Resources

1. Virginia Department of Social Services, Child and Family Services Manual, C. Child Protective Services, July 2017
   https://www.dss.virginia.gov/files/division/dfs/cps/intro_page/manuals/07-2017/section_10_substance_exposed_infants.pdf
2. Federal Administration for Children and Families program instructions to states: https://www.acf.hhs.gov/sites/default/files/cb/pi1702.pdf

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SUBSTANCE-EXPOSED INFANTS

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SUBSTANCE-EXPOSED INFANTS

10.1 Introduction

The Code of Virginia § 63.2-1509 B requires the local department of social services (LDSS) to accept as valid a report that a newborn infant may have been exposed to controlled substances prior to birth. This part of the CPS guidance chapter explains how the Code of Virginia impacts:

- Mandated reporting of substance-exposed infants (SEI) and the validity decision.
- CPS family assessments and investigations.
- Services to the families of SEI.
- Possible court actions.

In utero substance exposure can cause or contribute to premature birth, low birth weight, increased risk of infant mortality, neurobehavioral and developmental complications. Post-natal environmental factors associated with maternal substance use such as poverty, neglect and unstable or stressful home environments present additional risks for these children.

Interventions to reduce adverse outcomes and promote healthy home environments are critical to the well-being of SEI and their families.

Additional information on SEI and maternal substance use can be found by accessing:

- CWSE5501: Substance Abuse. This on-line course has four (4) modules and is available in the Virginia Learning Center (VLC).
- National Center on Substance Abuse and Child Welfare, including an online tutorial, “Understanding Substance Use Disorders, Treatment, and Family Recovery: A Guide for Child Welfare Professionals.”
- Children and Family Futures. This agency provides a library of various recorded webinars conducted in 2015 regarding SEI and child welfare.

- Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation.

- Virginia Department of Behavioral Health and Developmental Services (DBHDS) provides resources for pregnant and parenting women and their families.

10.2 SEI Definitions

The following definitions pertain to substance use disorders and SEI referrals:

Term	Definition
Assessment-(Substance Use)	Assessment refers to an in-depth look at an individual's past and current substance use and the impact of that use on the overall functioning of that individual. Assessment is a process for defining the nature of that problem, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis.
Dual diagnosis	Dual diagnosis refers to co-occurring Mental Health and Substance Use disorders (alcohol and/or drug dependence or abuse).
Fetal Alcohol Spectrum Disorder (FASD)	Fetal alcohol spectrum disorders (FASD) is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include physical, mental, behavioral, or learning disabilities with possible lifelong implications. See Appendix A for more information.
Neonatal Abstinence Syndrome (NAS)	Neonatal abstinence syndrome (NAS) is a group of problems that occur in a newborn as a result of sudden discontinuation of addictive opioids, licit or illicit, to which the newborn was exposed while in the mother's womb. See Appendix B for more information.
Opioid Treatment Program (OTP)	An Opioid Treatment Program (OTP) provides medication assisted treatment for the treatment of opioid addiction. OTPs may also provide comprehensive, individually tailored programs that can include: • Medication therapy • Psychosocial and medical treatment • Support services that address factors affecting the

client.

Screening	A screening is a brief preliminary interview with an individual intended to determine if that individual may be at risk to have problems in a certain area such as substance abuse. Screening does not identify substance abuse or dependency nor does it provide a substance use disorder diagnosis. It is a quick way to determine if someone needs to be referred for further assessment.
Screening tools	Screening tools have been developed to help identify individuals at risk for various disorders or problems such as substance use disorders or domestic violence. See Appendix C for two screening tools used to help identify substance abuse.
Substance abuse counseling or treatment services	These are professional services provided to individuals for the prevention, diagnosis, or treatment of chemical dependency. Substance abuse counseling or treatment should include education about the impact of alcohol and other drugs on the fetus and on the maternal relationship; and education about relapse prevention to recognize personal and environmental cues which may trigger a return to the use of alcohol or other drugs. The substance abuse counseling or treatment services must be provided by a professional (e.g., a "certified substance abuse counselor" or a "licensed substance abuse treatment practitioner").

10.3 Mandated reporting of SEI

The Code of Virginia and the Virginia Administrative Code (VAC) provide for the mandated reporting of SEI. *Effective July 1, 2017, § 63.2-1509 B of the Code of Virginia was significantly revised and supersedes the VAC, 22VAC40-705-40 A5.*

> *(§ 63.2-1509 B of the Code of Virginia) 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 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 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 facts relied upon by the person making the report.*

10.3.1 Health care providers required to report SEI

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.

Health care providers identify SEI typically by use of clinical indicators that include, but are not limited to, maternal and infant presentation at birth, substance use and medical histories or toxicology results.

The Code of Virginia specifically delineates *three (3)* circumstances which constitute a reason to suspect that a newborn infant was exposed to a controlled substance during pregnancy and therefore requires a report to CPS by health care providers.

Effective July 1, 2017, the circumstance regarding positive toxicology studies of the child was deleted from § 63.2-1509 B of the Code of Virginia. Additionally, as a result of federal legislation, SEI includes both legal and illegal controlled substance exposure.

10.3.1.1 First circumstance

> *(§ 63.2-1509 B of the Code of Virginia) (i) a finding made by a health care provider within six weeks of birth of a child that the child was born affected by substance abuse or experiencing withdrawal symptoms resulting from in utero drug exposure;*

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. Affected by substance abuse 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.

This circumstance also includes when a child has withdrawal symptoms due to dependency to a drug while in utero. This includes dependency on controlled substances prescribed for the mother by a physician or an opioid treatment program (OTP).

In utero exposure to certain drugs can cause neonatal withdrawal after birth when the drug is abruptly stopped because the infant, like the mother, has

developed physical dependence on the drug. Clinically relevant neonatal withdrawal most commonly results from in utero opioid exposure but has also been described in infants exposed to benzodiazepines, barbiturates, and alcohol. Neonatal Abstinence Syndrome (NAS) is a group of problems that occur in a newborn as a result of sudden discontinuation of addictive opioids, licit or illicit, to which the newborn was exposed while in the mother's womb. Additional information regarding NAS can be found in Appendix B.

10.3.1.2 *Second* circumstance

> *(§ 63.2-1509 B of the Code of Virginia) (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 abuse of a controlled substance during pregnancy;*

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.

10.3.1.3 *Third* circumstance

> *(§ 63.2-1509 B of the Code of Virginia) (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.*

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. See Appendix A of this section for additional information regarding FASD.

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 above, 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)

10.3.2.2 Report to the Community Services Board

The Code of Virginia § 32.1-127 B6 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.

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.

10.3.3 Multidisciplinary teams

In SEI cases, working collaboratively with a CSB and other health care professionals requires a coordinated approach. It is recommended that the LDSS establish a memorandum of understanding or a multi-disciplinary team to facilitate communication and collaboration between all involved agencies. See Section 1.6 in Section 1, Introduction to CPS of this guidance manual for more information and guidance regarding multi-disciplinary teams.

10.4 Plans of Safe Care

Section 106(b)(2)(B)(iii) of the Child Abuse Prevention and Treatment Act (CAPTA) requires "the development of a plan of safe care for the infant born and identified as being affected by substance abuse or withdrawal symptoms or Fetal Alcohol Spectrum Disorder." The Plan of Safe Care should address the needs of the child as well as those of the parent, as appropriate, and assure that appropriate services are provided to ensure the infant's safety.

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 the LDSS becomes involved in a SEI referral, the LDSS becomes a part of this Plan of Safe Care. The LDSS is one of many agencies that can provide a Plan of Safe Care for the SEI and the mother.

The following chart identifies three general populations of pregnant and post-partum women and who would typically create or take the lead in monitoring a Plan of Safe Care.

Populations of pregnant and post-partum women	***Potential lead agency/provider for the Plan of Safe Care***	
	Voluntary Participation During Prenatal Period	***Identified at Birth and Infant is Determined to be Affected***
*1. Using legal or 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 care provider in concert with pain specialist or other physician*	*Maternal and Child Health service providers (e.g. home visiting provider, Healthy Families); LDSS or community prevention services*

		provider
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 care provider in concert with OTP or other therapeutic substance use disorder treatment provider/CSB.*	*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 care provider or high-risk pregnancy clinic in concert with substance use disorder treatment agency/CSB*	*Child Welfare*

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.

A sample template for a Plan of Safe Care is located in Appendix D.

10.5 CPS response to SEI referrals

A report with facts indicating the presence of one of the *three (3)* circumstances outlined in the Code of Virginia § 63.2-1509 B prior to birth are sufficient, in and of themselves, to suspect that the child is abused or neglected and therefore constitutes a valid report requiring a CPS response.

Substance use, either during pregnancy or after the birth of an infant, does not in or of itself constitute a preponderance of evidence needed to substantiate abuse or neglect. *Although* caretakers may *be* able to care for the child, the use or abuse of drugs by caretakers increases the concern for the child's immediate safety and for future risk of harm to the child. When identified, a careful evaluation needs to be made of the impact that the substance use has on the caretaker's capacity to care for the child and the

ability to ensure the child's safety and well-being. Such an evaluation will determine whether the child is at substantial risk of harm.

10.5.1 *Track Decision*

Once a report has been made and determined to be valid, the LDSS must determine the response time and track. *Effective July 1, 2017,the Code of Virginia, § 63.2-1506, requires all* valid referrals involving SEI *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.* Because exposure to controlled substances prior to birth is not sufficient evidence for a founded disposition of abuse or neglect in an investigation, a family assessment that assesses safety, risk and service needs of the child and family and does not determine if abuse or neglect has occurred, *is usually* a more appropriate response.

10.5.1.1 *Investigation requirements*

According to § 63.2-1506 C of the Code of Virginia, an investigation is required in the following circumstances:

- *All sexual abuse allegations;*
- *Any child fatality;*
- *Abuse or neglect resulting in serious injury as defined in § 18.2-371.1 also consider medical neglect of disabled infant with life threatening condition (Baby Doe)];*
- *Child taken into agency custody due to abuse or neglect pursuant to § 63.2-1517 ;*
- *Child taken into protective custody by physician or law enforcement, pursuant to § 63.2-1517; or*
- *All allegations regarding a caretaker in an out of family setting as defined in § 63.2-1506 C.*

Important reminder: if the child is removed, *and the referral was responded to with a family assessment,* the track must be changed to an investigation. The LDSS must document in the automated data system at least one of the conditions for removal as "substance-exposed infant".

10.5.2 Initial *safety* assessment

(*22 VAC 40-705-40 A 6 b*). When a *valid* report or complaint alleging abuse or neglect is made pursuant to § 63.2-1509 B of the Code of Virginia, then the local department must

> immediately assess the *child's* circumstances and any threat to the *child's* health and safety. Pursuant to 22VAC40-705-110 A, the local department must conduct an initial *safety* assessment.
>
> (*22 VAC 40-705-40 A 6 c*). When a *valid* report or complaint alleging abuse or neglect is made pursuant to § 63.2-1509 B of the Code of Virginia, then the local department must immediately determine whether to petition a juvenile and domestic relations district court for any necessary services or court orders needed to ensure the safety and health of the infant.

The LDSS must complete an initial safety assessment of the SEI and family. All reports involving a SEI will require a safety plan be developed because of the safety concerns regarding these infants. *A safety plan is NOT the same as a Plan of Safe Care discussed in Section 10.4, 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.*

When assessing safety factors, it is critical to review the definitions for each safety factor. There are several safety factors that involve substance use and a SEI. The following safety factors will likely pertain to a SEI referral:

- Safety factor 1. Caretaker caused serious physical harm to the child and/or made a plausible threat to cause physical harm in the current investigation/assessment. May select h. *Substance*-exposed infant. Drugs are found in the child's system; infant is medically fragile as result of drug exposure; infant suffers adverse effects from introduction of drugs during pregnancy; or mother tested positive at delivery.

- Safety factor 10.Caretaker's substance use is currently and seriously affecting his/her ability to supervise, protect, or care for child. Caretaker is abusing legal or illegal substances or alcoholic beverages to the extent that control of his or her actions is significantly impaired. May select b. There is a current, ongoing pattern of substance abuse that leads directly to neglect and/or abuse of the child.

10.5.2.1 Substance use screening

An essential part of the initial safety assessment is to complete a brief substance use screening to determine if a substance abuse assessment is needed and if so, what services would best meet the needs of the mother. 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.

Two (2) of several universal substance use screening tools used with pregnant and child bearing women (the 4 Ps and 5 Ps) can be found in Appendix C. This screening and safety assessment may lead to consideration of court action or the need to conduct a Family Partnership Meeting (FPM) or both. Additional information regarding screening of pregnant and postpartum women can be found on the DBDHS website.

Initial contacts in SEI cases should include not only the mother and any other parent but also the family's support system. Collateral contacts can confirm or refute information provided by the mother.

10.5.3 Information to gather when responding to SEI referrals

In addition to conditions in the infant, conditions or behaviors in the mother that may indicate risk of harm should be assessed. These include, but are not limited to:

- special medical and/or physical problems in the infant;
- close medical monitoring and/or special equipment or medications needed by the infant;
- no prenatal care or inconsistent prenatal care;
- previous delivery of a SEI;
- prior CPS history;
- prior removal of other children by the courts or voluntary placement with relatives;
- no preparations for the care of the infant;
- intellectual limitations that may impair the mother's ability to nurture or physically care for the child;

- psychiatric illness;
- home environment that presents safety or health hazards;
- evidence of financial instability that affects the mother's ability to nurture or physically care for the infant;
- limited or no family support;
- young age of parent(s), coupled with immaturity;
- parenting skills demonstrated in the health care setting that suggest a lack of responsiveness to the SEI's needs (i.e., little or no response to infant's crying, poor eye contact, resistance to or difficulties in providing care);
- domestic violence.

10.5.4 *No* exception to completing the investigation or family assessment

Effective July 1, 2017, there is no longer an exception for an LDSS to respond to valid reports of SEI. When conducting the family assessment, the LDSS shall determine whether the mother sought substance abuse counseling or treatment prior to the child's birth. This information must be documented in the automated data system.

10.5.5 Complete the family assessment or investigation

> (*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 *in an investigation*.

Family assessments or investigations involving a SEI shall be conducted in accordance with Section 4, Family Assessment and Investigation of this guidance manual.

10.5.5.1 Collateral contacts in SEI referrals

Due to the vulnerability of the SEI, collateral involvement to determine risk and possible services is crucial, and may include contacts with the immediate or extended family, birthing hospital, pediatrician, and substance use disorder evaluation and treatment providers. When appropriate, the LDSS should coordinate services with the CSB.

At the minimum, contact should be made with health care providers, particularly those at the birthing hospital in order to obtain a copy of the discharge plan and gather information:

- *to identify how the infant was affected by in utero substance exposure, which may include results of laboratory tests or toxicology studies done on the infant;*
- to identify any needed medical treatment for the child or mother;
- to assess the mother's attitude and behavior with the infant;
- to determine the expected discharge dates of the mother and infant; and
- to determine whether there are other children in the home at risk.

Contact with the substance use disorder treatment provider *or OTP* can provide information on the mother's:

- *Plan of Safe Care that was developed while she was pregnant;*
- attempts to access treatment;
- compliance with recommendations;
- toxicology results, if applicable;
- assessment results, if applicable; and
- medication assisted treatment dosage and compliance.

10.5.5.2 Dispositions in SEI investigations

For investigations, facts establishing that the infant was exposed to controlled substances prior to birth are not sufficient to render a founded disposition of abuse or neglect. 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.

10.5.5.3 Assessing risk in SEI referrals

The Family Risk Assessment tool is used to assess future likelihood of child maltreatment in all referrals, including a SEI.

When assessing risk, it is critical to review the definitions for each factor. There are several risk factor definitions that specifically address the SEI and their caretakers. The following risk factors will likely pertain to a SEI referral:

- N1: Current complaint is for physical or medical neglect. (Score 2 if the current allegation is for a substance-exposed infant.)

- N9: Primary caretaker has/had a drug or alcohol problem. (Score 2 if the child was diagnosed with fetal alcohol syndrome or exposure or child had a positive toxicology screen at birth and the primary caretaker was the birthing parent.)

- N11: Characteristics of children in household. (Score 1 if a child has a positive toxicology report for alcohol or another drug at birth.)

Assessed risk will be:

- **Low**. The assessment of risk related factors indicates that there is a low likelihood of future abuse or neglect and no further intervention is needed.

- **Moderate**. The assessment of risk related factors indicates that there is a moderate likelihood of future abuse or neglect and minimal intervention may be needed.

- **High**. The assessment of risk related factors indicates there is a high likelihood of future abuse or neglect without intervention.

- **Very High**. The assessment of risk-related factors indicates there is a very high likelihood of future abuse or neglect without intervention.

Overrides, either by policy or discretionary, may increase risk one level and require supervisor approval. The initial CPS risk level may never be decreased.

10.5.5.4 Risk level guides decision to open a case

Important reminder: when risk is clearly defined and objectively quantified, resources are targeted to higher-risk families because of the greater potential to reduce subsequent maltreatment. The risk level helps inform the decision whether or not to open a case as follows:

Low Risk:	Close
Moderate Risk:	Open to CPS or close
High Risk:	**Open to CPS**
Very High Risk:	**Open to CPS**

The CPS worker and CPS supervisor should assess the decision to open a case for services and document in the automated data system when the decision is to not open a case.

10.5.6 Referral to early intervention programs for children

Regardless if a CPS on-going case is opened for services, the LDSS shall refer any child under the age of three (3) for early prevention services to the local Infant and Toddler Connection of Virginia who:

- Is identified as affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure;
- Is the subject of an investigation with a founded disposition; or
- Has a physical or mental condition that has a high probability of resulting in developmental delay, regardless of track or disposition.

All localities are served by an Infant & Toddler Connection of Virginia program. This referral is required by the Child Abuse Prevention and Treatment Act (CAPTA).

LDSS are encouraged to meet with the local Infant and Toddler program to learn about any referral issues that should be explained to the parent. LDSS are also encouraged to develop procedures with the Infant & Toddler Connection of Virginia program to make referrals of certain children under age three (3). Recommended elements of these procedures should include:

- As soon as possible but no later than **seven (7) calendar days** of completing the investigation or family assessment the LDSS should send a referral to the local Part C Early Intervention program using the local referral form.

The LDSS should:

- Send a referral as soon as possible when a child has been identified as exposed prenatally to an illegal substance or has withdrawal symptoms at birth.
- Send a copy of the referral to the family. The parent should also be informed verbally of the referral and have an opportunity to discuss the referral process.
- Request the family to sign a release form allowing the exchange of information between the Infant-Toddler Connection Program and the LDSS regarding the referral.
- Document the notification and referral in the state automated data system.

More information on the Infant & Toddler programs in Virginia can be found on the Infant & Toddler Connection of Virginia website and on the VDSS internal website in the Memorandum of Agreement dated May 2013 issued by the Commissioners of

the Department of Social Services and Department of Behavioral Health and Developmental Services and other agencies involved with implementation of Part C of the Individuals with Disabilities Education Act (IDEA).

10.6 CPS on-going services to families with SEI

Services for mothers with substance use disorders and their families may be different than services for other populations. A thorough assessment done by a certified substance abuse counselor will typically be the first step in providing services for SEI referrals. Assessment refers to an in-depth look at an individual's past and current substance use and the impact of that use on the overall functioning of that individual. Assessment is a process for defining the nature of that problem, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis.

10.6.1 Substance abuse services considerations

Special consideration should be given to the following:

- Is outpatient treatment needed and available?
- Is in-patient treatment required and available?
- Is detoxification required?
- Does the individual need a program for dual diagnosed patients?
- Does the individual need assistance in negotiating leave with an employer?
- Does the individual require a program that specializes in a particular addiction?
- Are family members willing to participate in treatment or education?
- Is peer support available through Alcoholics Anonymous (AA), Narcotics Anonymous (NA) or a psychotherapy group?
- Does the treatment facility address the special needs of women and their children?

10.6.2 Other services

In addition to substance abuse services, other services may include but are not limited to:

- Child care.

- Relapse prevention.
- Parenting education.
- Job skills training/employment.
- Mental health assistance.
- Safe housing.
- Support systems.

Home visiting services match parents and caregivers with trained paraprofessionals who can provide information and support during pregnancy and throughout the child's earliest years. Home visiting programs support healthy prenatal behaviors and parenting attitudes, engage infants in meaningful learning activities build positive parent-child relationships and promote family self-sufficiency. Project Link is one home visiting program offered in Virginia and is specifically for pregnant and parenting substance-using women. For additional information about Project Link and other home visiting programs, such as Healthy Families, go to the Early Impact website.

10.7 Petition the court on behalf of a SEI

When conducting a family assessment or investigation, the Code of Virginia § 16.1-241.3 also permits the LDSS to petition the juvenile and domestic relations district court solely because an infant has been exposed to controlled substances prior to his or her birth.

> (§ 16.1-241.3 of the Code of Virginia). Newborn children; substance abuse.
>
> Upon the filing of a petition alleging that an investigation has been commenced in response to a report of suspected abuse or neglect of the child based upon a factor specified in subsection B of § 63.2-1509, the court may enter any order authorized pursuant to this chapter which the court deems necessary to protect the health and welfare of the child pending final disposition of the investigation pursuant to Chapter 15 (§ 63.2-1500 et seq.) of Title 63.2 or other proceedings brought pursuant to this chapter. Such orders may include, but shall not be limited to, an emergency removal order pursuant to § 16.1-251, a preliminary protective order pursuant to § 16.1-253 or an order authorized pursuant to subdivisions 1 through 4 of subsection A of § 16.1-278.2. The fact that an order was entered pursuant to this section shall not be admissible as evidence in any criminal, civil or administrative proceeding other than a proceeding to enforce the order.

The order shall be effective for a limited duration not to exceed the period of time necessary to conclude the investigation and any proceedings initiated pursuant to Chapter 15 (§ 63.2-1500 et seq.) **of Title 63.2, but shall be a final order subject to appeal.**

10.7.1 LDSS may petition juvenile and domestic relations district court

The LDSS should consult with their attorneys when considering petitioning for protective and removal orders as described in Section 8, Judicial Proceedings, of this guidance manual.

The LDSS may petition a juvenile and domestic relation district court for any necessary services or court orders needed to ensure the safety and health of the infant.

10.7.1.1 Petition must allege SEI

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 report of suspected abuse or neglect of the child based upon a factor specified in § 63.2-1509 B of the Code of Virginia.

10.7.2 The court's authority to issue orders

The court may enter any order authorized pursuant to § 16.1-226 et seq. which the court deems necessary to protect the health and welfare of the child. The court may issue such orders as an emergency removal order pursuant to § 16.1-251, a preliminary protective order pursuant to § 16.1-253 or an order authorized pursuant to § 16.1-278.2 A.

For example, such authority would allow the court to remove the child from the custody of the mother pending completion of the investigation or family assessment or compel the mother to seek treatment or other needed services. Code of Virginia § 16.1-241.3 enhances the court's ability to act quickly in a potential crisis situation. In addition, the court will have the ability to use its authority to ensure that the mother of the child seeks treatment or counseling**.**

10.7.3 Any court order effective until investigation or family assessment is concluded

Any court order issued pursuant to § 16.1-241.3 is effective pending final disposition of the investigation or family assessment pursuant to § 63.2-1500 et seq. The order is effective for a limited duration not to exceed the period of time necessary to conclude the investigation or family assessment and any proceedings initiated pursuant to § 63.2-1500 et seq.

Any order issued pursuant to § 16.1-241.3 is considered a final order and subject to appeal. The fact that an order was entered pursuant to § 16.1-241.3 is not admissible as evidence in any criminal, civil or administrative proceeding other than a proceeding to enforce the order.

10.8 Appendix A: Fetal Alcohol Spectrum Disorder (FASD)

10.8.1 Definition of FASD

Experts now know that the effects of prenatal alcohol exposure extend beyond Fetal Alcohol Syndrome (FAS).

"Fetal alcohol spectrum disorders" (FASD) is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications. FASD is not a diagnostic term used by clinicians. It refers to conditions such as:

- FAS, including partial FAS
- Fetal alcohol effects (FAE)
- Alcohol-related neurodevelopmental disorder
- Alcohol-related birth defects

10.8.2 Fetal Alcohol Syndrome (FAS)

FAS consists of a pattern of neurologic, behavioral, and cognitive deficits that can interfere with growth, learning, and socialization. FAS has four (4) major components:

- A characteristic pattern of facial abnormalities (small eye openings, indistinct or flat philtrum, thin upper lip)
- Growth deficiencies, such as low birth weight
- Brain damage, such as small skull at birth, structural defects, and neurologic signs, including impaired fine motor skills, poor eye-hand coordination, and tremors
- Maternal alcohol use during pregnancy

Behavioral or cognitive problems may include mental retardation, learning disabilities, attention deficits, hyperactivity, poor impulse control, and social, language, and memory deficits.

Partial FAS describes persons with confirmed alcohol exposure, facial anomalies, and one other group of symptoms (growth retardation, central nervous system defects, or cognitive deficits).

10.8.3 Fetal alcohol effects (FAE)

FAE describes children with prenatal alcohol exposure who do not have all the symptoms of FAS. Many have growth deficiencies, behavior problems, cognitive deficits, and other symptoms. However, they do not have the facial features of FAS. Although the term FAE is still used, the Institute of Medicine has coined more specific terms. These include alcohol-related neurodevelopmental disorder and alcohol-related birth defects.

10.8.4 Alcohol- related neurodevelopmental disorder (ARND)

ARND refers to various neurologic abnormalities, such as problems with communication skills, memory, learning ability, visual and spatial skills, intelligence, and motor skills. Children with ARND have central nervous system deficits but not all the physical features of FAS. Their problems may include sleep disturbances, attention deficits, poor visual focus, increased activity, delayed speech, and learning disabilities.

10.8.5 Alcohol- related birth defects (ARBD)

ARBD describe defects in the skeletal and major organ systems. Virtually every defect has been described in some patient with FAS. They may include abnormalities of the heart, eyes, ears, kidneys, and skeleton, such as holes in the heart, underdeveloped kidneys, and fused bones.

10.8.6 Cause of FASD

The only cause of FASD is alcohol use during pregnancy. When a pregnant woman drinks, the alcohol crosses the placenta into the fetal blood system. Thus, alcohol reaches the fetus, its developing tissues, and organs. This is how brain damage occurs, which can lead to mental retardation, social and emotional problems, learning disabilities, and other challenges. No alcohol consumption is safe during pregnancy. In addition, the type of alcohol (beer, wine, hard liquor, wine cooler, etc.) does not appear to make a difference.

10.8.7 Prevalence of FASD

FASD occurs in about 10 per 1,000 live births or about 40,000 babies per year. FAS, the most recognized condition in the spectrum, are estimated to occur in 0.5 to 2 per 1,000 live births. It now outranks Down syndrome and autism in prevalence.

10.8.8 Assessment of FASD

It is extremely difficult to diagnose a FASD. A team of professionals is needed, including a physician, psychologist, speech pathologist, and physical or occupational therapist. Diagnostic tests may include physical exams, intelligence tests, and

occupational and physical therapy, psychological, speech, and neurologic evaluations. Diagnosis is easier if the birth mother confirms alcohol use during pregnancy. However, FAS can be diagnosed without confirming maternal alcohol use, if all the symptoms are present.

10.8.9 Impact of FASD

Children with FASD often grow up with social and emotional problems. They may have mental illness or substance abuse problems, struggle in school, and become involved with the corrections system. Costs of FAS alone are estimated at between one (1) and five (5) million dollars per child, not including incarceration. This estimate does not include cost to society, such as lost productivity, burden on families, and poor quality of life.

More information regarding FASD may be accessed at:

Fetal Alcohol Spectrum Disorder Center for Excellence.

10.9 Appendix B: Neonatal Abstinence Syndrome (NAS)

- What is Neonatal Abstinence Syndrome (NAS)?
    - NAS is a group of problems that occur in a newborn as a result of sudden discontinuation of addictive opioids, licit or illicit, to which the newborn was exposed while in the mother's womb.
- What causes NAS?
    - Almost all drugs pass through the placenta and into the fetus when the mother is pregnant and can cause the fetus to become dependent. At birth, the baby's dependence on that drug continues, however, since the drug is no longer available the baby's central nervous system becomes overstimulated causing symptoms of withdrawal.
    - Infants born to mothers participating in medication assisted treatment (MAT) programs are likely to present with NAS; yet MAT is an EBP for pregnant women that results in better outcomes for mothers with opioid use disorders and her infants (workers need to understand it is better for mom and baby both to be on MAT)
- Why is NAS a concern?
    - When a mother uses illicit substances, she places her baby at risk for many problems. Mothers who use drugs are less likely to seek prenatal care, which can increase risks to her and the baby. Women who use drugs are more likely to use more than one drug, which can complicate the treatment.
    - Additionally, specific difficulties of withdrawal after birth may include, but are not limited to: poor intrauterine growth; premature birth; seizures; and birth defects.
    - Specific drugs often pose specific problems in the baby:
        - Heroin and other opiates (including methadone): significant withdrawal, sometimes lasting four (4) to six (6) months. Seizures may occur from methadone withdrawal.
        - Amphetamines: low birthweight; premature birth.
        - Cocaine: poor fetal growth; developmental delays; learning disabilities; and lower IQ.
        - Marijuana: lower birthweights.

- Alcohol: slow growth during pregnancy and after birth; deformities of the head and face; heart defects; and intellectual disabilities.
- Cigarettes: smaller babies than non-smokers; increased risk for premature birth and stillbirth.

- What are the symptoms of NAS?
  - Symptoms may vary depending on the type of substance used and the last time it was used. Symptoms of withdrawal may begin as early as 24-48 hours after birth or as late as five (5) to ten (10) days.
  - The following are the most common symptoms:
    - Tremors (trembling).
    - Irritability (excessive crying).
    - Sleep problems.
    - High-pitched crying.
    - Tight muscle tone.
    - Hyperactive reflexes.
    - Seizures.
    - Yawning, stuffy nose and sneezing.
    - Poor feeding and sucking.
    - Vomiting.
    - Diarrhea.
    - Dehydration.
    - Sweating.
    - Fever or unstable temperature.
- How is NAS diagnosed?
  - An accurate report of the mother's drug usage is important, including the time of the last drug taken. A neonatal abstinence scoring system may be used to help diagnose and grade the severity of the withdrawal.

- How is NAS treated?

    - Babies suffering from withdrawal are irritable and often have a difficult time being comforted. Swaddling or snugly wrapping the baby in a blanket may help comfort the baby. Babies may also need extra calories because of their increased activity and may need a higher calorie formula. Intravenous fluids are sometimes needed if the baby becomes dehydrated or has severe vomiting or diarrhea.

    - Some babies may need medications to treat severe withdrawal symptoms, such as seizures and to help relieve the discomfort and problems of withdrawal. The treatment drug is usually in the same family of drugs as the substances the baby is withdrawing from. Once the signs of withdrawal are controlled, the dosage is gradually decreased to help wean the baby off the drug.

For additional information regarding NAS, see the Child Welfare Information Gateway.

10.10 Appendix C: Screening Tools Used with Pregnant or Postpartum Mothers

10.10.1 DBDHS screening resource

There are numerous screening instruments that can be used with pregnant and child bearing age women. For more information see the DBDHS website.

10.10.2 The 4 P's

The 4Ps (Parents, Partners, Past and Pregnancy) was developed for use with pregnant women and women of child bearing age. This screening device is often used as a way to begin discussion about drug and alcohol use. Any woman who answers yes to one or more questions should be referred for further assessment.

1. Have you ever used drugs or alcohol during this **PREGNANCY**?
    a. Yes
    b. No
2. Have you had a problem with drugs or alcohol in the **PAST**?
    a. Yes
    b. No
3. Does your **PARTNER** have a problem with drugs or alcohol?
    a. Yes
    b. No
4. Do you consider one of your **PARENTS** to be an addict or alcoholic?
    a. Yes
    b. No

10.10.3 The 5 Ps

The 5Ps was adapted by the Massachusetts Institute for Health and Recovery in 1999 from Dr. Hope Ewing's 4Ps (1990). This screening instrument is actually six (6) questions. It is the 4Ps and an additional question on peers and on smoking.

Before asking the following questions, develop a comfortable rapport with the mother. Any woman who answers yes to one or more questions should be referred for further assessment.

1. Did any of your PARENTS have a problem with using alcohol or drugs?
    a. Yes
    b. No
    c. No answer
2. Do any of your friends (PEERS) have problems with drug or alcohol use?
    a. Yes
    b. No
    c. No answer
3. Does your PARTNER have a problem with drug or alcohol use?
    a. Yes
    b. No
    c. No answer
4. Before you were PREGNANT, how often did you drink beer, wine, wine coolers or liquor or use any kind of drug?
    a. Not at all
    b. Rarely
    c. Sometimes
    d. Frequently
    e. No answer
5. In the PAST month, how often did you drink beer, wine, wine coolers or liquor or use any kind of drug?
    a. Not at all
    b. Rarely

c. Sometimes

d. Frequently

e. No answer

6. How much did you SMOKE before you knew you were pregnant?

a. Don't smoke

b. ½ pack a day

c. 1 pack a day

d. 1-2 packs a day

e. No answer

10.11 Appendix D: Sample Plan of Safe Care

PLAN OF SAFE CARE FOR MOTHER, OTHERS AND SUBSTANCE-EXPOSED INFANTS

A Plan of Safe Care is a guide developed by service providers with their clients to ensure mothers and others have the necessary resources to safely care for the unique challenges of an infant who is exposed to substances during pregnancy. Each woman and infant's needs vary.

A Plan of Safe Care should include input from all service providers involved in the mother and infant's care to promote the best health outcomes. Service Providers can include: OB/GYNs, Doctors, Nurse Practitioners, Midwives, Opioid Treatment Programs, Community Service Boards, Child Welfare Providers, Home Visitors, and Part C Early Intervention.

HEALTH CARE		
	Plan (include WHO, WHEN, WHERE)	*Comments*
Prenatal Medical Care (Mother)		

Medical Care Post-Natal (Mother/others)		
Medical Care Coverage for Mother (e.g. FAMIS, Medicaid, private insurance, etc.)		
Delivery Plan *(e.g. location, transportation, personal needs, medication at birth, etc.)*		
Other		
SUBSTANCE USE AND MENTAL HEALTH		
	Plan (include WHO, WHEN, WHERE)	*Comments*
Mental Health Treatment		
Substance Use Assessment		
Substance Use Treatment		
Medication Assisted Treatment		
Other		
DAILY LIVING		
	Plan (include WHO, WHEN, WHERE)	*Comments*

Financial Supports		
Safe Housing		
Food		
Transportation		
Other		
CHILD NEEDS		
	Plan (include WHO, WHEN, WHERE)	*Comments*
Safe Sleep Practices		
Post-discharge Supports		
Basic needs post-delivery *(e.g. diapers, formula, clothing, crib, car seat, etc.)*		
Breast Feeding (Y/N)		
Medical Care Coverage for Child *(e.g. FAMIS, Medicaid, private insurance, etc.)*		
Child Care		
Pediatric Care		
WIC		
Medical Home		

Other		
SUPPORTS		
	Plan (include WHO, WHEN, WHERE)	*Comments*
Family		
Formal Support Systems (e.g. DBDHS, CSB, CSA, CPS, DSS, VDH, etc.)		
Information Sharing (Release of Information)		
Home Visiting Program		
Early Intervention (Part C)		

ACF Administration for Children and Families	U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Administration on Children, Youth and Families	
	1. Log No: ACYF-CB-PI-17-02	**2. Issuance Date:** January 17, 2017
	3. Originating Office: Children's Bureau	
	4. Key Words: Child Abuse Prevention and Treatment Act (CAPTA);	

PROGRAM INSTRUCTION

TO: The State Office, Agency or Organization Designated by the Governor to Apply for a Child Abuse and Neglect State Grant

SUBJECT: 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

LEGAL AND RELATED: Title I of CAPTA; Public Law 114-198, the Comprehensive Addiction and Recovery Act of 2016 (CARA).

PURPOSE: To provide guidance to states on implementing provisions in CAPTA, as amended by CARA, relating to infants affected by substance abuse.

BACKGROUND: Since 2003, CAPTA has included a state plan requirement that the Governor of each state provide an assurance that the state has policies and procedures to address the needs of substance-exposed infants, including requirements to make appropriate referrals to child protective services (CPS) and other appropriate services, and a requirement to develop a plan of safe care for the affected infants. As originally incorporated in sections 106(b)(2)(B)(ii) and (iii) of CAPTA[1], the provisions 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." In 2010, the provision was amended by Congress to also include infants affected by Fetal Alcohol Spectrum Disorder.

Most recently, on July 22, 2016, the President signed into law CARA which, among other provisions, amended sections 106(b)(2)(B)(ii) and (iii) of CAPTA to remove the term "illegal" as applied to substance abuse affecting infants and to specifically require that plans of safe care address the needs of

[1] As originally incorporated into the statute in 2003, these provisions appeared in sections 106(b)(2)(A)(ii) and (iii).

both infants and their families or caretakers. CARA also added requirements relating to data collection and monitoring.

The text of sections 106(b)(2)(B)(ii) and (iii) of CAPTA, as amended by CARA, appears below.
* Deleted text is shown in ~~strike out~~
Added text is shown in **bold.

> 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…..
>
> (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 *~~illegal~~ 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 –
> (I) establish a definition under Federal law of what constitutes child abuse or neglect; or
> (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 *~~illegal~~ 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 –**
> **(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. States will now need to report, to the maximum extent practicable:

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

The Children's Bureau (CB) intends to collect this information through the National Child Abuse and Neglect Data System (NCANDS) beginning with the submission of fiscal year (FY) 2018 data. Information on reporting these data to NCANDS will be provided separately. As states consider any changes that may need to be made to their child welfare information systems to comply with updated data reporting requirements, they should be aware that system enhancements associated with NCANDS reporting may be eligible for Federal Financial Participation under the title IV-E foster care

program. To qualify for reimbursement, agencies must address these changes in their appropriate Advance Planning Document.

More information on the changes made to CAPTA by CARA, as well as information on best practices, can be found in Information Memorandum ACYF-CB-IM-16-05, issued August 26, 2016.

INSTRUCTION:

The changes to CAPTA made by CARA were effective upon enactment (July 22, 2016). Consistent with sections 106(b)(1)(C) and 108(e) of CAPTA, states will be required to submit an updated Governor's assurance (see Attachment A) and information on the actions the state has taken to comply with the CARA amendments as part of the Annual CAPTA Report submitted in conjunction with the FY 2018 Annual Progress and Services Report (APSR) (due June 30, 2017).

Because the changes made by CARA are already in effect, we expect states to be actively working to ensure they comply with these requirements prior to the FY 2018 APSR submission. We note that states provided updated information on the implementation of the CAPTA provisions relating to substance-exposed newborns as part of the Annual CAPTA Report submitted with the FY 2017 APSR. We encourage states to work with their CB regional offices to review that submission and determine the actions the state may need to take and the technical assistance the state may need to fully implement the changes.

To assist states in reviewing and adjusting their policies, as necessary, to comply with the provisions as amended, CB is taking this opportunity to reiterate and provide references to relevant guidance previously issued through the CB Child Welfare Policy Manual (CWPM) and provide information clarifying the scope of these changes.

What population of infants and families is covered by the CAPTA assurance in section 106(b)(2)(ii)?

CAPTA now requires states to have "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…." CAPTA does not define "substance abuse" or "withdrawal symptoms resulting from prenatal drug exposure." We recognize that by deleting the term "illegal" as applied to substance abuse affecting infants, the amendment potentially expands the population of infants and families subject to the provision. States have flexibility to define the phrase, "infants born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure," so long as the state's policies and procedures address the needs of infants born affected by both legal (e.g., prescribed drugs) and illegal substance abuse.

We encourage states to consult with the State Substance Abuse Treatment Authority, pediatricians and other health care professionals as they review their state policies and update definitions, consistent with the amendments to CAPTA.

Must states have a law, policy and/or procedure requiring Health Care Providers to refer substance-exposed infants to child protective services (CPS)?

Yes. Consistent with the definitions adopted by the state, the state must have statewide laws, policies and/or procedures requiring health care providers involved in the delivery or care of infants born and identified as affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder to notify CPS of the occurrence of such conditions of infants.

Does a notification to or referral of a case to CPS involving a substance-exposed newborn constitute a report of abuse or neglect?

Not necessarily. The CAPTA provision as originally enacted and amended requires the referral of certain substance-exposed infants to CPS and makes clear that the requirement to refer infants affected by substance abuse does not establish a federal definition of child abuse and neglect. Rather, the focus of the provision is on identifying infants at risk due to prenatal substance exposure and on developing a plan to keep the infant safe and address the needs of the child and caretakers. (See CWPM, Section 2.1F, Questions 1 and 2.) Further, the development of a plan of safe care is required whether or not the circumstances constitute child maltreatment under state law.

What is a plan of safe care?

While CAPTA does not specifically define a "plan of safe care," CARA amended the CAPTA state plan requirement at 106(b)(2)(B)(iii)(1) to require that a plan of safe care address the health and substance use disorder treatment needs of the infant and affected family or caregiver. We want to highlight that this change means that a plan of safe care must now address not only the immediate safety needs of the affected infant, but also the health and substance use disorder treatment needs of the affected family or caregiver. Consistent with good casework practice, the plan should be developed with input from the parents or other caregivers, as well as any collaborating professional partners and agencies involved in caring for the infant and family.

Who is responsible for developing and monitoring plans of safe care?

CAPTA does not specify which agency or entity must develop the plan of safe care; therefore the state may determine which agency will develop the plans. We understand that in most instances the state already has identified the responsible agency in its procedures. When the state reviews and modifies its policies and procedures to incorporate the new safe care plan requirements in CARA, the state may wish to revisit its procedures regarding which agency develops the plan of safe care, including any role for agencies collaborating with CPS in caring for the infant and family.

In addition to the requirements for developing plans of safe care, CARA also added a CAPTA state plan requirement for state monitoring of plans of safe care 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 (section 106(b)(2)(B)(iii)(2) of CAPTA). State monitoring may be carried out by the state child welfare agency or by another state-level entity. (See CWPM Question 2.1F.1, Question 1.)

As discussed in ACYF-CB-IM-16-05, development of a multi-agency collaborative to jointly assess, treat and monitor the progress of substance-exposed infants and their families is a best practice we encourage states to consider in implementing these new CAPTA provisions.

How will CB monitor states' compliance with these provisions?

Section 114 of CAPTA, as amended by CARA, requires the Secretary of Health and Human Services to monitor states to ensure compliance with the requirements in section 106(b) and specifically the policies and procedures of sections 106(b)(2)(B)(ii) - (iii). Consistent with this provision, CB will require states to provide an update on the steps the state has taken to implement provisions in 106(b)(2)(B)(ii) - (iii), as amended, as part of their annual CAPTA report submitted with the FY 2018 APSR due June 30, 2017. CB will also require states to submit the Governor's Assurance (Attachment A) at that time. States unable to provide the required assurance and document compliance by June 30, 2017 will be required to develop a Program Improvement Plan to address needed actions to come into full compliance. Additional information on submission requirements will be provided in the annual APSR Program Instruction to be issued in the spring of 2017.

CONCLUSION:

We encourage states to work with CB regional offices now to ensure that the state is meeting these new CAPTA requirements and to discuss any technical assistance needs. We also strongly encourage states to take a multi-disciplinary approach to implementation of these CAPTA requirements by including not only the state child welfare agency, but also partner agencies and professionals, such as the State Substance Abuse Treatment Authority, hospitals, health care professionals, home visiting programs, and Public Health or Maternal and Child Health Programs in the assessment and strengthening of state policies and procedures, as necessary.

INQUIRIES TO: Children's Bureau Regional Program Managers

/s/

Rafael López, Commissioner
Administration on Children, Youth and Families

Attachments:

A – Updated CAPTA Governor's Assurance
B – CB Regional Office Program Managers

Valerie L'Herrou, JD Disclosure:
I want to stress that I cannot give legal advice to the participants, my remarks were only intended to be legal information.

Clarification:
Infant who is *born* affected by substance exposure vs. a child who may be at risk for substance exposure in her environment due to neglect.
There would not need to be an *effect* for that child, if neglect was occurring.

Criteria for Child Abuse

- Alleged victim is under the age of 18 at the time of the report
- Alleged abuser is in a caretaking role
- Alleged abuse or neglect meets the definition of abuse or neglect as defined by the CPS laws, regulations and policy
- The Virginia Department of Social Services local agency has jurisdiction to respond to the report

Hotline Number
In Virginia: (800) 552-7096

In determining in any given situation about whether a report is mandated, they need to consult their organizational protocols and their own legal counsel. They can call the CPS hotline to ask if a case meets the standard if it's "on the line," and in addition, CPS has a guide for mandated reporters here:
https://www.dss.virginia.gov/files/division/dfs/mandated_reporters/cps/resources_guidance/B032-02-0280-00-eng.pdf

AND: Resources & Guidance Here: https://www.dss.virginia.gov/abuse/mr.cgi
This includes the following topics:

- Mandated Reporter Overview & Resources (PDF)
- Definition of Mandated Reporter
- Allegations Against Individuals Unrelated to Child (PDF)
- Child Protective Services Program Overview (PDF)
- Guide to Mandated Reporters (PDF)
- Information Needed to Make a Report (PDF)
- Minimum Standards for a Curriculum for Mandated Reporters on Recognizing & Reporting Child Abuse & Neglect (PDF)
- Perinatal Substance Use: Promoting Healthy Outcomes (PDF)
- Recognizing & Reporting Child Abuse & Neglect in Virginia (PDF)
- Recognizing & Reporting Child Abuse & Neglect in Virginia (Spanish) (PDF)
- Recognizing Child Abuse & Neglect - A Guide for School Employees (PDF)
- Responsibilities of Mandated Reporters (PDF)