

10

SUBSTANCE-EXPOSED INFANTS

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10

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.
- CWSE6010: Working with Families of Substance Exposed Infants. This on-line course has two (2) modules and is available in the [Virginia Learning Center \(VLC\)](#).

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.

Medication-Assisted Treatment (MAT)

Medication-Assisted Treatment, which includes some Opioid Treatment Programs (OTP), combines behavioral therapy and medications to treat substance use disorders.

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 refers to the use of tools and procedures designed to determine the risk or probability that an individual has a given condition or disorder. Screening may be a combination of observation, open-ended questions, and/or the use of a standardized set of questions.

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 Background of SEI

10.3.1 Federal law

- The Child Abuse and Prevention Treatment Act (CAPTA) of 1974 was created to provide federal funding to support prevention, assessment, investigation, prosecution and treatment activities related to child abuse and neglect.
- The Keeping Children and Families Safe Act of 2003 created new conditions for states to receive grant allocations under CAPTA. The grant conditions were intended to provide needed services and support for infants, their mothers, and their families, and to ensure a comprehensive response to the effects of prenatal drug exposure.
- The CAPTA Reauthorization Act of 2010 made further changes related to prenatal exposure issues to include identification of infants affected by Fetal Alcohol Spectrum Disorder (FASD) and a requirement for the development of Plans of Safe Care for infants affected by FASD.

- The Comprehensive Addiction and Recovery Act (CARA) of 2016 went into effect July 22, 2016, including Title V, Section 503, “Infant Plan of Safe Care.” The legislation (PL 114-198) made several changes to CAPTA and SEI:
 - Removed the term “illegal” in regards to substance abuse
 - Requires that Plans of Safe Care address the needs of both the infant and the affected family or caregiver
 - Specifies that data on affected infants and Plans of Safe Care be reported by states to the maximum extent practicable. Such data includes:
 - The number of infants identified as being affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or FASD.
 - The number of infants for whom a plan of safe care was developed.
 - The number of infants for whom referrals were made for appropriate services—including services for the affected family or caregiver.
- Requires that states develop and implement 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.

10.3.2 Virginia law

Virginia laws have been implemented and revised in accordance with the changes made to CAPTA. In the 2017 Session of the General Assembly, a bill was passed amending §§ 63.2-1505, 63.2-1506, and 63.2-1509 relating to CPS investigations, family assessments, and Virginia’s mandated child abuse and neglect reporting requirements to comply with CARA. The changes to the Code of Virginia became effective July 1, 2017.

Amendments made to the relevant sections of the Code of Virginia to comply with CARA include:

- [Section 63.2-1505](#) of the Code of Virginia, Subsection B(2) was amended to (1) eliminate language referencing an obsolete procedure, and (2) move language addressing substance-exposed infants out of this section that

pertains to CPS investigations and into §§ 63.2-1506 and 63.2-1509 of the Code of Virginia pertaining to family assessments and mandated reporting, respectively.

- [Section 63.2-1506](#) of the Code of Virginia was amended to add Subsection A(4), which requires LDSS to gather information as to “[w]hether the mother of a child who was exposed in utero to a controlled substance sought substance abuse counseling or treatment prior to the child’s birth” when conducting family assessments.
- [Section 63.2-1506](#) of the Code of Virginia was further amended to add the following to Subsection C: “If a report or complaint is based upon one of the factors specified in subsection B of § 63.2-1509, the local department shall (a) conduct a family assessment, unless an investigation is required pursuant to this subsection or other provision of law or is necessary to protect the safety of the child, and (b) develop a plan of safe care in accordance with federal law, regardless of whether the local department makes a finding of abuse or neglect.”
- [Section 63.2-1509](#) of the Code of Virginia, Subsection B, was amended to read: a “reason to suspect that 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. 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.”

10.4 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.

10.4.1 Health care providers required to report SEI

The Code of Virginia specifically delineates three (3) circumstances which constitute a reason to suspect that a newborn infant is abused or neglected due to the special medical needs of infants affected by substance exposure and therefore requires a report to CPS by health care providers. Such reports shall not constitute a per se finding of child abuse or neglect.

As a result of federal legislation, i.e., CARA (2016), SEI now includes both legal and illegal controlled substance exposure.

10.4.1.1 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.

10.4.1.1.1 Affected by substance abuse

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.

A positive toxicology for substances in the infant may or may not indicate that the child was born affected by substance abuse. If it is known that the drug was prescribed to the mother and is being used appropriately, the referral could be screened out. Conversely, if the mother has a positive toxicology at the time of the infant's birth or has had a medical or behavioral health assessment that is indicative of an active substance use disorder and she is demonstrating behaviors that may impact her capacity to provide proper care for the infant, or if there is a history of prior referrals involving substance abuse, the referral should be screened in.

In instances when a health care provider reports a positive toxicology result for a newborn child to a LDSS, but there is no other evidence or finding by the health care provider that the child was born affected by substance use or is experiencing withdrawal symptoms, the LDSS should make further inquiry into the circumstances of the report to determine whether the report should be screened in accordance with §§ 63.2-1509(B) and § 63.2-1503(I) of the Code of Virginia. Further inquiry should include asking the health care provider for all related information, records, and reports that form the basis of his or her suspicion that the infant is an abused or neglected child in accordance with § 63.2-1509(B).

The LDSS may not have a blanket policy which reflects that a positive toxicology report, standing alone, is or is not a valid referral. The LDSS must exercise its professional discretion and judgment in light of the information gathered from the health care provider to determine whether such report is valid.

The LDSS must gather enough information from the health care provider making the report to indicate that a finding has been made that the newborn child was born affected by substance abuse as described in [Section 10.4.1.1](#). Once the LDSS has determined that the health care provider has made such a finding, the report should be screened in as a family assessment (or investigation when required) and a Plan of Safe Care developed. The LDSS must document that the report was based on § 63.2-1509 (B) of the Code of Virginia along with the facts relied upon by the health care provider who made the report.

10.4.1.1.2 Withdrawal symptoms resulting from in utero drug exposure

This first 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. Because NAS is treatable, treatment providers typically recommend medication-assisted treatment (MAT) over abstinence for pregnant, opioid-addicted women. Additional information regarding NAS can be found in [Appendix B](#).

10.4.1.2 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.

10.4.1.3 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.

10.4.2 Health care provider responsibilities

10.4.2.1 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](#))

10.4.2.2 Report to the Community Services Board

The Code of Virginia §§ [32.1-127 B6](#) and [63.2-1509 B](#) require 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.

10.4.2.2.1 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 child welfare information system.

10.5 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.

10.5.1 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 | Prenatal care provider in concert with pain | Maternal and Child Health service providers (e.g. home |

| | | |
|--|--|--|
| result in dependency/withdrawal and does not have a substance use disorder. | specialist or other physician | 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 |

10.5.2 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](#).

10.6 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. Although, the validity of such reports does not constitute a per se finding of child abuse or neglect.

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.

10.6.1 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, [§ 63.2-1506](#) of the Code of Virginia 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.

10.6.1.1 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);
- A child's being left alone in the same dwelling with a person to whom the child is not related by blood or marriage and who has been convicted of

an offense against a minor for which registration is required as a violent sexual offender pursuant to § [9.1-902](#);

- 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](#).

A valid SEI allegation must be responded to through a family assessment. However, if the child is removed, the track must be changed to an investigation. Further, the LDSS must document “substance-exposed infant” as at least one of the reasons for removal.

10.6.1.2 Purpose of CPS intervention

The purpose of CPS intervention in response to reports of SEI is to assess both safety and risk factors associated with the newborn child and his family/caretaker(s). This should occur after a health care provider has identified the child as being affected by the abuse of legal or illegal substances by the child’s mother. The importance of a CPS response, whether by a family assessment or an investigation, is to mitigate the safety factors and the risk of harm associated with parental substance abuse when caretakers have the responsibility to actively care for this extraordinarily vulnerable population of children.

10.6.2 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. Most reports involving a SEI will require a safety plan due to the infants' vulnerability. 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 3. There is evidence that the mother used alcohol or other drugs during pregnancy, AND current circumstances suggest the infant's safety is of immediate concern.*
- *Safety factor 5. Caretaker does not provide supervision necessary to protect child from potentially serious harm. Caretaker's substance or alcohol use is having a serious impact on ability to provide adequate supervision to the child.*

10.6.2.1 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 [DBHDS 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.

10.6.3 Information to gather when responding to SEI referrals

In addition to conditions in the infant, conditions or behaviors in the mother that may indicate that 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); and
- domestic violence.

If the SEI allegation is invalid, the LDSS should evaluate all of the information received in order to assess the report for physical neglect associated with a threat to the infant's health or safety due to substance abuse by his parent(s) and/or other caretaker(s). See [Appendix E: Substance Exposed Infant Decision Tree](#) for more information on screening the invalid SEI referral for physical neglect.

10.6.4 No exception to completing the investigation or family assessment

Note that under prior Virginia law, before July, 2017, if the LDSS received a report involving a SEI, but determined that the mother sought and engaged in substance abuse counseling or treatment during pregnancy, the LDSS was not compelled to validate the report. This exception was removed with the changes made to changes to §§ 63.2-1505, 1506, and 1509 of the Code of Virginia in the 2017 General Assembly.

Effective July 1, 2017, once a report of a SEI has been validated, 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 child welfare information system.

10.6.5 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.

10.6.5.1 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 and/or extended family, birthing hospital, pediatrician, and substance use disorder evaluation and treatment providers. When appropriate, the LDSS should coordinate services with the CSB.

Contact with the health care provider(s) should include gathering 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.

10.6.5.2 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.

10.6.5.3 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.

10.6.5.4 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 child welfare information system when the decision is to not open a case.

10.6.6 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 child welfare information 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).

10.7 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.

10.7.1 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?

10.7.2 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 Virginia website](#).

10.8 Petition the court on behalf of a SEI

When conducting a SEI investigation, [§ 16.1-241.3](#) of the Code of Virginia permits the LDSS to petition the Juvenile and Domestic Relations District Court solely because an infant was exposed to a legal or illegal substance in utero.

([§ 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.

10.8.1 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.

10.8.1.1 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.

10.8.2 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.

10.8.3 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.

10.9 Appendix A: Fetal Alcohol Spectrum Disorder (FASD)

10.9.1 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.

10.9.2 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).

10.9.3 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.

10.9.4 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.

10.9.5 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.

10.9.6 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.

10.9.7 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.

10.9.8 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.

10.9.9 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.](#)

10.10 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](#).

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

10.11.1 DBHDS screening resource

There are numerous screening instruments that can be used with pregnant and child bearing age women. For more information see the [DBHDS website](#).

10.11.2 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

10.11.3 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

10.12 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 |

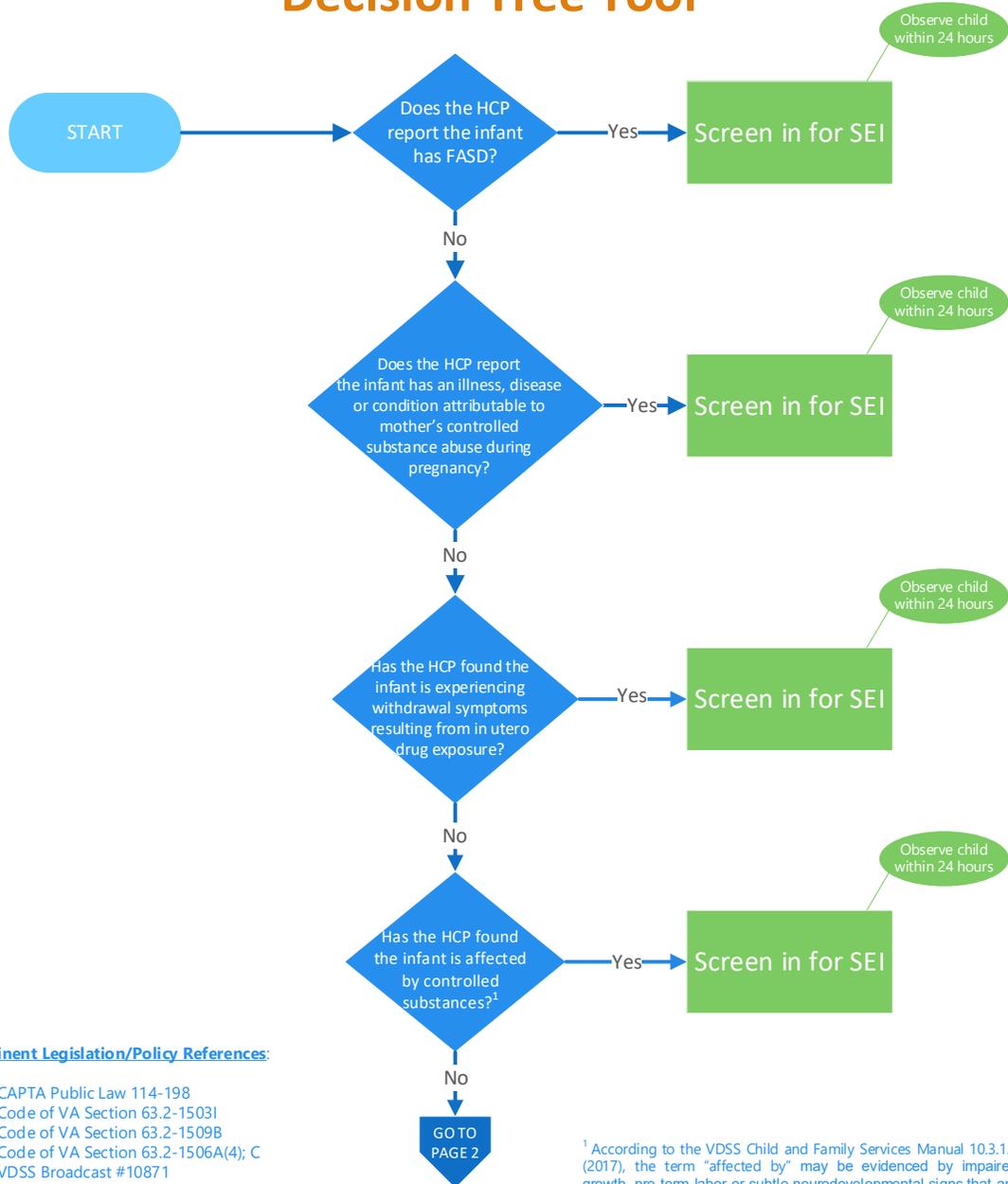
| | | |
|-------------------------------|---------------------------------|----------|
| Mental Health Treatment | | |
| Substance Use Assessment | | |
| Substance Use Treatment | | |
| Medication Assisted Treatment | | |
| Other | | |
| DAILY LIVING | | |
| | Plan (include WHO, WHEN, WHERE) | Comments |
| 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. DBHDS, CSB, CSA, CPS, DSS, VDH, etc.) | | |
| Information Sharing (Release of Information) | | |
| Home Visiting Program | | |
| Early Intervention (Part C) | | |

10.13 Appendix E: Substance Exposed Infant Decision Tree

Substance-Exposed Infants (SEI) Decision Tree Tool



Pertinent Legislation/Policy References:

- CAPTA Public Law 114-198
- Code of VA Section 63.2-15031
- Code of VA Section 63.2-1509B
- Code of VA Section 63.2-1506A(4); C
- VDSS Broadcast #10871

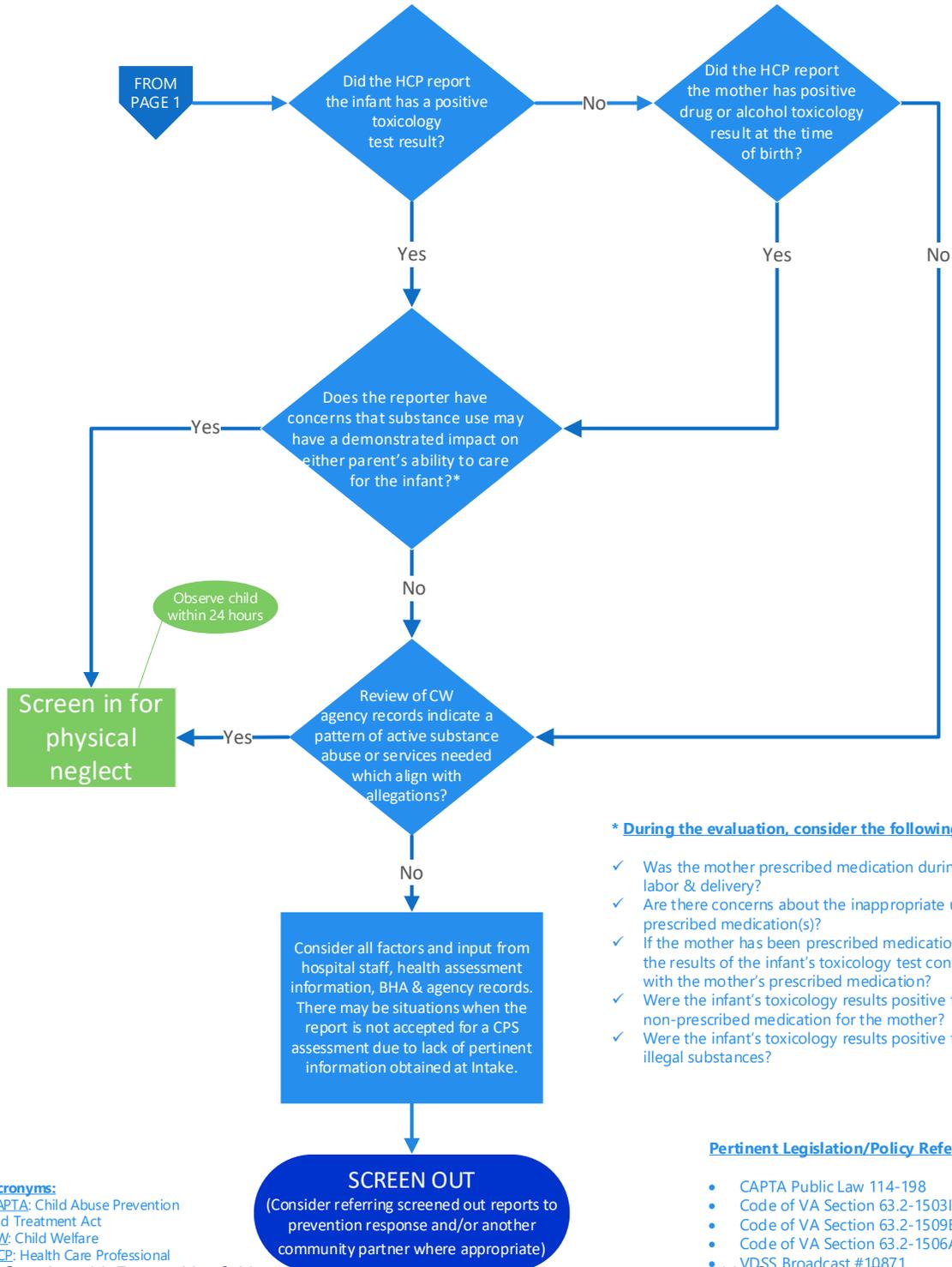
Acronyms:

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.

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?

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
- 10 Substance-Exposed Infants**

Acronyms:

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