDSS may affect the efficiency of the reporting mechanism.

However, a significant lack of clarity surrounds the definitions of these phrases. For instance, a medical provider must report an infant born "affected by substance abuse," but §63.2-1509(B) does not provide a definition for "substance abuse," nor does it indicate where this word is defined in the Code. Should reporters use the definition provided for "substance abuse" in §37.2-100 of the Code,[79] or should reporters apply their own definition of the word, informed by their medical background? If using their own definition, must an individual exhibit signs of dependence on the drug to meet the standard of "substance abuse" or may a provider find that one occurrence of substance use during pregnancy is enough?

[79] VA. CODE ANN. §37.2-100(2017) and Title 22 VA. ADMIN. CODE §40-73-10(2017) state that "substance abuse" means the use of drugs, enumerated in the Virginia Drug Control Act (§ 54.1-3400 et seq.), without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior and (iii), because of such substance abuse, requires care and treatment for the health of the individual. This care and treatment may include counseling, rehabilitation, or medical or psychiatric care.

Another aspect of the statute that may cause confusion is how the phrases "affected by substance abuse" and "withdrawal symptoms" should be defined. As mentioned earlier in this report, VDSS has established that a report made solely upon a positive toxicology screen is not valid, however no regulation or statute clarifies this. Additionally, various sections in the VDSS manual indicate that a positive toxicology screen is sufficient on its own for a valid 1509(B) report. For instance, Section 10.5.5.1 of the VDSS's manual states that identification of how the infant was affected by in utero substance exposure "may include results of laboratory tests or toxicology studies done on the infant."[80] It is unclear whether this statement means that evidence of an infant affected by substance abuse or experiencing withdrawal symptoms can be further supported by results of laboratory tests or toxicology studies, or whether laboratory tests or toxicology studies alone may serve as evidence of withdrawal systems.

Additionally, Section 10.3.1 of the VDSS manual, titled "Health care providers required to report SEI," equates substance exposure with being "affected by substance abuse or experiencing withdrawal symptoms." It notes that a positive toxicology screen is a clinical indicator of a substance exposed newborn, and that "[t]he Code of Virginia requires health care providers to make a report of abuse or neglect when there is a reason to suspect that a *mother exposed a newborn infant to controlled substances during the pregnancy*." (Emphasis added.) This statement is incorrect. The Code requires health care providers to make a report of suspected abuse or neglect when the "child was born affected by substance abuse or experiencing withdrawal symptoms resulting from in utero drug exposure." Thus, Section 10.3.1 ultimately concludes that prenatal exposure serves as evidence that the newborn is "affected by substance abuse or experiencing withdrawal symptoms."

[80] VDSS, CHILD AND FAMILY SERVICES MANUAL, PART C. CPS, SECTION 10, SUBSTANCE-EXPOSED INFANTS, §10.5.5.1 (July 2017).

According to local experts on the process, reports made by health care providers exhibit inconsistent interpretations of the phrases "substance abuse," "affected by substance abuse," and "withdrawal symptoms." While discretion among healthcare providers can be necessary to accurately assess a situation, a general lack of perimeters indicating how the VDSS defines these terms can cause a significant range of interpretations.[81] Local experts also note that the 1509(B) report is often made solely upon a positive toxicology screen.[82] This results in an over-reporting of cases, which likely causes Virginia's reporting mechanism to be less efficient as LDSS workers must take time to sift through invalid reports.[83] It is important to note that the VDSS is aware of this issue and is currently making efforts to communicate to medical providers and LDSS workers that a positive toxicology screen is not sufficient for a valid 1509(B) report;[84] however, additional actions are necessary to make this fact clear in the manual, the Administrative Code, and the Virginia Code so that incorrect reporting practices can be further reduced.

Factors Affecting Virginia's Ability to Prioritize Treatment over Punishment

Though the Virginia Code does not explicitly criminalize prenatal substance use by statute or regulation, the legal framework surrounding the State's tracking and reporting

[81] Interview with Local OB/GYN (Nov. 20, 2018).

[82] Interviews with Local OB/GYN (Nov. 20, 2018), Local Social Services Expert (Nov. 16, 2018), Local Substance Abuse Specialist (Nov. 15, 2018).

[83] If a questionable report makes its way to an LDSS, VDSS insists that invalid reports be marked as such upon their receipt. This is illustrated in the SEI decision tree tool. The last step, if none of the factors beyond a positive test result, is for the infant to be screened out. Even those reports can be referred to other community partners or prevention response. However, that decision is made by bureaucrats in locally administered departments. These departments are state-supervised, but there is inconsistent application across the Commonwealth. For example, estimates by local experts on how many reports are closed without a home visit at this level vary from 10-90%, depending on the jurisdiction.

[84] Local Social Services Expert (Nov. 16, 2018)- The VDSS has distributed a substance exposed infant (SEI) decision tree tool with the aim to clear up the intent for reporting of SEI by hospitals. The decision tree stresses that a positive toxicology test result is not grounds for screening in a family, but the basis to rise to that level is merely the concerns of the reporter. While VDSS intends that reports based solely on a positive screen be marked invalid, there are indications among concerned experts that that intent is not yet being enforced. See Appendix A.

mechanism implicitly emphasizes an undertone of criminality. This ultimately impacts the state's ability to prioritize treatment over punishment and weakens the state's position of compliance with CAPTA's mandate of family treatment and care. The state's undertone of criminality is apparent upon a review certain language in the Virginia Code, the Administrative Code, and various VDSS manuals.

One clear indication of this undertone is simply the location in which Virginia's tracking and reporting law appears in the State Code. This law is located in Chapter 15 of Title 63.2, which centers on child abuse, not treatment. As substance use disorders fall within behavioral health, and pregnant women with substance use disorders best serve their infant by seeking treatment, it would be more appropriate for the law to be located in Chapters 5 or 6 of Title 37.2, which centers on Behavioral Health and Developmental Services. Additionally, the punishment approach is emphasized in Section 32.1-127 of Code, which describes mothers with substance use disorder as "substance-abusing post-partum women." This term is repeated in Section 10.3.2.2 of VDSS's manual. According to SAMHSA's Center for the Application of Prevention Technologies, this type of language is stigmatizing and highly discouraged. Unlike the phrase "women with substance use disorder," the phrase "substance-abusing ... women" suggests that these women are the problem, not that these women have a problem that can be addressed.[85]Using the phrase "substance-abusing ... women" can perpetuate negative stereotypes and can decrease public support for prevention and treatment programs.[86] This leads a systemic characterization of these women as criminals who should be punished for breaking the law.[87]

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[85] SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, CENTER FOR THE APPLICATION OF PREVENTION TECHNOLOGIES, WORDS MATTER: HOW LANGUAGE CHOICE CAN REDUCE STIGMA (NOV. 2017) https://www.samhsa.gov/capt/sites/default/files/resources/sud-stigma-tool.pdf.
[86] *Id.*
[87] *Id.*

Certain subtleties in the language of the legal framework further support the criminal characterization of these women. For instance, 22 VAC 40-705-40(A)(6)(h) states that "facts establishing that the infant was exposed to controlled substances prior to birth are not sufficient to [for the LDSS to] render a founded disposition of abuse or neglect;" however, the Code omits acknowledgment of this policy. Because a founded disposition of abuse or neglect can inform a prosecutor's charges, the lack of a codified version of this rule translates to a lack of protection against criminal prosecution of mothers with substance use disorder. Furthermore, the VDSS Manual implies that prenatal substance exposure is on its own a type of abuse or neglect, just not one that can serve as a basis for a founded disposition. This is implied in Section 10.5.5.2 by the use of the word "another" in the statement: "The LDSS must establish by a preponderance of the evidence that the infant was injured or experienced a threat of injury or harm according to the statutory and regulatory definitions of another type of abuse or neglect to support a founded disposition."

A deeper look at the elements of a valid 1509(B) report reveals an emphasis on the criminal characterization of mothers identified in the report. To constitute a valid 1509(B) report, the VDSS manual notes that the report must include facts indicating that the child was born affected by substance abuse or experiencing withdrawal symptoms resulting from in utero drug exposure. Section 10.5 of the manual states that these facts are sufficient, in and of themselves, to suspect that the child is abused or neglected.[88] The reason these facts are sufficient on their own is clarified in 22 VAC 40-705-50(B), which states that the facts of a valid report describe suspected child abuse or neglect as defined in Section 63.2-100 of the Code. This section defines an abused or neglected child as one whose parent "creates or inflicts, threatens to create or

[88] VDSS, CHILD AND FAMILY SERVICES MANUAL, PART C. CPS, SECTION 10, SUBSTANCE-EXPOSED INFANTS, §10.5 (July 2017).

inflict, or allows to be created or inflicted upon such child a physical or mental injury by other than accidental means, or creates a substantial risk of death, disfigurement, or impairment of bodily or mental functions." When 22 VAC 40-705-50(B) is juxtaposed with Section 63.2-100 of the Code, it becomes clear that a valid 1509(B) report does more than allege that a child was born affected by substance abuse or experiencing withdrawal symptoms.[89] In fact, it alleges that the child's mother has created or inflicted, threatened to create or inflict, or allowed to be created or inflicted upon her child a physical or mental injury by other than accidental means, or has created a substantial risk of death, disfigurement, or impairment of bodily or mental functions, thereby committing child abuse. Therefore, the way in which the law is currently written establishes that if a woman's infant shows signs of withdrawal symptoms, she is per se guilty of child abuse. Further, if she used a substance during her pregnancy but this substance did not appear in her infant's toxicology screen, she could still be found to have abused her child as her prenatal actions threatened to create an injury upon her child.[90]

When these implicit policies supporting the criminalization of mothers are considered along with the clear avenues for prosecution outlined in Section III of this paper, it becomes clear that a foundation for punishment exists within Virginia's legal framework. Another factor increasing the possibility for punishment is the fact that local entities play a significant role in interpreting the treatment and tracking processes implemented through §63.2-1509(B). This results from Virginia's decentralized social services system involving local departments of social services and local community service boards. Though various statutes and regulations provide a framework for the tracking and reporting mechanism, the lack of defined terms and consistency

[89] A valid 1509(B) must indicate that a baby is born "affected by substance abuse or experiencing withdrawal symptoms."

[90] Note that as some signs of prenatal substance use may not appear in the child immediately upon birth, one could argue that a negative toxicology screen does not rule out injury.

in the law, coupled with codified discretion to local agencies, creates the possibility of varying implementation depending on one's geographic location. Each jurisdiction's LDSS can ultimately proceed with a separate course of action when processing Group A mothers, Group B mothers, and Group C mothers.

Finally, CAs have the discretion to prosecute claims as they see fit, even when those decisions go outside of the intent of a law.[91] It is evident that the possible variability in the way the law is interpreted by these stakeholders can cause an inconsistent application of the law. CAs across the state may take widely different approaches to these instances, and some may decide to prosecute women from Groups A, B, or C. As a result, a woman in one region of the state may have a very different experience navigating through this system than a woman in another region of the state. If the law is applied differently in various regions throughout the state, the possibility arises that CAPTA's federal mandate is not consistently upheld.

As discussed above, the focus at the national legislative level is shifting away from punishment as treatment is being prioritized. Prevention is also a major emphasis of the CAPTA legislation.[92] In the effort to align Virginia's laws with federal intent, the Commonwealth should concentrate on promoting those ideas and not on punishment options. While attempts to use statutes to allow felony prosecution are few and far between, they are present.[93] Fear of these charges are having effects on pregnant women and dissuading them from seeking treatment.[94] If

[91] For evidence of how laws can be used outside of their intended scope, as well as how outdated beliefs can affect women's lives, *See* https://www.nytimes.com/2015/04/01/magazine/purvi-patel-could-be-just-the-beginning.html. https://www.washingtonpost.com/local/i-know-whats-buried-in-the-back-yard-a-woman-faces-a-rare-charge-of-self-induced-abortion/2017/04/20/6276452c-1fc1-11e7-a0a7-8b2a45e3dc84_story.html?utm_term=.581318244d3e)

[92] 162 CONG. REC. S826 (daily ed. Feb. 11, 2016) (statement of Sen. Portman).

[93] *See* Brief of Commonwealth, *Evans*, No. CR 15-93 and CR 15-94 (Cir. Ct. of Shenandoah Cty. Dec. 1, 2016).

[94] Keith Epps, *Four Members of Spotsylvania Family Arrested after Birth of Drug-Addicted Baby*, THE FREELANCE STAR (OCT. 27, 2017).

those instances become more prevalent, the entire intent of CAPTA, treatment, prevention, and tracking, will be subverted by scattershot enforcement.

V. Expansion of DSS Discretion in Other States and the Prosecutorial Results of this Expansion

As of this writing, every State has passed laws tailored to fit within the CAPTA mandate and govern the issue. However, they are diverse in their allowances for States to enforce the standard in widely different manners. As such, State laws are inconsistent in their enforcement of the laws that affect women and families.

Some States have followed a stringent policy that demands immediate reporting.[95] They do not contain allowances to protect women from possible criminal actions. Other states included clauses that offer protections for women who have legitimate medical needs.[96] Finally, some included language that offers protection against prosecution based on the first toxicology screen of the infant.[97] Adding another layer, Alabama passed Amendment 2, which protects the "rights of unborn children"; this establishes that 1) the unborn involved are children; 2) their rights are subject to State protection.[98] While this amendment was intended to target abortion rights, it could be used to prosecute women whose substance use affects a fetus in utero.

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[95] Alaska ("shall immediately notify the nearest office of the Department of Health of the infant's condition"); Arizona ("reasonably believes that the newborn infant may be affected by the presence of alcohol or a drug . . . shall immediately report this information, or cause a report to be made"). See Appendix B.

[96] Colorado ("Any case in which a child tests positive . . . that [has] no legitimate medical use . . ., or a Schedule II controlled substance, including any potentially addictive substance . . . unless the child tests positive for a Schedule II controlled substance as a result of the mother's lawful intake of such substance")

[97] California ("a positive toxicology screen at the time of delivery of an infant is not in and of itself a sufficient basis for reporting child abuse or neglect.")

[98] Alabama Amendment 2; subject to USCON challenge.

Maryland struck an interesting balance in importing the federal mandates. There, state laws protect mothers while increasing the threat of punitive or intrusive measures. Maryland states "a newborn is 'substance-exposed' if: the newborn displays a positive toxicology screen", and the State requires an oral report as well as a written report to a local department.[99] However, reports are not required if the doctor verifies that the use of the controlled substance was "currently prescribed for the mother by a licensed health-care practitioner", or "the presence of the controlled substance was consistent with a prescribed medical or drug treatment administered to the mother or the newborn."[100] The code is also explicit "[a] report made under this section does not create a presumption that a child has been . . . abused or neglected."[101] Additionally, "the local Department of Social Services and the Department of Health and Mental Hygiene shall assist the mother of a child who is born drug-exposed in obtaining drug treatment and providing supportive services to maintain family unity."

While Maryland offered those legislative protections, the possibility of punitive actions against a mother are explicitly described, as well. A "Child in Need of Assistance [CINA] petition shall be filed if the mother refuses the recommended level of drug treatment, or does not successfully complete the recommended level of drug treatment."[102] A CINA "means a child who requires court intervention because: . . . (2) The child's parents . . . are unable or unwilling to give proper care and attention to the child and the child's needs."[103] Once a CINA petition has been filed, the CINA hearing allows the Juvenile Court to remove the child from the house.[104]

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[99] MD. CODE. ANN., FAM LAW §5-704.2(b)(1)(LexisNexis 2018).
[100] MD. CODE. ANN., FAM LAW §5-704.2(e)(2)(i)(LexisNexis 2018).
[101] MD. CODE. ANN., FAM LAW §5-704.2(i)(LexisNexis 2018).
[102] MD. CODE. ANN., FAM LAW §5-706.3(d)(LexisNexis 2017).
[103] MD. CODE. ANN., Cts and Jud Pro § 3-801(f)(2)(LexisNexis 2017).
[104] MD. CODE. ANN., Cts and Jud Pro § 3-819(f)LexisNexis 2016).

Maryland offers protections and treatment options beyond what is offered in other States; however, the possibility remains for reporting and punitive measures that can break apart the mother-child dyad.

As seen at the national level, the CARA mandate was passed down resulting in State laws that vary widely and approach the issue from markedly different perspectives. Virginia maintains a decentralized government that allows localities to write and enforce laws using different methods. Currently, the laws written to enforce CARA are being interpreted and implemented in an inconsistent manner across the Commonwealth. This opens the door for abuse and over-zealous prosecution that defies the intent of CAPTA and the Virginia Code. Indeed, jurisdictions in Virginia experienced prosecutions along these lines in the 1990's when women were prosecuted during the crackdown on the drug boom of that era.[105] The law within the Commonwealth should be uniform to protect the rights of Virginia's mothers and children.

PART TWO: CURRENT CHALLENGES FACED BY STAKEHOLDERS

I. Health Care Providers and Community Counsellors

The Code of Virginia should be amended to increase clarity for the doctors, social workers, CSB members, and law enforcement officers of the Commonwealth, not to decrease the autonomy of local governments. There are several levels of discretionary decision-making that affect pregnant mothers and families with infants. As the mother and the child make their way through the system, each layer of discretion presents the risk of an over-zealous or over-cautious bureaucrat determining the fate of the family. Well-intentioned individuals could place the whole family in an unnecessary assessment or investigation, while liability-averse stakeholders could

[105] LYNN M. PALTROW CRIMINAL PROSECUTIONS AGAINST PREGNANT WOMEN 37-38 (Reproductive Freedom Project April 1992), http://advocatesforpregnantwomen.org/file/1992%20State-by-State%20Case%20Summary.pdf.

overestimate the need to oversee these cases. In each jurisdiction the chance exists that the law will be applied unevenly or unfairly.

A doctor makes the initial determinations in a long string of decisions that could control the fate and the record of these families. The doctor who first treats a pregnant woman performs a toxicology screen. A positive screen "must be confidential and is not admissible in any criminal proceeding."[106] Next, "practitioners must advise their patients of" (1) the screening; (2) appropriate treatment; and (3) possible poor birth outcomes due to the substance abuse.[107] There is not codification requiring a referral to a treatment facility for a pregnant mother at the prenatal stage.

While the prenatal screen during pregnancy is confidential, the Child and Family Services Manual instructs LDSS that reports are required by healthcare providers when there is "reason to suspect that a mother exposed a newborn infant to controlled substances during the pregnancy."[108] The Manual also instructs that SEI includes both legal and illegal controlled substances, due to the change in VA law after implementing CARA.[109] As soon as the child is born, a report of child abuse or neglect is required if the child was born "affected by substance abuse or experiencing withdrawal symptoms."[110] The doctor's report in this situation is presumed to be valid.[111] The problem is that the subtle neurological difficulties resulting from

[106] VA. CODE ANN. §54.1-2403.1(2004).
[107] *Id.*
[108] VDSS, CHILD AND FAMILY SERVICES MANUAL, PART C. CPS, SECTION 10, SUBSTANCE-EXPOSED INFANTS, §10.3.1 (July 2017).
[109] *Id.*
[110] VA. CODE ANN. §§63.2-1509(A)(2017), 63.2-1509(B)(2017).
[111] VDSS, CHILD AND FAMILY SERVICES MANUAL, PART C. CPS, SECTION 10, SUBSTANCE-EXPOSED INFANTS, §10.5.5 (July 2017).

substance abuse while pregnant can be difficult to determine; Fetal Alcohol Spectrum Disorder (FASD) can also be difficult to determine.[112]

After the birth, doctors do not have discretion about determining if the substance exposure followed from a legitimate medical need under current Virginia law. They must report cases of SEI to CSB.[113] If doctors have determined that the mother is substance-abusing, a discharge plan must be written with input from the doctor, the family, and the woman.[114] This plan should include all appropriate referrals, follow-up appointments for the mother and the infant, and a referral to early intervention Part C of the Individuals with Disabilities Act.[115]

If a pregnant woman has tested positive for a substance that (1) indicates substance abuse; (2) may lead to withdrawal symptoms after birth; or (3) may lead to FASD, then a doctor is required by CAPTA to assist in forming a Plan of Safe Care. Upon discovery of an SEI, the doctor should also begin a Plan of Safe Care. At the point where an SEI is born, LDSS should become involved in the plan as well.[116] Doctors at the neonatal stage need more education about identifying and tracking infants born either exposed to or affected by substances. Currently, Virginia is putting in place guidelines for pediatricians to help direct their focus after a determination is made of substance exposure.[117] This will enable neonatal treatment that is effective and works within the desired scope of the plans of safe care.

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[112] VDSS, CHILD AND FAMILY SERVICES MANUAL, PART C. CPS, SECTION 10, SUBSTANCE-EXPOSED INFANTS (July 2017).
[113] VA. CODE ANN. §63.2-1509(A)(2017).
[114] VA. CODE ANN. §32.1-127(2018).
[115] VDSS, CHILD AND FAMILY SERVICES MANUAL, PART C. CPS, SECTION 10, SUBSTANCE-EXPOSED INFANTS, §10.3.2.2.1 (July 2017); P.L. 108-446.
[116] VDSS, CHILD AND FAMILY SERVICES MANUAL, PART C. CPS, SECTION 10, SUBSTANCE-EXPOSED INFANTS, §10.4.1 (July 2017).
[117] Interview with Doctor (Dec. 10, 2018).

The Plan of Safe Care directive in Virginia is based on the Groups A, B, and C mothers referenced above. As there are differing levels of danger and substance exposure, the A, B, and C women are offered different levels of intervention and supervision in these plans. Ideally, these plans are instituted at the prenatal stage.[118] Once a plan of safe care is in place, it is a collaborative effort between the family, the health care provider, the CSB, and CPS. VDSS stresses that these plans should be user tailored and respectful, but they remain invasive and burdensome on the mother-child dyad.[119] The plans must be finalized before discharge from the hospital, and they involve treatment, counselling, scheduling home visits, and financial planning among other requirements. The plans are drawn up with assistance from health care providers, but that assistance does not extend past the discharge from the hospital. While the plan of safe care is not punitive, it is a burden on the recipient.

There is a general suspicion that because of the stress and dangers that accompany a report from a doctor, pregnant women with substance use disorders are avoiding seeking prenatal care. The number of SEI receiving prenatal treatment could be as low as 25%.[120] The lack of prenatal care can exacerbate the damage from substance exposure that could have been assuaged in the prenatal services. In the typology of women described in this paper, categories A and B women can generally expect positive birth outcomes.[121] Only category C women run a serious risk of negative birth outcomes.[122] Including Groups A and B in the law flies in the face of legislative intent, and stakeholders from doctors to prosecutors agree that prenatal care is the most important facet of this problem.

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[118] VA. DEP'T OF SOC. SERV., PLAN OF SAFE CARE (POSC) TOOL KIT (NOV. 2017). The Tool Kit instructs doctors to refer women in these positions to care, but this is not legally enforceable.
[119] *Id.*
[120] Interview with Local OB/GYN (Nov. 20, 2018).
[121] *Id.*
[122] *Id.*

There are examples of women with substance use issues avoiding prenatal care.[123] That may be driven by fear of criminal liability, fear of separation, shame, or social stigma.[124] If women are avoiding prenatal services, how can the Commonwealth adapt its laws to mitigate over-punishment and enforce treatment outcomes for women who find themselves reported in any of the A, B, or C categories? After CARA was enforced, the goal was to affect outcomes where women and SEI suffering from substance use and exposure receive the healthcare assistance required.

II. Treatment Options under a Plan of Safe Care

Unfortunately, there are limited resources in Virginia that women in these situations can seize. Treatment centers are more readily available and covered by Medicare and Medicaid, but they are only temporary solutions.[125] Housing is a problematic issue, as affordable housing often puts a sufferer of Substance-Use Disorder in a location rife with triggers for their use.[126] In Albemarle County, the Women's Center at Moores Creek opened in 2018 and offers treatment and housing to women and children under five years old.[127] It is one of the few in the Commonwealth that offers integrated prenatal, recovery, and child care treatment. In order to complete the construction, Region 10, the Albemarle CSB, accepted an anonymous, $250,000 donation.[128]

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[123]Keith Epps, *Four Members of Spotsylvania Family Arrested after Birth of Drug-Addicted Baby*, THE FREELANCE STAR (OCT. 27, 2017). https://www.fredericksburg.com/news/crime_courts/four-members-of-spotsylvania-family-arrested-after-birth-of-drug/article_5c1da5df-35b0-5f6f-8ff9-c6b8e39a7dc3.html.

[124] Telephone Interview with Local Substance Abuse Specialist (Nov. 16, 2018).

[125] Telephone Interview with Local Drug Treatment Court Representative (Oct. 23, 2018).

[126] *Id.*

[127] *Id.*

[128]Karen Osterhaus, *Open House at Women's Center at Moores Creek*, REGION TEN NEWS (June 6, 2018), http://regionten.org/news/open-house-at-womens-center-at-moores-creek/.

The North Campus of Richmond Behavioral Health Authority (RBHA), the CSB for the city of Richmond, offers live-in treatment for women with substance-use disorders. It also can house women and young children. Besides these facilities that offer housing for families, treatment options for pregnant women are similarly few and far between in Virginia.[129] As district CSBs, RBHA and Region 10 have the responsibility for behavioral health, mental health, and substance use issues for the region, and they have to spread their resources among all the citizens in those affected communities. Additionally, the North Campus and the Women's Center are not geographically restrained, but their priorities are for people from their districts.[130] These are two of the most well-funded CSBs in the Commonwealth, and both have relied upon outside sources for funding to craft their support services for pregnant and postpartum mothers.[131]

CSBs are either buoyed or anchored by the locality they represent. While Charlottesville and Albemarle County may have a very effective and able CSB because of their wealthier tax base, District 19, which represents from Colonial Heights to Surry, VA, is one of the most overworked and underfunded.[132] More rural areas may have even less representation and opportunity because of the monetary situations.[133] Systems that are more equitable and effective at distributing resources will help women and babies across the Commonwealth get the services and treatment they need.

Virginia needs to look to other sources to offer consistent services among all jurisdictions. CSBs' funding is written into the local codes of each district.[134] State and federal

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[129] Telephone Interview with Local Substance Abuse Specialist (Nov. 15, 2018). There are four housing centers which can take pregnant women and three that can house women with children.
[130] *Id.*
[131] *Id.*
[132] Interview with Criminal Adjudication Specialist (Oct. 23, 2018).
[133] *Id.*
[134] Telephone Interview with Behavioral Health Specialist (Nov. 16, 2018).

funding filter down to the individual CSBs, but most of their budgets originate in the local governments. Unfortunately, state funding does not level the playing field.[135] So, in districts with smaller or less affluent populations, funding for services is lower.

RBHA worked to acquire federal grants under SAMHSA and PHSA to expand their campus, but those grants are competitive.[136] Underfunded CSBs may lack the manpower to write and edit long applications. However, as of October of 2018, the grants for treatment options for pregnant women will almost double.[137] Virginia must take a step forward and look to acquire federal money to extend treatment options and recovery programs across the Commonwealth.

In the meantime, one differential response CSBs can take is the Family Drug Treatment Court system (FDTC). FDTC takes the lesson of the Adult Drug Treatment Courts and applies them to families struggling with substance use disorder.[138] These Courts are 100% voluntary, but they provide intensive intervention and supervision of families to protect young children and help parents and guardians overcome their addictions. The goal is to offer permanency to the children and keep as many as possible out of the foster care system.

FDTC are the creatures of CSB; several have closed. Currently, there are only two in operation. In the traditional Adult Drug Treatment Court, when a woman is pregnant and tests positive, the only sanction some judges will allow is a revocation of the bond and locking the woman in jail until the baby is born.[139] Others agree, imprisonment is the best way to enforce sobriety.[140] However, while in prison, the woman is receiving no treatment for the underlying

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[135] *Id.*

[136] Telephone Interview with Local Substance Abuse Specialist (Nov. 16, 2018).

[137] SUPPORT for Patients and Communities Act, Pub. L. No. 115-27, § 7062, 132 Stat 3894, 4020 (2018).

[138] OFFICE OF THE EXEC. SEC'Y, SUPREME COURT OF VIRGINIA, 2017 ANNUAL REPORT: VIRGINIA DRUG TREATMENT COURTS (2017).

[139] Interview with Presiding Judge, Local Drug treatment Court (Oct. 21, 2018).

[140] Interview with Local Commonwealth's Attorney (Oct. 23, 2018).

substance use disorder. If the woman is unlucky enough to live in a jurisdiction without adequate recovery housing for a mother or a Drug Treatment Court that can meet the needs of the defendant and her family, she will face the traditional Court System and be stuck in the cycle of hearings, bonds, and jail.

PART THREE: SOLUTIONS, IMPLEMENTATION AND EVALUATION

I. Solutions: Statutory Amendments and Federal Funding

The "Little Fix" to the Reporting Statute

The first step should be to adopt the proposed amendment to § 63.2-1509(B). Advocates have proposed language that guarantees the use of substances during pregnancy cannot be the sole grounds for criminal liability for child abuse or neglect. This will protect women in Groups A and B from prosecution based on their medical treatment. It also removes a threat to women in Group C, which may remove an impediment to unborn children receiving prenatal services. While substance use while pregnant is not currently being treated as child abuse or neglect, it is foreseeable that prosecution could happen. In fact, some prosecutors have tried, only to be reluctantly rebuffed.[141]

Require Prenatal Referral to Treatment Services

Guaranteeing protection to these women has the potential to improve birth outcomes for all three categories of vulnerable women. The suggested statutory changes suggested also codify,

[141] *See* Brief of Commonwealth, *Evans*, No. CR 15-93 and CR 15-94 (Cir. Ct. of Shenandoah Cty. Dec. 1, 2016).

within the reporting statute, that the health care provider shall start the plan of safe care immediately. This change ensures that women are on the track to receive treatment at the same time that the newborn is receiving care in the hospital. These two, small statutory changes will cement protections for women in Groups A and B, and it will offer a more hopeful outcome from hospital care for the more vulnerable women in Group C. Without the fear of punitive measures, the Commonwealth could women in all three Groups receiving higher rates of prenatal care at a minimal cost.

Virginia should attempt to secure treatment for the mothers in Group C at the earliest possible time; a statutory requirement that doctors shall refer pregnant women who test positive for illicit substances to treatment could expand the benefits of prenatal testing to the mother as well as the fetus. A referral system could increase the number of women getting treatment prior to birth by offering the referrals in a non-punitive and shame-free environment. It could lead to a proliferation of Group C women seeking prenatal treatment, with long-term benefits and cost reductions for the Commonwealth. As it stands now, the law demands that doctors advise women of negative outcomes, but a more proactive law, requiring referrals at the prenatal stage, would connect women in need with treatment options.

There will be push back from doctors, hospitals, and their attorneys over this change. As compliance commitments increase, health care professionals may find themselves with an unwanted increase in responsibility and liability.[142] However, if treatment options expand, the issues that arise from problems with compliance would decrease as treatment becomes more available. Virginia is also working on educating Doctors at prenatal and neonatal stages so that

[142] Interview with Local OB/GYN (Nov. 20, 2018).

either exposure or affect is properly identified and tracked.[143] This enables doctors to communicate to the mother and the system the proper level of treatment and care needed. Making these changes in conjunction with each other would be most effective in ensuring that pregnant women and postpartum women get the treatment they need.

Taking Advantage of Expanded Federal Funding under CARA

Virginia must to focus on the resources that are available and utilizing those resources where they are most effective to combat this epidemic. CARA appropriated money to be used to support the treatment options for pregnant women.[144] The money available to support this goal increased this year.[145] Capturing those funds to expand the treatment options for pregnant women could help combat the generational effect of these issues. The most effective treatment is integrated, offering women prenatal services and addiction treatment concurrently. Currently there are limited residential options, but Virginia could seize on new opportunities to increase the number of women who could receive treatment from such centers.

In areas where treatment and prenatal services are offered through different organizations, the women fall through the cracks of the system.[146] In these areas, where integrated service centers are unavailable, pregnant women struggle to meet the demands of maintaining treatment for addiction and prenatal services. Treatment centers in Virginia that have taken advantage of federal funds offer some of the most comprehensive treatment options. RBHA is one such organization, and their example could be repeated across Virginia to expand options to all citizens.

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[143] Interview with Doctor (Dec. 10, 2018).

[144] 42 U.S.C. § 290bb–1 West, Current through Pub. L. 115-231).

[145] SUPPORT for Patients and Communities Act, Pub. L. No. 115-27, § 7062, 132 Stat 3894, 4020 (2018).

[146] Interview with Local OB/GYN (Nov. 20, 2018). Each different service provider requires signing up for a new service. None of these are automatic enrollment. Some programs have offered "navigators" to guide women through the process, but integrated treatment remains the most effective means of providing the multiple treatments needed.

CARA was expanded this year. The budget for the program that offers grants to public and nonprofit private entities to provide integrated housing options for women and children was expanded in October of this year.[147] The program was expanded from $17 million to $30 million starting in 2019, an increase of 77%.[148] The money for expanding treatment options is available at a federal level. At a state and local level, Virginia and the CSBs need to secure these funds to offer more effective treatment to women and families that are suffering from substance use disorders.

Performing a Code Audit of Relevant Laws and Regulations

While treatment options should be increased, the system should be simplified to increase the likelihood that women needing services receive them. As outlined in Part 1, Section III, numerous different statutes, regulations, and service manuals govern the process from prenatal services to reporting a child under § 63.2-1509(B). The language of these documents is used interchangeably, but it is never defined. Because they are undefined, they are interpreted inconsistently and applied irregularly. Health care providers use differing standards, ultimately defined by their own concerns, to determine if a report should occur. Once a report is made, front-line workers for CSB and LDSS make their own judgement calls about follow-ups.

An audit by the Code Commission could go through the many stages to clarify the steps that must be followed, define the ambiguous terms, and ensure that the law is enforced in a more uniform manner. Language should be changed to reflect current medical knowledge[149] and approach the problem from person-first perspectives.[150] Small changes across the sections that

[147] 42 U.S.C. § 290bb–1 West, Current through Pub. L. 115-231).
[148] SUPPORT for Patients and Communities Act, Pub. L. No. 115-27, § 7062, 132 Stat 3894, 4020 (2018).
[149] Interview with Local OB/GYN (Nov. 20, 2018). The most recent medical knowledge is reflected in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).
[150] Person-first language fits within the modern medical perspective of maintaining the humanity of a person with a disability, preventing the disease or disability from supplanting the need to focus on treatment for the affected.

govern this issue could increase positive birth outcomes and enable more people who need treatment to receive it.

Virginia also needs to address that addiction is a larger issue. While the federal focus is on opioid abuse now, some localities are seeing a reemergence of cocaine abuse.[151] Everywhere, alcohol abuse is still an issue. In the context of in utero exposure, FASD is the most dangerous and damaging problem for Virginia families.[152] Some problems remain chronic and require continuous treatment; there is no panacea against the struggle to treat and prevent drug use and abuse.

Any reform efforts must maintain focus on sustainable treatment. Drug policy goes through whack-a-mole cycles, and while the focus is on opioids in the current, national environment, other threats still exist. Family Drug Treatment Courts closed in the early 21st century due to economic issues in conjunction with a decreased focus on cocaine addiction. VCU has cycled through four separate outpatient treatment centers opening and closing. These changes will not solve the problems associated with substance use disorder, but the focus should continue as Virginia works to prevent the generational effect of drug abuse by pregnant mothers.

II. Implementation and Evaluation

The goal of these changes, taken together, is to protect women from over criminalization and their infants from negative birth outcomes due to lack of prenatal treatment. If women are per se protected from prosecution due to use of substances while pregnant, the pursuit of criminal liability against pregnant women and postpartum mothers should decrease. With a lowered threat, the incidence of women avoiding prenatal services out of fear should also decrease.

[151] Telephone Interview with Local Drug Treatment Court Representative (Oct. 23, 2018).
[152] Interview with Local OB/GYN (Nov. 20, 2018).

Currently, the numbers of endangered women seeking prenatal services are shockingly low. This intensifies the effect of their substance use and passes it down to the next generation.

To evaluate these changes, the Commonwealth should use the tracking data collected by doctors and LDSS to oversee the effectiveness of any changes. Clarification of the laws should increase the numbers of women taking advantage of the service that are available. There should be a corresponding increase in the referral of pregnant women for integrated treatment. Addiction services and prenatal treatment should rise for women across the suggested typology. Attempted prosecutions against these families should stop. This program can be administered and inspected at treatment centers across the Commonwealth. As their numbers increase due to the availability of funding, the ability to provide services and manage treatment should grow. They can work in close conjunction with Drug Treatment Courts to focus on care instead of punitive measures. Finally, any changes should be sustainable. Virginia must focus on long-term treatment options to provide care and services for citizens across the Commonwealth.

Sustainability is key; part of that effort involves keeping costs minimal. Amending statutes and acquiring federal funds to support them can be accomplished, but it will take a political commitment. Minimal political effort is needed to alter the reporting provision of the Code of Virginia, but any changes which add to the responsibilities of the Commonwealth's health care providers will be met with resistance. State sovereignty concerns may cause political pushback against accepting more federal grants. These issues have to be confronted, but the long-term benefits to Virginia's families demands that the future generations are protected now from falling through legislative cracks. The Virginia Code Commission (VACC) will play a part in that as well, and amending the multitude of statutes and regulations at play here fall within the VACC's purview and budget.

III. Conclusion

CAPTA intended to protect children from suffering long-term injury as a result of prenatal substance exposure; CARA amended CAPTA in an effort to close national gaps in addiction services offered for people struggling with use of legal substances. These federal mandates aimed to protect the citizens of the United States from suffering the dual indignities of systemic invasion of privacy on top of untreated substance use issues. In many States, implementation of these federal laws has worked in opposition to their intent. The Code of Virginia was written to reflect the federal goal, but Virginia must amend its statutes to guarantee that treatment and prevention remain the most important considerations, especially when dealing with pregnant mothers and families with newborn infants.

Statutory language changes will codify the intent of the Virginia General Assembly: prosecution of postpartum mothers is not the goal; planning for safe care of the mother and the infant is the priority. That will signal to doctors, social workers, and prosecutors the intent of the Commonwealth. Beyond signaling, Virginia needs to continue taking steps to procure federal funding to make shifts in the services that are available. While the federal focus remains on treatment of drug usage, Virginia needs to take advantage of the growing pool of resources offered for the provision of family-based services. As the resources for recovery services expand, pregnant women should be offered the same treatments, allowing for lower risk child development and a healthier future for the mother-infant dyad.

Changes to Virginia law need to focus on sustainable drug treatment. An audit of the existing Code to amend or eliminate obsolete and ambiguous language will simplify the law and convey to the stakeholders the intent of the General Assembly. This will ensure that misinterpretation of the Assembly's intent will not lead to the subversion of the values of the

Commonwealth: care for all children, treatment for community members, and equal opportunity across Virginia.

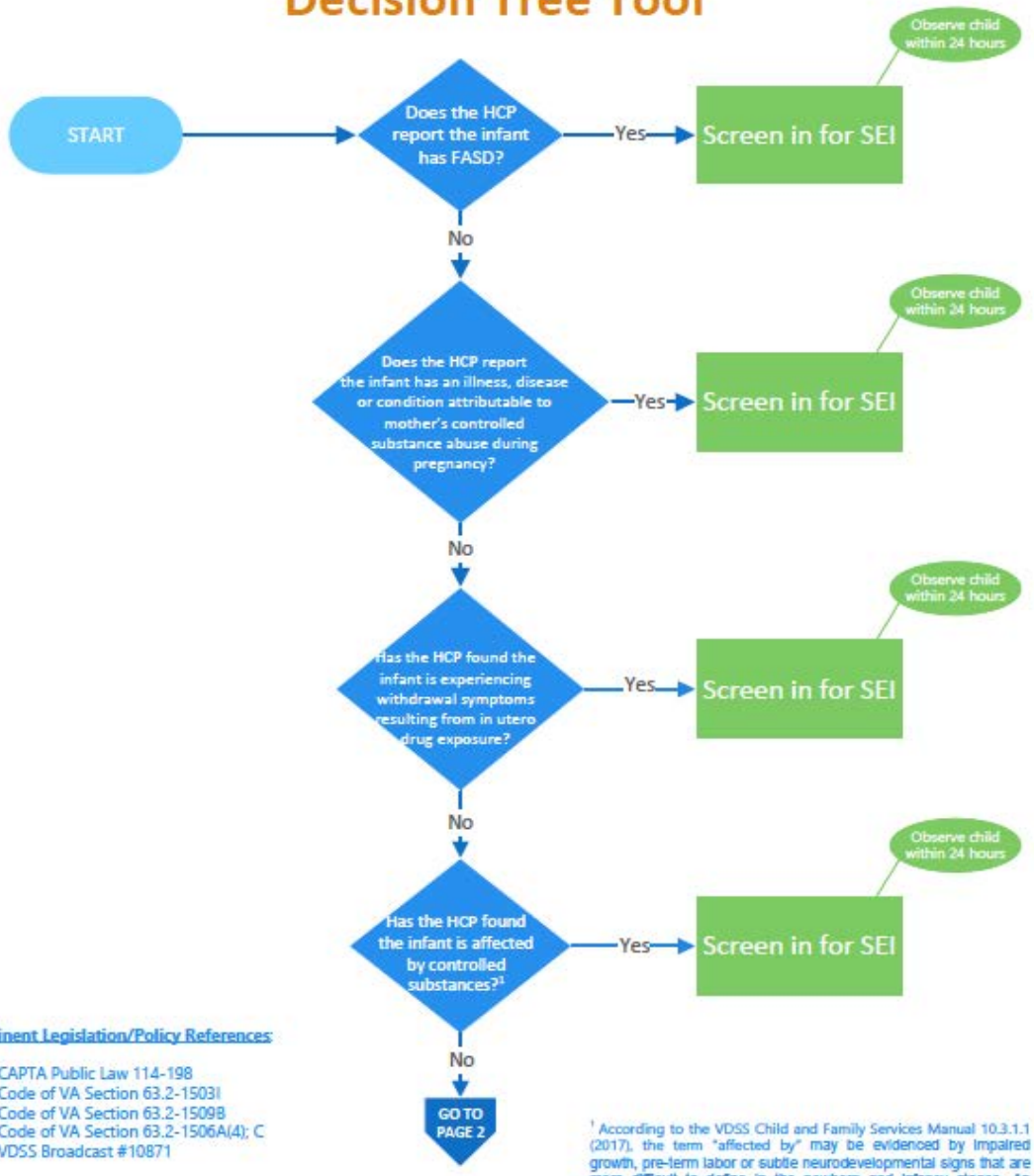
This project was made possible by the thoughtful contributions of the following individuals:

- Hon. David M. Barredo, *Presiding Judge, Charlottesville Albemarle Family Treatment Court Program*
- Gray Collins III, *Commonwealth's Attorney, City of Colonial Heights, VA*
- Joanna Jennings, *Coordinator, Charlottesville Albemarle Family Treatment Court Program*
- Valerie L'Herrou, *Staff Attorney, Center for Family Advocacy, Virginia Poverty Law Center*
- Dr. James May, *Director, Planning Development, Research, Evaluation & Substance Use Disorders Services, RBHA*
- Karen O'Brien, *Chief Operating Officer, CARITAS*
- Hon. Frederick G. Rockwell, III, *Presiding Judge, Chesterfield Adult Drug Treatment Court*
- E. Nicole Shipp, *CPS Policy Specialist, Division of Family Services, Virginia DSS*
- Mira Signer, *Chief Deputy Commissioner, Virginia DBHDS*
- Dr. Mishka Terplan, *OB/GYN, VCU Health*
- Stephanie Kollman Underwood, *Probation Officer, Virginia Department of Juvenile Justice*

Appendix A

SEI Decision-Tree Tool

Substance-Exposed Infants (SEI) Decision Tree Tool



Pertinent Legislation/Policy References:

- CAPTA Public Law 114-198
- Code of VA Section 63.2-1503I
- Code of VA Section 63.2-1509B
- Code of VA Section 63.2-1506A(4); C
- VDSS Broadcast #10871

Acronyms:
FASD: Fetal Alcohol Spectrum Disorder
HCP: Health Care Professional

Rev Date: 7/19/18

[1] According to the VDSS Child and Family Services Manual 10.3.1.1 (2017), the term "affected by" may be evidenced by impaired growth, pre-term labor or subtle neurodevelopmental signs that are more difficult to define in the newborn and infancy stages. An alcohol or other drug affected infant is one in which there is detectable physical, developmental, cognitive or emotional delay or actual harm that is associated with parental substance use. The LDSS should collect and document how the child is affected by parental substance abuse.

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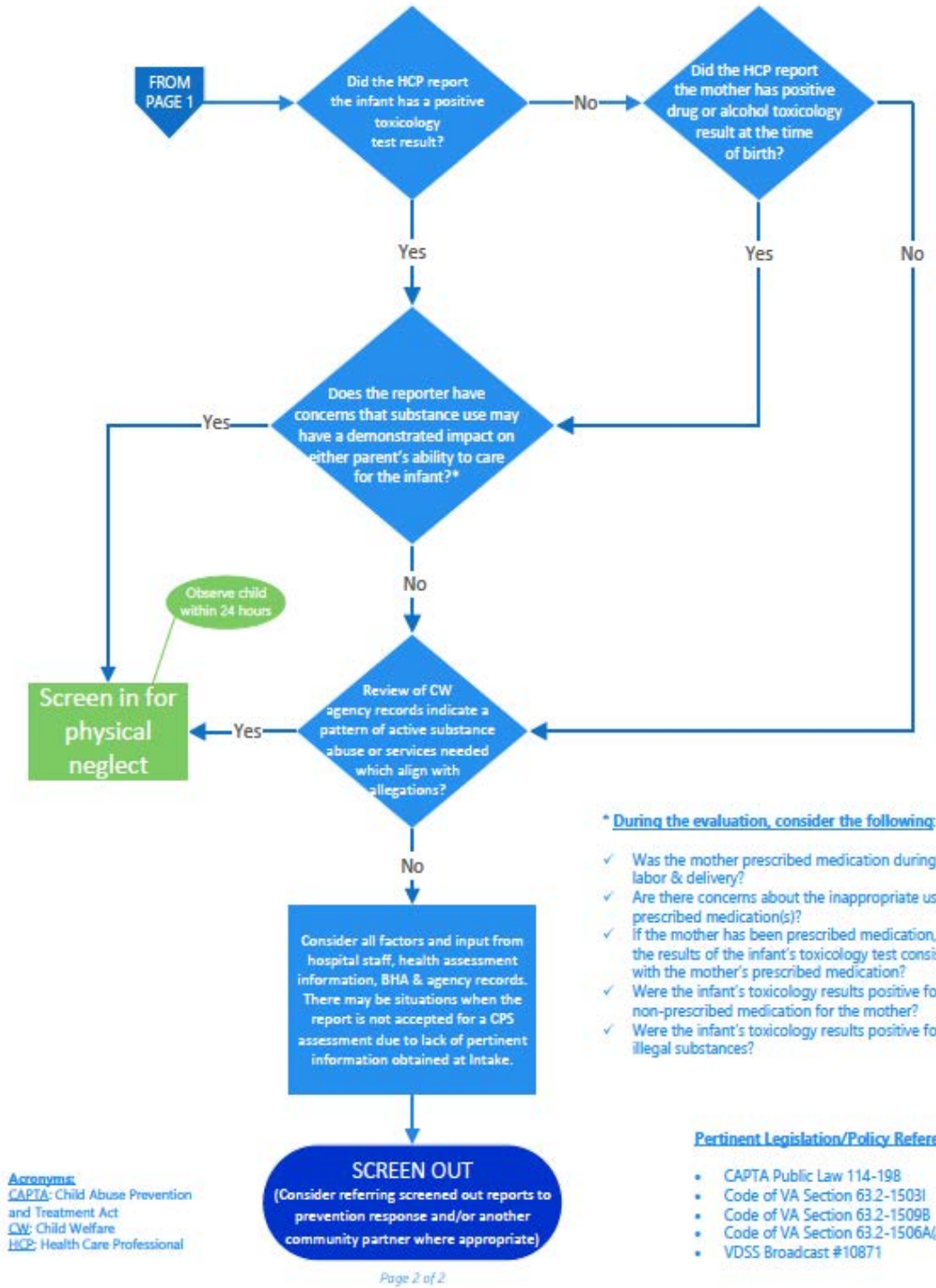
SEI Decision Tree Tool (Page 2)



*** During the evaluation, consider the following:**

- ✓ Was the mother prescribed medication during labor & delivery?
- ✓ Are there concerns about the inappropriate use of prescribed medication(s)?
- ✓ If the mother has been prescribed medication, are the results of the infant's toxicology test consistent with the mother's prescribed medication?
- ✓ Were the infant's toxicology results positive for a non-prescribed medication for the mother?
- ✓ Were the infant's toxicology results positive for illegal substances?

Acronyms:
CAPTA: Child Abuse Prevention and Treatment Act
CW: Child Welfare
HCP: Health Care Professional

Pertinent Legislation/Policy References:

- CAPTA Public Law 114-198
- Code of VA Section 63.2-1503I
- Code of VA Section 63.2-1509B
- Code of VA Section 63.2-1506A(4); C
- VDSS Broadcast #10871

Appendix B

50 State Survey of Child Abuse and Neglect Laws[153]

States that have specific reporting procedures for SEI	States that demand reporting of all SEI	States without specific statutes addressing SEI	States that offer per se protection against charges of child abuse or neglect
Alaska, Arizona, Arkansas, California, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, Oklahoma, Pennsylvania, South Carolina, Utah, Virginia, Washington, West Virginia, Wisconsin	Alaska, Arizona, Indiana, Maine, Mississippi, Montana, Nevada, Oklahoma, Utah	Connecticut, Delaware, Georgia, Hawaii, Idaho, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Rhode Island, Tennessee, Texas, Vermont, Wyoming	California, Hawaii, Iowa, Maine,

[153] CHILD WELFARE INFORMATION GATEWAY: STATE STATUTES SEARCH, https://www.childwelfare.gov/topics/systemwide/laws-policies/state/?CWIGFunctionsaction=statestatutes:main&CWIGFunctionspk=6 (last visited Dec. 5, 2018).

States that allow a positive toxicology screen to be the sole basis for reporting	States that do not allow a positive toxicology screen to be the sole basis for reporting	States that demand or allow pregnant women be reported or referred	States that offer services for the mother of SEI
Arizona, Arkansas, Indiana, Louisiana, Minnesota, Mississippi, Missouri, Oklahoma, South Carolina	Colorado, District of Columbia, Iowa, Kansas, Kentucky,	Illinois, Minnesota, Wisconsin	Maryland, Missouri,

States that allow HCP leeway in making a determination	States that allow prenatal exposure to rise to child abuse	States that allow prenatal exposure to rise to child neglect
Alaska, Arizona, Iowa, Maine, Maryland, Michigan	Colorado, Florida, Kentucky, Massachusetts, South Carolina, South Dakota	District of Columbia, Illinois, Louisiana, Minnesota, North Dakota