2024 ANNUAL JDR CLE

Friday the 13th of September!!! Advanced Technology Theater

8:30am Registration and Breakfast

9-10:30am Navigating Substance Abuse Issues in Criminal and Civil Cases Before the Court

10:30am-11:30am Juvenile Criminal Cases-A True Issue Spotting Adventure

11:30am-11:45am Break

11:45am-12:45pm The Schools have a Docket? Truancy & Parental Participation

12:45pm-1:45pm Lunch / Special Guest Speaker – Lawren Burroughs, Esq.

1:45pm-2:45pm Transgender & Identity Issues in Practice

2:45pm-3:45pm Lawyer Wellness??? JLAP

3:45p-4:00pm Break

4:00pm-5:00pm Ethics

**Reception to Follow at Baker's Crust-Landstown

2024 ANNUAL VBBA JDR CLE

8:30am — Registration and Breakfast

9-10:30am — **Navigating Substance Abuse Issues in Criminal and Civil Cases Before the Court**

- The Hon. Phillip J. Hollowell
- The Hon. Cheshire I'Anson Eveleigh
- Christianna Dougherty-Cunningham, VB Associate City Attorney
- David Talmage, VB Assistant Commonwealth Attorney
- Allison Kronenberg, VB Community Corrections Pretrial Administrator
- Dominique Delagnes, COO, Averhealth

10:30am — **Swearing In of New CASA Volunteers**

10:31am-11:30am — **Juvenile Criminal Cases-A True Issue Spotting Adventure**

- The Hon. Timothy J. Quick
- Brian Latuga, Esq., Wolcott Rivers Gates
- Jerrell Johnson, Esq., JR Law
- Tabitha Anderson, VB Deputy Commonwealth Attorney

VIRGINIA BEACH BAR ASSOCIATION

11:30am-11:45am — Break

11:45am-12:45pm — **The Schools have a Docket? Truancy & Parental Participation**

- The Hon. Adrianne L. Bennett
- The Hon. James P. Normile
- Kami Lannetti, Deputy Schools Attorney
- Danielle Hall-McIvor, Associate Schools Attorney
- Simone Boothe, Associate Schools Attorney

12:45pm-1:45pm — Lunch / **Special Guest Speaker: Lawren Burroughs, Esq.**

1:45pm-2:45pm — **Transgender & Identity Issues in Practice**

- The Hon. Jennifer Shupert
- Sarah Nelson, Esq. Phillips Peters, PLC
- Cynthia Chaing, Esq., Chaing Anders
- Lawren Burroughs, Esq., Burroughs Law Office
- Madison Wagner, Esq., Rice & Gregg, PC

2:00pm-3:00pm **Alternative Session: Mentorship Training** (Adjacent Room)

2:45pm-3:45pm **Lawyer Wellness: Navigating Occupational Risks to Practicing Law & Cultivating Attorney Well-Being**

- Charlene Reilly, Virginia JLAP Program

3:45p-4:00pm **Break**

4:00pm-5:00pm **Ethics**

- Bretta Lewis, Esq. Pender & Coward

VIRGINIA BEACH BAR ASSOCIATION

*Reception to Follow at Baker's Crust ~ Landstown

NAVIGATING SUBSTANCE ABUSE ISSUES IN CRIMINAL AND CIVIL CASES IN JUVENILE COURT

The Hon. Philip J. Hollowell

The Hon. Cheshire I'Anson Eveleigh

Christianna Dougherty-Cunningham, Esq. ~ Associate City Attorney

David Talmage, Assistant Commonwealth Attorney

Allison Kronenberg, VBDHS~ Pretrial

Dominique Delagnes, COO, Averhealth

DUIs/DWIs ..... ETOH v. DRUGS.....

1. **Statutory differences**
2. **Juvenile v. Adult Considerations**
3. **Effect on DMV**

It's Only a Little Weed... What's the Big Deal?

a. **Effects of Marijuana / Cannabis Use on the Brain**
    i. **Adults**
    ii. **Juveniles**
b. **Possible Linkage Between Use and Mental Health and Behavioral Health Disorders**
c. **THC Potency *may matter***
d. **"Laced" Marijuana .... Fentanyl? Cocaine?**

Testing and Nuisances (Panels? Time? Best Test?)

a. **Urine Screens**
b. **Nail Screens**
c. **Hair Follicle Testing**
d. **Use v. Exposure**
e. **Chain of Custody using a third-party lab**

Rules of Pretrial/Probation/CSU

a. **ADULTS- It is all based on the Court order and then the Defendant**

   i. **Is the Defendant already in treatment?**

   ii. **Are they being tested?**

   iii. **What is their drug of choice, status of use, and what is their charge(s)?**

   iv. **Criminogenic needs?**

   v. **ASAM Criteria ~ Continuum of Care for Adult Addiction Treatment**

ASAM levels of care include:

Level 0.5, which is called Early Intervention. Early intervention can consist of assessment and education for people at risk of developing a substance use disorder, or programs like DUI classes for people arrested for driving under the influence. The goal of .5 services is to intervene before a person develops a substance use disorder.

Level 1 outpatient treatment consists of treatment for substance use that is less than 9 hours a week. Level 1 is appropriate for people with less severe disorders, or as a step-down from more intensive services.

Level 2.1 is intensive outpatient services consisting of at least 9 and no more than 20 hours per week of treatment. These programs typically offer medical care 24 hours a day by phone or within 72 hours in person.

Level 2.5 is partial hospitalization, which is at least 20 hours a week but is less than 24-hour care. This level of care provides structure, and daily oversight for people who need daily monitoring, but not 24/7 care.

Level 3.1 is clinically managed low-intensity residential treatment. Residential services at this level consist of a setting, such as a group home, where people live. However, treatment is only required to be 5 hours per week, which helps people with such topics as relapse management.

Level 3.3 is clinically managed high-intensity and population-specific services. These programs are targeted for providing treatment designed to move at a slower pace, for people with cognitive functioning issues,

including people with traumatic brain injuries, the elderly, or people with developmental disabilities.

Level 3.5 is clinically managed residential services. These services are designed for people with serious psychological or social issues who need 24-hour oversight and are at risk of imminent harm.

Level 3.7 is medically managed high-intensity inpatient treatment These services are for people who need intensive medical or psychological monitoring in a 24-hour setting but do not need daily physician interaction.

Level 4 provides 24-hour nursing care and daily physician visits. People in this level of care need daily physician monitoring, along with 24-hour oversight.

b. **Testing is *usually* random but at minimum, must be done monthly.**

c. **Positive Drug Screen?**

   i. **When a Defendant is positive, that in and of itself can tell a lot about what is going on.**

   ii. **If a Defendant has a scheduled appointment and has known about it for a period of time-- that and test positive - that says that things might be out of control.**

   iii. **Virginia Code** §19.2-123(B) Any test given under the provisions of this subsection which yields a positive drug or alcohol test result shall be reconfirmed by a second test if the person tested denies or contests the initial drug or alcohol test positive result. The results of any drug or alcohol test conducted pursuant to this subsection shall not be admissible in any judicial proceeding other than for the imposition of sanctions for a violation of a condition of release.

d. **In-Patient v. Outpatient Treatment**

e. **Pretrial and Probation are Mandated Reporters**

    a. **CPS ~ Virginia Code §63.2-1509**

    b. **APS ~ Virginia Code §63.2-1606**

f. **Pretrial Confidentiality**

    a. **Article 9; §9.1-173 *et. seq.***

    b. **§19.2-152.2**

    c. **§19.252.4**

    d. **42 CFR Part 2 & HIPPA?**

g. **Special Considerations for Juvenile Defendants ~ CSU**

    a. **Child & Youth**

    b. **Juvenile SA Treatment**

h. **Court ordered SA evaluations and Screens in Civil Cases**

    a. **Custody & Visitation**

    b. **DHS Cases**

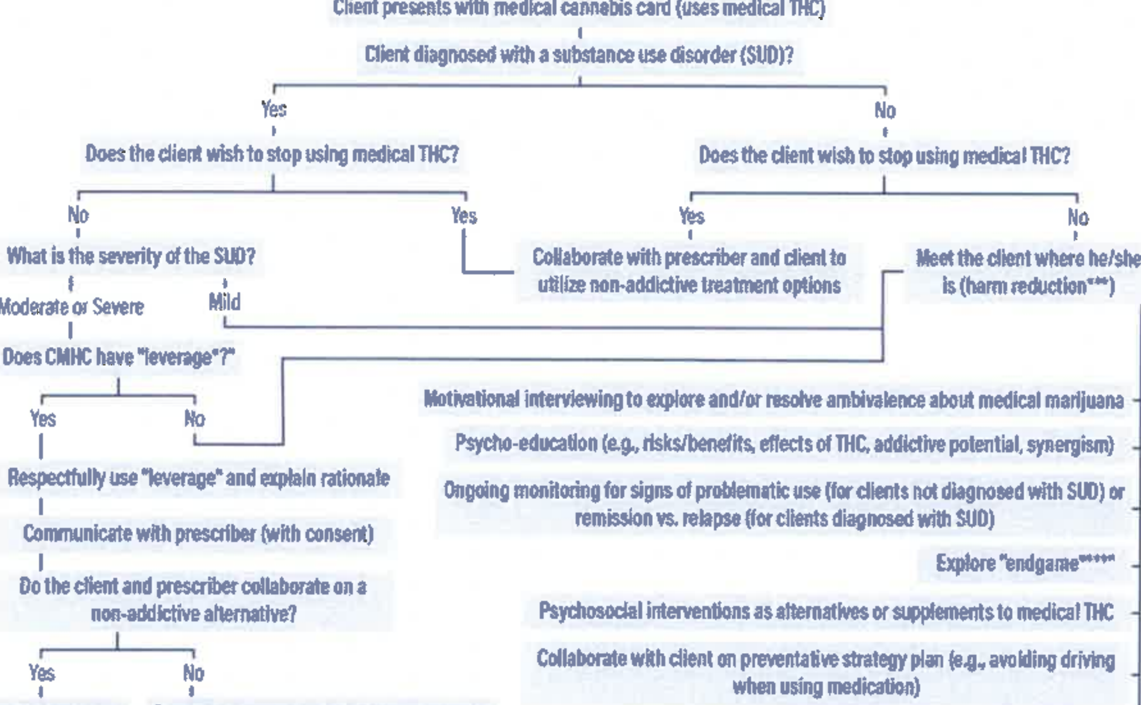
    c. **The Medical Marijuana Card Conundrum: Clients on Psychotropics who possess Medical Marijuana Cards**

        i. **Usually no communication between providers**

        ii. **Frequent Use of On-line and Out-of-State Providers/ Based solely on client oral hx**

        iii. **Matrix for Providers (see next pg)**

Decision matrix for clinical mental health counselors encountering medical cannabis use in mental health and substance abuse treatment settings



Definitions: ***Leverage:** Resources or outcomes pursued by a client that may be conditional to successful treatment completion (e.g., successful compliance with probation/avoidance of incarceration, reunification with children, eligibility for social programs, reinstatement of driver's license)

** **Addiction medicine specialist:** a physician or psychiatrist who is certified by the American Society of Addiction Medicine (ASAM) with expertise in prevention, screening, intervention, and treatment for substance use (asam.org)

*** **Harm reduction:** A treatment and prevention approach focused on decreasing health and socio-economic costs and consequences of addiction-related problems, whether the client is still using an addictive substance or not

****__Endgame:__ Refers to the long-term strategies and approaches the client will use for his or her presenting problem(s) vs. short-term approaches. In other words, because addictive medications, when used daily over extended periods of time, tend to produce tolerance, what will the client do when the medication stops having as much therapeutic effect in the future?

Decision matrix by Aaron Norton

https://www.counseling.org/publications/counseling-today-magazine/article-archive/article/legacy/the-impact-of-legalized-marijuana-on-professional-counseling

Changes in Releases of Information ~ 2024

Background

On February 8, 2024, the Federal Government amended the Federal Confidentiality Act (42 CFR P. 2/Substance Abuse Info Law) and made significant changes that impact all covered providers; it changes the manner in which releases of information must be handled. The City, as a recipient of federal funding for substance abuse prevention, education, and treatment, must comply with 42 CFR P. 2. The City, as a provider of health care services, must also comply with HIPAA. As a result, the Releases of Information ("ROI") used by DHS have been amended to comport with the new regulations.

In understanding the changes, it is helpful to think about *why* the changes to the law were made and to focus on three main questions that users of the ROIs will need to ask to determine which ROIs need to be completed:

- The Federal Confidentiality Act (42 CFR P. 2/Substance Abuse Info Law) **was amended to accomplish 2 main goals:**
  - 1- to make it align more closely with HIPAA –at least from a treatment provider and third party-payor perspective (insurance co.); **and**
  - 2- to address concerns and complaints from patients whose information was finding its way into both criminal and civil court proceedings without the patients truly being cognizant of how the information was released.
- Given the main reasons for the changes, the amended federal regulations set out to ensure that releases of information would now be governed solely by **purpose**. Thus, when having clients execute releases of information ("ROI"), **3** questions are to be considered:
  - 1) **why is the release needed (for what main *purpose*)**;
  - 2) to whom am I needing to release the information; and
  - 3) what information do I need to release?

Based upon the amendments to law, the ROIs used by DHS have been amended so that they are, with one exception, designated by ***purpose***.

There are now **4 different ROIs; each has a specific purpose as the law now generally prohibits using one release for differing purposes.**

The 4 ROIs are as follows:

ROI1 ~ Release of Information for Treatment, Payment, and Healthcare Operations

ROI2 ~ Release of Information for the Release of Substance Use Disorder ("SUD") Counseling Notes

ROI3 ~ Release of Information for Use of Records or Testimony in Criminal, Civil, Administrative, or Legislative Proceedings Involving, or Against, VBDHS Clients

ROI4 ~ Release of Information for Client Involved in Criminal Pretrial, Probation, Forensic Diversion, and Drug Court/or MH/BH Dockets/Treatment Bond/Any Criminal Court Ordered Program or Treatment (42 CFR 2.35)

Commonly Asked Questions (thus far):

- Do these ROIs allow us to both disclose and receive records?

  Yes! 42 CFR P. 2 now allows for all ROIs to be for a mutual *exchange* of information between named individuals or entities; thus no "ROI B" is needed!

- Why is there a specific release for this type of record called "SUD Counseling Notes?" What is that and why is it considered different from anything else in the record?

  This is a new federal term of art; it is defined as "notes recorded (in any medium) by a part 2 program provider who is a **SUD or mental health professional** *documenting or analyzing the contents of conversation during a private SUD counseling session or a group, joint, or family SUD counseling session and that are separated from the rest of the patient's SUD and medical record*."

  SUD counseling notes **DO NOT INCLUDE** medication lists, prescription lists, and monitoring or counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests/drug tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

  Again, the issue is for the most part is what is the **purpose** of the release?? We no longer can mix ROIs for treatment or payment with anything related to court, admin hearings, etc., thus the purpose of the ROI is what is the distinguishing factor. *Generally*, it is not the "*type*" of information to be disclosed within the record that determines the ROI used.

  However, the exception to the "purpose rule" has to do with the new regulation regarding SUD Counseling Notes, which are to NOW be kept separate from all other types of information contained in a patient's record. Thus, the question is- *do you need to disclose the SUD counseling notes for your purpose or can you merely exclude that information*. Depending on your answer is whether you need to have ROI2 completed.

- What is the difference between …

  ROI3 ~ Release of Information for Use of Records or Testimony in Criminal, Civil, Administrative, or Legislative Proceedings Involving, or Against, VBDHS Clients

  and

ROI4 ~ Release of Information for Client Involved in Criminal Pretrial, Probation, Forensic Diversion, and Drug Court/or MH/BH Dockets/Treatment Bond/Any Criminal Court Ordered Program or Treatment (42 CFR 2.35)?

ROI4 is only to be used where the records are being released in connecting with a client who is a criminal defendant and is being court ordered into some sort of treatment program as a part of conditions of pretrial release, post-conviction sentencing, or diversion, including but not limited to, participation in drug court or a mh/bh docket, forensic diversion, or on a treatment bond.

ROI3 is used for all other court or administrative proceedings where the information is being requested in connection with the client's involvement in that proceeding. i.e.) CPS or Foster Care hearings, custody cases, civil cases, or criminal cases where the *reason for the disclosure is NOT related to any pre- or post-trial program.*

- Are there penalties for breaches of the law?

  Yes- There are now **both criminal and civil penalties** which can be incurred for breaches. However, there are safe harbor time frames for remedying breaches- so prompt disclosure of breaches is required to mitigate penalties incurred. Providers are also obligated to timely report all suspected breaches to the client and to a newly designated portal within HSS. Also- DOJ has moved the enforcement division of 42 CFR P.2 and HIPAA to HHS and enforcement will formally begin 7.1.26. It is not clear whether complaints acted upon will be retroactive to the February 8, 2024 effective date or to the April 16, 2024 compliance date.

There are likely more questions and concerns that will arise as we implement the releases. Please do not hesitate to call or email where needed. We also expect guidance from HHS as providers across the nation work with the new law. We are all learning together when changes like this come down with little notice and so patience with staff learning the changes is welcomed.

What is 42 CFR Part 2?

Title 42, Code of Federal Regulations (CFR) Part 2, also known as the Confidentiality of Substance Use Disorder Patient Records, is a set of regulations that protect the confidentiality of patient records for substance use disorder (SUD) treatment. The U.S. Department of Health and Human Services (HHS) publishes these regulations. Part 2 was first established in 1975 to address concerns about the potential use of SUD information in settings other than treatment, such as criminal or administrative hearings. The regulations aim to protect patient confidentiality and help address concerns that fear of prosecution or discrimination may prevent people from seeking treatment for SUD.

Who has to comply with it?

Any Part 2 Program MUST strictly comply with 42 CFR Part 2. "Part 2 programs" are facilities that are federally assisted and hold itself out as providing or provide substance use disorder (SUD) diagnosis, treatment, or referral for treatment. Federally assisted programs are organizations that receive Medicare and/or Medicaid reimbursement or receive federal funds in some manner.

The City of Virginia Beach- VBDHS/BHDS is a Part 2 Program.

Fact Sheet 42 CFR Part 2 Final Rule

Date: February 8, 2024

On February 8, 2024, the U.S. Department of Health & Human Services (HHS) through the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Office for Civil Rights announced a final rule modifying the Confidentiality of Substance Use Disorder (SUD) Patient Records regulations at 42 CFR part 2 ("Part 2"). With this final rule, HHS is implementing the confidentiality provisions of section 3221 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act - PDF (enacted March 27, 2020), which require the Department to align certain aspects of Part 2 with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Rules and the Health Information Technology for Economic and Clinical Health Act (HITECH).

Background

The Part 2 statute (42 U.S.C. 290dd-2) protects "[r]ecords of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to substance use disorder education, prevention, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States." Confidentiality protections help address concerns that discrimination and fear of prosecution deter people from entering treatment for SUD.

The modifications in this final rule reflect the proposals published in the December 2, 2022, Notice of Proposed Rulemaking (NPRM) and public comments received from: substance use disorder and other advocacy groups; trade and professional associations; behavioral and other health providers; health information technology vendors and health information exchanges; state, local, tribal and territorial governments; health plans; academic institutions, including academic health centers; and unaffiliated or anonymous individuals. Following a 60-day comment period, HHS analyzed and carefully considered all comments submitted from the public on the NPRM and made appropriate modifications before finalizing.

Major Changes in the New Part 2 Rule

The final rule includes the following modifications to Part 2 that were proposed in the NPRM:

- **Patient Consent**
  - Allows a single consent for all future uses and disclosures for treatment, payment, and health care operations.

    - Allows HIPAA covered entities and business associates that receive records under this consent to redisclose the records in accordance with the HIPAA regulations.[1]
- **Other Uses and Disclosures**
    - Permits disclosure of records without patient consent to public health authorities, provided that the records disclosed are de-identified according to the standards established in the HIPAA Privacy Rule.
    - Restricts the use of records and testimony in civil, criminal, administrative, and legislative proceedings against patients, absent patient consent or a court order.
- **Penalties**: Aligns Part 2 penalties with HIPAA by replacing criminal penalties currently in Part 2 with civil and criminal enforcement authorities that also apply to HIPAA violations.[2]
- **Breach Notification**: Applies the same requirements of the HIPAA Breach Notification Rule[3] to breaches of records under Part 2.
- **Patient Notice**: Aligns Part 2 Patient Notice requirements with the requirements of the HIPAA Notice of Privacy Practices.
- **Safe Harbor**: Creates a limit on civil or criminal liability for investigative agencies that act with reasonable diligence to determine whether a provider is subject to Part 2 before making a demand for records in the course of an investigation. The safe harbor requires investigative agencies to take certain steps in the event they discover they received Part 2 records without having first obtained the requisite court order.

Substantive Changes Made Since the NPRM

In addition to finalizing modifications to Part 2 that were proposed in the NPRM, the Final Rule includes further modifications informed by public comments, notably the following:

- **Safe Harbor:** Clarifies and strengthens the reasonable diligence steps that investigative agencies must follow to be eligible for the safe harbor: before requesting records, an investigative agency must look for a provider in SAMHSA's online treatment facility locator and check a provider's Patient Notice or HIPAA Notice of Privacy Practices to determine whether the provider is subject to Part 2.
- **Segregation of Part 2 Data**: Adds an express statement that segregating or segmenting Part 2 records is not required.
- **Complaints**: Adds a right to file a complaint directly with the Secretary for an alleged violation of Part 2. Patients may also concurrently file a complaint with the Part 2 program.
- **SUD Counseling Notes**: Creates a new definition for an SUD clinician's notes analyzing the conversation in an SUD counseling session that the

clinician voluntarily maintains separately from the rest of the patient's SUD treatment and medical record and that require specific consent from an individual and cannot be used or disclosed based on a broad TPO consent. This is analogous to protections in HIPAA for psychotherapy notes.[4]

- **Patient Consent:**
  - Prohibits combining patient consent for the use and disclosure of records for civil, criminal, administrative, or legislative proceedings with patient consent for any other use or disclosure.
  - Requires a separate patient consent for the use and disclosure of SUD counseling notes.
  - Requires that each disclosure made with patient consent include a copy of the consent or a clear explanation of the scope of the consent.
- **Fundraising:** Create a new right for patients to opt out of receiving fundraising communications.

What has not changed in Part 2?

As has always been the case under Part 2, patients' SUD treatment records cannot be used to investigate or prosecute the patient without written patient consent or a court order.

Records obtained in an audit or evaluation of a Part 2 program cannot be used to investigate or prosecute patients, absent written consent of the patients or a court order that meets Part 2 requirements.

What comes next?

The final rule may be downloaded at https://www.federalregister.gov/public-inspection/2024-02544/confidentiality-of-substance-use-disorder-patient-records. HHS will support implementation and enforcement of this new rule, including through resources related to behavioral health developed by the SAMHSA-sponsored Center of Excellence for Protected Health Information . Persons subject to this regulation must comply with the applicable requirements of this final rule two years after the date of its publication in the *Federal Register*. The Department will conduct outreach and develop guidance on how to comply with the new requirements, such as filing breach reports when required.

OCR plans to finalize changes to the HIPAA Notice of Privacy Practices (NPP) to address uses and disclosures of protected health information that is also protected by Part 2 along with other changes to the NPP requirements, in an upcoming final rule modifying the HIPAA Privacy Rule.

HHS planning to implement in separate rulemaking the CARES Act antidiscrimination provisions that prohibit the use of patients' Part 2 records against them.

Endnotes:

[1] However, these records cannot be used in legal proceedings against the patient without specific consent or a court order, which is more stringent than the HIPAA standard.

[2] *See* 42 U.S.C. 1320d–5 and 1320d-6.

[3] Section 13400 of the HITECH Act (codified at 42 U.S.C. 17921) defined the term "Breach". Section 13402 of the HITECH Act (codified at 42 U.S.C. 17932) enacted breach notification requirements, discussed in detail below.

[4] *See* https://www.hhs.gov/hipaa/for-professionals/faq/2088/does-hipaa-provide-extra-protections-mental-health-information-compared-other-health.html.

Content created by Office for Civil Rights (OCR)
Content last reviewed February 8, 2024

City of Virginia Beach ~ ROI4

Release 4 **Authorization for Use or Disclosure**

VBDHS AS PROVIDER FOR A PRE-TRIAL PARTICIPANT, PROBATIONER, PARTICIANT IN ANY DIVERSION PROGRAM, TREATMENT BOND, OR ANY CRIMINAL COURT ORDERED TREATMENT OR PROGRAM/TREATMENT COURT/DOCKET

42 CFR 2.35 **2 pages**

I, ____________________(Defendant Name), whose date of birth is ________**(D/O/B),** hereby agreed and understand that as a part of my pretrial/conditional release, participation in forensic diversion, or post-trial sentencing and probation, relating to, and/or involved in, the criminal case(s) set forth below, I am being referred to a program which may provide substance abuse testing, treatment, prevention, and/or education as ordered and/or authorized by the Court with jurisdiction over my case(s). I hereby authorize the use and disclosure of my personal health (mental and physical health) and substance abuse (screens, treatment, etc.) information and records as described in this authorization. I understand this release allows communication **to and from** the named parties.

(1.) The City of Virginia Beach -Department of Human Services ("VBDHS"), shall disclose all of the records and information ***as designated below in section 4*** to the following parties: ***the Circuit Court, General District Court, and/or Juvenile and Domestic Relations Court with jurisdiction over my case(s), the Commonwealth Attorney assigned to my case and Commonwealth Attorney Staff, the Pretrial or Probation Office/Officer assigned to my case and their staff, any attorney retained by me or appointed to represent me in my case(s) and their staff, as well as with any other VBDHS Programs, including but not limited to all Virginia Beach DHS (BHDS and/or DSS programs and services), to which I am referred by my Pretrial or Probation Officer or case manager and/or which I am already participating in by means of other court orders under which I am bound and/or participating in on a voluntarily basis, as well to the City Attorney's Office or other such counsel representing such programs;*** and

(2) that such information be used solely for the purposes of: ***monitoring my progress in treatment and requested services, overseeing and supervising my adherence to any rules of pretrial, probation, forensic diversion, treatment bond, or like conditions for which I am under in connection with my criminal case(s)*** and no other purpose unless otherwise directed by me or allowed by a court of competent jurisdiction; and

(3) that such information only be disclosed to the parties named in section number 1 above, unless otherwise directed by a court of competent jurisdiction; and

(4) **Designated Records:** I hereby request that the following records and information located in my files held by the City of Virginia Beach be disclosed to the parties listed in paragraph 1 above ("xxx" all that you wish to disclose):

XXX medical test results, evaluations, medication list, and treatment records

XXX mental health, psychiatric, and psychological test results, evaluations, medication list, and treatment records

XXX diagnostic testing and developmental service-related records

XXX substance abuse test results, evaluations, medication list, education, and treatment records to include compliance with a substance abuse classes and treatment, group participation, and other therapeutic interventions; and

____ OTHER: ____

(5) I agree and understand that in the event the above-referenced information is sought for the purpose of my criminal court case(s) proceeding listed below in paragraph 13, I hereby additionally expressly authorize the disclosure and re-disclosure of the information to the following: any experts retained by me/my attorney or the Commonwealth; and

Revised 5.1.24

Client's Initials__________

Date__________

(6) I also agree and understand that any of the persons/entities authorized herein to receive my information and records under this section **may re-disclose** and use it only to carry out that individual's/entities official duties with regard to my probation/pretrial/ conditional release or other action in connection with which this consent was given; and

(7) I agree and understand that, if requested by any of the parties or entities authorized herein to receive this information, disclosure of my records and information may also be disseminated by VBDHS staff through direct Court testimony. I hereby authorize VBDHS staff to testify in open Court and in such case, I hereby understand that in so doing, members of the public and/or persons outside of those authorized to receive my information may become privy to my information. As such, I authorize all such disclosure as a part of my consent given herein; and

(8) I understand that my initial and continued receipt of services from VBDHS is not subject to my agreement to this authorization or any other authorization by VBDHS. However, I understand that should I not agree to the disclosure of my information, I may no longer be eligible for the pretrial release/conditions/probation and may be referred back to the Court overseeing my criminal case(s); and

(9) I understand I have the right to receive a copy of this authorization; and

(10) I understand and fully acknowledge my right not to have this information disclosed and only do so after full disclosure by counsel of my choosing. I understand the potential consequences of having this information disclosed. I hereby represent and warrant that in authorizing such disclosure, I have not been induced or coerced in any manner. I hereby release the City of Virginia Beach, its departments, employees, agents, and representatives from any and all liability which may result from my execution of this release and my causing of my information to be released to the parties listed above; and

(11). I agree that this consent will terminate on **30 days after the later of termination of supervision or the date set forth in any sentencing order, conditional release, and/or termination of probation**; and

(12) I understand and agree that his consent is only revocable once there has been a final disposition of the sentencing order, diversion conditions, conditional release, and/or termination of probation for which this consent was given. ** **I understand this release covers both the district and circuit courts for the jurisdiction where my case(s) may be pending.** For releases executed in consideration for post-trial dispositions, this means that revocation may only occur upon successful completion of any service for which such court ordered post-trial disposition is based. For releases executed in consideration of any pretrial program, diversion, or release, this means any revocation may trigger a revocation of my pretrial release and/or participation in diversion or other pretrial program; and

(13) **The following is/are my criminal case(s) for which this consent is given:**

Court of Jurisdiction: ________ **Current Case No(s).** ______________________ **

Commonwealth Attorney: ________________

Defendant Attorney: ________________

Monitoring Agency: ________ **Contact Name:** ____________ **Phone#** ________

Type of Conditional Release:

____ **PreTrial** ___ **Probation** ____ **FDP** ____ **Other (explain):** ________________

______________________ ______________________________ ________________

Authorized Printed Name | Authorized Signature | Date

Revised 5.1.24

Client's Initials________

Date__________

Printed Name	Witness Signature	Date

VBDHS RELEASE OF INFORMATION FOR THE USE OF RECORDS AND TESTIMONY IN CIVIL, CRIMINAL, ADMINISTRATIVE, AND LEGISLATIVE PROCEEDINGS INVOLVING OR AGAINST PATIENTS/CLIENTS OF VBDHS

I, ____________________(Name), whose date of birth is ________(D/O/B), hereby acknowledge that I am a party to and/or in some manner involved in the civil, criminal, administrative case(s) or legislative proceedings set forth below. In conjunction with my acknowledgement of the foregoing, I hereby authorize the use or disclosure of my personal health information, **and** if my child or protected person for which I am guardian is involved, my child's/protected person's information, ____________________(name of child, d/o/b____________________) as described in this authorization. . I understand this release allows communication **to** and **from** the named parties.

(1.) The City of Virginia Beach -Department of Human Services ("VBDHS"), shall disclose all of the records and information ***as designated below in section 4*** to the following court(s) and involved parties:

***Case(s) Style**: ____________________________________; **Case No(s).** ____________________________________

***Court(s)/Administrative Hearing Setting** [includes judges, clerk staff, deputies, hearing officers, security]:
____

***Attorneys** (including office staff): ____
____

***Other involved parties** (i.e. experts, investigators, agencies, etc.): ____________________________________
____

***Legislative Proceeding**: ____

***Named Legislative Parties:**____

(2) that such information be used solely for the purposes of: **all aspects of the above styled proceeding(s)** and no other purpose unless otherwise directed by me or allowed by a court of competent jurisdiction; and

(3) that such information only be disclosed to the parties named in section number 1 above, unless otherwise directed by a court of competent jurisdiction; and

(4) **Designated Records:** I hereby request that the following records and information located in my files held by the VBDHS be disclosed to the parties listed in paragraph 1 above ("xxx" all that you wish to disclose):

XXX medical test results, evaluations, medication list, and treatment records
XXX mental health, psychiatric, and psychological test results, evaluations, medication list, and treatment records
XXX diagnostic testing and developmental service-related records
XXX substance abuse test results, evaluations, medication list, education, and treatment records to include compliance with a substance abuse classes and treatment, group participation, and other therapeutic intervention; and

Client's Intitials__________

Date__________

(5) I also agree and understand that any of the persons/entities authorized herein to receive my information and records under this section **may re-disclose** and use it only to carry out that individual's/entities official duties in connection with which this consent was given.

(6) I agree and understand that disclosure of my records and information may also be disseminated by VBDHS staff through direct Court testimony if requested by any of the parties or entities authorized herein to receive this information. I hereby authorize VBDHS staff to testify in open Court and in such case, I hereby understand that in so doing, members of the public and/or persons outside of those authorized to receive my information may become privy to my information. As such, I authorize all such disclosure as a part of my consent given herein.

(7) I understand that my initial and continued receipt of services from VBDHS is not subject to my agreement to this authorization or any other authorization by VBDHS. However, I understand that should I not agree to the disclosure of my information, the parties set forth herein will be notified.

(8) I understand I have the right to receive a copy of this authorization.

(9) I understand and fully acknowledge my right not to have this information disclosed and only do so after full disclosure by counsel of my choosing. I understand the potential consequences of having this information disclosed. I hereby represent and warrant that in authorizing such disclosure, I have not been induced or coerced in any manner. I hereby release the City of Virginia Beach, its departments, employees, agents, and representatives from any and all liability which may result from my execution of this release and my causing of my information to be released to the parties listed above.

(10). This consent will terminate on **30 days after the expiration of the last appeal in the case or matter listed above** .

Authorized Printed Name	Authorized Signature	Date
Witness Printed Name	Witness Signature	Date

Client's Intitials

Date

VBDHS RELEASE OF INFORMATION OF SUD COUNSELING NOTES

42CFR P.2 / 2.8.24 AMENDMENT

NOTICE TO PATIENT/CLIENT OF VBDHS: This release of information operates as a single consent for all future uses and disclosures of **Substance Use Disorder ("SUD") COUNSELING NOTES** from the City of Virginia Beach-Department of Human Services ("VBDHS") to those entities specified herein that receive and exchange records and information under this consent. I understand this release allows communication to and from the named parties.

I, ____________________________(d/o/b)______[**Client's name and Birth Date/Guardian name** hereby authorize the use or disclosure of my (**or my child's/protected person's** ____________________ **(d/o/b)** _________**(name of protected person or child and their d/o/b)** personal health information as described in this authorization:

(1) The City of Virginia Beach -Department of Human Services ("VBDHS"), shall disclose certain records and exchange information ***as designated below in section 6*** to, and with, the following parties ("**Covered Entities**"): (you must *specifically list all parties you want to have access to the information):* ____

(2) that such information be used solely for the purposes of ______________________________ unless otherwise directed by me or allowed by a court of competent jurisdiction; and

(3) that such information only be exchanged with the Covered Entities named in section number 1 above, unless otherwise directed by me or a court of competent jurisdiction; and

(4) **My consent is subject to revocation at any time except to the extent VBDHS takes action in reliance on this consent or to the extent otherwise ordered by a court of competent jurisdiction; and**

(5) I understand that once disclosed, federal law may not protect it and the recipient may re-disclose the information; and

(6) **Designated Records:** I hereby request that the following records and information located in my files held by VBDHS be released and disclosed to the Covered Entities set forth above: **all SUD Notes defined as notes recorded (in any medium) by DHS as a SUD treatment provider or mental health professional documenting or analyzing the contents of conversation during a private SUD counseling session or a group, joint, or family SUD counseling session and that are separated from the rest of the patient's SUD and medical record. *****SUD counseling notes*** **specifically** ***excludes*** **medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date**; and

(7) I understand that my initial and continued receipt of services from VBDHS is not subject to my agreement to this authorization or any other authorization by VBDHS; and

(8) I understand I have the right to receive a copy of this authorization; and

(9) I understand and fully acknowledge my right not to have this information disclosed and only do so after full disclosure by counsel of my choosing. I understand the potential consequences of having this information disclosed. I hereby represent and warrant that in authorizing such disclosure, I have not been induced or coerced in any manner. I hereby release the City of Virginia Beach, all of its departments, employees, agents, and representatives from any and all liability which may result from my execution of this release and my causing of my information to be released to the covered entities listed above; and

(10). If not previously revoked, my consent will terminate on ____________(a date or event must be listed or this release will be deemed invalid).

____________________	____________________	____________________
Authorized Printed Name	Authorized Signature	Date
____________________	____________________	____________________
Witness Printed Name	Witness Signature	Date

VBDHS RELEASE OF INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

**NOTICE TO PATIENT/CLIENT OF VBDHS: This release of information operates as a single consent for all future uses and disclosures for treatment, payment, and health care operations between the City of Virginia Beach-Department of Human Services ("VBDHS") and those HIPAA covered entities and business associates specified herein that receive and exchange records and information under this consent. It allows for the redisclosure of the records in accordance with HIPAA and 42 CFR Part 2, and allows for communications to and from covered entities.

I, ______________________________(d/o/b)______**[Client's name and Birth Date or Guardian name]** hereby authorize the use or disclosure of my (or my child's/protected person's ____________________ (d/o/b) ___________**(name of child or protected person and d/o/b)** health information as described in this authorization:

(1) The City of Virginia Beach -Department of Human Services ("VBDHS"), shall disclose certain records and exchange information ***as designated below in section 6*** to, and with, the following parties: (you must *specifically list all parties you want to have access to the information):* ______________________________

____

____

____

____

____

(2) that such information be used solely for the purposes of all future uses and disclosures for treatment, payment, and health care operations between VBDHS and the individuals and entitles set forth herein and no other purpose unless otherwise directed by me or allowed by a court of competent jurisdiction; and

(3) that such information only be exchanged with the covered entities named in section number 1 above, unless otherwise directed by me or a court of competent jurisdiction; and

(4) My consent is subject to revocation at any time except to the extent VBDHS takes action in reliance on this consent or to the extent otherwise ordered by a court of competent jurisdiction; and

(5) I understand that once disclosed, federal law may not protect it and the recipient may re-disclose the information; and

(6) **Designated Records:** I hereby request that the following records and information located in my files held by the VBDHS to be **disclosed to, and exchanged with, the individuals and/or entities** listed in paragraph 1 above (**check all that you wish to disclose**):

__ medical test results, evaluations, medication list, and treatment records
__ mental health, psychiatric, psychological records, evaluations, medication list, and treatment records
__ diagnostic testing and developmental service-related records
__ substance abuse test results, evaluations, medication list, education, and treatment records
__ parenting and visitation records (to include city sponsored classes such as father's in training)
__ child protective services and foster care records
__ Other: ______________________________

(7) I understand that my initial and continued receipt of services from VBDHS is not subject to my agreement to this authorization or any other authorization by VBDHS; and

(8) I understand I have the right to receive a copy of this authorization; and

(9) I understand and fully acknowledge my right not to have this information disclosed and only do so after full disclosure by counsel of my choosing. I understand the potential consequences of having this information disclosed. I hereby represent and warrant that in authorizing such disclosure, I have not been induced or coerced in any manner. I hereby release the City of Virginia Beach, all of its departments, employees, agents, and representatives from any and all liability which may result from my execution of this release and my causing of my information to be released to the covered entities listed above; and

(10). I understand this release does not allow for the release of any Substance Use Disorder Counseling Notes and does not allow my information to be used in any criminal, civil, administrative, or legislative proceeding and that in order for such a release to occur, I will need to execute one or more additional release forms, and may need to have certain court orders entered on my behalf; and

(11). If not previously revoked, my consent will terminate on ______________(a date or event must be listed or this release will be deemed invalid).

______________________	______________________
Authorized Printed Name	Authorized Signature

____
Date

______________________	______________________
Youth 14 and over Printed Name	Youth Signature

____
Date

______________________	______________________
Witness Printed Name	Witness Signature

____
Date

§ 19.2-152.2. Purpose; establishment of pretrial services and services agencies

It is the purpose of this article to provide more effective protection of society by establishing pretrial services agencies that will assist judicial officers in discharging their duties pursuant to Article 1 (§ 19.2-119 et seq.) of Chapter 9. Such agencies are intended to provide better information and services for use by judicial officers in determining the risk to public safety and the assurance of appearance of persons age 18 or over or persons under the age of 18 who have been transferred for trial as adults held in custody and charged with an offense, other than an offense punishable as a Class 1 felony, who are pending trial or hearing. Any city, county or combination thereof may establish a pretrial services agency and any city, county or combination thereof required to submit a community-based corrections plan pursuant to § 53.1-82.1 shall establish a pretrial services agency.

1994, 2nd Sp. Sess., cc. 1, 2;1999, cc. 829, 846;2004, c. 378;2007, c. 133;2021, Sp. Sess. I, cc. 344, 345.

The chapters of the acts of assembly referenced in the historical citation at the end of this section(s) may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

§ 9.1-173. Purpose

It is the purpose of this article to enable any city, county or combination thereof to develop, establish, and maintain a local community-based probation services agency to provide the judicial system with sentencing alternatives for certain misdemeanants or persons convicted of felonies that are not felony acts of violence, as defined in § 19.2-297.1 and sentenced pursuant to § 19.2-303.3, for whom the court imposes a sentence of 12 months or less and who may require less than institutional custody.

The article shall be interpreted and construed so as to:

1. Allow individual cities, counties, or combinations thereof greater flexibility and involvement in responding to the problem of crime in their communities;

2. Provide more effective protection of society and to promote efficiency and economy in the delivery of correctional services;

3. Provide increased opportunities for offenders to make restitution to victims of crimes through financial reimbursement or community service;

4. Permit cities, counties or combinations thereof to operate and utilize local community-based probation services specifically designed to meet the rehabilitative needs of selected offenders; and

5. Provide appropriate post-sentencing alternatives in localities for certain offenders with the goal of reducing the incidence of repeat offenders.

1980 c. 300, § 53.1-180; 1982, c. 636; 1983, c. 344; 1990, c. 578; 1992, c. 196; 1994, 2nd Sp. Sess., cc. 1, 2;1995, cc. 502, 574;1996, c. 568;2000, c. 1040;2001, c. 844;2002, c. 491;2007, c. 133.

The chapters of the acts of assembly referenced in the historical citation at the end of this section(s) may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

Code of Virginia
Title 19.2. Criminal Procedure
Chapter 9. Bail and Recognizances
Article 1. Bail

§ 19.2-123. Release of accused on secured or unsecured bond or promise to appear; conditions of release

A. Any person arrested for a felony who has previously been convicted of a felony, or who is presently on bond for an unrelated arrest in any jurisdiction, or who is on probation or parole, may be released only upon a secure bond. This provision may be waived with the approval of the judicial officer and with the concurrence of the attorney for the Commonwealth or the attorney for the county, city or town. Subject to the foregoing, when a person is arrested for either a felony or a misdemeanor, any judicial officer may impose any one or any combination of the following conditions of release:

1. Place the person in the custody and supervision of a designated person, organization or pretrial services agency which, for the purposes of this section, shall not include a court services unit established pursuant to § 16.1-233;

2. Place restrictions on the travel, association or place of abode of the person during the period of release and restrict contacts with household members for a specified period of time;

2a. Require the execution of an unsecured bond;

3. Require the execution of a secure bond which at the option of the accused shall be satisfied with sufficient solvent sureties, or the deposit of cash in lieu thereof. Only the actual value of any interest in real estate or personal property owned by the proposed surety shall be considered in determining solvency and solvency shall be found if the value of the proposed surety's equity in the real estate or personal property equals or exceeds the amount of the bond;

3a. Require that the person do any or all of the following: (i) maintain employment or, if unemployed, actively seek employment; (ii) maintain or commence an educational program; (iii) avoid all contact with an alleged victim of the crime and with any potential witness who may testify concerning the offense; (iv) comply with a specified curfew; (v) refrain from possessing a firearm, destructive device, or other dangerous weapon; (vi) refrain from excessive use of alcohol, or use of any illegal drug or any controlled substance not prescribed by a health care provider; and (vii) submit to testing for drugs and alcohol until the final disposition of his case;

3b. Place a prohibition on a person who holds an elected constitutional office and who is accused of a felony arising from the performance of his duties from physically returning to his constitutional office;

3c. Require the accused to accompany the arresting officer to the jurisdiction's fingerprinting facility and submit to having his photograph and fingerprints taken prior to release; or

4. Impose any other condition deemed reasonably necessary to assure appearance as required, and to assure his good behavior pending trial, including a condition requiring that the person return to custody after specified hours or be placed on home electronic incarceration pursuant to § 53.1-131.2 or, when the person is required to execute a secured bond, be subject to monitoring by a GPS (Global Positioning System) tracking device, or other similar device. The defendant may

be ordered by the court to pay the cost of the device.

Upon satisfaction of the terms of recognizance, the accused shall be released forthwith.

In addition, where the accused is an individual receiving services in a state training center for individuals with intellectual disability, the judicial officer may place the individual in the custody of the director of the training center, if the director agrees to accept custody. The director is hereby authorized to take custody of the individual and to maintain him at the training center prior to a trial or hearing under such circumstances as will reasonably assure the appearance of the accused for the trial or hearing.

B. In any jurisdiction served by a pretrial services agency which offers a drug or alcohol screening or testing program approved for the purposes of this subsection by the chief general district court judge, any such person charged with a crime may be requested by such agency to give voluntarily a urine sample, submit to a drug or alcohol screening, or take a breath test for presence of alcohol. A sample may be analyzed for the presence of phencyclidine (PCP), barbiturates, cocaine, opiates or such other drugs as the agency may deem appropriate prior to any hearing to establish bail. The judicial officer and agency shall inform the accused or juvenile being screened or tested that test results shall be used by a judicial officer only at a bail hearing and only to determine appropriate conditions of release or to reconsider the conditions of bail at a subsequent hearing. All screening or test results, and any pretrial investigation report containing the screening or test results, shall be confidential with access thereto limited to judicial officers, the attorney for the Commonwealth, defense counsel, other pretrial service agencies, any criminal justice agency as defined in § 9.1-101 and, in cases where a juvenile is screened or tested, the parents or legal guardian or custodian of such juvenile. However, in no event shall the judicial officer have access to any screening or test result prior to making a bail release determination or to determining the amount of bond, if any. Following this determination, the judicial officer shall consider the screening or test results and the screening or testing agency's report and accompanying recommendations, if any, in setting appropriate conditions of release. In no event shall a decision regarding a release determination be subject to reversal on the sole basis of such screening or test results. Any accused or juvenile whose urine sample has tested positive for such drugs and who is admitted to bail may, as a condition of release, be ordered to refrain from use of alcohol or illegal drugs and may be required to be tested on a periodic basis until final disposition of his case to ensure his compliance with the order. Sanctions for a violation of any condition of release, which violations shall include subsequent positive drug or alcohol test results or failure to report as ordered for testing, may be imposed in the discretion of the judicial officer and may include imposition of more stringent conditions of release, contempt of court proceedings, or revocation of release. Any report of a violation of any pretrial condition of release provided to the court shall be sent by the pretrial services agency to the attorney for the Commonwealth and the counsel of record for the accused or juvenile, or directly to the accused or juvenile if such person is not represented by counsel. Any test given under the provisions of this subsection which yields a positive drug or alcohol test result shall be reconfirmed by a second test if the person tested denies or contests the initial drug or alcohol test positive result. The results of any drug or alcohol test conducted pursuant to this subsection shall not be admissible in any judicial proceeding other than for the imposition of sanctions for a violation of a condition of release.

C. [Repealed.]

D. Nothing in this section shall be construed to prevent an officer taking a juvenile into custody

from releasing that juvenile pursuant to § 16.1-247. If any condition of release imposed under the provisions of this section is violated, a judicial officer may issue a capias or order to show cause why the recognizance should not be revoked.

E. Nothing in this section shall be construed to prevent a court from imposing a recognizance or bond designed to secure a spousal or child support obligation pursuant to § 16.1-278.16, Chapter 5 (§ 20-61 et seq.) of Title 20, or § 20-114 in addition to any recognizance or bond imposed pursuant to this chapter.

Code 1950, § 19.1-109.2; 1973, c. 485; 1975, c. 495; 1978, cc. 500, 755; 1979, c. 518; 1981, c. 528; 1984, c. 707; 1989, c. 369; 1991, cc. 483, 512, 581, 585; 1992, c. 576; 1993, c. 636; 1999, cc. 829, 846;2000, cc. 885, 1020, 1041;2001, c. 201;2006, c. 296;2008, cc. 129, 884;2011, cc. 799, 837; 2012, cc. 476, 507;2013, c. 614;2014, c. 466;2024, c. 74.

The chapters of the acts of assembly referenced in the historical citation at the end of this section(s) may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

Video		
Body Camera	Yes	No
In-Car Camera	Yes	No

VIRGINIA BEACH POLICE DEPARTMENT - DUI CHECK SHEET

Defendant: ______ IBR: ______

PHASE ONE: Vehicle in Motion

1. First observation of defendant's vehicle: Date: ______ Time: ______
2. Location: ______
3. Reason for stop: (weaving, swerving, speeding, equipment violation, other): ______
4. Time of stop: ______ Location of stop: ______
5. Observation of stop (pulled over, did not react to emergency lights, eluded, other behavior): ______
6. Defendant (driver) identified as: ______

CRASH CASE:

7. First officer on scene: ______ Time: ______ DUI investigating officer: ______ Time on scene: ______
8. Location of crash: ______
9. Date: ______ Time of crash (NOT call for service time): ______ Verified how?: ______
10. Defendant identified as driver: ______ Explain how identified as driver: ______
11. Defendant was asked:
    - How many minutes ago the crash occurred: ______
    - What road they were driving on when the crash occurred: ______
    - Where they were coming from: ______
12. Did defendant consume alcohol/medication/drugs since crash: **YES / NO** Verified how: ______
13. Defendant injured from the crash: **YES / NO** Defendant transported to hospital: **YES / NO** Hospital: ______
14. If the defendant is unavailable/unconscious/unable to communicate:
    - Which witness can verify the time that the crash occurred: ______
    - Which witness can verify that the defendant was the driver: ______
    - Which witness can verify the defendant consumed no alcohol/drugs since the crash: ______

PHASE TWO: Personal Contact

1. When I asked the defendant for his/her driver's license and registration, the following occurred: ______
2. The defendant stated the date and time was: ______ Actual date/time: ______

OBSERVATIONS OF DEFENDANT:

3. SPEECH: slurred, incoherent, hysterical, shouting, or ______
4. ODOR OF ALCOHOLIC BEVERAGE: strong, faint, or ______
5. EYES: bloodshot, watery, glassy, or ______
6. FACE: flushed, pale, or ______
7. CLOTHING: dirty, soiled, disheveled, or ______
8. WALK: swaying, stumbling, falling, or ______
9. ABILITY TO STAND: swaying, falling, leaning on objects for support, or ______
10. ACTIONS: cooperative, fighting, abusive language, crying, or ______
11. MEDICAL / PHYSICAL DEFECTS: ______
12. MEDICATIONS: ______ Time taken: ______
13. ALCOHOL / DRUGS CONSUMED (amount, what, when, where): ______ Time of first drink: ______ Time of last drink: ______

PHASE THREE: Pre-Arrest Screening

Horizontal Gaze Nystagmus Test

Yes	No	*Medical Impairment*
		Equal Pupil Size
		Was Resting Nystagmus Present
		Equal Tracking

Left Eye	*Standardized Clues*	Right Eye
	Lack of Smooth Pursuit	
	Distinct and Sustained Nystagmus at Maximum Deviation	
	Onset of Nystagmus Prior to 45-Degrees	

Vertical Gaze Nystagmus: Yes ☐ No ☐

Number of Clues (Observed out of 6) ☐

Notes: (for example, difficulty following stimulus; eye observations; etc. ____________

Walk and Turn Test

	1st Nine	2nd Nine
Stops Walking		
Misses Heel-Toe		
Steps Off Line		
Raises Arms		
Actual Steps Taken		

Improper Turn ☐

Cannot keep balance ____________

Starts too soon ____________

Number of Clues (Observed Out of 8) ☐

One Leg Stand

L	R	
		Sways while balancing
		Uses arms to balance
		Hopping
		Puts foot down

Type of Footwear ____________

Number of Clues (Observed out of 4) ☐

NOTES: ____________

If additional tests are conducted, please refer to inserts

Preliminary Breath Test

(IF AVAILABLE, THE PRELIMINARY BREATH TEST SHALL BE OFFERED TO PERSONS SUSPECTED OF DUI, OMVICA, OR 18.2-272 VIOLATIONS. READ THE RIGHTS BEFORE OFFERING THE TEST)

A. You have the right to take a Preliminary Breath Test.
B. You have the right to refuse a Preliminary Breath Test.
C. You have the right to know the results of this test.
D. The results of this test or your refusal to take it shall not be used as evidence in any prosecution of DUI, OMVICA, or Driving while suspended for DUI.

Preliminary Breath Test Rights read to the defendant at ________ hours

Before blowing, ensure it has been at least 15 minutes of no eating, drinking, smoking, or anything in their mouth

Preliminary Breath Test offered to the defendant at ________ hours.

DO NOT TESTIFY TO THE FOLLOWING UNLESS ASKED BY AN ATTORNEY OR JUDGE:
Refused: YES / NO Result: ________ BAC PBT provided by Officer: ________

Arrest

Time placed under arrest: ________ Time Miranda Rights read: ________

Searched incident to arrest and located: ____________

Consent to Testing

Implied Consent (Public roadway + arrest occurred within 3 hours of offense): Explain to the defendant that Virginia State Code 18.2-268.2 (Implied Consent) requires them to submit to a breath and/or blood test.

The defendant intended to take the required test: **YES / NO**

OR

Private Property: Explain to the defendant that a breath and/or blood test is not required but can be taken voluntarily.

The defendant voluntarily submitted to the test: **YES / NO**

Breath Test

1. Location of Breath Test: ______________________________
2. ______________________ was the breath test operator who performed the test.
3. The card number is ______________ and expires on *(date)* ______________.
4. The above listed breath test operator completed a visual inspection of the defendant's mouth.
5. The accused was advised by the breath test operator of his/her rights to observe the process and to see the breath alcohol analysis reading on the equipment used to perform the test. The accused *(circle one)* **DID / DID NOT** elect the opportunity to observe the process of analysis and to see the breath alcohol analysis reading on the equipment used to perform the breath test.
6. Observation start time: __________ hours.
7. Remain with the defendant during the entire observation and test period. Ensure he/she did not drink, smoke, vomit, belch, or place his/her hands in his/her mouth. (*Defendant was asked prior to each sample given if he/she did any of these things.*)
8. The sample was taken at __________ hours.
9. The breath test operator gave the defendant a copy of the test results at __________ hours. BAC: __________

Refusal

1. The defendant refused to take a breath/blood test.
2. Acknowledgement/Declaration of Refusal form read to the defendant at __________ hours.
3. The defendant was asked again if they are going to comply with the breath or blood test.
4. Defendant Response: ______________________________

DUID

The defendant was believed to be under the influence of drugs due to: ______________________________

The defendant **CONSENTED / REFUSED** the blood test. Refer to blood draw insert.

The defendant participated in a voluntary Drug Influence Evaluation: **YES / NO**

Evaluation conducted by Drug Recognition Expert: ______________________________

Search Warrant

If the defendant was transported to a hospital for treatment and a search warrant was completed, see below.

Type of search warrant(s): **HOSPITAL TREATMENT RECORDS / TRAUMA BLOOD VIALS**

Search Warrant Execution Date: __________ Time: __________ Location: ______________________

Executed Search Warrant certified to ______________ Circuit Court on (Date) ______________

Witnesses

Name: ____________ Address: ____________

Phone: ____________ Summary: ____________

Name: ____________ Address: ____________

Phone: ____________ Summary: ____________

Name: ____________ Address: ____________

Phone: ____________ Summary: ____________

Officer Notes

Misc. Info

Vehicle Description: ____________

Vehicle searched: **YES / NO** By Officer: ____________

Evidence located in vehicle: ____________

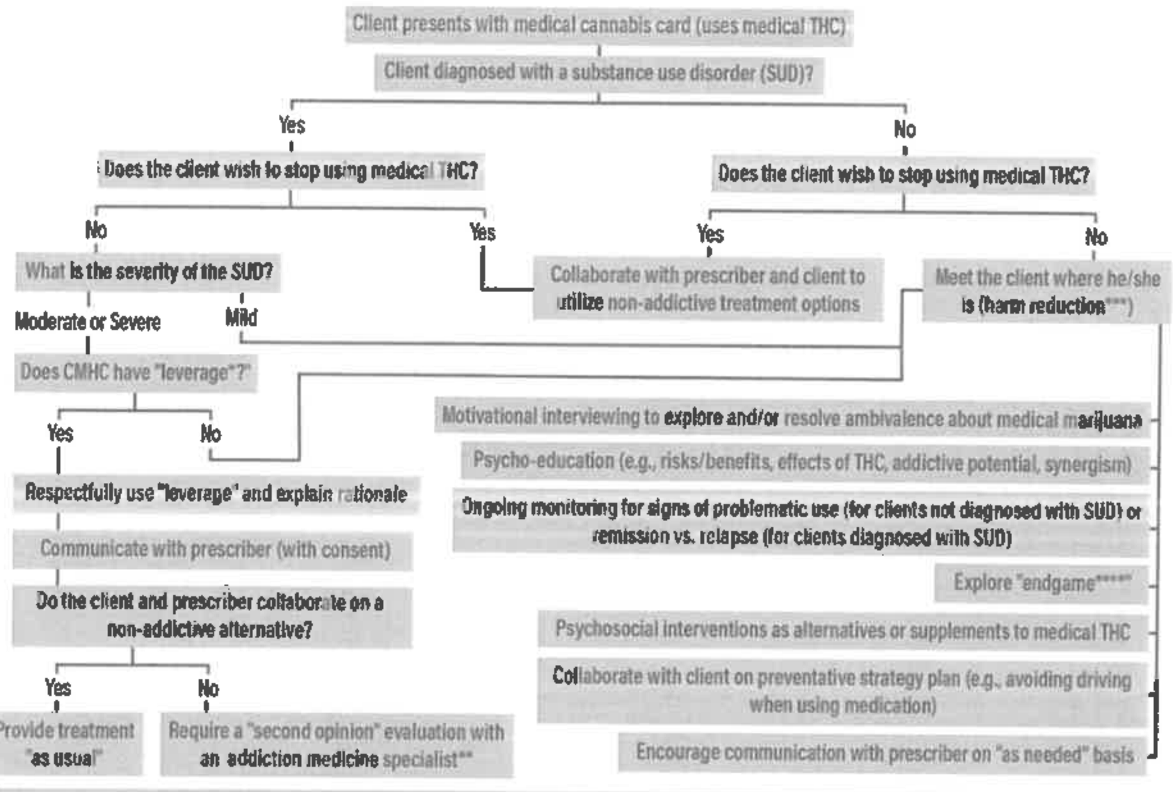
Vehicle Tag # ____________ State ____________

Driver's License # ____________ State ____________

SSN # ____________

Check Sheet completed by Officer: ____________

Decision matrix for clinical mental health counselors encountering medical cannabis use in mental health and substance abuse treatment settings



Definitions: ***Leverage:** Resources or outcomes pursued by a client that may be conditional to successful treatment completion (e.g., successful compliance with probation/avoidance of incarceration, reunification with children, eligibility for social programs, reinstatement of driver's license)

** **Addiction medicine specialist:** a physician or psychiatrist who is certified by the American Society of Addiction Medicine (ASAM) with expertise in prevention, screening, intervention, and treatment for substance use (asam.org)

*** **Harm reduction:** A treatment and prevention approach focused on decreasing health and socio-economic costs and consequences of addiction-related problems, whether the client is still using an addictive substance or not

****Endgame:** Refers to the long-term strategies and approaches the client will use for his or her presenting problem(s) vs. short-term approaches. In other words, because addictive medications, when used daily over extended periods of time, tend to produce tolerance, what will the client do when the medication stops having as much therapeutic effect in the future?

Decision matrix by Aaron Norton

https://www.counseling.org/publications/counseling-today-magazine/article-archive/article/legacy/the-impact-of-legalized-marijuana-on-professional-counseling

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Short communication

Association between cannabis potency and mental health in adolescence

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ARTICLE INFO

Keywords:
Cannabis
THC
Depression
Anxiety
Hallucination
Adolescent

ABSTRACT

Introduction: In legal and illegal markets, high-potency cannabis (>10 % delta-9-tetrahydrocannabinol (THC)) is increasingly available. In adult samples higher-potency cannabis has been associated with mental health disorder but no studies have considered associations in adolescence.
Methods: A population-wide study compared no, low and high potency cannabis using adolescents (aged 13–14 years) self-reported symptoms of probable depression, anxiety, and auditory hallucinations.
Results: Of the 6672 participants, high-potency cannabis was used by 2.6 % (n=171) and low-potency by 0.6 % (n=38). After adjustment for sociodemographic factors, tobacco and alcohol use, in comparison to participants who had never used cannabis, people who had used high-potency but not low-potency cannabis were more likely to report symptoms of depression (odds ratio 1.59 [95 % confidence interval 1.06, 2.39), anxiety (OR 1.45, 95 % CI 0.96, 2.20), and auditory hallucinations (OR 1.56, 95 % CI 0.98, 2.47).
Conclusions: High-potency cannabis use is associated with an increased risk of probable mental health disorders. Services and programming to minimise drug harms may need to be adapted to pay more attention to cannabis potency.

1. Introduction

Cannabis use policy is liberalising in many jurisdictions, and regular cannabis use has become more prevalent where cannabis is legal (United Nations: World Drug Report, 2023). Cannabis potency, defined as the concentration of Δ⁹-tetrahydrocannabinol (THC), doubled in the USA and Europe between 2008 and 2017 (Chandra et al., 2019; Petrilli et al., 2022), and new legal markets have facilitated the rapid development of cannabis products with higher potencies. Understanding the health effects of higher-potency cannabis is important as the experimental admiration of THC produces dose-dependent effects on anxiety and psychosis-like experiences (D'Souza et al., 2004), suggesting people who use higher-potency cannabis products may exposed to more risk.

A systematic review of 20 observational studies with adults found higher-potency cannabis was associated with increased risk of psychosis, and may be associated with anxiety, but little evidence was found for an association with depression (Petrilli et al., 2022). As far as we are aware, no studies have considered the relationship between cannabis potency and mental health in adolescence, despite evidence that the risks from cannabis use are greatest when use starts at younger ages (Hosseini and Oremus, 2019). Accordingly, we compared the mental health of people who use high- and low-potency cannabis in adolescence.

2. Materials and methods

2.1. Study sample

Data were from baseline assessments within a randomised controlled trial conducted in England and Wales (White, 2019). Schools were randomly sampled, and questionnaires completed before allocation. All procedures were approved by Cardiff University's School of Social Sciences Ethics Committee (SREC/3342; 11th June 2019) and comply with

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the Helsinki Declaration of 1975, as revised in 2008. Written informed consent was obtained from all participants. The data that support the findings of this study are openly available at http://doi.org/10.17035/d.2023.0244798057. This manuscript adheres to the STROBE reporting guidelines (Von Elm et al., 2007).

2.2. Measures

Probable depressive disorder was assessed using 13-item Short Mood and Feelings Questionnaire applying the ≥12 cut-off point to indicate a disorder (Ancold and Stephen, 1995). *Probable anxiety disorders* were assessed using the Generalized Anxiety Disorder scale applying the ≥10 cut-off point (Spitzer et al., 2006). *Auditory hallucinations* were self-reported using three questions from the World Health Organization Composite International Diagnostic Interview (Kessler and Üstün, 2004).

Cannabis potency was assessed by asking participants whether they have ever tried "Cannabis (also called: marijuana, spliff, hash, skunk, grass, draw, dab, shatters)". Those who reported having tried cannabis were asked "What type of cannabis have you most commonly used in the past year?" and were able to select from the following options: "herbal cannabis/ marijuana (herbal cannabis containing seeds, dark green to brown colour, earthy smell)", "skunk/ sinsemilla/ other high-potency herbal cannabis (herbal cannabis without seeds, bright green, strong smell)", "hashish/ resin/ solid (compressed blocks, brown coloured)", "cannabis concentrate/ shatters (cannabis in a viscous oil or brittle form, extremely strong effects)", or "I don't know which type". Images used in previous studies to estimate the relative concentrations of THC and cannabidiol (CBD) in each type of cannabis were provided to aid identification (see the Appendix; Freeman et al., 2014; Potter et al., 2018; Raber et al., 2015; Wilson et al., 2019). To be consistent with previous research that has validated self-reported data on three types of cannabis according to concentrations of THC and CBD among people who use cannabis in the UK (Freeman et al., 2014), we categorised use into never, used low (typically <10 % THC, 1–2 % CBD; "herbal cannabis/ marijuana", "hashish/ resin/ solid") or high-potency cannabis (typically >10 % THC, <1 % CBD; "skunk/ sinsemilla/ other high potency herbal cannabis", "cannabis concentrate/ shatters"; Di Forti et al., 2019)).

Covariates were sociodemographic factors including self-reported gender identity (boy, girl, gender minority), age, ethnicity, socioeconomic disadvantage (free school meal entitlement, parental unemployment), smoking, alcohol consumption, frequency of cannabis use, and problematic cannabis use based on scoring ≥2 on the Cannabis Abuse Screening Test (Legleye et al., 2007).

2.3. Analysis

Missing data per variable ranged from 1.0 % to 11.4 % (Appendix Table 1). Missing data in all variables (exposures, outcomes, and covariates) were addressed through multiple imputation using chained equations and included a number of auxiliary variables to make the missing at random assumption more plausible. Each model included all variables, including the following auxiliary variables: age, ethnicity, and problematic cannabis use, and alcohol consumption in the past 30 days. Estimates were obtained by pooling results across 20 imputed datasets using the Rubin rules and assessment of Monte Carlo errors suggested this was a suitable number of imputations (White et al., 2011).

To test differences in the characteristics of participants by cannabis potency, we used logistic regression for binary exposures, multinomial for categorical exposures and linear regression for age (years). We estimated odds ratios (ORs) for the association between cannabis potency and outcomes using multilevel logistic regression (students nested within schools). These are reported alongside 95 % confidence intervals (CIs). The association between low- and high-potency cannabis compared to never having used cannabis was adjusted for the potential confounding effects of age, gender identity, socioeconomic disadvantage, then weekly smoking and alcohol use. Sensitivity analyses were conducted after excluding participants with any missing data, with lifetime cannabis use as the exposure, comparing low versus high potency cannabis use, then applying inverse-probability weighting by a propensity score.

3. Results

Of 7077 eligible to take part, 6672 participated (94.3 % response). Of these respondents, 60 (1.0 %) did not know what type of cannabis they had used, so were removed from the dataset. Of the 6612 participants, 0.6 % reported low-potency and 2.6 % high-potency cannabis use. Use of high-compared to low potency cannabis was more common in participants who smoked, drank alcohol, a gender minority, and came from a socioeconomically deprived household, but were no more likely to have a cannabis use problem, or have used cannabis in the past month (Table 1).

People who used high-potency cannabis were more than three times as likely to report a probable depressive disorder, anxiety disorder and auditory hallucinations, compared to those who had never used cannabis (Table 2). There was evidence of similar associations in unadjusted analyses for people who used low-potency cannabis. There was little evidence of attenuation of these associations after adjustment for

Table 1
Characteristics of young people by cannabis potency (n = 6612).

Characteristic	Cannabis use %			
	Never used (n = 6402)	Low potency (n = 38)	High potency (n = 171)[a]	P value for trend[b]
Mental health outcomes				
Probable depressive disorder[c]	21.5	35.6	50.2	<0.001
Probable generalized anxiety disorder[c]	18.9	38.8	41.7	<0.001
Auditory hallucination	18.7	25.9	44.8	<0.001
Sociodemographic Characteristics				
Gender identity				
Boy	51.3	63.7	47.2	
Girl	46.6	33.1	46.6	0.89
Gender minority	2.1	3.2	6.2	0.001
Age (years) (Mean, SD)	13.69 (0.40)	13.75 (0.37)	13.76 (0.39)	0.003
Black, Asian and Minority Ethnicity	8.6	7.9	7.7	0.67
Entitled to free school meals	10.5	17.6	19.1	<0.001
Parent(s) / carer(s) unemployed	5.8	5.4	15.4	<0.001
Substance use				
Smoked in the past week	0.4	22.9	31.6	<0.001
Consumed alcohol in past 30 days	36.4	90.8	93.0	<0.001
Screened for a cannabis use problem	0.0	22.2	21.3	<0.001
Frequency of cannabis in past 12 months				
Weekly or more	0.0	18.0	18.1	<0.001
Monthly	0.0	82.0	81.8	<0.001

[a] All numbers estimated from imputed proportions.
[b] Determined by logistic, linear, or multinomial regression.
[c] Probable depressive disorder: Scoring ≥12 on Short mood and feelings questionnaire; Probable generalized anxiety disorder: Scoring ≥ 10 on Generalized Anxiety Disorder Scale; Cannabis use problem: Scoring ≥ on the Cannabis Abuse Screening Test.

Table 2
Association between the reported cannabis potency with probable mental health disorders and auditory hallucinations (n = 6612).[a]

	Odds ratio (95 % confidence interval)			
	Unadjusted	Adjusted for sociodemographic factors[b]	Adjusted for tobacco use[c]	Adjusted for alcohol and tobacco use[c]
Probable depressive disorder				
Never used	1.00 (reference)	-	-	-
Low potency	2.46 (1.13, 5.34)	2.45 (1.13, 5.32)	1.84 (0.81, 4.20)	1.18 (0.50, 2.76)
High potency	3.71 (2.63, 5.26)	3.53 (2.49, 5.01)	2.47 (1.66, 3.68)	1.59 (1.06, 2.39)
Probable generalized anxiety disorder				
Never used	1.00 (reference)	-	-	-
Low potency	3.43 (1.58, 7.45)	3.44 (1.58, 7.50)	2.69 (1.19, 6.10)	1.91 (0.83, 4.41)
High potency	3.01 (2.11, 4.29)	2.86 (2.00, 4.09)	2.04 (1.35, 3.09)	1.45 (0.96, 2.20)
Auditory hallucinations[d]				
Never used	1.00 (reference)	-	-	-
Low potency	1.54 (0.59, 3.97)	1.54 (0.59, 4.01)	1.10 (0.40, 3.01)	0.79 (0.29, 2.17)
High potency	3.34 (2.25, 4.94)	3.13 (2.10, 4.66)	2.20 (1.39, 3.48)	1.56 (0.98, 2.47)

[a] All results estimated from imputed data. Multivariable model adjustment is incremental.
[b] Sociodemographic factors comprise age, gender identity, free school meal entitlement and parent/caregiver unemployment.
[c] Tobacco use assessed as weekly cigarette smoking and alcohol assessed as consuming alcohol in the past 30 days.
[d] Analytical n = 4813 as excludes those who responded that they preferred not to say or didn't know whether they had hallucinated.

sociodemographic factors. Associations were, however, markedly reduced after the addition of weekly smoking and after the addition of alcohol use associations for low potency cannabis were no longer evident.

In the datasets where there was no missing data, the confidence intervals for estimates overlapped with those from the main results using imputed data indicating there were no meaningful differences. There was evidence of an association between lifetime cannabis use and symptoms of a depressive, anxiety, conduct disorder and auditory hallucinations. There was little difference between the estimates from the multivariate and propensity-score model (Appendix, Tables 2–5).

4. Discussion

To our knowledge, the present study is the first to report on the use of low- and high- cannabis potency in early adolescence. High-potency cannabis using adolescents were significantly more likely than their peers who had never used cannabis use to report a probable depressive disorder, anxiety disorder, and auditory hallucination.

Of those using cannabis, the majority (82 %) reported that they were using high-potency cannabis. In other general population samples where use of high-potency herbal cannabis was measured, prevalence of use was reported at 69 % in a global, self-selecting sample young adults who use drugs (Chan et al., 2017), and 13 % (Hines et al., 2020) in a UK general population sample of 24 year-old participants. In this context, the prevalence of high-potency cannabis use in this young adolescent sample is high. However, published analyses of police seizure data in the UK identified that 80 % of samples of herbal cannabis had high (≥10 %) THC content (Potter et al., 2018). Consequently the prevalence of use in the present sample may reflect the availability of high-potency cannabis in the UK's illegal market.

The present study is the first to show associations between high potency cannabis use and mental health disorder apparent in adults are also evident in adolescence. We found associations between the use of high-potency cannabis and depression, anxiety, and auditory hallucinations, after adjustment for sociodemographic factors, tobacco and alcohol use. This is in line with existing research on high potency cannabis use and anxiety in older populations (Hines et al., 2020) and psychosis in adults (Chan et al., 2017; Di Forti et al., 2015), as well as research showing lower-potency cannabis is not associated with auditory hallucinations (Di Forti et al., 2019); but contrasts with studies that have not previously found cannabis potency is associated with depressive symptoms (Chan et al., 2017; Hines et al., 2020; Prince and Conner, 2019).

This study is the first to describe the use of high-potency cannabis in a general-population sample of adolescents, utilising validated measures of mental health and images to aid the identification of different types of cannabis. However, there are a number of limitations that need to be considered when interpreting the results of this work. Firstly, the study is cross-sectional and, consequently, it is not possible that reverse causation may explain our findings. For the mental health disorders we assessed symptoms are likely to fist emerging at a similar time to or after onset of cannabis use. Secondly, we cannot be certain participants are correct when stating the type of cannabis that they're using. Thirdly, most of the sample did not report cannabis use and consequently some of the analyses might be underpowered.

5. Conclusions

Among early adolescents using cannabis in an illegal market, high-potency cannabis is the most used type of cannabis. Even in such a young population, associations with negative mental health are already present, and notably high-potency cannabis is most prevalent among groups which are already disadvantaged. Our findings signal to educators and clinicians a need for policies, organisational practices, and programmes that better attend to the potency cannabis in efforts to minimise harms associated with its use.

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CRediT authorship contribution statement

Matthew Hickman: Writing – review & editing, Funding acquisition. **Jemma Hawkins:** Writing – review & editing, Funding acquisition. **Chris Bonell:** Writing – review & editing, Methodology, Funding acquisition. **Lindsey A. Hines:** Writing – original draft, Methodology, Conceptualization. **Rebecca Cannings-John:** Writing – review & editing, Methodology, Funding acquisition, Conceptualization. **Julia Townson:** Writing – review & editing, Project administration, Funding acquisition. **James White:** Writing – review & editing, Methodology, Funding acquisition, Formal analysis. **Stanley Zammit:** Writing – review & editing, Methodology, Conceptualization. **Linda Adara:** Writing – review & editing, Project administration, Methodology.

Declaration of Competing Interest

The authors have no conflicts of interest to disclose.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.drugalcdep.2024.111359.

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Exposure to maternal cannabis use disorder and risk of autism spectrum disorder in offspring: A data linkage cohort study

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ABSTRACT

This study aimed to investigate the association between pre-pregnancy, prenatal and perinatal exposures to cannabis use disorder (CUD) and the risk of autism spectrum disoder (ASD) in offspring. Data were drawn from the New South Wales (NSW) Perinatal Data Collection (PDC), population-based, linked administrative health data encompassing all-live birth cohort from January 2003 to December 2005. This study involved 222 534 mother-offspring pairs. . The exposure variable (CUD) and the outcome of interest (ASD) were identified using the 10th international disease classification criteria, Australian Modified (ICD-10-AM). We found a three-fold increased risk of ASD in the offspring of mothers with maternal CUD compared to non-exposed offspring. In our sensitivity analyses, male offspring have a higher risk of ASD associated with maternal CUD than their female counterparts. In conclusion, exposure to maternal CUD is linked to a higher risk of ASD in offspring, with a stronger risk in male offspring. Further research is needed to understand these gender-specific effects and the relationship between maternal CUD and ASD risk in children.

1. Introduction

According to the Fifth Diagnostic and Statistical Manual of Mental Disorders (DSM-5), autism spectrum disorder is defined as persistent deficits in social communication and social interaction across multiple contexts and skills in developing, maintaining, and understanding relationships (APA, 2013). Globally, the most recent prevalence of ASD is estimated at 0.6 % (95 % confidence interval: 0.4–1 %), where the highest prevalence (1.7 %) is reported in Australia (95 % CI: 0.5–6.1 %), followed by Africa (1 % with 95 % CI: 0.3–3.1) (Salari et al., 2022). Until now, no single aetiology has been identified as the cause of ASD in childhood and adolescence (Lord et al., 2000; Sajdeya et al., 2021). Emerging epidemiological studies suggest that approximately 55–58 % of ASD is explained by environmental factors, including maternal cannabis use in pregnancy (Corsi et al., 2020; Hallmayer et al., 2011; Hwang and Lee, 2024) and familial factors, such as genetics (Bailey et al., 1995; Choi and An, 2021; Hallmayer et al., 2011; Hwang and Lee, 2024; Lichtenstein et al., 2010). Cannabis has become the most frequently used illicit substance during pregnancy, with its prevalence steadily increasing over the last two decades. This trend is likely influenced by the legalisation of recreational cannabis use and shifts in illicit drug policies (Volkow et al., 2019). For example, a 2020 scoping review conducted by Singh et al. highlighted the substantial variation in the prevalence of cannabis use among pregnant women, with the highest prevalence reported in the first trimester of pregnancy (12.1 %) and United States (22.6 %) (Singh et al., 2020). Previous studies conducted in Australia reported that 1 in 5 pregnant women use cannabis during pregnancy (Passey et al., 2014; Stephanie et al., 2016); however, recreational cannabis use in the general population, including pregnant women, has not been legalised yet (Hall, 2008; Hughes, 2020; Sutton and Hawks, 2005). In-utero exposure to cannabis could be associated with long-lasting effects on neurological development, including ASD, as documented by various studies (Corsi et al., 2020; Grant et al., 2018; Metz and Borgelt, 2018).

Existing epidemiological research investigating the link between in-utero cannabis exposure and the risk of ASD in offspring has not been conclusive (Corsi et al., 2020; DiGuiseppi et al., 2021; Moore et al., 2023; Nutor et al., 2023). For example, an illustration of this variability is evident in a study conducted in 2020 by Corsi et al., which reported a 1.51 times higher likelihood of ASD in offspring prenatally exposed to

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cannabis compared to those unexposed (Corsi et al., 2020). On the contrary, contrasting findings emerged from other studies that did not establish a significant association between in-utero cannabis exposure and the occurrence of ASD in offspring (DiGuiseppi et al., 2021; Moore et al., 2023; Nutor et al., 2023; Pham et al., 2022; Sajdeya et al., 2021). Further, most studies to date on cannabis use relied on self-reported information that has well-documented limitations, under-reporting and recall bias (Brener et al., 2003; Brown et al., 1992). Additionally, the previous studies have involved small samples of mother-offspring pairs (Moore et al., 2023; Nutor et al., 2023; Pham et al., 2022), and none investigated gender-specific risk of ASD in exposed offspring. Hospital admission records and other administrative data provide an objective measure for assessing maternal cannabis use during pregnancy, serving as a valuable supplement to self-reported data and similar methodologies. Additionally, as reported by a 2023 meta-analysis study by Tadesse et al., there are limited and inconclusive studies to date to examine the impact of maternal perinatal cannabis use on neurodevelopmental outcomes, specifically ASD in offspring (Tadesse et al., 2024).

To fill the gaps identified in the current body of research, this study examines the association between maternal CUD diagnoses during pre-pregnancy, prenatal, and perinatal periods and the increased risk of ASD in exposed offspring using diagnostic variables derived from large linked data.

2. Methods and materials

This study was based on population-based, linked administrative data that included a sample of 259,150 mothers-offspring pairs, including all live births from 01 January 2003 to 31 December 2005 in New South Wales (NSW), Australia. NSW state is the most populous state in Australia, with a total population of 8294,100 as of March 2023 (ABS., 2023).

2.1. *The study population and data sources*

The data comes from routinely collected health data sources, primarily hospitalisations. Mothers of offspring in this study were followed from the twelve months before pregnancy through the end of the first year after birth to identify hospital admissions with cannabis use disorder (CUD) diagnoses. Furthermore, all live offspring were followed from birth to December 2018 to identify hospital admissions and outpatient visits with a diagnosis of ASD. Thus, our analyses included all mothers-offspring pairs during the specified study period.

The birth records in the Prenatal Data Collection (PDC) from 01 January 2003 to 31 December 2005 were linked with the Admitted Patients Data Collection (APDC) and outpatients visit (Mental Health Ambulatory data collection) (MH-AMB-DC) records, containing diagnoses of psychiatric illness and mental health disorders due to substance use spanning from 01 January 2002 to 31 December 2006. The PDC is a comprehensive population-based data collection in New South Wales (NSW) that records information on all live births and stillbirths that meet specific criteria- at least 20 weeks' gestation and 400 g birth weight. It encompasses births across various settings, such as hospitals, birth centres, and homes. It provides data on maternal characteristics, such as age, smoking habits, country of birth, remoteness, parity, and neonatal outcomes. Additionally, it incorporates the Index of Relative Socio-economic Disadvantage (IRSED) disadvantaged) (ABS., 2016; Adhikari, 2006). On the other hand, both APDC and MH-AMB-DC data sources routinely collected data that include details on hospital separations, encompassing patient demographics, diagnoses (i.e., principal, additional, or stay diagnoses), and clinical procedures for all hospitalisations across public and private hospitals in NSW, including psychiatric hospitals. Notably, the diagnosis of the exposure of interest, maternal CUD, was abstracted from APDC. However, the outcome of interest (ASD) was derived from both APDC and MH-AMB-DC data sources. The diagnoses of maternal mental health disorders due to substance use and ASD in children have been coded according to the 10th revision of the International Statistical Classification of Diseases and Related Health Problems, Australian Modification (ICD-10-AM) since 1999 (NCCH, 1999).

The data linkage was done by the Centre for Health Record Linkage (CHeReL), overseen by the NSW Ministry of Health. CHeReL linked datasets that included information on outcomes, exposure, potential confounding factors and covariates. CHeReL employed personal information and probabilistic data linkage methods to establish data linkage among the aforementioned sources. It assigned a project person number (PPN) and record ID to the data sources. In matched records, a 95 % and 99 % consistency rate was observed between the APDC and PDC datasets for delivery outcomes and discharge status, respectively. This high level of consistency confirms the quality of the APDC dataset (Lam, 2011). Additional details about these datasets, including information on the probabilistic linkage and quality assurance methods, are available on their website (CHeReL, 2012).

2.2. *Measures*

2.2.1. *The outcome variable (ASD)*

The outcome of interest (ASD) was derived from two main data sources, namely hospital admissions (APDC) and hospital outpatient visits (AMB-MH-DC). Diagnosis of ASD was determined by ICD-10-AM criteria for mental and behavioural disorders (codes F84.0–F84.9).

2.2.2. *Maternal CUD (exposure variable) and comorbid disorders*

Maternal prenatal Cannabis Use Disorder (CUD), along with other concurrent maternal substance use and mental health disorders during pregnancy, were extracted from the APDC data collection, considering principal or secondary diagnoses. CUD is defined by ICD-10 criteria for mental and behavioural disorders due to the use of cannabinoids (F12.0–F12.9). Further, for maternal CUD to be categorised as occurring during the prenatal period, the episode of care indicating the diagnosis of CUD must fall between the date of conception and the date of delivery. The date of conception was estimated as the delivery date in weeks minus gestational age at delivery in weeks (Betts et al., 2022). According to the PDC records, gestational age, also known as weeks of pregnancy, is often dated from the first day of the last menstrual period (LMP) to the date of delivery, confirmed using the first ultrasound examination for more accuracy. The date of delivery is recorded as the exact date of birth.

Similarly, the other maternal substance use disorders were also identified using ICD-10 codes (alcohol, F10.0–F10.9; opioids, F11.0–F11.9; sedative/hypnotics, F13.0–F13.9; stimulants, F14.0-F15.9, tobacco, F17.0–F17.9, and polydrug, F19.0-F19.9). Mental health disorders were also captured, including non-affective psychotic disorders (F20.0–F29.0), bipolar depressive disorders (F30.0–F31.9), unipolar depressive disorders (F32.0–F39.9), and anxiety disorders (F40.0–48.9).

Studies suggest that exposure to cannabis during the pre-pregnancy period (i.e., 6 to12 months prior to the date of conception or knowledge of pregnancy), prenatal period, and postnatal period has been associated with long-term behavioural and neurodevelopmental disorders that persist from early childhood to young adulthood (Hanan El Marroun et al., 2019; Sophia and Graeme, 2020). Therefore, we further investigated the associations between maternal exposure to CUD during the pre-pregnancy, prenatal and perinatal periods and the risk of ASD in offspring. Notably, exposure to CUD during the pre-pregnancy period includes the time span from 12 months before pregnancy to the date of conception, as calculated from the date of delivery in weeks minus the gestational age in weeks at birth [i.e., exposure periods ranging from negative 52 weeks to 0 weeks, exclusive of zero]. Additionally, postnatal exposure to CUD includes the time elapsed from birth to 52 weeks postnatally [i.e., exposure periods ranging from birth to 52 weeks of

postnatal]. Furthermore, perinatal exposure to CUD refers to the combination of the prenatal and postnatal periods, during which the episode of care for CUD extends from the prenatal to the postnatal period.

2.3. Confounding variables

A range of a priori confounders, which are linked with both the exposure and outcome, were included in the final model. These confounders were extracted from the PDC, APDC, and outpatient/ambulatory data collection (MH-AMB-DC) datasets. Among these factors, socioeconomic indexes for areas (SEIFA codes) were used by the Australian Bureau of Statistics to assess postcodes based on their relative economic advantage or disadvantage, categorised into quartiles (1st quartile - most disadvantaged and 4th quartile - least disadvantaged) (ABS., 2016). We further included a wide range of confounding variables, such as smoking during pregnancy (Rosen et al., 2015; von Ehrenstein et al., 2021), maternal mental health disorders- depression, anxiety, schizophrenia, and bipolar disorders (yes/no) (Chen et al., 2020; Jokiranta et al., 2013; Larsson et al., 2005), maternal medical conditions (i.e., hypertension and diabetes mellitus (yes or no)) (Dachew et al., 2018; Krakowiak et al., 2012), child sex (male or female) (Croen et al., 2002; Nabbijohn et al., 2019; Schendel and Bhasin, 2008), low birth weight (birth weight <2500 g- yes/no) (Lampi et al., 2012; Schieve et al., 2016), and prematurity at birth (gestational age <37 weeks- yes/no) (Schieve et al., 2015, 2016). Further, we also included parental sociodemographic characteristics— such as maternal age (<20, 20–24, 25–29, 30–34 and ≥ 35), maternal education (degree and above, diploma, certificate qualifications, unknown/not stated), and maternal occupation (managers/professionals, tradesman/other paid workers, non-paid workers, unknown/not stated).

2.4. Statistical analysis

Firstly, a chi-square test was carried out to examine the significance of the variations across the categories of covariates by tabulating maternal and child-related factors with ASD in offspring. Subsequently, associations between maternal CUD diagnoses (i.e., pre-pregnancy, prenatal, and perinatal periods) and ASD in offspring were examined using a univariate binomial generalised linear model (GLM) with a log link function that calculated the relative risks (RRs) with 95 % confidence intervals (Models 1–3).

Finally, the three separate models (Model 1–3) were adjusted for a range of confounders such as, socio-economic indexes for areas (SEIFA) (1 = 1st quartile- most disadvantaged, 2 = 2nd quartile, 3 = 3rd quartile and 4 = 4th quartile - least disadvantaged), maternal other substance use disorder diagnoses (i.e., tobacco, polydrug, stimulants use disorders- 1 = yes, 0 = no), parity (categorized as; 1 = nil, 2 = one, and 3 = two plus), maternal psychiatric admission diagnoses in pre-pregnancy, prenatal and postnatal periods (i.e., schizophrenia, bipolar and anxiety disorders- 1 = yes, 0 = no), maternal chronic medical conditions (i.e., diabetes, and hypertension- 1 = yes, 0 = no) and child-related factors, including child sex (1 = male, 2 = female), low APGAR scores at the 5th minute of birth (1= yes, 0 = no), the birth plurality (1 = single, 2 = twins or more), and prematurity at birth (1 = yes, 0 = no). The analyses were performed using STATA 17, and all ' statistical significance was set at a P-value < 0.05.

Further, sensitivity analysis was carried out to examine the gender-based effect of maternal CUD exposure on ASD in offspring. Additionally, we tested the interaction effects of maternal smoking during pregnancy with CUD and declared statistically significant interaction effects if the interaction term has a p-value < 0.05.

2.5. Missing data

This population-based cohort study included all births in New South Wales (NSW), Australia, between January 2003 and December 2005. Initially, we have 223 068 matched live birth cohorts recorded in NSW. Our research objective aimed to encompass all live births to investigate the associations between maternal CUD and the risk of ASD in offspring. Following the exclusion of stillbirths, duplicated observations, and missing observations on the main outcome and potential confounding factors, we retained 222 534 mother-offspring pairs for complete-case analysis.

2.6. Ethics

Ethics approval was granted from the Cancer Institute NSW, the NSW Population and Health Service Research Ethics Committee (HREC/18/CIPHS/22), and Curtin University (HRE/2019/0601/01). All authors participating in the present study have full access to the data.

3. Results

3.1. Characteristics of participants

The mean of maternal age at birth, neonatal birth weight, and newborns' gestational age were 29.83 ± 5.56 SD years, 3394.23 ± 557.63 SD grams, and 39.13 ± 1.79 SD weeks, respectively.

As presented in Table 1, in this study, 2.1 %, 1.1 %, and 2.6 % of offspring with ASD cases had been exposed to maternal prenatal, pre-pregnancy, and perinatal CUD, respectively. Out of the 1441 offspring diagnosed with ASD, 32.1 % were from the most disadvantaged socio-economic background, 9.8 % were preterm birth, 8.7 % were low birth weight, 3.0 % had low APGAR scores at 5th-minute birth, 14.4 % had been exposed to prenatal smoking, 1.9 % had been exposed to prenatal opioid use disorder, 2.4 % had been exposed to prenatal depressive disorder, and 1.9 % had been exposed to maternal prenatal anxiety disorders. Additionally, male children were more likely to be diagnosed with ASD in offspring (77.3 versus 51.4 %, P < 0.01). Furthermore, mothers in younger age groups (i.e., age < 20 years) had a higher likelihood of having offspring with ASD cases (8.6 % versus 5.9 %, *P* < 0.001), suggesting that those aged less than 20 are more prone to having children diagnosed with ASD compared to older age groups (Table 1).

3.2. Maternal cannabis use disorder and the risk of ASD in offspring

As presented in Table 2, in unadjusted analysis, we found that the offspring of mothers with prenatal CUD had a 3.5 times higher risk of ASD compared to non-exposed offspring [cRR = 3.56 (95 % CI 2.49, 5.10)] (Model 1). In a separate analysis (model 2), when we examined perinatal CUD as the predictor of ASD in offspring, we found a slightly higher effect estimate compared to prenatal CUD exposure [cRR = 3.88 (95 % CI 2.81, 5.36)]. Further, we carried out additional analysis (Model 3) to examine the effect of CUD diagnosis before pregnancy on ASD in offspring; we observed a strong association between CUD during pre-pregnancy and ASD in offspring [cRR = 4.34 (95 % CI 2.63, 5.36)].

We conducted three separate models (Models 1–3) to examine the effect of CUD exposure before, during pregnancy and perinatal periods on the risk of ASD in offspring. Therefore, we found consistently significant associations between during pregnancy [aRR = 3.02 (95 % CI 2.07, 4.40)] (Model 1), perinatal [aRR = 3.13 (95 % CI 2.21, 4.43)] (Model 2), and before pregnancy [aRR = 3.21 (95 % CI 1.89, 5.45) (Model 3) exposures to CUD and the increased risk of ASD in offspring, after adjusting the final models to the potential confounders, including maternal socioeconomic status (SEIFA quartiles), parity, prenatal substance use disorders (i.e., tobacco use, alcohol use, stimulants use including cocaine disorders), prenatal psychiatric diagnoses (i.e., schizophrenia, bipolar depressive, and anxiety disorders), maternal clinical factors (i.e., maternal diabetes and hypertension), low APGAR score at 5th minute of birth, plurality at birth, premature birth, and baby gender (Table 2). Furthermore, we examined the overlap between the three exposure window periods associated with diagnoses of CUD. We

observed minimal overlaps when examining exposure to Cannabis Use Disorder during the pre-pregnancy and prenatal periods, as well as between exposure to CUD during the prenatal and postnatal periods. However, the observed overlap does not influence the associations in each model (Table S1).

We observed a significant interaction effect between maternal smoking and CUD concerning the risk of ASD in offspring ($P < 0.001$). The fact that the small p-value (i.e., p-value < 0.05) associated with the interaction test suggests that the interaction between maternal CUD and smoking is statistically significant at conventional levels of significance. In our sensitivity analyses, we observed an increased risk of ASD in offspring exposed to maternal prenatal CUD within the strata of non-smokers [aRR = 4.55 (95 % CI 2.26, 9.16)], which indicates maternal prenatal CUD has a significant effect on ASD in offspring when maternal smoking is absent. Similarly, we found a significant association between maternal prenatal CUD and risk of ASD in offspring within strata of smokers [aRR = 1.87 (95 % CI 1.21, 2.91)], suggesting exposure to maternal prenatal CUD has been persistently associated with ASD in offspring when maternal smoking is present. Overall, the statistically significant interaction effect between maternal smoking and prenatal CUD in the final model [CUD*smoking; aRR = 3.28 (95 % CI 2.11, 4.90)] indicates a notable difference in the effect estimates for prenatal CUD by maternal smoking status (Table 3).

3.3. Sensitivity analyses by child sex

In this study, we observed that male offspring had a higher risk of ASD compared to their female counterparts [aRR = 3.10 (95 % CI 2.80, 3.58)] after adjusting covariates, including socio-economic status (SES), parity, mode of delivery (C-section), prenatal tobacco use disorders (TUD), mental health disorders (schizophrenia and depression), maternal diabetes, hypertension, low APGA score at the 5th minute of birth, and plurality at birth (adjusted Model 1).

When we tested the interaction effect of child sex and maternal CUD on ASD in offspring, we observed a significant interaction effect between maternal CUD and the sex of the child regarding the risk of ASD in offspring, with a p-value of less than 0.01.

In our sensitivity analyses, we observed a similar risk of ASD in offspring exposed to maternal CUD within the strata of the male offspring [aRR = 3.01 (95 % CI 1.70, 4.16)], which revealed persistently significant associations between maternal CUD and ASD in offspring, even when the analysis was limited to the male offspring observations derived from the full sample size. Similarly, we found a significant association between maternal CUD and risk of ASD in offspring within strata of female offspring [aRR = 2.71 (95 % CI 1.56, 9.12], suggesting exposure to maternal CUD has been consistently associated with ASD in offspring when the analysis was limited to a sample of female offspring. These findings suggest that maternal CUD poses an independent and persistently higher risk of ASD development in children, irrespective of their gender (Table 4).

4. Discussion

4.1. Main findings

In this linked data cohort study, we found that offspring exposed to maternal prenatal CUD exhibited a three-fold increased risk of ASD. Further, we observed associations between pre-pregnancy and perinatal CUD exposure and ASD in offspring. These findings contribute to the existing evidence on the association between prenatal CUD and ASD in children and adolescents (Corsi et al., 2020; DiGuiseppi et al., 2021). Moreover, our study addresses gaps in previous research and enhances the existing evidence by investigating gender-specific effects. We observed a more pronounced risk of ASD associated with exposure to maternal CUD in male offspring compared to their female counterparts. Our sensitivity analysis and the adjustment for relevant confounders affirmed the robustness of the results observed in the primary analysis.

Our findings are supported by a prior study conducted in Ontario, Canada (Corsi et al., 2020). In a 2020 cohort study, Corsi and colleagues reported a 51 % increased risk of ASD among offspring exposed to prenatal cannabis compared to non-exposed children (Corsi et al., 2020), aligning with our main findings. Our study and this prior study were population-based cohort studies involving large samples of mother-offspring pairs. Additionally, our study indicated that exposure to CUD before and during pregnancy is persistently associated with ASD in offspring, which is consistent with a study conducted in the United States (Paul et al., 2021). A study by Paul et al. (2021) reported that cannabis exposure, specifically occurring before and after maternal knowledge of pregnancy, was associated with an increased risk of psychiatric illnesses in children and adolescents, such as ASD symptoms, psychotic-like experiences (PLEs) as well as internalising, externalising, and attention deficit problems (Paul et al., 2021).

Nevertheless, some studies presented contrasting findings with our study, failing to establish significant associations between in-utero cannabis exposure and the risk of ASD in offspring (DiGuiseppi et al., 2021; Moore et al., 2023; Nutor et al., 2023; Pham et al., 2022; Sajdeya et al., 2021). The discrepancies could be explained by the fact that most of the prior studies have employed case-control study designs and small samples of mother-offspring pairs (DiGuiseppi et al., 2021; Mark et al., 2020; Moore et al., 2023; Nutor et al., 2023; Pham et al., 2022). Furthermore, the disparities between the current study, which evaluates exposure to diagnosable disorder (CUD), and previous research examining merely cannabis use as exposure could account for these discrepancies. Research indicates that clinical disorders as exposure, ascertained using ICD diagnostic criteria, represent the most reliable measure for psychiatric and mental health disorders associated with cannabis use in pregnancy (Burns et al., 2006; Tiet et al., 2019; Xu et al., 2013). This diagnostic criterion helps describe the severity of substance use disorder based on the number of criteria met; for example, 2–3 for moderate and four or more symptoms for severe forms of psychoactive substances. Additionally, our study has comprehensively examined the associations between pre-pregnancy, prenatal, and perinatal exposure to CUD and the risk of ASD in offspring.

On the other hand, many of these studies have predominantly relied on self-reported data when investigating the relationship between maternal cannabis use during pregnancy and the risk of ASD in offspring. Self-reported data are known to have limitations, including under-reporting and recall bias, as evidenced by previous research (Brener et al., 2003; Brown et al., 1992; Latkin et al., 2017). This highlights the potential limitations of relying on self-reporting, which changes the direction of true associations between exposure and outcome of interest. For example, a 2022 study by Sujan et al. indicated that studies relying on self-report data may mistakenly classify exposed offspring as unexposed, which could reduce the likelihood of detecting a true association between exposure and the outcome of interests (Sujan et al., 2022).

4.2. Biological mechanism for the associations

Several animal and human studies have investigated the mechanism of how PCE affects neurodevelopmental conditions in exposed children; however, the mechanism is not well understood. Prior studies suggested that Δ9-tetrahydrocannabinol (THC) in cannabis, the psychoactive ingredient of cannabis, can readily pass through the placental and blood-brain barrier (Blackard and Tennes, 1984; Gómez et al., 2003; Little and VanBeveren, 1996), which may compromise placenta blood circulation and development (H. El Marroun et al., 2010; Natale et al., 2020) and in-utero foetal brain development (Baschat and Hecher, 2004). A 2021 study by Thomason and colleagues suggested that maternal PCE is associated with variation in human brain hippocampal functional connectivity, which results in alterations in foetal dorsolateral, medial and superior frontal, insula, anterior temporal, and posterior cingulate

connectivity (Thomason et al., 2021). Similarly, other studies from longitudinal studies reported that THC exposure during pregnancy might alter dopamine receptors (i.e., D1 and D2), which significantly influences neurodevelopmental growth (Jutras-Aswad et al., 2009) and impairs mental development in offspring (Morris et al., 2011; Szutorisz and Hurd, 2018; Wu et al., 2011). To conclude, these all influence the fundamental developmental processes such as molecular pathways, cell proliferation, neurogenesis, migration and axonal pathfinding in human brain development, which are associated with neurodevelopmental disorders such as ASD, ADHD and other psychiatric disorders in exposed offspring.

Furthermore, existing epidemiological studies suggested that residual confounding factors, including unmeasured familial factors such as genetics, could alternatively explain the impact of cannabis on neurodevelopmental outcomes in children and adolescents. For example, studies have recognised that genetics has been one of the stronger contributors to the development of ASD in offspring (Bailey et al., 1995; Choi and An, 2021; Hallmayer et al., 2011; Hwang and Lee, 2024; Lichtenstein et al., 2010). These implied that these factors might alternatively explain the observed associations.

4.3. Sensitivity analysis by child sex and risk of ASD

In our sensitivity analysis, we observed that male offspring had a higher risk of ASD associated with maternal CUD compared to their female counterparts. This finding is consistent with studies by Palmer et al. and Bara et al., which reported higher rates of ASD among exposed males than female offspring in the general population (Bara et al., 2018; Palmer et al., 2017). This could be explained related to neurodevelopmental trajectories exhibiting variations based on gender, with female brains displaying indications of earlier maturation compared to their male counterparts, showing 1 to 2 years earlier in females (Crane et al., 2013; Lenroot et al., 2007; Tirado-Muñoz et al., 2020). Moreover, genetics has been recognised as one of the stronger contributors to sex-dependent variations in the development of ASD in offspring (Bailey et al., 1995; Choi and An, 2021; Hallmayer et al., 2011; Hwang and Lee, 2024; Lichtenstein et al., 2010). Therefore, these factors could alternatively account for the observed associations.

4.4. Strengths and limitations of the study

The present study has several notable strengths. Firstly, it benefits from a larger sample size, enhancing statistical robustness for the power of the study. Secondly, it relies on robust population-based register data sourced from multiple channels. Thirdly, it stands out as the first investigation to assess ASD in the offspring of mothers with pre-pregnancy, pregnancy, and perinatal CUD, leveraging high-quality linked data from health facilities. Fourth, our comprehensive gender-specific analyses and the adjustment for relevant confounders affirmed the robustness of the results observed in the primary analysis. Finally, we examined the interaction effect between CUD and smoking, which indicates the robustness of our final estimates to examine associations between maternal cannabis use disorder and the risk of ASD in offspring. For example, studies suggested the significance of elucidating the complex interplay between tobacco use, cannabis use and neurodevelopmental outcomes (Rosen et al., 2015; von Ehrenstein et al., 2021).

The current study acknowledges some limitations. While our study comprehensively utilised linked health registries to capture ASD diagnoses and maternal CUD, it is important to acknowledge that there may still be limitations in the completeness of the data. For instance, the inclusion of only hospitalised mothers of offspring in our study may lead to missing individuals with less severe maternal CUD who do not require hospitalisation. Similarly, despite our efforts to include data from both inpatient and outpatient settings, there may still be instances where ASD diagnoses were not fully documented or captured. Additionally, the reliance on registry data means that diagnoses may be subject to coding errors or misclassifications, which could impact the accuracy of our findings. Moreover, the duration of follow-up for ASD diagnoses in offspring varied depending on the availability of data within the linked health registries, potentially limiting the ability to capture diagnoses occurring later in childhood or adolescence. These factors should be considered when interpreting the results of our study.

Additionally, the absence of information on paternal (biological father) substance use and mental health disorders in this study raises the possibility that paternal characteristics might contribute to the reported associations in this study. For example, studies indicated that paternal characteristics might influence maternal cannabis use during pregnancy (Epstein et al., 2018; McLaughlin et al., 2012) and offspring psychiatric and neurodevelopmental outcomes (Kosty et al., 2015; Sujan et al., 2022; Xerxa et al., 2021). Finally, the potential for residual confounders, including unmeasured familial factors, exists, as we did not account for essential residual confounding factors, such as genetic factors. Existing evidence suggests that approximately 55–58 % of ASD is explained by environmental factors, such as lifestyle factors (Hallmayer et al., 2011; Hwang and Lee, 2024), but genetics has been recognised as one of the stronger contributors to the development of ASD in offspring (Bailey et al., 1995; Choi and An, 2021; Hallmayer et al., 2011; Hwang and Lee, 2024; Lichtenstein et al., 2010). These imply that these factors might alternatively explain the observed associations. Therefore, caution is warranted when interpreting and translating the observed associations.

5. Conclusion

This study reveals that offspring exposed to cannabis use disorder during pre-pregnancy, prenatal and perinatal periods are at an increased risk of developing ASD compared to non-exposed offspring. Notably, male offspring exhibit a significantly greater risk than their female counterparts, emphasising the need for comprehensive investigations into gender-specific mechanisms. Furthermore, future research should consider the impact of the duration and timing of CUD exposure, encompassing exposure during different trimesters of pregnancy, as potential predictors of ASD in offspring. It is also advisable for future studies to account for the mental health and substance use disorders of biological fathers to enhance and validate these findings.

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CRediT authorship contribution statement

Abay Woday Tadesse: Writing – review & editing, Writing – original draft, Visualization, Software, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Getinet Ayano:** Writing – review & editing, Writing – original draft, Supervision. **Berihun Assefa Dachew:** Writing – review & editing, Supervision, Methodology. **Kim Betts:** Writing – review & editing, Supervision. **Rosa Alati:** Writing – review & editing, Supervision.

Declaration of competing interest

All authors have no conflicts of interest to disclose.

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.psychres.2024.115971.

Annex I: List of Tables

Table 1
Maternal demographic, obstetric, mental health, and neonatal factors by diagnosis of ASD in offspring ($N = 222, 534$).

List of potential predictors	List of categories (if any)	Overall N (%)	ASD diagnosis in offspring		P-value
			Yes N (%)	No N (%)	
Maternal age (in years)	<20	13,085 (5.9)	124 (8.6)	12,961 (5.9)	<0.001
	20–24	27,055 (12.2)	226 (15.7)	26,829 (12.1)	
	25–29	61,360 (27.6)	403 (28.0)	60,957 (27.6)	
	30–34	75,948 (34.1)	414 (28.7)	75,534 (34.2)	
	35+	45,086 (20.3)	274 (19.0)	44,812 (20.2)	
Socio-economic status (in quartile)	1st (most disadvantaged)	55,963 (25.2)	463 (32.1)	55,500 (25.1)	<0.001
	2nd	48,806 (21.9)	330 (22.9)	48,476 (21.9)	
	3rd	54,529 (24.5)	348 (24.1)	54,181 (24.5)	
	4th (least disadvantaged)	63,236 (28.4)	300 (20.8)	62,936 (28.5)	
Child sex	Female	107,729 (48.4)	327 (22.7)	107,402 (48.6)	<0.001
	Male	114,805 (51.6)	1114 (77.3)	113,691 (51.4)	
Low birth weight at birth (<2500 g)	Yes	11,714 (5.3)	125 (8.7)	11,589 (5.2)	<0.001
	No	210,820 (94.7)	1316 (91.3)	209,504 (94.8)	
Small-for-gestational age (<10th percentile)	Yes	3998 (1.8)	43 (3.0)	3955 (1.8)	<0.001
	No	218,536 (98.2)	1398 (97.0)	217,138 (98.2)	
Prematurity at birth (< 37 weeks)	Yes	13,544 (6.1)	141 (9.8)	13,403 (6.1)	<0.001
	No	208,990 (93.9)	1300 (90.2)	207,690 (93.9)	
APGAR score at 5th minutes of birth (<7)	Yes	2525 (1.1)	43 (3.0)	2482 (1.1)	<0.001
	No	220,009 (98.9)	1398 (97.0)	218,611 (98.9)	
Admitted to NICU	Yes	5419 (2.4)	86 (6.0)	5333 (2.4)	<0.001
	No	217,115 (97.6)	1355 (94.0)	215,760 (97.6)	
Birth plurality	Single	215,990 (97.1)	1395 (96.8)	214,595 (97.1)	0.159
	Twins or more	6544 (2.9)	46 (3.2)	6498 (2.9)	
Parity	Nil	92,125 (41.4)	672 (46.6)	91,453 (41.4)	<0.001
	1	76,077 (34.2)	452 (31.4)	75,625 (34.2)	
	2+	54,332 (24.4)	317 (22.0)	54,015 (24.4)	
Birth order	1st born	219,257 (98.5)	1416 (98.3)	217,841 (98.5)	0.407
	2nd born	3232 (1.5)	25 (1.7)	3252 (1.5)	
Mode of delivery	SVD	138,005 (62.0)	818 (56.7)	137,187 (62.0)	<0.001
	Assisted*	22,875 (10.3)	161 (11.2)	22,714 (10.3)	
	C-section	61,654 (27.7)	462 (32.1)	61,192 (27.7)	
Foetal presentation at birth	Vertex	210,785 (94.7)	1356 (94.1)	209,429 (94.7)	0.573
	Breech	10,075 (4.5)	73 (5.1)	10,002 (4.5)	
	Other+	1674 (0.8)	12 (0.8)	1662 (0.8)	
Smoking in pregnancy	Yes	32,109 (14.4)	352 (24.4)	31,757 (14.4)	< 0.001
	No	190,425 (85.6)	1089 (75.6)	189,336 (85.6)	
Pre-existing DM	Yes	1227 (0.5)	14 (1.0)	1213 (0.6)	0.031
	No	221,307 (99.5)	1427 (99.0)	219,880 (99.4)	
Gestational DM	Yes	10,139 (4.6)	76 (5.3)	10,063 (4.5)	0.190
	No	212,395 (95.4)	1365 (94.7)	211,030 (95.5)	
Pregnancy induce hypertension	Yes	11,788 (5.3)	108 (7.5)	11,680 (5.3)	<0.001
	No	210,746 (94.7)	1333 (92.5)	209,413 (94.7)	
Maternal prenatal mental health and substance use disorders					
Prenatal cannabis use disorder (CUD)	Yes	1319 (0.6)	30 (2.1)	1289 (0.6)	<0.001
	No	221,215 (99.4)	1411 (97.9)	219,804 (99.4)	
Pre-pregnancy CUD	Yes	538 (0.3)	15 (1.1)	523 (0.3)	<0.001
	No	221,996 (99.7)	1426 (98.9)	220,570 (99.7)	
Perinatal CUD diagnosis	Yes	1500 (0.7)	37 (2.6)	1463 (0.7)	<0.001
	No	221,034 (99.3)	1404 (97.4)	219,630 (99.3)	
Postnatal CUD	Yes	281 (0.1)	9 (0.6)	272 (0.1)	<0.01
	No	222,253 (99.9)	1432 (99.4)	221,981(99.9)	
Prenatal alcohol use disorders	Yes	257 (0.1)	8 (0.6)	249 (0.1)	<0.001
	No	222,277 (99.9)	1433 (99.4)	220,844 (99.9)	
Prenatal opioid use disorders	Yes	966 (0.4)	28 (1.9)	938 (0.4)	<0.001
	No	221,568 (99.6)	1413 (98.1)	220,155 (99.6)	
Prenatal tobacco use disorders	Yes	233 (0.1)	11 (0.8)	222 (0.1)	<0.042
	No	222,301 (99.9)	1430 (99.2)	220,871 (99.9)	

(continued on next page)

Table 1 (*continued*)

List of potential predictors	List of categories (if any)	Overall N (%)	ASD diagnosis in offspring		P-value
			Yes N (%)	No N (%)	
Prenatal sedative use disorders	Yes	338 (0.2)	4 (0.3)	334 (0.2)	0.219
	No	222,196 (99.8)	1437 (99.7)	220,759 (99.8)	
Prenatal schizophrenia disorders	Yes	235 (0.1)	4 (0.2)	231 (0.1)	0.044
	No	222,299 (99.9)	1437 (99.8)	220,862 (99.9)	
Prenatal depressive disorders	Yes	1946 (0.9)	34 (2.4)	1912 (0.9)	<0.001
	No	220,588 (99.1)	1407 (97.6)	219,181 (99.1)	
Prenatal bipolar depressive disorder	Yes	215 (0.1)	3 (0.2)	212 (0.1)	<0.016
	No	222,319 (99.9)	1438 (99.8)	220,881 (99.9)	
Prenatal anxiety disorder	Yes	1394 (0.6)	28 (1.9)	1366 (0.6)	<0.001
	No	221,140 (99.4)	1413 (98.1)	219,727 (99.4)	

Keynotes: *others+ (face, brow, footling, shoulder), and Assisted* (vacuum, forceps). ASD- autism spectrum disorder in Offspring. CUD- cannabis use disorder.*

Table 2
Associations between maternal CUD and ASD in offspring (N = 222,534).

List of predictors	ASD in offspring					
	Crude RR (95 % CI)	P-value	Adjusted RR (95 % CI)	P-value	Further adjusted RR (95 % CI)	P-value
Prenatal CUD exposure (Model 1)	3.56 (2.49, 5.10)	<0.001	3.03 (2.08, 4.42)	<0.001	3.02 (2.07, 4.40)	<0.001
Perinatal CUD exposure (Model 2)	3.88 (2.81, 5.36)	<0.001	3.20 (2.24, 4.52)	<0.001	3.13 (2.21, 4.43)	<0.001
Pre-pregnancy CUD exposure (Model 3)	4.23 (2.63, 7.17)	< 0.001	3.32 (2.1.94, 5.66)	<0.001	3.21 (1.89, 5.45)	< 0.001

Keynotes: RR- Relative Risk, CI- Confidence Interval.
Model 1: Adjusted for maternal factors- SEIFA index, parity, prenatal tobacco use and stimulant use disorders, prenatal psychiatric admission diagnoses: schizophrenia, bipolar and anxiety disorders, chronic medical conditions: diabetes and hypertension. Further, this model was subsequently adjusted for child-related factors: child sex, low APGAR scores at the 5th minute of birth, and a birth plurality (see further adjusted models 1).
Model 2 was adjusted for maternal factors- SEIFA index, parity, perinatal tobacco use, polydrug use, and stimulant use disorders, perinatal psychiatric admission diagnoses: schizophrenia, bipolar and anxiety disorders, chronic medical conditions: diabetes and hypertension. Further, this model was subsequently adjusted for child-related factors: child sex, preterm birth, low APGAR scores at the 5th minute of birth, and a birth plurality (see further adjusted models 2).
Model 3: This model accounted for a range of covariates, including maternal factors- SEIFA index, parity, pre-pregnancy substance use disorders: tobacco use and stimulants use disorders, maternal pre-pregnancy psychiatric admission diagnoses: schizophrenia, bipolar and anxiety disorders, and maternal chronic medical conditions such as pre-existing diabetes and hypertension. Further, a subsequent adjustment was carried out for child sex.

Table 3
The interaction between maternal CUD and smoking and the combined effect on the risk of ASD in offspring.

List of predictors	ASD in offspring			
	Crude RR (95 % CI)	P-value	Adjusted RR (95 % CI)	P-value
prenatal CUD (within smoker strata)	1.92 (1.25, 2.95)	< 0.003	1.87 (1.21, 2.91)	< 0.01
prenatal CUD (within Non-smoker strata)	5.27 (2.91, 11.43)	< 0.001	4.55 (2.26, 9.16)	< 0.001
perinatal CUD (within smoker strata)	2.03 (1.36, 3.01)		1.74 (1.14, 2.66)	< 0.05
perinatal CUD (within non-smoker strata)	6.83 (3.82, 12.23)	< 0.001	4.83 (2.62, 8.82)	< 0.001
Prenatal CUD interacts with smoking	3.60 (2.37, 5.47)	<0.001	3.25 (2.11, 5.01)	<0.001
Perinatal CUD interacts with smoking	3.77 (2.57, 5.54)	<0.001	3.37 (2.15, 4.85)	<0.001

Keynotes: The reported relative risks (RRs) reported in the table were carried out separately for each predictor. The final analyses for each model were adjusted for maternal factors- SEIFA index, parity, maternal substance use disorders: polydrug use and stimulants use disorders, maternal psychiatric admission diagnoses: depressive and anxiety disorders, maternal chronic medical conditions: diabetes and hypertension, child sex, low APGAR scores at 5th minute of birth, and prematurity at birth.

Table 4
Sensitivity analysis by child sex to examine the association between maternal CUD and ASD in offspring.

List of predictors	ASD				ASD in the full sample (N = 222,534)
	Male (N = 114,805)		Female (N = 107,729)		
	aRR (95 % CI)	P-value	aRR (95 % CI)	P-value	RR (95 % CI)
Prenatal CUD (Model 1)	3.01 (1.70, 4.16)	<0.001	2.71 (1.56, 9.12)	<0.001	3.02 (2.07, 4.40)
Perinatal CUD (Model 2)	3.06 (2.06, 4.54)	<0.001	2.85 (1.64, 8.81)	<0.001	3.13 (2.21, 4.43)

Keynote: *aRR: adjusted relative risk, CI: confidence interval, and CUD: cannabis use disorder. Models were adjusted for maternal factors, including socio-economic status (SES), parity, mode of delivery (C-section), prenatal tobacco use, and clinical factors such as maternal prenatal mental health disorders (schizophrenia and depression), maternal diabetes, and hypertension. Further adjustment was carried out for child-related potential confounding variables such as low APGA score at the 5th minute of birth and plurality at birth.*

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The Developmental Trajectory to Cannabis Use Disorder

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The increase of cannabis use, particularly with the evolution of high potency products, and of cannabis use disorder (CUD) are a growing health care concern. While the harms of adult use and potential medicinal properties of cannabis continue to be debated, it is becoming evident that adolescent cannabis use is a critical window for CUD risk with potential lifelong mental health implications. Herein, we discuss mental health consequences of adolescent cannabis use, factors that contribute to the risk of developing CUD, and what remains unclear in the changing legal landscape of cannabis use. We also discuss the importance of preclinical models to provide translational insight about the causal relationship of cannabis to CUD-related phenotypes and conclude by highlighting opportunities for clinicians and allied professionals to engage in addressing adolescent cannabis use.

ADOLESCENT CANNABIS USE

In 2022, cannabis use had an estimated lifetime prevalence of 38% among 12th grade students in the United States, a 17% increase compared to 1992 (1). Additionally, while the prevalence of use remained relatively steady among youth aged 12–17 years over the past decade, rates have continued to rise among older youth and emerging adults aged 18–25 years (2). These older youth also have the highest prevalence of cannabis use compared to other age groups. Although not all individuals who consume cannabis develop a CUD, broadly conceptualized as a pattern of continued cannabis use despite the development of clinically significant problems (3), a significant number do. Epidemiologic data of the prevalence of CUD in youth are limited and largely predate broad adoption of medical and recreational marijuana laws in the United States. However, a recent meta-analysis which included youth and adult studies reported that among individuals who used cannabis, 22% met criteria for CUD (95% CI 18%–26%) (4). CUD was most prevalent in young adults, with the highest risk of CUD (41.1%, 95% CI 38.4%–43.8%) among the cohort of 21-year-old emerging adults (4).

The complex biological properties of cannabis and cannabinoid products and their potential medicinal or adverse effects and their relation to the developing brain are still actively being explored. Of the more than 500 chemicals in the cannabis plant, Δ9-tetrahydrocannabinol (THC) is known to be the most abundant intoxicating cannabinoid. Although most individuals who consume cannabis use full-spectrum cannabis products, THC has been shown to be associated with adverse mental health outcomes (5). Moreover, the higher the THC potency, the greater the risk of developing CUD and poorer mental health outcomes (5, 6). The potential of THC to impact neurodevelopment is thought to be mediated through its direct effects on the endocannabinoid system. This modulatory system plays a vital role in regulating neural differentiation and migration, axon guidance, synaptogenesis, and myelination, as well as neurotransmitter system development (7). Consequently, cannabis exposure during neurodevelopment, whether through exposure in early life (prenatal or childhood) or adolescent use, has the potential to alter the endocannabinoid system. Such exposure could thus impact the development of neural pathways that mediate reward; emotional regulation; and multiple cognitive domains including executive functioning and decision making, learning, abstraction, and attention, all processes central to substance use disorder and other psychiatric disorders (8).

> **Given that the increased potency of cannabis and cannabinoid products is expected to increase CUD risk, it is disturbing that less than 10% of youth who meet the criteria for a substance use disorder, including CUD, receive treatment.**

Growing concerns regarding adolescent-onset cannabis use relates to its association with the increased prevalence and severity of mental health disorders, including psychosis (9, 10), depression (11), anxiety (11), bipolar disorder (12), and other substance use disorders (13). Youth who use cannabis are also more likely to endorse suicidal behavior including suicide attempts (14). Of the various mental health challenges, significant attention has focused on the co-occurrence of cannabis use and psychosis. Though significant debates remain regarding their causal relationship, the literature has highlighted factors of cannabis use, including frequency, potency, and earlier age of onset, as risk factors for psychosis (9, 10). Moreover, a recent study of over 6 million individuals in Denmark showed that CUD was a major risk factor for schizophrenia, particularly among young males (15). While Hjorthoj et al., were not able to establish causality or conclude CUD was a modifiable risk factor, the authors estimated that as many as 30% of cases of schizophrenia among men aged 21–30 years might be prevented by averting CUD. The relationship between cannabis

FIGURE 1. Early predictors of cannabis use and presentations and outcomes of cannabis use disorder

Early Predictors of Use
Prenatal exposure
ACEs
Childhood adversity
Early tobacco/ alcohol use
Daily use patterns
High potency products and THC analogs
Unknown Impact

CUD Presentation and Outcomes
Sex differences
Male
Female
Frequent use before age 16
Psychiatric vulnerability
Stress reactivity/ emotional dysregulation
Increased cortical thinning
13
Age
>25

use and mental health is likely bidirectional, with shared common predisposing risk factors, neurobiological perturbations and overlapping genetics that may contribute to high rates of comorbidity (16).

CANNABIS USE DISORDER RISK

In addition to psychiatric comorbidities, several risk factors for the development of CUD have been identified, including social factors, environmental conditions, and personality traits (17) (Figure 1). However, large-scale studies consistently report two main factors associated with CUD risk. The first is age, both for the onset and frequency of use at younger age. Similar to a number of other psychiatric conditions, CUD risk peaks in adolescence, with most CUD cases becoming evident between ages 18–30 years (18, 19). Those who start using cannabis prior to age 16 years are at the highest risk of developing CUD (4). Moreover, youth who initiate use before the age of 18 years are significantly more likely to develop CUD, with substance-related problems continuing into adulthood, and to experience adverse psychiatric and personal outcomes (20, 21). The risk of developing CUD also increases significantly among youth who use cannabis at least weekly, with the highest prevalence among youth who use cannabis daily (4). One large-scale study reported increased use frequency associated with an 8–17-fold increased risk for developing CUD (20).

As noted above, the increased vulnerability to CUD following early use has implicated developmental perturbations in mesocorticolimbic brain regions, which mediate reward and emotion processing as well as cognitive control (17, 22, 23). Prospective longitudinal neuroimaging studies from the European IMAGEN consortium of teens from age 14 revealed that adolescent cannabis use is associated with accelerated cortical thinning, which was correlated with impulsive behavior (24). This finding of cortical thinning is consistent with a number of cross-sectional neuroimaging studies (25). Furthermore, amygdala reactivity during adolescence prospectively predicts cannabis use and CUD (26). Neuroimaging studies in adult individuals diagnosed with CUD also report similar mesocorticolimbic alterations (8, 23). More recent ongoing longitudinal neuroimaging efforts includes the long-term Adolescent Brain Cognitive Development (ABCD) study that has tracked youth from age 9–10 years. Emerging data has so far revealed that early initiation of cannabis use and CUD is predicted by early childhood adversity (19, 27), early initiation of tobacco and alcohol use, and maternal prenatal cannabis use (28). However, the causal relationship between these factors and cannabis use remains challenging to establish.

The second factor consistently associated with the risk of CUD is biological sex. CUD rates are normally higher among male individuals (18, 19, 29, 30), but marked gender differences in use patterns, motivations, and CUD presentation are noted. For example, male individuals are more likely to be diagnosed with CUD and show higher frequency of use (18, 29, 31). However, when controlling for frequency of use, CUD incidence does not differ between genders (29). Female individuals show faster CUD progression, referred to as telescoping (30, 32, 33). Similarly, female individuals with CUD may be more likely to show increased withdrawal symptoms (34), comorbidity with anxiety or mood disorders, and interpersonal difficulties (29, 30). These data suggest that cannabis and certain products may have different subjective and physiological effects in male and female individuals, which ultimately may influence the development of CUD. Importantly, the sex gap for CUD is narrowing, which might be due to higher consumption by young females or the higher potency of products used today.

A CHANGING PRODUCT AND USE PATTERN IN THE CANNABIS LANDSCAPE

Commercialization of cannabis products in legal markets has led to a sharp rise in THC potency, as well as availability and utilization of high-THC products, such as dab pens, wax, or shatter, among youth (2). Though recent studies have shown that high THC potency may be associated with increased risk of developing CUD (5), the neurodevelopmental impact of using *current* THC concentrates during adolescence remains understudied. To date, the integration of research findings has also been compromised by diverse and inconsistent measures of exposure. This is in part due to the wide array of cannabis products, with many individuals regularly using more than one type of product. Moreover, very limited information is known about the *type* of cannabis and cannabinoid products being used including a recently identified rare but extremely potent cannabinoid, tetrahydrocannabiphorol (THC-P), now widely available commercially (35). Information is also lacking regarding the proliferation of hemp-derived products that circumvented state and federal laws in manufacturing cannabinoids such as Δ^8-THC other THC analogs (e.g., Δ^{10}-THC and hexahydrocannabinol [HHC]), through the chemical conversion of cannabidiol, a non-intoxicating cannabinoid (36). The same challenges are evident with precursor products such as THC-acid (THCA) which converts to Δ^9-THC upon heating (36). Though adolescents and young adults often think that these popular new THC-analogs are "healthier," they can produce cannabimimetic effects similar or greater than Δ^9-THC (36, 37). The mental health implications expected with these new THC analogs requires significant monitoring and research attention.

Another factor critical for CUD is the developmental pattern of cannabis use relevant to severity of use. Most epidemiologic studies query the prevalence of cannabis use within a set time frame, most often past 30-day, past year, or lifetime. As noted above, the frequency of cannabis use is associated with increased risk of developing a CUD (20), but some clinicians misapply frequency of use as a measure of CUD severity. Consideration of factors used with identifying alcohol use disorder may yield new insights into high-risk patterns of cannabis use and the development of CUD. For instance, cannabis use in the morning (e.g., "eye opener," "wake and bake") may be more indicative of problematic use. Such information is, however, not often considered within screening and diagnostic constructs of CUD. Similarly, binge patterns of cannabis use have not been characterized, and the impact of episodic consumption of large amounts of high potency THC on the development of CUD is unknown. Alternatively, improved characterization of an individual's use beyond timeline follow-back may be accomplished via boarder adoption of subjective measures of cannabis use (38), though further studies are needed to validate such measures and establish a consensus guideline for future research.

INSIGHTS FROM PRECLINICAL MODELS

Multidisciplinary efforts are required to address the critical need to understand the neurodevelopmental impact of the proliferating diverse cannabis and cannabinoid products. Animal models therefore remain a critical resource to interrogate the causal impact of cannabinoids on the developing brain that may be relevant to the genesis of CUD (22, 39). Preclinical studies to date have provided unique insights demonstrating that prenatal and adolescent THC exposure increases anxiety behavior, deficits in sociality, increased depressive-like behavior, addiction vulnerability, and cognitive deficits (8, 22). Deficits are tied to perturbations in mesocorticolimbic (prefrontal cortex, nucleus accumbens, and amygdala), gene expression, protein, and cell morphology (40, 41). For example, rodent models of adolescent THC exposure demonstrate reduced morphological complexity of pyramidal cortical neurons (42), which would be in line with cortical thinning seen in human adolescent studies (24, 43). These animal models have also elucidated unique neurobiological underpinnings associated with high potency THC during adolescence on brain and cognitive behavior relevant to CUD risk (8).

There are still, however, substantial translational gaps between existing animal models and the current cannabis landscape. For example, the majority of preclinical studies utilize parenteral administration of cannabinoids to determine the impact on behavioral, physiological, and molecular phenotypes. This is due to the challenge that rodents do not readily self-administer THC through traditional intravenous preclinical "addiction" methods and often find THC aversive (44–46). Although injections of THC have revealed important relationships between drug and outcomes, human users mainly smoke, vape, or consume edible cannabis products (47). Novel rodent data indicate that vaporized THC produces different peak plasma and brain concentrations, metabolism profiles, molecular, and behavioral outcomes compared to injected THC (48–51). Furthermore, vaporized cannabis extracts are self-administered by rats (52) and adolescent animals will volitionally consume edible THC gelatin (53). These novel translational models create new inroads to better understand how developmental cannabis exposure and self-administration impact the trajectory of brain processes and behavior relevant to CUD risk.

To maximize the potential of novel translational models, both the clinical and preclinical fields need to standardize metrics of key outcomes. This includes determining fundamental pharmacological metrics (e.g., peak plasma concentrations, metabolite profile) to better compare the potency impact in animal models versus humans, as well as setting standard translationally relevant behavioral outcomes that recapitulate phenotypes observed in humans. Integration of longitudinal designs should test behaviors across development into adulthood using doses and routes of administration relevant to the current landscape seen in human cannabis consumption. These preclinical efforts

will accelerate our mechanistic understanding as to how developmental THC and cannabinoids causally influence phenotypes relevant to psychiatric and CUD risk.

ADDRESSING ADOLESCENT CANNABIS USE

Another important factor in tackling the changing cannabis landscape is treatment. There is currently an unfortunate disparity between the estimated prevalence of CUD and the number of youths who receive evidence-based treatment. Treatment strategies are currently limited and consist mainly of motivational enhancement and cognitive behavioral therapies. Given that the increased potency of cannabis and cannabinoid products is expected to increase CUD risk, it is disturbing that less than 10% of youths who meet the criteria for a substance use disorder, including CUD, receive treatment (54). More recently, there has been a decline in treatment admissions for CUD among youths across the United States, including in states with recreational marijuana laws (55).

Even when treatment is available, adolescents often do not engage due to lack of perceived need for treatment. With the expansion of recreational laws and statutory classification as "medicinal" at the state level, perceived harmfulness of cannabis use continues to decline (2). In fact, some studies suggest that youths perceive concentrated THC products, particularly vapes or dab pens, as less harmful than combustible plant-based products (56, 57). This is further complicated by the perception that cannabis use is helpful for mental health problems that may be exacerbated by cannabis use (58, 59). Broad education efforts are needed, but educating youths about cannabis is complicated by the extensive amount of information and misinformation available online and via social media. Individualized interventions may be better targeted by primary care and mental health professionals, who can address individual and family factors that often contribute to comorbid mental health problems as well.

Challenges in treatment provision also exist. Of the few evidence-based interventions currently used to treat CUD, their availability and efficacy remain limited. This is paired with potential lack of insight into cannabis-related problems. For example, self-reported physiologic changes consistent with tolerance and withdrawal are often not recognized as problems related to cannabis use (57). Insufficient clinical screening and unrecognized substance-related problems may also result in clinicians missing problematic cannabis use entirely or inaccurately classifying adolescent cannabis use as misuse rather than a CUD. Further, clinicians may not screen for substance use problems because of a lack of available resources or programs to which youth may be referred.

A multifaceted approach is required to address this gap in care, including broader implementation of universal and selective interventions. Risk and protective factors for the onset of youth cannabis use can be conceptualized using the socio-ecological model, which posits that factors at multiple levels, including individual and peer, family, school, and community, contribute to cannabis use (60). Using this framework, current evidence supports the broad implementation of universal and selective interventions that enhance protective and reduce risk factors. This may include implementation of evidence-based interventions at the institutional (e.g., school) or community level. Integration of behavioral interventions into primary care, social work, and school-based settings presents a significant opportunity to leverage current infrastructure and provide treatment where youth are already engaged in other services. Moreover, as states vie to leverage tax dollars from the growing cannabis industry, a significant portion of such funds must be used for early intervention/prevention strategies to reduce the impact of cannabis on the developing brain.

CONCLUSIONS

The relationship between developmental cannabis, the impact of high potency products, and increased risk of developing CUD and mental health problems must be taken seriously, especially in light of the current mental health crisis. The plasticity of the developing brain offers windows of opportunity for prevention and early intervention to change that trajectory. Clearly new treatment strategies are needed to address the mounting challenge of CUD risk in teens and young adults. While data accumulated over the past decades about the effects of now "low dose" THC has been very valuable, significant research efforts in preclinical models are needed, focused on THC potency relevant to today's products. Additionally, longitudinal studies such as ABCD should be able to provide important insights about factors related to resilience that may also help guide the development of intervention strategies. Altogether, the combined longitudinal, clinical and preclinical efforts will help provide unprecedented knowledge to mitigate the trajectory of CUD and related psychiatric disorders, both of which have a strong neurodevelopmental etiology.

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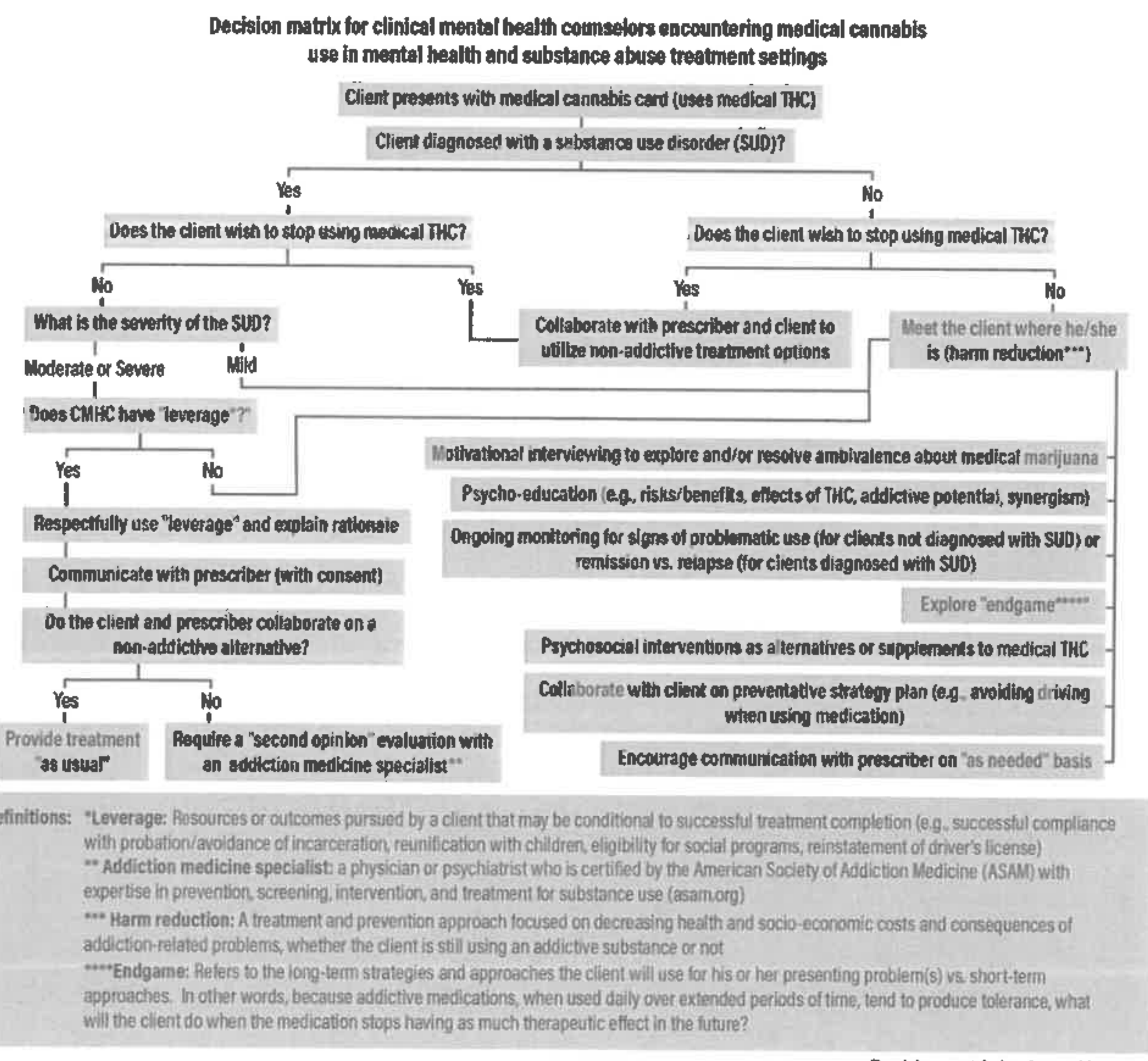
The impact of legalized marijuana on professional counseling

By Bethany Bray
March 2022



Decision matrix by Aaron Norton

In 1996, California voters passed Proposition 215, making the Golden State the first in the U.S. to legalize the use of medical marijuana.

Two decades later, the medical use of cannabis is legal in 37 states, Washington, D.C., and the territories of Guam, Puerto Rico and the U.S. Virgin Islands. Additionally, 18 states, Washington, D.C., and two territories have enacted legislation to regulate cannabis for nonmedical (i.e., recreational) uses, **according to** the National Conference of State Legislatures. Just three states — Kansas, Nebraska and Idaho — do not allow public access to cannabis in any form, medical or otherwise.

In states where cannabis use has been legalized, many medical and mental health practitioners have found it necessary to shift their mindset — from viewing marijuana as an illegal substance to something that medical doctors can condone or even recommend and that potentially has benefits for a range of conditions, including chronic pain and posttraumatic stress disorder (PTSD).

"When it was first becoming legalized, it was a bit of a panic for the [addictions] treatment community around 'How are we going to deal with this?' What has evolved is that now, it's viewed in a similar way as alcohol is: There is a continuum of users, [and] it can be abused but also used socially or occasionally," says **Adrianne Trogden**, a licensed professional counselor and supervisor (LPC-S) and licensed addiction counselor (LAC) with a private practice in New Orleans. "It's a hard transition for treatment providers to go from thinking of it as an illegal street drug to being dispensed as a medicinal medication. … In treatment facilities, you see the worst of the worst — those whose lives have been ruined by substance. It's easy to see the ugly side of addiction and naturally be leery of [marijuana] being used for medicinal use. That mindset is hard to shift."

Legalization has also meant that professional counselors cannot keep their heads in the sand about this issue, regardless of how they feel personally about the use of marijuana, says **Paula Britton**, a licensed professional clinical counselor and supervisor with a private practice in Cleveland. Practitioners need to be comfortable broaching the subject of how and why a client uses marijuana, and they should be familiar with the pros and cons of the substance as it relates to adult mental health and wellness. In addition, they should understand the nuances of cannabis regulation in their state.

At the same time, counselors must know how to assess clients for cannabis use disorder and listen for indicators that an individual may be drug seeking, Britton says.

Talking about clients' marijuana use "gets tricky," admits Britton, who is licensed as both a counselor and a psychologist. "Because of that, many counselors don't want to get involved or learn about it. But I don't know if we're going to have that option in the years to come" as it becomes increasingly legalized. "We have to be aware that this is going on and that [marijuana use] is helpful for some people," she continues. "We have to acknowledge that our clients are using it, or wanting to use it, for medical or recreational purposes and [consider] what … that mean[s] for us in counseling."

Mixed messages

Cannabis is classified as a Schedule 1 substance under the Controlled Substances Act, which makes its distribution a federal offense. This puts marijuana alongside heroin, ecstasy, LSD and other substances that are "defined as drugs with no currently accepted medical use and a high potential for abuse," **according to** the U.S. Drug Enforcement Administration.

This sends a confusing and mixed message, both to the public and to health professionals, given that marijuana may be legal and OK to use at the state level yet illegal federally, Britton says. In addition, the complicated regulatory scheme has impeded much-needed research on the effects marijuana can have on a range of conditions when used in a controlled, medically sanctioned way.

In the meantime, counselors must rely on the limited research that has been done by other disciplines or by researchers outside of the country. The few studies that have been done have yielded mixed results on marijuana's efficacy for mental health diagnoses, particularly anxiety and depression, Britton notes.

"There's just so much we don't know," says Britton, a professor of clinical mental health counseling at John Carroll University. "If we [counselors] are going to be evidence based, it's hard to have an informed decision about what you think without that [research] behind you."

One example of the mixed messaging surrounding cannabis use involves the U.S. Department of Veterans Affairs (VA). The VA has done studies that show medical marijuana can help individuals with PTSD, yet it will not endorse its use for VA patients because of the federal law, Britton notes.

The American Psychiatric Association issued a position statement in 2019 saying that it would not endorse the use of medical cannabis for the treatment

of PTSD "because of the lack of any credible studies demonstrating [its] clinical effectiveness."

Aaron Norton, a licensed mental health counselor, licensed marriage and family therapist and certified rehabilitation counselor with a private practice in Largo, Florida, suggests that the mixed data regarding marijuana use allows people who argue either for or against its legalization to cherry-pick studies that support their view. Some people, for example, have cited reports linking the legalization of medicinal cannabis with lower opioid overdose mortality rates as evidence that medical marijuana is the answer to ending America's opioid epidemic.

"What I am concerned about is the touting of medical cannabis as the cure-all magical wonder drug," says Norton, who has written and **presented** on legalized marijuana's impact on the counseling profession. "There is contradictory evidence out there ... [and] overall there's very little evidence that medical marijuana helps many of the things that we think it does. I'm concerned about the claims that are made and [the] use of it in mental health treatment."

It *is* well-known, however, that marijuana use can have a negative impact on child and adolescent brain development and has also been tied to lung problems (when used in inhaled forms) and other challenges later in life, Britton says. She advises counselors to also be mindful that marijuana use can affect the efficacy of psychotropic medications such as antidepressants that are commonly used by clients.

Even when used legally, marijuana can still have adverse effects on clients' employment, particularly if they work for the federal government or in fields that require regular drug testing. Marijuana stays in the human body and can show up on drug tests weeks after a person uses it, notes Britton, who co-authored a recent ***Journal of Counselor Practice*** article on Ohio mental health professionals' attitudes, knowledge and experience regarding medical marijuana.

This aspect of marijuana use also has implications for counselors who work in the field of substance use because it can be difficult to determine an individual's length of abstinence, says Trogden, an assistant professor in the counseling department at the University of the Cumberlands.

Dosing concerns

Dosing is another potential area of confusion related to legalized marijuana for individual users and health professionals.

Norton says that in Florida, it is mostly left up to the individual to purchase and use whatever dose they believe is best — a situation he labels a "free-for-all." Physicians in Florida do not prescribe specific doses to patients who are granted a medical marijuana card because it remains illegal federally, he explains.

Similarly, Britton points out that employees at marijuana dispensaries in Ohio are not doctors and will often sell customers whatever dosing amount they request. Determining the correct cannabis dosing is complicated because the "optimal dose" will be different for every person, she says. The same amount of substance will affect people differently depending on whether it is inhaled or eaten, such as in gummy candy or baked goods.

Matthew McClain, a school counselor in Fort Morgan, a small town in northeast Colorado, notes that dosing is a concern for youth because they often won't read or adhere to the instructions or labeling for items that have come from a cannabis dispensary. For example, a teenager may open a marijuana brownie or piece of cake and eat the entire thing without pausing to read or acknowledge that it may be equal to two or three servings. "That can be pretty significant for the [body] systems of a teen," says McClain, the executive director of the Colorado School Counselor Association (CSCA).

School counselors in Colorado are finding that youth (mostly in middle or high school settings) have adopted more casual attitudes about marijuana since its legalization in the state, McClain notes. In recent years, he says, school counselors' awareness and concerns have shifted from students smoking marijuana to their consumption of it via vaping or edibles, both of which feature a high concentration of tetrahydrocannabinol (THC), the component in marijuana that produces a high. These methods allow students to consume the substance in a more clandestine way than smoking does, including during the school day. Edibles such as candy or gummy bears also make exposure and consumption of marijuana more familiar and less foreboding to youth.

One way to counteract this issue is to train teachers and noncounseling school staff in mental health first aid, McClain says. This can better prepare school staff members to notice behavior changes and other indicators that a student might benefit from talking with a school counselor — about marijuana use or anything else, McClain says. CSCA also offers regular trainings and

continuing education programming to its members on marijuana use and its effects in school settings, he adds.

"This just adds another layer of complexity to the job, one other thing that can be going on" with students, McClain says. "We [at CSCA] have made sure that we've provided [educational] opportunities by seeking out experts and people who are well-versed to provide information and training, and other states are in a similar situation. We may want to stick our heads in the sand, but at the same time, if we're dealing with the day-to-day lives of our kids, we want to make sure we can provide help and support."

Use as instructed?

Norton says that in his experience, only a small fraction of his clients who have medical marijuana cards use the substance for medical reasons. He believes the majority obtained a medical marijuana card so they could use it recreationally, which remains illegal in Florida, or because they have cannabis use disorder.

When asked, many of these clients are unable to tell Norton why they have a medical marijuana card, or they name conditions — such as headaches, attention-deficit/hyperactivity disorder and trouble sleeping — that aren't listed on the state statute that allows for the use of medical marijuana. The only mental health diagnosis mentioned in Florida's statute is PTSD, Norton says. However, there is language in the law that allows medical marijuana to be prescribed for "similar" conditions to those listed in the statute, which gives physicians flexibility. Norton says he has never heard of a client who has been turned down for a medical marijuana card.

"Even clients who perceive they are using it medically ... judge its efficacy by [not only] if they feel better but also [if they] feel high or euphoric — and that's not the point of medicine," says Norton, the executive director of the National Board of Forensic Evaluators and an adjunct instructor at the University of South Florida's rehabilitation and mental health counseling program. "People are using cannabis to feel better in the moment — sleep better, lessen anxiety, etc. — but at the expense of addressing their core problems, which are thoughts and behaviors. They're missing the opportunity for recovery from their behaviors."

Trogden agrees, saying, "The challenge, just as with any other medication, is that you really need therapy and counseling services to gain insights and awareness [about a presenting issue] along with taking the medication." She adds that in her experience, medical marijuana has benefited clients who

have depression or other mood disorders, trouble sleeping, anxiety, racing thoughts or a history of trauma. But Trogden also notes that in addition to its potential benefits, marijuana use can cause paranoia or lead individuals to use it as a "crutch" to cope with pain and other difficult feelings.

Britton has done research on medical marijuana and counseled clients who use it. She says the substance can be tied to symptom relief or otherwise benefit individuals who have chronic pain, sleeping difficulties, autism spectrum disorders, anxiety and hyperarousal, nausea (such as in those undergoing chemotherapy treatment for cancer) and a range of other issues. At the same time, she says that more research is needed.

In Britton's experience, medical marijuana has helped some of her clients, while others did not reap any benefit — or even had negative outcomes — from its use. "And that's consistent with the literature," she notes. "Not everyone benefits. It's not a miracle cure. But just like with antidepressants [and other psychotropic medications], it can soften a client's symptoms … [so they can] do the therapeutic work. But they still need behavioral intervention."

Now that marijuana is legal in most states, the counselors interviewed for this article agree that clinicians should include specific, detailed questions about its use during the client intake process. Asking clients how often and why they use marijuana can help practitioners better understand the context of their use and assess for dependence or cannabis use disorder.

Cannabis use disorder is characterized by behaviors that indicate that a person cannot stop using the substance even though it is causing the person social or health problems, such as overusing or craving marijuana or driving while impaired. **According to** the Centers for Disease Control and Prevention, individuals who use cannabis frequently or began using it in adolescence are at greater risk of developing this disorder.

Practitioners should embed questions into assessment about how much and how often clients use marijuana, similar to the way they would ask about clients' consumption of alcohol, suggests Trogden, who teaches in an addiction counseling training program for the state of Louisiana and is the chief operating officer of a behavioral health organization in New Orleans.

"We should be assessing for a variety of things. It's helpful to understand the whole person and get a holistic understanding of what's going on. Substances would be a part of asking about medication, whether it's blood pressure [medication], mental health medication or marijuana," Trogden says. "It's

important to call it out specifically, [asking] 'Do you use marijuana?' If you just ask, 'Do you use drugs?' they'll probably say 'no.'"

Trogden says multiple clients have mentioned to her in later counseling sessions that they smoke marijuana after initially answering "no" to generalized substance use questions at assessment. As a result, she's learned to ask specifically about marijuana in assessment because some clients do not consider it to be a drug or on the same level as illegal substances.

Britton suggests that counselors take a nonjudgmental, curious and respectful approach to marijuana assessment with clients. "If a client senses that you are going to judge them — on any topic — they're probably not going to tell you," she says. "Start thinking differently about how you ask [and] how you put it on intake forms. Get outside of judgment."

When clients ask

Clinicians in states where marijuana is legalized may have clients ask whether it could help them with symptoms related to their presenting concern or mental illness. Counselors cannot prescribe medication, however, and making a recommendation or giving guidance on marijuana use — or any other kind of health regimen — goes beyond a counselor's scope of practice, says Emily St. Amant, counseling resources and continuing education specialist for the American Counseling Association. She recommends that counselors refer to the 2014 ***ACA Code of Ethics***, particularly Standard C.2.a.

St. Amant, a licensed professional counselor with a mental health services provider designation in Tennessee, urges counselors to respond to client questions about legalized marijuana use with a nonjudgmental attitude and a recommendation to speak with a licensed psychiatric medical provider about the topic.

"I would also provide education about why I'm making that recommendation: my own scope of practice [and how a prescriber is qualified] to discuss risks and benefits, side effects, drug interactions, etc.," says St. Amant, whose background is in substance use counseling. "As a counselor, I need to ensure I'm staying within my scope of practice or what I'm personally licensed to do. We open ourselves up for liability and ethical violations when we drift out of our lane and into the lane of other areas of expertise. We also open ourselves up for potentially harming our clients if we impose our own values or ideas on them. That takes away their autonomy, can damage the therapeutic relationship and creates a power imbalance."

Rather than offering advice to clients regarding legal marijuana use, counselors should focus on strengthening clients' personal autonomy and decision-making skills, St. Amant emphasizes. Ultimately, it is the client, not the counselor, who must make and live with the decision to use (or not use) marijuana, medicinally or recreationally.

"That doesn't mean we leave them hanging and avoid helping in some way. That would be risking invalidating the client's concern and a missed opportunity to be supportive," St. Amant says. "We *can* help our clients by providing education, teaching problem-solving skills, eliciting their decision-making process, validating their concerns and promoting their empowerment and autonomy. ... Even for us experienced counselors, it's vital to ensure we are staying true to the fundamentals of client-centered principles. Those that are particularly relevant here include the fact that clients are the experts in their own lives and that we genuinely trust that they can decide what's best for them."

Decision-making

Talking about a client's marijuana use in counseling sessions will have a very different dynamic depending on whether the individual is voluntarily pursuing treatment or has been mandated to complete therapy, often as the outcome of a court case.

In the second scenario, practitioners must remember — and explain to the client — that their work goes beyond the needs of the individual client, Norton says. The client may want to get their driver's license returned after a DUI violation, for example, and this is contingent on completing a regimen of counseling sessions.

"The counselor is responsible not only for the safety of their client but [also for] the safety of the public," Norton says. "You have to address the issue [of their marijuana use]. You can't ethically clear them if they're just as unsafe now [at the conclusion of therapy] as when they first came to you. Counselors now have more than one stakeholder in what you do."

Norton is a counselor supervisor, and his interns often work with clients who are mandated to complete counseling after a DUI or whose children have been removed from their care by child protective services because of their marijuana use and related behaviors. Norton also sees similar scenarios in the work he does as a substance use and DUI evaluator for the court system in Florida.

It is common for clients to try to skirt the sobriety requirements in mandated treatment situations by obtaining a medical marijuana card, according to Norton. This scenario puts the counselor in a no-win situation because the client has a way to legally obtain marijuana and continue their behaviors, he says. Addressing the root of the problem that brought the client into counseling becomes exponentially harder because the counselor is not a medical professional and cannot advise the client to stop a medically prescribed treatment, Norton points out.

Norton's experience — and frustration — with this scenario led him to create a decision-making matrix (*see below*) for counselors to use when discussing marijuana use with clients who have been prescribed legal cannabis for medical use.

When addressing marijuana use in counseling sessions, Norton suggests that practitioners focus on clients' motivation to change and their attitudes toward stopping their use of marijuana. His model offers different treatment scenarios for clients who have and have not been diagnosed with a substance use disorder and for situations in which the counselor has leverage (i.e., resources or outcomes the client wants, such as the return of a driver's license or child custody, that are conditional to successful treatment completion).

In the case of clients who want to stop using cannabis, the counselor can collaborate with and refer them to a physician to find an alternative treatment. For those who do not want to stop using cannabis, the counselor can take a harm reduction approach to make gains toward behavior change in other ways, Norton explains. This includes strategies such as using motivational interviewing to explore the client's thoughts on continuing their marijuana use or co-creating a "preventative strategy plan" with the client to identify benchmarks such as avoiding driving while using cannabis.

A harm reduction approach can prompt growth and behavior change in clients even while they continue to use cannabis — and much more so than simply leaving it unaddressed, Norton emphasizes.

Taking a nonconfrontational and supportive approach

Many of the harm reduction techniques Norton includes in his decision-making matrix involve collaboration between the counselor and the client. This ensures the counselor meets the client where they are, he says, and increases the likelihood of positive behavior change.

Katharine Sperandio, Daniel Gutierrez, Alex Hiller and Shuhui Fan, co-authors of the April 2021 *Journal of Addictions & Offender Counseling* article "**The lived experiences of addiction counselors after marijuana legalization**," interviewed six professional counselors in Washington and Colorado (the first states to legalize marijuana for recreational use) who work with clients experiencing substance use disorders. They found that using a nonconfrontational, "motivational enhancement" approach with clients regarding marijuana use was more beneficial than addressing it head-on.

One participant in the study provided an example of a nonconfrontational approach. They broached clients' marijuana use by framing it as a question: "Why do you think it's a problem for you?"

The co-authors also learned that with the legalization of marijuana, practitioners are seeing an increase in client justification and rationalization of marijuana use and less acceptance that it can be harmful or problematic, particularly among adolescents. Many clients were found to be using legal marijuana to numb negative thoughts and emotions, ease chronic pain, cope with trauma and "as a substitute for alcohol or other drugs rather than seeking [counseling] treatment because it was so readily available."

The study participants also reported that clients were "more likely to walk out of treatment" and less likely to communicate about marijuana use (even if it was a source of other problems) if they felt there was a policy or recommendation to decrease marijuana use.

When school students are facing discipline for marijuana use, addressing it in a supportive way is the best approach to discourage those students from returning to risky behaviors, McClain says. When possible, it is helpful to involve the student and their parent(s) or guardian(s) as well as the school counselor and administrator to ensure that the student has a support system and reentry plan that doesn't involve marijuana use and related behaviors, he says. Such a plan might include regular check-in conversations with a school counselor.

Taking a holistic approach, rather than only punishing, avoids setting the student up for failure and ensures that all of the student's stakeholders are on the same page, McClain adds.

"We want to make sure they have a support system, including a counselor, to turn to for help. As much as we can surround them with support, hopefully the

outcome will be better," says McClain, who has worked as a school counselor for 17 years.

Case example

An adult woman came to see Britton for PTSD after experiencing sexual trauma. The client was experiencing intense flashbacks, having trouble sleeping and struggling with chronic pain. Britton surmised that the pain was related to her trauma because the client held her trauma in her body.

Britton used dialectical behavior therapy with the client, who made a small amount of progress in the first year but eventually stalled despite staying engaged in sessions and showing a willingness to try exercise and other actions that Britton suggested. The client continued to be plagued with sleep difficulties and night terrors, even while using a prescription sleep aid. Britton continued to co-treat the client while referring her to a practitioner who specialized in eye movement desensitization and reprocessing (EMDR) therapy.

"It took her a long time to forge trust; it took her several months to even tell me what happened. Once we got to that part, we started making some progress, but then she hit a wall," Britton recalls. "Not only was the EMDR not helpful, but she [also] found it upsetting and she started going downhill, discouraged that she'd 'never get better.' ... She felt really stuck and scared, and we weren't making a whole lot of progress. The more she couldn't sleep, the worse her symptoms got."

Eventually, the client brought up the possibility of trying medical marijuana. Britton responded by saying that she couldn't advise her on whether it would be effective, but she could write a letter confirming that the client had PTSD in case she wanted to pursue obtaining a medical marijuana card.

Ultimately, the client did receive a medical marijuana card and began using cannabis to alleviate her pain and trauma symptoms.

"It wasn't a miracle cure. ... She still presented with some trauma symptoms [while using medical marijuana], but it helped her sleep, and that was huge," Britton says. "It didn't 'cure' her, but it took the edge off so she could look at things a little clearer, and she started feeling some hope [after] feeling so deflated, so defeated. It gave her the energy to work toward some other behavioral treatments.

"She wasn't drug seeking; she was seeking symptom relief. It helped enable her to do the work that was in front of us [and] gave her the braveness to face it. It was just part of [her treatment]. It wasn't the full answer, but I was glad we tried it."

Bias management

The counselors interviewed for this article agree that clinicians have a responsibility to seek training, consult with colleagues and stay up to date on the regulations regarding marijuana in their area as well as the ways that its use — and misuse — can affect mental health.

At the same time, counselors are ethically bound to keep their personal views about marijuana (and all substance use) out of their counseling work, St. Amant notes.

"Substance use exists on a spectrum, and just because someone uses legal or illegal substances does not mean they have a substance use disorder," she says. "Counselors must be careful not to impose their own values about substances use on their clients or project their own beliefs onto others. When the use of substances is conceptualized as a moral concern or a personal failing, we add to the stigma of substance use. Our attitudes must remain nonjudgmental and nonmoralistic when it comes to substances."

****

Can counselors use legalized marijuana?

In states where marijuana use is legal for medicinal or recreational purposes, counselors have the right to use it on their own time, but they also have the ethical obligation to ensure that it does not cause an impairment to their clinical performance and their relationship with their clients. They can do this by approaching it the same way they do with alcohol use.

Counselors can ethically use legal substances as long as they do not perform clinical duties under the influence, the use does not impair their ability to function (e.g., seeing clients while experiencing a hangover or the prolonged impacts of the substance) and they are able to use the substances responsibly (e.g., not driving under the influence). If counselors choose to use legalized marijuana, one should be aware of how long the effects last (which can linger into the next day for marijuana) and ensure that no pictures are posted of them using the substance on social media.

If counselors have difficulty controlling their use or if it affects their health or clinical abilities, they should seek out an evaluation to see if they could benefit from treatment, and they should refrain from providing clinical care until it's determined that they can do so safely and ethically.

Our ethics are founded upon ensuring client safety and preventing harm to those we serve, so our clients' right to be protected from potential harm by their counselor using substances supersedes our personal freedom during the time in which we are working with them. Yes, we counselors are adults who are allowed to live our lives how we personally see fit, but, no, our personal choices cannot come at the cost of our clients' safety.

See Standards C.2.g. and A.1.a. of the 2014 *ACA Code of Ethics* at ***counseling.org/ethics***.

— Emily St. Amant, counseling resources and continuing education specialist for ACA

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https://www.counseling.org/publications/counseling-today-magazine/article-archive/article/legacy/the-impact-of-legalized-marijuana-on-professional-counseling

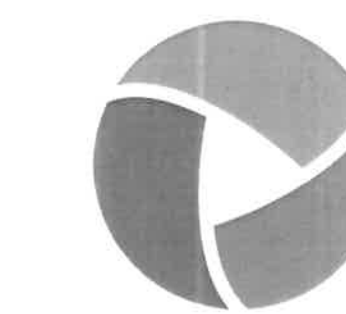
Welcome to Averhealth

Bench Guide—

Drug Testing Best Practices

averhealth

At Averhealth, our mission is to reclaim lives, unite families, and strengthen communities by creating and providing the smartest, most innovative solutions for substance use disorder monitoring and recovery.



We hope this guide is a helpful resource and gives you a glimpse of the ways we can serve you. We look forward to working with you today, tomorrow, and for many years to come.

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Why Averhealth

Since 1995, Averhealth has specialized in providing substance use monitoring services tailored to the unique needs of courts and social service agencies that operate at the holistic intersection of health care and criminal justice. We partner with you to help people achieve recovery.

Every element of the Averhealth solution incorporates evidence-based practices, positioning your program and your clients for the best possible outcome. Random selection, daily engagement, robust sample collection, and rapid results combine to help clients develop coping and refusal skills to new-use events. While our agile and easy-to-navigate software and automation tools streamline your daily workflows and ultimately support recovery.

The result: better outcomes, and better communities. Welcome to Averhealth.

Random Selection

- Randomized testing 365 days/year
- Equal chance of testing any day of the week

Reliable, Next Business Day Test Results

75% ACCURACY — Instant Screens
97% ACCURACY — Averhealth

- Lab-based testing is CAP-FDT, CLIA, and DEA accredited
- Next business day results for rapid interventions
- Strategy that reduces cost and time associated with confirmation testing

Broad and Customizable Testing Panels

- Testing for more than 1,500 illicit, prescription, and synthetic substances, including designer drugs
- Urine, oral fluid, hair, breath, and sweat testing
- Panel rotation

Daily Engagement and Reinforcement

- Daily check-ins via text, website, or phone
- Messages of affirmation

Pre-Relapse Intervention

- Predictive analytics identify clients at risk for relapse—before they relapse

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Lab Certifications and Information

The Averhealth laboratory is accredited by the U.S. Department of Health and Human Services Clinical Laboratory Improvements Amendment (CLIA), the College of American Pathologists-Forensic Drug Testing (CAP-FDT), and the Drug Enforcement Agency (DEA). Located in St. Louis, Missouri, our laboratory is operated by PhD- and Masters-level toxicologists.

Averhealth tests for over 1,500 substances across urine, breath, oral fluid, and hair using laboratory instruments and applying scientifically valid and forensically defensible methodologies that satisfy Daubert and Frye legal standards and fulfill CAP-FDT specifications.

Test Methodologies

The three common test methods are instant screens, laboratory screens, and confirmation tests.

Considerations	Instant Screen	Laboratory Screen	Laboratory Confirmation
Sensitivity (false positive)	Variable & Subjective	>99%	Definitive
Specificity (false negative)	Variable & Subjective	>99%	Definitive
# of Substances Tested	~15	~35	All
Specimen Types	Urine Oral Fluid	Urine Oral Fluid Hair Blood Sweat Nails	Urine Oral Fluid Hair Blood Sweat Nails
Time	Minutes	24 to 48 Hours	2 to 4 days

Instant screens versus laboratory testing

Instant screens can provide results within minutes. However, instant screens require a higher level of confirmation (19 per every 100) due to subjective results and accuracy limitations. One in every four instant screens is wrong (false positive or false negative).

Instant screens also mean testing for the same drugs repeatedly. This rigidity does not allow for panel rotations, an evidenced-based practice that mitigates drug of choice migration.

Laboratory testing at Averhealth is completed on an Olympus AU5400 Chemistry Immuno Analyzer, the same instruments used by large hospital systems. Just two of every 1,000 laboratory screens require confirmation testing. Laboratory screens are objectively accurate greater than 97% of the time.

Confirmation testing

Confirmation testing at Averhealth is conducted via LC-MS/MS, a methodology exceeding GC/MS standards. This allows for:

- Greater compound coverage, including designer and synthetic substances
- Better precision and sensitivity
- Faster panel expansion to adapt to changing substance use trends

If no affirmation,
there must be confirmation.

Treatment Tip

Laboratory screens combined with confirmation tests serve as an incredible tool in the recovery process. Positive screens provide an opportunity for a patient to honestly acknowledge a new use event. Only in cases of adamant denial or loss of liberty (e.g., child custody, jail) is confirmation testing necessary—saving you time and money.

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Specimen Options

Before choosing the specimen type, it is important to consider use case, desired detection window, range of detectable substances, test frequency, and substance combinations.

Specimen Type	Range of Detectable Substances	Detection Window	Collection Process	Common Use
Blood	>1,500	8 - 12 hours	Invasive	DWI, Post Mortem
Breath	1	8 - 12 hours	Non-invasive	DWI
Oral Fluid	>100	5 - 48 hours	Non-invasive	Abstinence Monitoring
Urine	>1,500	2 - 3 days	Moderately Invasive	Abstinence Monitoring
Sweat	<10	5 - 10 days	Non-invasive	Travel, Rural
Hair	<20	2 weeks - 3 months	Non-invasive to Invasive	Child Custody, Rural

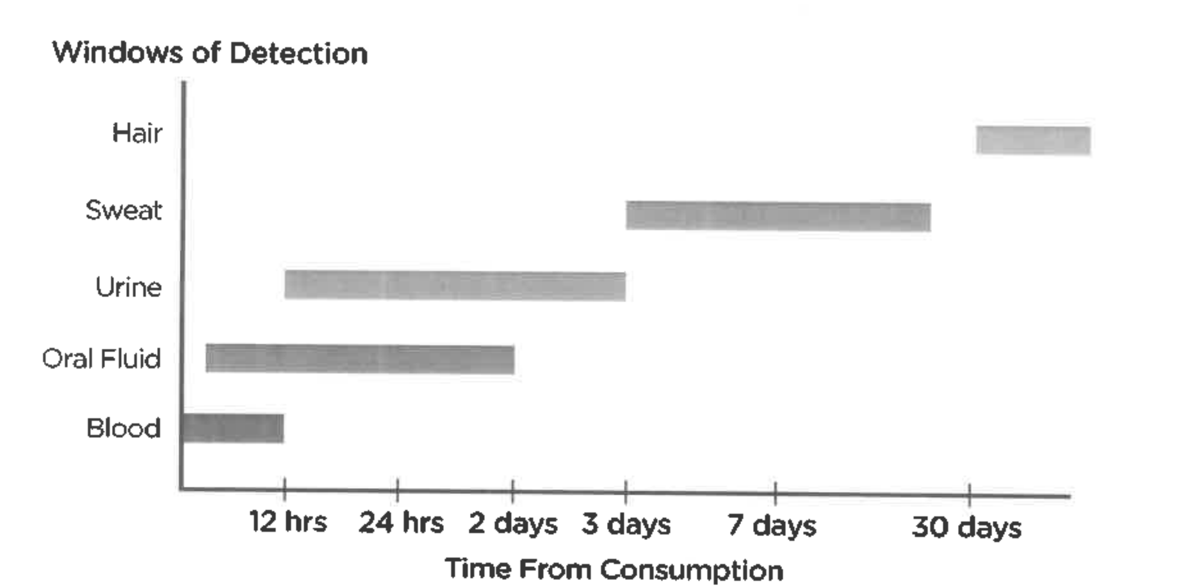
Substances are detectable in various sample types at different times and in different concentration levels. For this reason, results across sample types (e.g., urine results and oral fluid results) are not comparable.

Windows of Detection

Hair
Sweat
Urine
Oral Fluid
Blood

12 hrs 24 hrs 2 days 3 days 7 days 30 days

Time From Consumption



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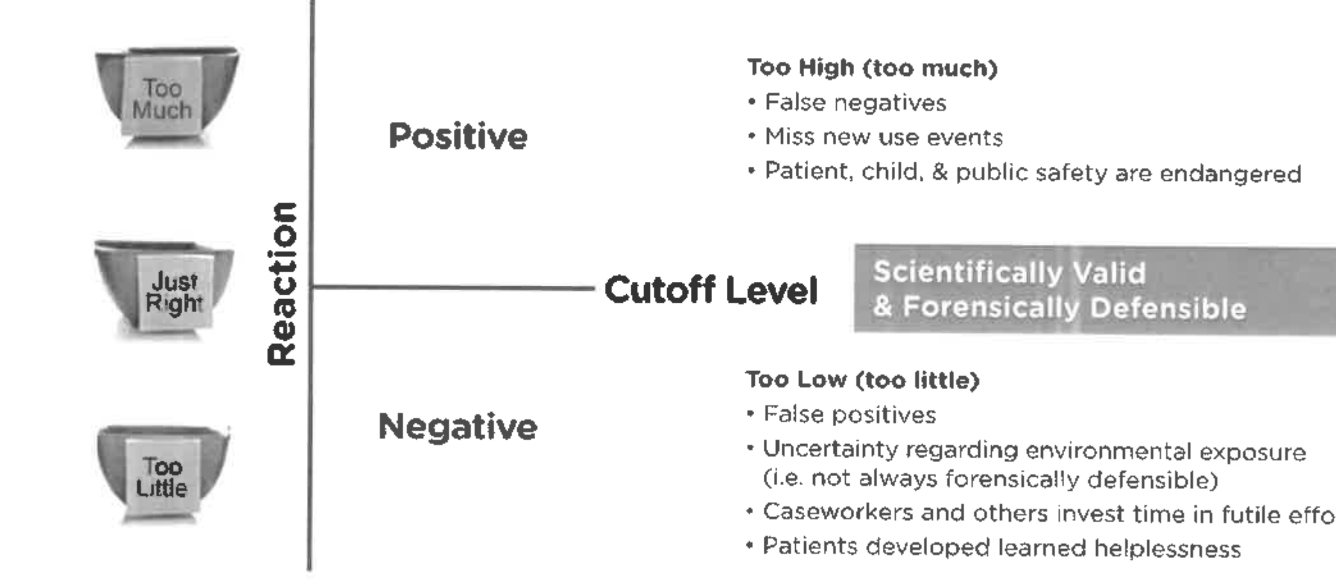
Cutoff Levels

With very few exceptions, drug test levels should only be compared to a cutoff to determine whether a sample is positive or negative. A sample that produces a drug test below the cutoff is deemed negative, while a sample that produces a drug test at or above the cutoff is deemed positive. Cutoff levels are determined by:

- Use case
- Scientific validity
- Forensic defensibility
- Sample type



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Oral Fluid Common Substances

Assay	Detection Window	Screening Cutoff	Confirmation Cutoff
Amphetamines	2 days	12.5 ng/mL	10 ng/mL
Benzodiazepines	3 days	5 ng/mL	5 ng/mL
Buprenorphine	2 days	1.25 ng/mL	5 ng/mL
Cocaine	<1 day	5 ng/mL	5 ng/mL
Methadone	1-2 days	12 ng/mL	5 ng/mL
Methamphetamine	2 days	12.5 ng/mL	10 ng/mL
Opiates	1-2 days	10 ng/mL	5 ng/mL
Oxycodone	1 day	10 ng/mL	5 ng/mL
Phencyclidine	5-7 days	2.5 ng/mL	5 ng/mL
Cannabinoids (THC)	1-2 days	2 ng/mL	2 ng/mL

*nanogram per milliliter of oral fluid

Urine Common Substances

Assay	Detection Window	Screening Cutoff	Confirmation Cutoff
Amphetamines	3 days	500 ng/mL	100 ng/mL
Barbiturates	1-2 days	200 ng/mL	50 ng/mL
Benzodiazepines	1-7 days	200 ng/mL	50 ng/mL
Buprenorphine	3 days	10 ng/mL	25 ng/mL
Cocaine	<1 day	300 ng/mL	50 ng/mL
Non-Synthetic THC	3-5 days	20 ng/mL	5 ng/mL
Synthetic Cannabinoids	1-2 days	15 ng/mL	5 ng/mL
Ketamine	1-2 days	100 ng/mL	50 ng/mL
Methadone	1-2 days	200 ng/mL	25 ng/mL
Methamphetamine	3 days	500 ng/mL	100 ng/mL
Opiates	1-3 days	300 ng/mL	50 ng/mL
Oxycodone	1-2 days	100 ng/mL	50 ng/mL
Tramadol	1 day	200 ng/mL	50 ng/mL

*nanogram per milliliter of urine

Hair Common Substances

Assay	Detection Window	Screening Cutoff	Confirmation Cutoff
Amphetamines	30 to 90 days**	200 pg/mg	200 pg/mg
Benzodiazepines	30 to 90 days	50 pg/mg	50 pg/mg
Cannabinoids (THC)	30 to 90 days	10 pg/mg	10 pg/mg
Cocaine	30 to 90 days	100 pg/mg	100 pg/mg
Methamphetamine	30 to 90 days	200 pg/mg	200 pg/mg
Opiates	30 to 90 days	100 pg/mg	100 pg/mg
Oxycodone	30 to 90 days	100 pg/mg	100 pg/mg

*picogram per milligram of hair

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Results Interpretation

Why Didn't My Specimen Confirm?

Imagine a bowl of M&Ms and Skittles.

- Green M&Ms are strictly prohibited, while green Skittles are permitted.
- Immunoassay screens detect all green candy; both M&Ms and Skittles.
- Immunoassay screens will deem a client that consumes green Skittles as positive for green.
- This is **cross reactivity,** a known limitation of the immunoassay screen methodology.
- Conversely, confirmation testing distinguishes between green M&Ms and green Skittles.

Why bother to screen specimens and not just confirm every sample?

- Time and cost.
- Confirmations are rarely required when high standards are followed and patients abstain from banned substances.
- When a client adamantly denies substance use, request a confirmation prior to punitive intervention.
- Intervention should not be delayed if there is a concern for client or public safety.
- Averhealth recommends a confirmation test when the client denies use and is faced with a loss of liberty.

THC - New Use vs. Residual Elimination

- Popular assumption is that the THC detection window is 30 days or more.
- Assumption is supported by various non-scientific media that indicate the body retains THC for a couple months to 17 years after use.
- Conventional wisdom quandary:
  - Delays intervention (therapeutic or child protection)
  - Delays timely judicial sanction
  - Encourages client to deny use

THC urine detection window is closer to 7 to 25 days & is only an issue when a client initially submits to testing.

Urine THC Detection Time at Different Cutoff Levels

Detection Time	20 ng/ml	50 ng/ml
Occasional Use	Up to 7 days	Up to 3 days
Chronic Use	Up to 25 days	Up to 14 days

Dilution

Urine specimen dilution is the most common ploy used to avoid detection of new drug and alcohol use. Dilution occurs when someone consumes an excessive amount of fluid (2-4 quarts) over a short period of time (90 minutes). Dilution significantly lowers the concentration of detectable drugs and alcohol in urine and also reduces urine creatinine levels.

> "Urine specimen dilution is the most common ploy used to avoid detection of new drug and alcohol use."

Creatinine is a by-product of muscle metabolism. It's produced and filtered at a relatively constant rate throughout the day and is only excreted via urine. Creatinine levels can be accurately estimated at 95% confidence using just age, gender, weight, and race. Low creatinine levels may very rarely be caused by certain medical conditions; however, they are not caused by controlled diabetes, exercise, high blood pressure, obesity, diet, pregnancy, menstrual cycles, working in the hot sun, or drinking fluids to hydrate.

- Negative-dilute test results do not provide accurate data regarding a client's potential relapse and consequently compromise the ability to affect positive behavior.
- A positive-dilute is a positive test. The dilution is nonconsequential.
- In many cases of dilution, a client is following the instructions of a product that falsely claims to cleanse the body of drugs and alcohol.

How to Avoid a Dilution

Avoiding a dilute sample is easy; a client only needs to limit fluid consumption to 32 ounces for two (2) hours prior to providing a sample. A 7-11 Big Gulp or a large McDonald's drink are 32 ounces. A Starbucks Venti drink is 24 ounces.

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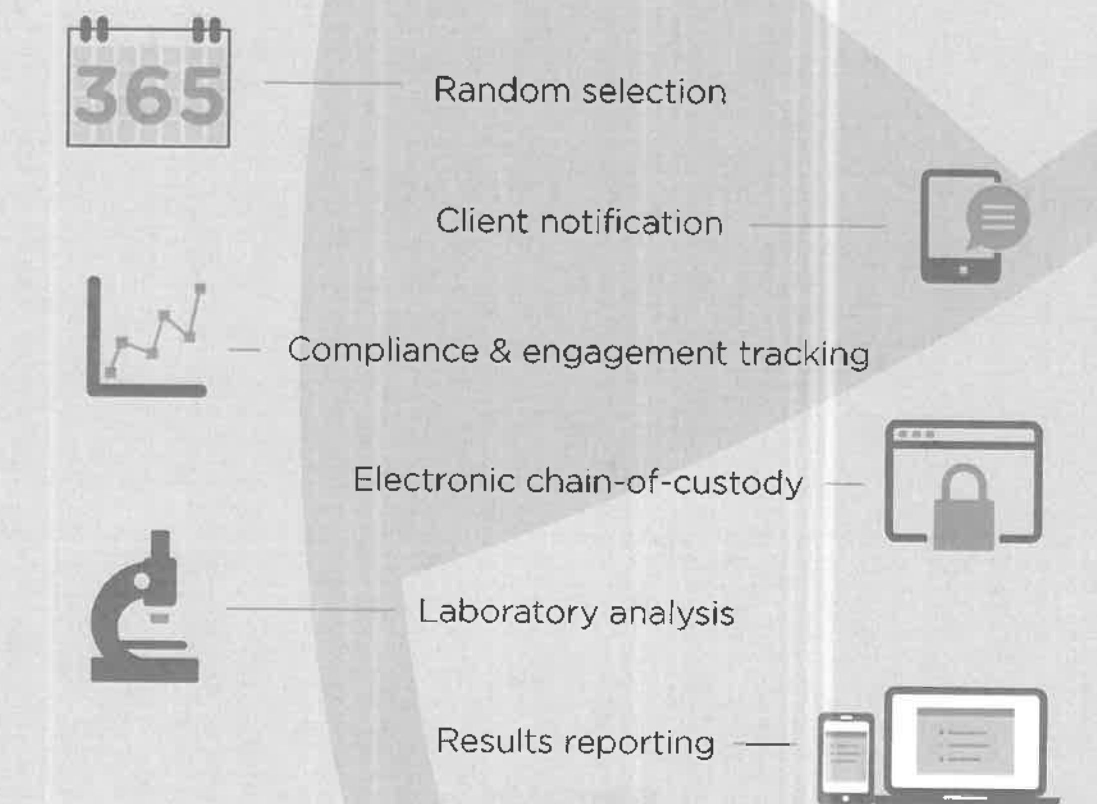
Aversys

Aversys is Averhealth's proprietary, secure web-based application. Aversys manages referrals, reports testing results, provides comprehensive reporting, and so much more. It's accessible from virtually any computer, tablet, or smart phone with an Internet connection, and no additional software is required. Aversys was designed based on more than 25 years working with justice-involved organizations across the country.

Aversys is a user-friendly experience that is HIPAA, Part II, and HITECH compliant. Case managers, related/authorized agencies, and Averhealth can easily access program data and seamlessly collaborate via a single, user-friendly application that integrates:



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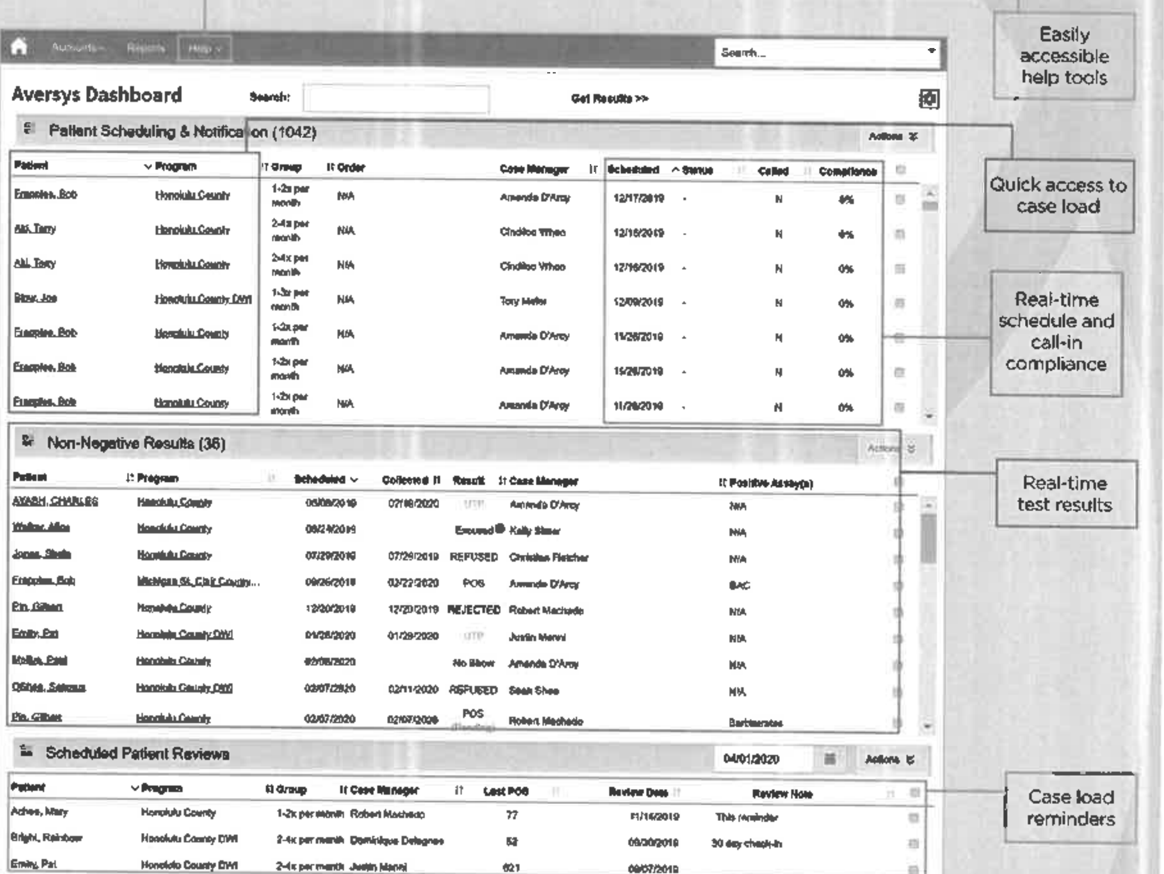
User-Specific Preferences:

- Customizable, individualized dashboard
- Quick access to entire caseload
- Real-time information on test schedules, call-in compliance, and test results
- Case load reminders
- User-specific notification preferences (e.g., immediately, daily, etc.)
- Case load preferences (e.g., case manager or supervisor experience)



How to Refer a Client

How to Access Aversys

Please visit aversys.averhealth.com to obtain access to Aversys. Once you have access to Aversys, please bookmark the Aversys URL: https://aversys.averhealth.com/UserManagement/Users/LogOn

Note: The original password you are given will expire in 48 hours, so you will need to set a new one. If your password expires, you will need to click the Forgot my Password link and enter your username to generate a new password. After logging into the system for the first time, your password will no longer expire after 48 hours.

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User name

Password

Log On

Please enter your user name and password.
If you forgot your username and/or password, click here

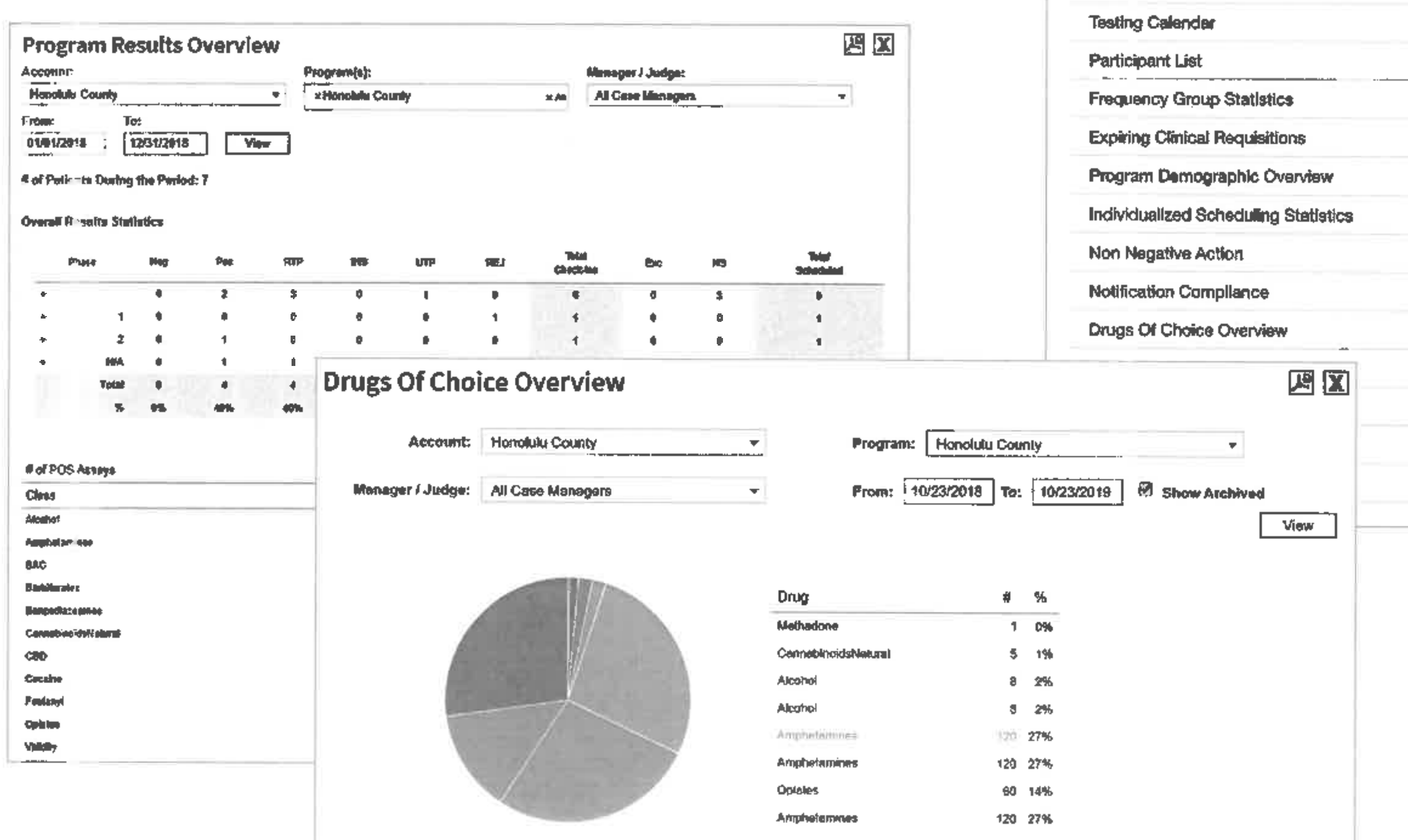
Custom Panels and Rotation

Panel Customization—Instant testing devices do not offer flexibility or customization. The panels are static, whether you are using a 3-, 5-, 10-, or 12-panel test. It's easy for clients to see what they're being tested for and simply switch their drug of choice in order to "beat" the test. With Averhealth, you can easily rotate panels so you are not testing for the same substances over and over again.

Panel Rotation—Rotating panels allows you to individualize testing to include drugs a client is more likely to use. If you know a client isn't likely to use amphetamines, there's no need to test for them. You can replace that drug and test for one they are more likely to use. Panel rotation also prevents clients from migrating to an alternative substance to avoid detection. By rotating panels according to evidence-based practices, clients will not know which drugs they are testing for. This enhancement provides a more robust testing regimen and increases the client's chances of reaching recovery.

Aversys Reports

Averhealth will provide all required information pertaining to clients via Aversys. These reports can be customized by user and can be retrieved as a PDF or Excel file. Test results and related data can be segmented by program/agency, agent, and clients. You can also view macro trends by program or drill down and view standard or custom substance use reports.



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Better Client Communication

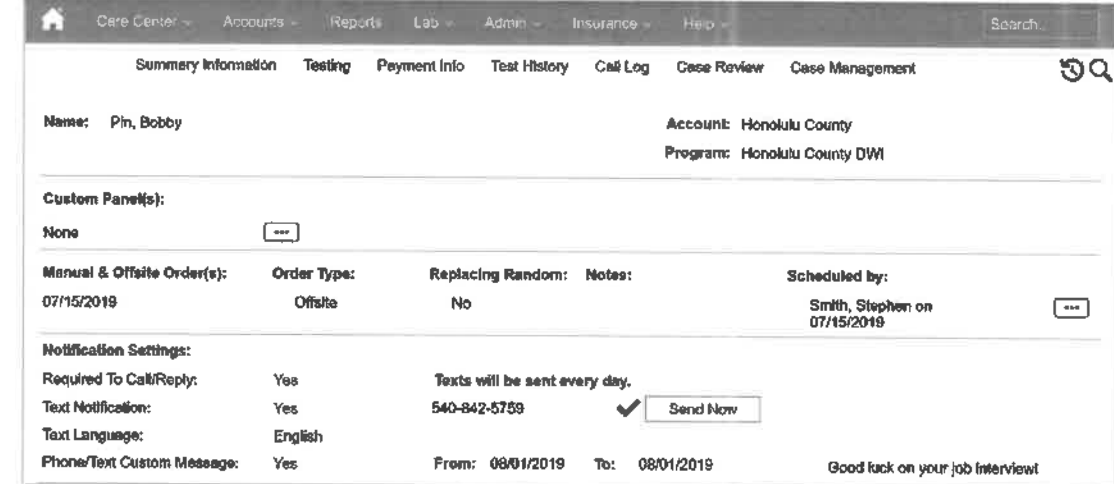
Aversys combines automation with customization capabilities that create a robust client communications system, employ best practices to drive better outcomes.

Daily Check-Ins—On a daily basis, clients contact an interactive, multilingual (English and Spanish) Notification System to determine if they are required to test. Daily individual client notification is a treatment booster that interrupts negative behavior chains, helping clients to overcome promptings to use, cravings, and preparatory behaviors. The process averages 30 seconds per call, with no hold time, 7 days per week, 365 days per year.

Automated Random Selection—Aversys automates the random selection and notification features, which reduce the administrative burden on local personnel and increase compliance with the substance use monitoring program by eliminating a barrier to monitoring experienced by clients.

The Client Notification System—As part of Averhealth's dedication to innovation, the Client Notification System, which includes text message and email alert capabilities, allows you to send individual/customized or group messages, such as:

- Individual, customized testing schedules
- Client-specific affirmations
- Future appointment reminders
- Court reminders
- Advice
- Notifications regarding inclement weather and holiday schedules



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Reducing Positive Rates

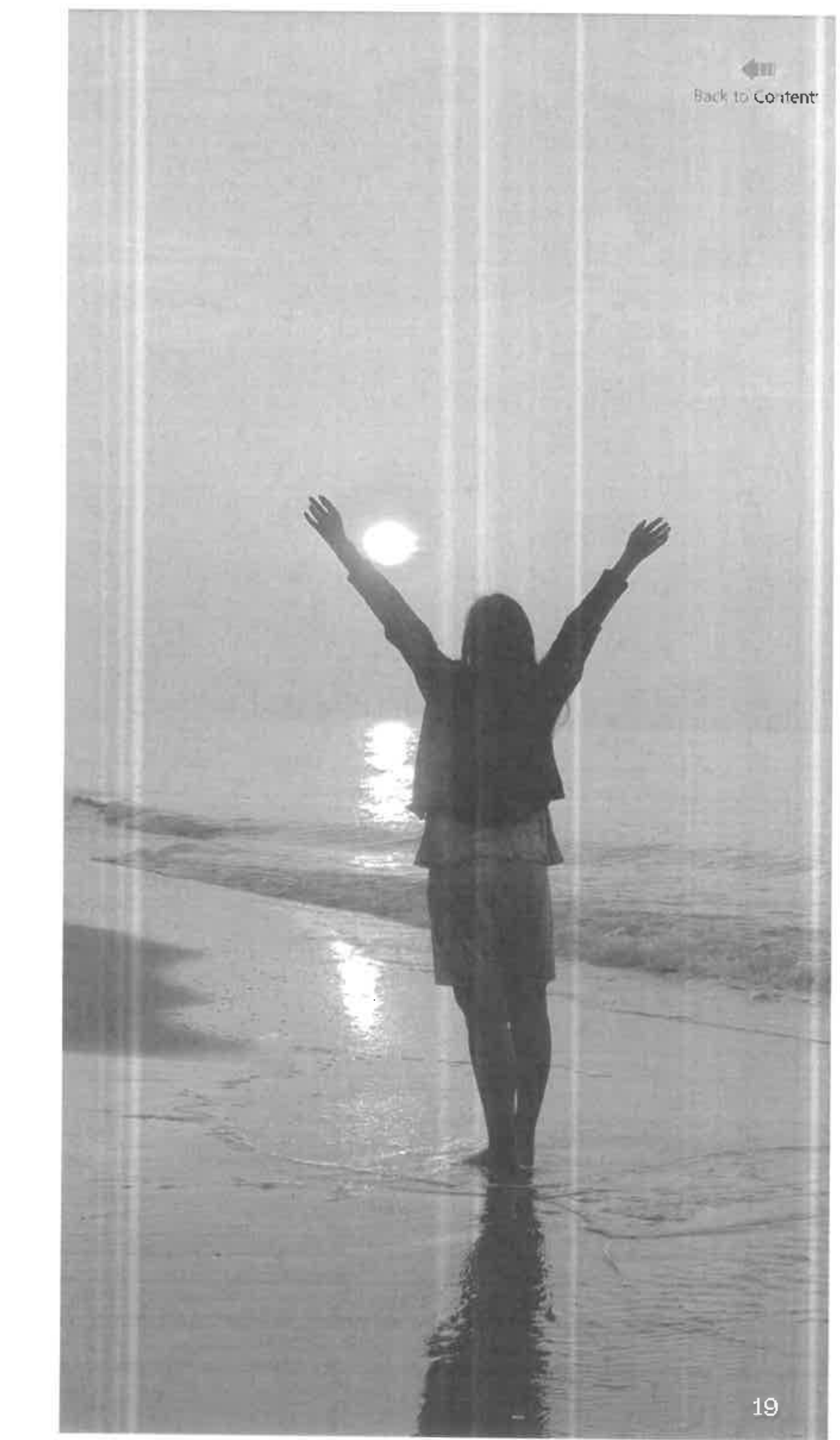
The proof is in the numbers. Averhealth clients see an average 54% reduction in the number of positive drug tests over time. Our model of better science, better technologies, and better client communications is consistently driving sustained recovery, enhanced public safety, and positive long-term outcomes for clients, for their families, and for their communities.

Compliance Over Time

53.84% Reduction
in the Positive Rate

Positive test results

Time



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Frequently Asked Questions

I tried to log in for the first time and am being denied access. How can I get logged in?
Click on "If you forgot your username and/or password. click here" link below the login field. That should send you another email with a temporary password.

When should I expect results?
Results ae reported via Aversys as soon as they are available. Typically, screen results are reported within one business day of receipt of the specimen at the lab, and within two to three days of request for confirmation.

What time zone are results reported in?
Results are reported with UTC (Coordinated Universal Time).

- 5 hours ahead of EST (6 PM UTC is 1 PM EST)
- 6 hours ahead of CST (6 PM UTC is 12 PM CST)
- 7 hours ahead of MST (6 PM UTC is 11 AM MST)
- 8 hours ahead of PST (6 PM UTC is 10 AM PST)

Which testing locations can clients use? Do they have to go to the same location every time they test?
If Averhealth has standalone or co-located locations in your area, clients are able to use any collection location. If clients are traveling, they can sometimes use a location in a different area. But generally, they would need to go to their assigned location.

Do the reports in Aversys show what testing location the client reported to for random testing?
Yes. you will be able to see the testing location on Batch Result reports, the Individual Screening Report, and the Patient History Report (Detailed).

Can the notification line be provided in Spanish?
Yes.

If a client is on a random testing schedule, can I add a manual test in without affecting their normal schedule?
Yes. Manual orders can be easily placed through Aversys, and you can set that test to replace a random test or to be added on top of the normal testing.

What if my client has alternative names (e.g., they just got married)?
You can add an alternative name in the "Nickname" field of Aversys under the Summary Information tab. This will then be a searchable field when you are searching for your client. *(Note: If you only add the maiden last name in the nickname field, they will only be searchable if you type in the maiden name only).*

Do you separate THC and CBD on tests?
When testing for marijuana, we do not separate THC and CBD as we are testing for the THC metabolite. Averhealth has an add-on test for CBD, which will determine whether a client is using CBD. This test can be added on in place of or in conjunction with THC testing.

Can Averhealth verify if a client is taking their prescription as prescribed?
We can correlate whether someone is taking a medication, but not whether it's being taken as prescribed.

Will we be notified if a client's test result is so high that it is a danger to their life?
Yes, Averhealth will absolutely notify you if a client's test result is life threatening!

What access will supervisors have to Aversys? Will they be setup differently than case managers?
Aversys access can be setup with any preset access levels that you choose.

Why didn't my specimen confirm from an immunoassay test?
There are multiple reasons a specimen might not confirm even after a positive screen. There is a very small chance (<3%) that the screen was a false positive. More likely is that there was cross reactivity between the drug being tested for and something else the client took. Cross reactivity is when an analyte or drug molecule very similar to the target analyte binds to an antibody. This won't be a perfect fit, but it will be close enough to show a positive result on the initial screen. Upon confirmation testing, the specimen will show negative for the target analyte, because it is a much more sensitive test.

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We're here when you need us

If you ever have a question or simply need some assistance, we're always happy to help.

866.680.3106

info@averhealth.com

Connect with us:

@averhealthcare

www.linkedin.com/company/averhealth1

@averhealth

@averhealth

Smarter solutions. **Better outcomes.**

aver**health**.com

(Program Name) – ADMISSION

Client: ______________________________ DOB: _______________________

Client was admitted on:____at_____ AM/PM for the following level of care.

Level of Care	Please Check the Level of Care that is applicable.
Residential Levels of Care	
Level 3.7 WM- Withdrawal Management in a residential setting (Detox)	☐
Level 3.5 – Clinically Managed High-Intensity Residential Services (Clients are not able to leave the facility)	☐
Level 3.1 – Clinically Managed Low-Intensity Residential Services (Clients are allowed to leave the facility with staff or when approved for outing)	☐
With Concurrent:	
Level 2.5 Partial Hospitalization Services 5 hrs. of group, Monday-Friday (25 hours weekly)	☐
Level 2.1 – Intensive Outpatient Services 3 hrs. of group, Monday, Wednesday, Friday (9 hours weekly)	☐
Outpatient Levels of Care	
Level 2.5 Partial Hospitalization Services 5 hrs. of group, Monday-Friday (25 hours weekly)	☐
Level 2.1 – Intensive outpatient services 3 hrs. of group, Monday, Wednesday, Friday (9 hours weekly)	☐
Level 1 – Outpatient Services Weekly outpatient groups and/or individual therapy and support.	☐

The projected release date is:__________________________

Please note that client discharge date is subject to change based on progress in treatment.

Person at Pyramid to contact for release information:__________________________

Phone: ___________________________

Email:________________________________

Staff Name:___________________ Signature: _____________________ Date: __________

The form can be sent to VBCCP@vbgov.com

Juvenile Criminal Cases… a True "Issue Spotting" Adventure

The Hon. Timothy Quick, Chief Judge

Brian Latuga, Esq.

Jerrell Johnson, Esq.

Tabitha Anderson, Deputy Commonwealth Attorney

Juvenile Criminal Cases... a True "Issue Spotting" Adventure

The Hon. Timothy Quick, Chief Judge

Richard Edgington, Assistant Public Defender

Brian Latuga, Esq.

Jerrell Johnson, Esq.

Tabitha Anderson, Deputy Commonwealth's Attorney

Fact Pattern: Taylor Smith is a 16-year-old that lives in Virginia Beach. He attends a local High School and is in the 11th grade. Taylor lives with his Grandparents along with his siblings (sister (8) and brother (13)). Last year, Taylor and his siblings were removed from their parents' home and placed in foster care when his father went to jail, and his mother died from an overdose. After the removal, his grandparents got custody. Taylor has a mild learning disability and may be on the spectrum. Taylor also has an issue with sexual boundaries and may have been abused while in his parents' care.

One afternoon, Taylor's Grandmother opens the door to Taylor's room and finds Taylor fondling the buttocks of his unclothed sister. The Grandmother freaks out and charges at Taylor. Taylor runs out of the house and Grandmother calls 911. On the way out of the house, Taylor grabs a bottle of vodka and his Grandfather's semi-automatic handgun that was sitting open and obvious on a shelf in the garage. Taylor runs through the woods behind the house and ultimately heads down Virginia Beach Boulevard chugging the vodka as he runs.

Taylor spies a used car dealership up ahead and notices an attendant opening the door to a car that is running. The used car salesman leaves the car door open and appears to be placing a temporary tag on the back of the car. Taylor seizes the opportunity and runs to the car, jumps in the driver's seat, and is about to put the car in gear when the attendant yells. Taylor leans out the door with the gun in his hand and the attendant backs off. Taylor takes off in the car, driving erratically all the way to the interstate. Ultimately, Taylor brings the car to a slow roll and jumps out of the car on I-264, and hops the guardrail. Taylor is located by the police hiding in a shed behind a church. He has a strong odor of alcohol, glassy eyes, and is unsteady on his feet. He blows a .04 BAC on the PBT. The police confiscate the gun and also find a bottle of pills on his

person. The pills are later determined to be fentanyl. Taylor is taken to the Juvenile Detention Center (JDC) after refusing to take a breath test at the station.

JDC and Court Service Unit (CSU) staff repeatedly try to call Taylor's Grandparents, but they fail to respond. When they do finally respond, Taylor's Grandmother says his Grandfather is in the hospital after suffering a stroke and is not expected to live. Grandmother says Taylor cannot come home and not to call her back until his trial when she will gladly testify as to what she saw him do to his sister.

ISSUE SPOTTING....

1.) Possible Charges:
   a. Aggravated Sexual Battery (Virginia Code § 18.2-67.3)
   b. Grand Larceny of An Automobile (Virginia Code §18.2-95)
   c. Car Jacking (Virginia Code §18.2-58.1)
   d. Robbery (Virginia Code §18.2-58)
   e. Possession of Certain Firearm by a Minor (Virginia Code §18.2-308.7)
   f. Use of a Firearm During Commission of a Felony (Virginia Code §18.2-53.1)
   g. Possess Weapon while possessing certain substances (Virginia Code §18.2-308.4)
   h. Brandishing (Virginia Code §18.2-282)
   i. Under 21 Driving after Consumption of Alcohol (Virginia Code §18.2-266.1)
   j. Driving Under the Influence (Virginia Code §18.2-266)
   k. Refusal (Virginia Code §18.2-268.3)
   l. Possession of Controlled Substances (Virginia Code §18.2.250)
   m. Trespass (Virginia Code §18.2-119)
   n. Felony Child Neglect (Virginia Code §18.2-371.1C1)

2.) Issues
   a. Competency
      i. Virginia Code §16.1-356 - §16.1-361
   b. Appointment of Guardian ad Litem
      i. 16.1-266
   c. Certification v. Transfer
      i. Virginia Code §§16.1-248.1,16.1-263,16.1-264, 16.1-269.1, 16.1-269.3
   d. Secure Detention status
      i. Virginia Code §16.1-248.1
   e. Inability to Return Home/Unresponsive Custodian/Possible Abandonment
      i. Virginia Code §16.1-228, §16.1-251
   f. Need for Trauma Informed Services / Adverse Childhood Experiences
      i. Virginia Code §16.1-278 *et. seq.*

Chapter 3 – Juvenile Delinquency Procedures

Case Procedures

The preceding narrative description and flowchart of the juvenile delinquency case process are overviews of the basic steps required to process a juvenile case. The following detailed procedures describe the existing procedures to be used by the juvenile and domestic relations district court for processing these cases. Each procedure section contains a brief discussion of the process involved and then presents the detailed procedures.

NOTE: A delinquent act is an act designated as a crime under the law of this Commonwealth, or an ordinance of any city, county, town or service district, or under federal law, or a violation of Va. Code § 18.2-308.7 or a violation of a court order as provided for in Va. Code § 16.1-292, except for otherwise lawful acts which are designated a crime only if committed by a child. Va. Code § 16.1-228. However, any child who is tried and convicted in a circuit court as an adult under the provisions of Va. Code §§ 16.1-269.1, *et seq.* and 16.1-272 will be considered an adult in any criminal proceeding resulting from a subsequent offense.

Filing of a Petition or Issuance of a Warrant

A juvenile delinquency case involving a violation of criminal laws by a minor may be initiated by an arresting officer observing a violation or by a citizen complaint following an offense.

The Chief Judge may make arrangements for a replacement intake officer from another court service unit to be available when the court is closed. Va. Code § 16.1-235.1. This replacement intake officer may have the juvenile appear via two-way electronic video and audio communication. Va. Code § 16.1-255.

If an intake officer or judge cannot be contacted after the child arrives at the magistrate's office or is not readily available, then the complaint may be filed with the magistrate. The procedures to be followed by an intake officer upon receipt of a complaint that are discussed in the following narrative can be found in Va. Code § 16.1-260.

An intake officer has the authority to issue a detention order/capias for an adult under age 21 when the adult is alleged to have committed an offense as a minor. These proceedings shall be initiated by a DC-511, PETITION. The capias is intended to work in a similar way as a detention order for a juvenile. Intake will generate the DC-529, DETENTION ORDER/CAPIAS pursuant to § 16.1-247(K). The DC-529, DETENTION ORDER/CAPIAS pursuant to § 16.1-247(K) is not indexed. Parents of the person charged are not summoned.
Upon receipt of a complaint, the court services unit will:

Review the complaint.

Determine if probable cause exists.
If probable cause exists, then determine whether the complaint may be diverted to out-of-court adjustment; if not, then a juvenile district court form DC-511, PETITION, is prepared for signing by the petitioner (person making the complaint).
Determine if detention is required; if so, the intake officer will prepare and sign a district court form DC-529, DETENTION ORDER/CAPIAS pursuant to § 16.1-247(K).
If the intake officer refuses to issue a petition relating to an offense that, if committed by an adult would be punishable as a Class 1 misdemeanor or as a felony, the complainant shall be notified in writing of his right to apply to a magistrate for a warrant. A magistrate may issue a warrant in such cases if he determines that probable cause exists. If the intake officer refuses to authorize a petition relating to a child in need of services or in need of supervision, a status offense, or a misdemeanor other than Class 1, his decision is final.
NOTE: Attorneys may file a petition directly with the clerk, except for CHINS and delinquency petitions. §16.1-260(A)(iv) The Commonwealth's Attorney may file a petition directly with the clerk, including CHINS and delinquency petitions. §16.1-260(A)(i).

The magistrate may issue a warrant for a juvenile after a finding of probable cause when the intake officer or judge is not reasonably available or upon the intake officer's refusal to issue a petition. Va. Code § 16.1-256. If probable cause is found, the magistrate will prepare and issue a district court form DC-312, WARRANT OF ARREST – FELONY, district court form DC-314, WARRANT OF ARREST – MISDEMEANOR (STATE), or district court form DC-315, WARRANT OF ARREST –MISDEMEANOR (LOCAL) which shall be delivered forthwith to the juvenile and domestic relations district court. The warrant shall be returned to the clerk's office for re-delivery to the court services unit (intake) for conversion to a petition, with the warrant attached to the original petition being returned to court.

The signature of the complainant on the petition is not required; however, the clerk should attach a copy of the warrant to each copy of the petition or the summons for service on the juvenile and parent(s) or guardian(s).

After the filing of a petition alleging that a juvenile has committed one or more of the following offenses, the intake officer shall notify the superintendent of the school division in which it is alleged that the juvenile should be enrolled, by telephone and by mail, of the filing of the petition.

- A firearm offense pursuant to Articles 4 (§§ 18.2-279 et seq.), 5 (§§ 18.2-288 et seq.), 6 (§§ 18.2-299 et seq.), or 6.1 (18.2-307.1 et seq.), or 7 (§ 18.2-308.1 et seq.) of Chapter 7 of Title 18.2;
- Homicide, pursuant to Article 1 (§§ 18.2-30 et seq.) of Chapter 4 of Title 18.2;
- Felonious assault and bodily wounding, pursuant to Article 4 (§§ 18.2-51 et seq.) of Chapter 4 of Title 18.2;

- Criminal sexual assault, pursuant to Article 7 (§§ 18.2-61 et seq.) of Chapter 4 of Title 18.2;
- Manufacture, sale, gift, distribution or possession of Schedule I or II controlled substances pursuant to Article 1 (§§ 18.2-247 et seq.) of Chapter 7 of Title 18.2;
- Manufacture, sale, or distribution of marijuana pursuant to Article 1 (§§ 18.2-247 et seq.) of Chapter 7 of Title 18.2;
- Arson and related crimes, pursuant to Article 1 (§§ 18.2-77 et seq.) of Chapter 5 of Title 18.2;
- Burglary and related offenses, pursuant to §§ 18.2-89 through -93; or Robbery pursuant to § 18.2-58.
- Prohibited criminal street gang activity pursuant to § 18.2-46.2.
- Recruitment of juveniles for criminal street gang activity pursuant to § 18.2-46.3. An act of violence by a mob pursuant to § 18.2-42.1
- Abduction of any person pursuant to §§ 18.2-47 or 18.2-48
- A threat pursuant to § 18.2-60.

The filing of a petition is not necessary if the juvenile is released on a VIRGINIA UNIFORM SUMMONS by the arresting officer for violation of:

- Possession of marijuana, if released to custody of a parent/guardian.
- Underage drinking and driving, if released to custody of a parent/guardian.
- Traffic laws (including Child Restraint Devices Act violations, bicycle offenses, hitchhiking and other pedestrian offenses).
- Driving or sailing while intoxicated or other alcohol-related offenses, (including refusal to take a blood or breath test,) if released to custody of a parent/guardian.
- Game and fish laws.
- Surfing ordinances.
- Curfew ordinances.
- Animal control violations
- Littering violations
- Offenses, which, if committed by an adult would be punishable as a Class 3 or Class 4 misdemeanor.

For specific procedures for the handling of traffic cases, including prepayment of traffic infractions, see the chapter on "Juvenile Traffic and Traffic Misdemeanor Procedures" in this manual. When found guilty of a traffic infraction (not a traffic-related offense which would be a misdemeanor or felony if committed by an adult), a juvenile is subject to only those judicial sanctions applicable to an adult who has committed a traffic infraction. Va. Code § 16.1-278.10. However, the Department of Motor Vehicles may require attendance at a driver improvement clinic for certain infractions.

Processing of a Child Taken into Immediate Custody

A child may be taken into immediate custody pursuant to Va. Code § 16.1-246 in the following situations:

- With a district court form DC-529, DETENTION ORDER/CAPIAS pursuant to § 16.1-247(K), or district court form DC-530, Shelter Care Order issued by the judge, the intake officer or, when authorized by the judge, the clerk of the juvenile and domestic relations district court in accordance with provisions of law, or
- With a district court form DC-312, WARRANT OF ARREST – FELONY, district court form DC-314, WARRANT OF ARREST – MISDEMEANOR (STATE), or district court form DC-315, WARRANT OF ARREST –MISDEMEANOR (LOCAL), and a district court form DC-529, DETENTION ORDER/CAPIAS pursuant to § 16.1-247(K) issued by a magistrate; or
- When a child is alleged to be in need of services or supervision, and (1) there is a clear and substantial danger to the child's life or health, or (2) the assumption of custody is necessary to ensure the child's appearance before the court; or
- When, in the presence of the officer who makes the arrest, a child has committed an act designated a crime under the law of this State, or an ordinance of any city, county, town or service district, or under federal law and the officer believes that such is necessary for the protection of the public interest; or
- When a child has committed a misdemeanor offense involving shoplifting in violation of Va. Code § 18.2-103, assault and battery, or carrying a weapon on school property in violation of Va. Code § 18.2-308.1 and, although the offense was not committed in the presence of the officer who makes the arrest, the arrest is based on reasonable complaint of a person who observed the alleged offense; or
- When the officer believes that there is probable cause to believe that a child has committed an offense which if committed by an adult would be a felony; or
- When a law-enforcement officer has probable cause to believe that a person committed to the Department of Juvenile Justice as a child has run away or that a juvenile has escaped from a jail or detention home; or
- When a law-enforcement officer has probable cause to believe a child has run away from a residential, child-caring facility or home in which he had been placed by the court, the local department of social services or a licensed child welfare agency; or
- When a law-enforcement officer has probable cause to believe that a child (1) has run away from home, or (2) is without adult supervision at such hours of the night and under such circumstances that the law-enforcement officer reasonably concludes that there is a clear and substantial danger to the child's welfare.
- When a child is believed to be in need of inpatient treatment for mental illness as provided in § 16.1-340.

A person taking a child into custody in the above situations shall, with all practicable speed and depending on the situation, bring the child to the judge or intake officer and the judge, intake officer, or arresting officer shall, in an expeditious manner, give notice of the action taken and a statement of reasons why the child was taken into custody to the parent, guardian, legal custodian or other person standing *in loco parentis*. Va. Code § 16.1-247. The required notice may be given orally or in writing.

A child taken into custody who is brought before a judge, intake officer or magistrate, must be released on specific conditions to his or her parent, guardian, legal custodian or other suitable person able and willing to provide supervision and care for such child unless the child meets the criteria of Va. Code § 16.1-248.1 for secure detention or shelter care and is so placed. If an intake office or magistrate releases a juvenile, either on bail or recognizance or under conditions, no motion to revoke bail or change the conditions may be made unless the juvenile has violated a term or condition of his release, is convicted of or taken into custody for an additional offense, or the Commonwealth's attorney presents evidence that incorrect or incomplete information was relied upon by the intake officer or magistrate.

For detention in a secure facility, there must be probable cause to believe that the child committed the alleged act *and:*

- the juvenile is at least 11 years of age
- the alleged act would be a felony or Class 1 misdemeanor if committed by an adult or the juvenile violated the terms of his probation or parole and the underlying charge which resulted in the probation or parole would be a felony or Class 1 misdemeanor if committed by an adult; and there is clear and convincing evidence that:
  - the child's liberty constitutes an unreasonable danger to the person or property of others considering the seriousness of the current offense(s), other pending charges and prior adjudicated offenses, the legal status of the child and any aggravating and mitigating circumstances; or
  - the child's liberty would present a clear and substantial threat of serious harm to the child's life or health; or
  - the child has threatened to abscond from the court's jurisdiction during this case or has a record of willful failure to appear in court during the last 12 months; or
- the child absconded from a detention home or other facility; or
- the child is a fugitive from a jurisdiction outside Virginia and subject to a verified petition or warrant (to be held pending arrangement for the child's return); or
- the child failed to appear in court after service of a summons when it is alleged the child has committed a delinquent act or that the child either is in need of services or is in need of supervision. If either of the latter is the case, the child may be held for good cause shown until the next date that the court sits or seventy-two hours,

whichever occurs first. If the seventy-two hour period ends on a Saturday, Sunday, legal holiday or day on which the court is lawfully closed, the time period is extended to the next day that is not a Saturday, Sunday, legal holiday or day on which the court is lawfully closed.

When a juvenile is detained in a secure facility, the juvenile's probation officer may review such placement for the purpose of seeking a less restrictive alternative to confinement in that secure facility.

*A juvenile younger than 11 years of age who is alleged to have committed one or more of the delinquent acts enumerated in subsection B or C of § **16.1-269.1** and who is ordered to remain in detention or shelter care pursuant to § **16.1-248.1** pending a court hearing may only be detained in a place described in subdivision 1, 2, or 4 of §**16.1-249** , but under no circumstances shall such juvenile be detained pursuant to this section in a secure detention facility.*

For shelter care placement, one of the following must be present:

- The child is eligible for placement in a secure facility; *or*
- The child failed to obey directions of the court, intake officer or magistrate while on conditional release; *or*
- The child's parent, guardian or other person able to provide supervision cannot be reached nor arrive to assume custody within a reasonable time; *or*
- The child does not consent to return home, *or*
- The child's parent or guardian refuses to permit the child to return home and no relative or other person willing and able to provide proper supervision and care can be reached within a reasonable time.

The places of confinement of juveniles are subject to the restrictions of the Code of Virginia and approval by the Department of Juvenile Justice in a certain instance. If it is ordered that a juvenile remain in detention or shelter care, such juvenile may be detained, pending a court hearing, in the following places:

- An approved foster home or a home otherwise authorized by law to provide such care;
- A facility operated by a licensed child welfare agency;
- If a juvenile is alleged to be delinquent, in a detention home or group home approved by the Department of Juvenile Justice;
- To the extent permitted by federal law, a separate juvenile detention facility located upon the site of an adult regional jail facility constructed after 1994 and approved by the Department of Juvenile Justice and certified by the Board of Juvenile Justice for the holding and detention of juveniles.
- Any other suitable place designated by the court and approved by the Department of Juvenile Justice.

Any juvenile who has been ordered detained in a secure detention facility may be held incident to a court hearing (i) in a court holding cell for a period not to exceed six hours provided the juvenile is entirely separate and removed from detained adults or (ii) in a non-secure area under constant supervision.

No juvenile age fourteen or older may be detained in jail except when:

- The case has been transferred to circuit court or certified to the grand jury; or
- The juvenile has been determined by *the judge* to be a threat to the security or safety of the other detainees, or the staff of the detention facility provided that the juvenile is detained in a room or ward entirely separate and removed from adults, adequate supervision is provided and the facility is approved for detention of juveniles by the State Board of Corrections, or
- It has been demonstrated, in the judgment of *the custodian*, that the presence of the juvenile creates a threat to the security or safety of other detainees or the staff of the facility, provided that it is for no longer than six hours prior to a court hearing and six hours after the court hearing, unless a longer period is ordered by a judge under the circumstances in the paragraph immediately preceding and the juvenile is detained in a room or ward entirely separate and removed from adults, adequate supervision is provided and the facility is approved for detention of juveniles by the State Board of Corrections, or
- The juvenile is charged with a felony or class 1 misdemeanor and the judge or intake office determines that secure detention is needed for the safety of the juvenile or the community, provided that the juvenile is detained for no longer than six hours prior to a court hearing and six hours after the court hearing pending transfer to a juvenile facility and the juvenile is detained in a room or ward entirely separate and removed from adults, constant supervision is provided and the facility is approved for detention of juveniles by the State Board of Corrections. Va. Code § 16.1-249(F). The State Board of Corrections is authorized and directed to prescribe minimum standards for temporary lock-up rooms, wards and court holding cells based on the requirements set out in this subsection.

The Department of Corrections, Department of Juvenile Justice and Department of Criminal Justice Services shall assist the localities or combinations thereof in implementing this section and ensuring compliance.

Clerk's Office Processing of the Petition or Warrant

Upon receipt of the case papers from the magistrate or the court services unit, the clerk's office must perform several functions prior to the court date to prepare the case for court. The clerk's office will complete these case indexing and filing functions:

- Assign a case number to the case. The case number is the juvenile's base file number (for the file containing all of his case records) plus a suffix for each petition. Retrieve the next available pre-numbered file folder, if no case file folder for the juvenile exists.

- Enter the case into the automated system.

- Enter the case number on the district court form DC-511, PETITION.

- Scan and assign all case documents in the court's records management system.

- Complete and issue a copy of the district court form DC-510, SUMMONS together with a copy of the juvenile district court form DC-511, PETITION to the child, and to at least one parent, guardian, legal custodian or other person standing *in loco parentis*, (and to any other persons as may appear to the court to be proper and necessary parties) and forward for service. If a custodian is summoned who is not a parent, a parent shall also be served with a summons. See the discussion above of case initiation procedures, regarding cases in which a detention order was issued. The case number should be added to all forms.

- Attach case papers to the case.

A summons is not required if the judge certifies on the record that the identity of a parent or guardian is not reasonably ascertainable. An affidavit of the mother that the identity of the father is not reasonably ascertainable shall be sufficient evidence of that fact, if no other evidence is available to the court that refutes the affidavit. *See* district court form DC-509, AFFIDAVIT/CERTIFICATION OF PARENTAL IDENTITY OR LOCATION.

The SUMMONS may be served by the following methods:

- Personal service or substituted service (as prescribed in Va. Code § 8.01-296 (2)) if the recipient can be found in the state.

- Certified mail return receipt requested or personal service if the recipient is out of state and the address is known or can be ascertained with reasonable diligence.

- Publication if the recipient cannot be found or his post office address cannot be ascertained.

Service of process may be waived by a party (other than a child) by stipulation or voluntary appearance at hearing. Personal service may be obtained by:

- Sheriff
- Deputy sheriff

- Police officer
- Other suitable persons designated by the court (with proof of service by affidavit or otherwise under oath).

Pre-Trial Procedures

Prior to the court date, the clerk's office will prepare the docket as follows:

- Retrieve all cases from the files for a given court date.
- Print the online docket prior to trial from JCMS.

If ordered by the judge, the court services unit will prepare an intake report to be filed with the case prior to court.

Right to Representation by A Lawyer (Counsel)

Children who are alleged to be delinquent, in need of supervision or in need of services are entitled by Va. Code § 16.1-266 to be represented by a lawyer. The following are the statutory procedures concerning the right of representation by a lawyer:

- Prior to the detention review hearing held pursuant to Va. Code § 16.1-250, the court shall appoint an attorney to represent the child, unless an attorney has been retained and appears on behalf of the child.

- Subsequent to the detention hearing, if any, and prior to the adjudicatory or transfer hearing, the child and his parents, guardian, legal custodian or other person standing *in loco parentis* are informed by a judge, clerk or probation officer of the child's right to counsel and the liability of the parent, guardian, legal custodian or other person standing *in loco parentis* for the costs of legal services.

At the same time, they are given the opportunity to:

- Obtain private counsel of their own choice; or

- Permit the child to waive his right of representation by a lawyer by signing the waiver portion of district court form DC-515, WAIVER OF RIGHT TO BE REPRESENTED BY A LAWYER (JUVENILE) if the court finds after conducting the examination of the child and the parent(s), guardian, legal custodian or other person standing *in loco parentis* as required by the waiver form that:

  - the waiver and consent to the waiver are made knowingly and intelligently,
  - the interests of the parent(s), guardian, legal custodian or other person standing *in loco parentis* are not adverse to the child, and
  - the waiver and consent to waiver are appropriately signed

- If the juvenile is alleged to have committed a delinquent act that would be a felony if committed by an adult, the court is required to have the juvenile consult with an attorney before waiving the right to counsel; or,

- If the court determines that the child is indigent within the meaning of the law pursuant to the guidelines set forth in Va. Code § 19.2-159 after reviewing the district court form DC-333, FINANCIAL STATEMENT - ELIGIBILITY DETERMINATION FOR INDIGENT DEFENSE SERVICES of the child, and the parent, guardian, legal custodian or other person standing *in loco parentis* does not retain a lawyer to represent the child, the statement of indigency portion of district court form DC-513, ADVISEMENT AND REQUEST FOR APPOINTMENT OF COUNSEL shall be signed by the child and the court shall appoint a lawyer to represent the child. After July 1, 2005, an attorney appointed to represent a defendant must be from the appropriate list of qualified attorneys maintained by the Virginia Indigent Defense Commission. If no attorney who is on the list maintained by the Indigent Defense Commission is reasonably available, the court may appoint as counsel an attorney not on the list who has otherwise demonstrated to the court's satisfaction an appropriate level of training and experience. The court shall provide notice to the Commission of such appointment by sending a copy of the district court form DC-513, ADVISEMENT AND REQUEST FOR APPOINTMENT OF COUNSEL. There is no statutory requirement as to the frequency of mailing such notices, therefore: it is recommended to send in copies at least once a month. Copies may be mailed to:

  Virginia Indigent Defense Commission
  Administration Office
  1604 Santa Rosa Road, Suite 109
  Richmond, VA 23229
  Attn: ATTORNEY CERTIFICATION SECTION

- The defendant should be instructed to promptly contact his court-appointed attorney. A copy of the district court form DC-513, Advisement and Request for Appointment of Counsel with the order of appointment portion completed should be transmitted to the court-appointed counsel together with the forms that counsel will need to prepare (time sheet, etc.). Public defenders may be appointed only for cases in the courts of the jurisdictions set out in Va. Code § 19.2-163.04. If the parents of the child also claim to be indigent, they must complete a separate district court form DC-333, FINANCIAL STATEMENT - ELIGIBILITY DETERMINATION FOR INDIGENT DEFENSE SERVICES and execute the parent's portion of district court form DC-513, ADVISEMENT AND REQUEST FOR APPOINTMENT OF COUNSEL.

The person conducting this proceeding should also advise parents, guardians, legal custodians or persons standing *in loco parentis* of their liability for the costs of the lawyer appointed to represent the child if the court appoints a lawyer to represent the child and

the parents are later found to be financially able to pay for a lawyer. Va. Code § 16.1-267. Their liability would be up to the limits set forth in Va. Code § 19.2-163 (1). The lawyer representing the child would be compensated by the court within the limits set forth in Va. Code § 19.2-163 (1).

An attorney is not required to be appointed to represent an otherwise eligible child in traffic infraction cases because "delinquent act" does not include a traffic infraction.

In every case involving a child charged with being a delinquent or a child in need of services (CHINS), a copy of either the district court form DC-513, ADVISEMENT AND REQUEST FOR APPOINTMENT OF COUNSEL, or the district court form DC-515, WAIVER OF RIGHT TO BE REPRESENTED BY A LAWYER must be given to the child. By doing so, the child receives a written notice of the records expungement provisions required by Va. Code § 16.1-306.

A number of juvenile courts apprise the child of his right to representation by a lawyer as soon as possible after detention or service of the summons in order to avoid last-minute trial delays and inconvenience to witnesses and other trial participants by requests for continuance to obtain a lawyer or to confer with a newly-appointed lawyer. In some localities, extensive use of specially trained probation officers is made for advising parties of their right to representation by a lawyer and helping them prepare the district court form DC-333, FINANCIAL STATEMENT - ELIGIBILITY DETERMINATION FOR INDIGENT DEFENSE SERVICES. This practice not only relieves judges and clerks of this duty, but also permits the proceeding to be scheduled at night so as to minimize inconvenience to the child and his parents.

Detention Hearing

Va. Code § 16.1-250

When a child is held in custody and not released, the child must be brought before a judge on the next day on which the court sits within the county or city wherein the charge against the child is pending. If the court does not sit on the day after the child is taken into custody, the child shall be brought before a judge within a reasonable time not to exceed seventy-two hours after he or she has been taken into custody. Also, in the event that the court does not sit on the following day within the county or city wherein the charge against the child is pending, the court may conduct the hearing in another city or county, but only if two-way electronic video and audio communication is available in the courthouse of the county or city wherein the charge is pending. However, if the seventy-two hour period expires on a Saturday, Sunday or other legal holiday, the seventy-two hours shall be extended to the next day which is not a Saturday, Sunday or legal holiday. The court may subpoena witnesses to assist in determining probable cause, in which case the hearing may be continued and the child remain in detention, but in no event longer than three consecutive days, exclusive of Saturdays, Sundays, and legal holidays.

Further procedures for the detention hearing include:

- Notice of the hearing or any rehearing shall be given to the parent, guardian, legal custodian, or other person standing *in loco parentis*, to the child if 12 years of age or older, to the child's attorney, to the probation and parole department of the local or state court services unit, and to the attorney for the Commonwealth. This notice may be either oral or written.

- Prior to the detention hearing, an attorney must be appointed to represent the child at the detention hearing unless the child has retained an attorney who appears on his or her behalf. Indigency is presumed for purposes of appointment of counsel for the detention hearing. Va. Code § 16.1-266 (B).

- The judge shall advise the parties during the hearing of the child's right to remain silent, and the contents of the petition. The attorney for the Commonwealth shall be given the opportunity to be heard.

- The juvenile, the attorney for the Commonwealth, the attorney for the child and the parent, guardian, legal custodian or other person standing *in loco parentis* may appear in person or by means of a two-way electronic video and audio communication system that meets the standards of Va. Code § 19.2-3.1 (B). Any documents filed in such a hearing may be transmitted by electronic facsimile process. The fax may be served by the officer to whom it is sent with the same force and effect as if it were an original document.

- If the judge finds that there is not probable cause to believe the child committed the delinquent act alleged, the court shall order his or her release.

- If the judge finds that there is probable cause to believe that the child committed the delinquent act but that full-time detention is not required, the court shall order his release subject to conditions imposed by the court. In determining probable cause, the judge may consider information that is not otherwise competent as evidence.

- If a child is not released and a parent, guardian, legal custodian or other person standing *in loco parentis* is not notified and does not appear or does not waive appearance at the hearing, upon request of such person, the court shall rehear the matter on the next court day or within seventy-two hours after the request.

- If a child is not released after a detention hearing and the child was not represented by a lawyer, the court shall afford the child an opportunity to be represented by a lawyer prior to a detention review hearing. If the lawyer requests, a detention review hearing must be scheduled as soon as practicable but no later than seventy-two hours after such request is made. If the seventy-two

hour period ends on a Saturday, Sunday, legal holiday or day on which the court is lawfully closed, the time period is extended to the next day that is not a Saturday, Sunday, legal holiday or day on which the court is lawfully closed. At the review hearing, the judge reviews the need for continued detention. Notice of the hearing, either oral or written, is given to the parent, guardian or other person standing *in loco parentis* (if he can be found), to the attorney, and to the child, if twelve years old or older, and to the attorney for the Commonwealth, who shall be given an opportunity to be heard. Va. Code § 16.1-250 (D).

If the Juvenile and Domestic Relations District Court releases the juvenile over the objection of the Commonwealth, the attorney for the Commonwealth may appeal the decision to the circuit court. The appeals should be noted on the DC-580, NOTICE OF APPEAL - CRIMINAL.

Competency to Stand Trial

Va. Code § 16.1-356

At any time between appointment or retention of an attorney and the end of trial, on motion of either the Commonwealth's Attorney or the attorney for the juvenile or on the court's own motion, the judge may hear evidence to determine whether there is probable cause to believe that the juvenile lacks substantial capacity to understand the proceedings against him or to assist in his own defense. If that probable cause is found:

- The court orders a competency evaluation to be performed by at least one psychiatrist, clinical psychologist, licensed professional counselor, licensed clinical social worker or licensed marriage and family therapist who is qualified by training and experience in the forensic evaluation of juveniles.

- This evaluation should be performed on a local outpatient basis, unless the court specifically finds:

  - The results of the outpatient competency evaluation indicate that hospitalization of the juvenile for evaluation of competency is necessary; or
  - The juvenile is currently hospitalized in a psychiatric hospital.

- Inpatient evaluation should be ordered only if one of the above situations exists. If inpatient evaluation is to be used, the evaluating facility is selected by the Commissioner of the Department of Behavioral Health and Developmental Services (whose designee at the Office of Forensic Services may be contacted at (804) 786-4837 to ascertain to which hospital the juvenile should be transported). The length of stay is determined by the director of the hospital based on the director's determination of the time necessary to perform an adequate evaluation, but it is not to exceed ten days from the date of admission to the hospital.

The court shall require the Commonwealth's Attorney, the juvenile's attorney and the moving party to provide the evaluator with specified information within ninety-six hours of issuance of the order requiring the evaluation, or if the ninety-six hours ends on a Saturday, Sunday or holiday, on the next business day.

The Commonwealth's attorney must provide any information relevant to the evaluation, including but not limited to:

- a copy of the warrant or petition,
- the names and addresses of the attorney for the Commonwealth, the attorney for the juvenile and the judge ordering the evaluation, and
- information about the alleged offense.

The defendant's attorney must provide the evaluator with any available psychiatric records or other information that is deemed relevant.

The moving party must provide the evaluator with a summary of the reasons for the evaluation request.

The clerk will prepare and (after signature by the judge) distribute district court form DC-522, ORDER FOR EVALUATION TO DETERMINE COMPETENCY TO STAND TRIAL - JUVENILE, and, if needed, a district court form DC-354, Custodial Transportation Order after which the sheriff will be notified of the need for transporting the juvenile.

The appointed evaluator or director of the facility must acknowledge receipt of the order for evaluation to the clerk of court by close of business on the next business day after the order is received. At the time of acknowledgement, inform the court if the evaluation is unable to be conducted. Both of these provisions are contained on the acknowledgment portion of THE DC-522, ORDER FOR EVALUATION TO DETERMINE COMPTENECY TO STAND TRIAL – JUVENILE.

The evaluator must submit a report in writing to the court and the attorneys of record within fourteen days after receipt of all the required information. The report must address:

- The juvenile's capacity to understand the proceedings against him;
- The juvenile's ability to assist his attorney;
- The juvenile's need for services in the event he is found incompetent, including a description of the suggested necessary services and the least restrictive setting to assist the juvenile in restoration to competency

After receiving the evaluation report, the court must promptly determine whether the juvenile is competent to stand trial. A hearing is not required unless the Commonwealth

or the attorney for the defendant requests it. If a hearing is held, the juvenile has a right to notice of the hearing and the right to personally participate and introduce evidence. The party alleging that the juvenile is incompetent bears the burden of proving the juvenile's incompetency by a preponderance of the evidence.

If the judge finds that the juvenile is incompetent to stand trial and that treatment is required to restore the juvenile to competency, then the judge shall enter district court form DC-523, ORDER FOR PROVISION OF RESTORATION SERVICES TO INCOMPETENT JUVENILE. A finding of incompetency should not be made based solely on any or all of the following:

- The juvenile's age or developmental factors,
- The juvenile's claim to be unable to remember the time period surrounding the alleged offense,
- The fact that the juvenile is under the influence of medication.

NOTE: A copy of the order must be forwarded to the Commissioner of Department of Behavioral Health and Developmental Services, who shall arrange the provision of restoration services in a manner consistent with the order.

The district court form DC-523, ORDER FOR PROVISION OF RESTORATION SERVICES to the Incompetent Juvenile should indicate whether the juvenile will receive services to restore his competency in a nonsecure community setting or a secure facility as defined in Va. Code § 16.1-228.
If the court finds that the juvenile is restorable to competency in the foreseeable future, it shall order restoration services for up to three months.

If the agent providing restoration services believes the juvenile's competency has been restored, the agent shall immediately send a report to that effect to the court and the court shall make a ruling on the juvenile's competency in accordance with the procedures above.

NOTE: No statements of the juvenile relating to the alleged offense shall be included in the evaluation report. In addition, no statement or disclosure by the juvenile concerning the alleged offense made during a competency evaluation or provision of services may be used against the juvenile at the adjudication or disposition hearings as evidence or as a basis for such evidence.

At the end of the three months, if the juvenile remains incompetent, the agent providing restoration services shall notify the court and make recommendations concerning disposition of the juvenile. The court shall hold a hearing and if the court finds that:

- that the juvenile is restorable, it may order continued restoration services for additional three month periods, provided a hearing is held at the completion of each such period.

- that the juvenile is unrestorably incompetent, it shall order one of the dispositions pursuant to Va. Code § 16.1-358. (*See* below for the disposition alternatives).

If the initial evaluator or the agent providing restoration services concludes that the juvenile is likely to remain incompetent for the foreseeable future, a report stating so should be sent to the court. The report shall also provide recommendations for the disposition of the juvenile. The court may order that:

- the juvenile be committed pursuant to Article 16 of Chapter 11 of Title 16.1, or, if the juvenile has reached the age of eighteen at the time of the competency determination, pursuant to Va. Code §§ 37.2-814 to 37.2-820

- the juvenile be certified pursuant to Va. Code § 37.2-806

- a child in need of services petition be filed on the juvenile's behalf pursuant to Va. Code § 16.1-260 (D) or

- the juvenile be released.

If the charges are not dismissed without prejudice at an earlier time, charges against an unrestorably incompetent juvenile shall be dismissed as follows:

- in the case of a charge which would be a misdemeanor if committed by an adult, one year from the date of the juvenile's arrest for the charge.

- in the case of a charge which would be a felony if committed by an adult, three years from the date of the juvenile's arrest for such charge.

Compensation of Experts: Each psychiatrist, clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed marriage and family therapist or other expert appointed by the court, except services provide by state mental health, hospitals or training centers, shall receive a reasonable fee determined by the court that appointed the expert. The fee should be determined in accordance with the guidelines established by the Supreme Court. If the expert is required to appear as a witness, the expert shall receive mileage and a fee of $100 for each day during which he is required to serve. Va. Code § 16.1-361.

Sexually Transmitted Infections Testing

The attorney for the Commonwealth may request after consultation with a complaining witness, or shall request upon the request of the complaining witness, that any person

charged with (i) any crime involving sexual assault pursuant to this article; (ii) any offense against children as prohibited by §§ 18.2-361, 18.2-366, 18.2-370, and 18.2-370.1; or (iii) any assault and battery, and where the complaining witness was exposed to body fluids of the person so charged in a manner that may, according to the then-current guidelines of the Centers for Disease Control and Prevention, transmit a sexually transmitted infection, be requested to submit to diagnostic testing for sexually transmitted infections and any follow-up testing as may be medically appropriate. The person so charged shall be counseled about the meaning of the tests and about the transmission, treatment, and prevention of sexually transmitted infections. If the person so charged refuses to submit to testing or the competency of the person to consent to testing is at issue, the court with jurisdiction of the case shall hold a hearing in a manner as provided by § 19.2-183, as soon as practicable, to determine whether there is probable cause that the individual has committed the crime with which he is charged and that the complaining witness was exposed to body fluids of the person so charged in a manner that may, according to the then-current guidelines of the Centers for Disease Control and Prevention, transmit a sexually transmitted infection. If the court finds probable cause, the court shall order the person so charged to undergo testing for sexually transmitted infections. The court may enter such an order in the absence of the person so charged if the person so charged is represented at the hearing by counsel or a guardian ad litem. The court's finding shall be without prejudice to either the Commonwealth or the person charged and shall not be evidence in any proceeding, civil or criminal. At any hearing before the court, the person so charged or his counsel may appear. Form DC 3010, Request for Sexually Transmitted Infection Testing Pursuant to §18.2-61.1, and Form CC 1390, Order for DNA or Sexually Transmitted Infections Testing are used to complete this process. The motion is not indexed by the clerk's office separately from the underlying case and no costs are associated with the testing for juveniles. Test results are sealed in the court's file pending the court hearing.

Subpoenas, Witness Summoning

The procedures for witness subpoenas are described in this manual, "Criminal Case Procedures- Pre-Trial Procedures". The same basic procedures apply in the juvenile and domestic relations district court. Law enforcement officers may issue subpoenas to witnesses in traffic infraction cases and in cases charging a Class 3 or Class 4 misdemeanor. Even though delinquency proceedings are often described as having characteristics of civil proceedings, the provisions for attorney-issued subpoenas in other civil proceedings *do not* apply to delinquency proceedings. Va. Code § 8.01-407 (A).

Juvenile Felony

Confidentiality

Unless closed by the judge by entry of district court form DC-501, Order to Close Hearing, a hearing on a felony case involving a juvenile 14 years of age or older, is open to the public. Pursuant to Va. Code § 16.1-305 (B1), the court records are not open to the public until there is an adjudication of guilt on a felony case for a juvenile age fourteen or older. Records that are excluded from public record include social, medical, psychiatric or psychological reports, including preliminary inquiries, predisposition studies and supervision records. The judge may also order certain records in the file closed to protect the juvenile victim or a juvenile witness. Please note that an order transferring a juvenile or certifying a juvenile to the Circuit Court for trial does not constitute an adjudication of guilt and therefore, the records are not open to the public.

Cases that May Be Tried in Circuit Court

Under certain circumstances, juveniles charged with felonies who are fourteen years of age and older, may be tried in the circuit court of the jurisdiction in which the offense occurred. The case begins in the juvenile and domestic relations district court, and depending on the severity of the offense, the Commonwealth's Attorney and the district court may take the following actions:

- If the juvenile is 14 years of age or older at the time of the alleged offense, Pursuant to Va. Code § 16.1-269.1 (A), upon motion of the Commonwealth's Attorney, and except as provided for under subsections B and C, the court shall conduct a transfer hearing. Notice of the transfer hearing is provided to the juvenile and his parent, guardian, legal custodian, or person standing *in loco parentis*; or attorney, by the JDR clerk's office. **If the Court finds probable cause and the other conditions are met pursuant to Va. Code § 16.1-269.1, 1-4, the juvenile is transferred to the circuit court for hearing.**

  Within seven days after receipt of notice of an appeal from the transfer decision pursuant to subsection A of Va. Code § 16.1-269.1, by either the attorney for the Commonwealth or the juvenile, or if an appeal to such a decision to transfer is not noted, upon expiration of the time in which to note such an appeal, the clerk of the court shall forward to the circuit court all papers connected with the case, including any report required by

subsection B of Va. Code § 16.1-269.2, as well as a written court order setting forth the reasons for the juvenile court's decision. Within seven days after receipt of notice of an appeal, the clerk shall forward copies of the order to the attorney for the Commonwealth and other counsel of record. Va. Code § 16.1-269.6.

- If the juvenile is 16 years of age or older at the time of the alleged offense Pursuant to **Va. Code § 16.1-269.1 (B)**, in cases of murder in violation of **Va. Code §§ 18.2-31**, **18.2-32**, or **18.2-40**, or aggravated malicious wounding in violation of **Va. Code § 18.2-51.2**, the Court shall conduct a preliminary hearing. No motion or notice is required on behalf of the Commonwealth. **Similar to an adult preliminary hearing, the juvenile is certified to the grand jury if the court finds probable cause.**

  Upon motion of the juvenile, the court may conduct a hearing to allow the juvenile to present any evidence that the juvenile was a victim of felonious criminal sexual assault in violation of Article 7 (Va. Code §18.2-61 *et seq.*) of Chapter 4 of Title 18.2 or trafficking in violation of Article 3 (Va. Code §18.2-344 *et seq.*) of Chapter 8 of Title 18.2 by the alleged victim prior to or during the commission of the alleged offense. If the court finds by a preponderance of the evidence that sufficient evidence exists to believe that the juvenile was a victim and that such alleged offense was a direct result of the juvenile being a victim of such felonious criminial sexual assault or trafficking, then the court shall proceed as provided in Va. Code § 16.1-269.1 (A) and a motion to transfer is required on behalf of the Commonwealth.

- If the juvenile is 14 or 15 years of age at the time of the alleged offense, the court may proceed with a transfer hearing on motion of the attorney for the Commonwealth pursuant to Va. Code § 16.1-269.1 (A).

- If the juvenile is 16 years of age or older at the time of the alleged offense Pursuant to Va. Code § 16.1-269.1 (C), in cases of murder in violation of Va. Code § 18.2-33, injury by mob in violation of Va. Code § 18.2-41, abduction in violation of Va. Code § 18.2-48, malicious wounding in violation of Va. Code § 18.2-51, malicious wounding of law enforcement in violation of Va. Code § 18.2-51.1, poisoning in violation of Va. Code § 18.2-54.1, adulteration of

products in violation of Va. Code § 18.2-54.2, robbery in violation of Va. Code § 18.2-58, carjacking in violation of Va. Code § 18.2-58.1, rape in violation of Va. Code § 18.2-61, forcible sodomy in violation of Va. Code § 18.2-67.1, object sexual penetration in violation of Va. Code § 18.2-67.2, ; manufacturing, selling, giving, distributing, or possessing with intent to manufacture, sell, give, or distribute a controlled substance or an imitation controlled substance in violation of § 18.2-248 if the juvenile has been previously adjudicated delinquent on two or more occasions of violating § 18.2-248 provided the adjudications occurred after the juvenile was at least 16 years of age; manufacturing, selling, giving, distributing, or possessing with intent to manufacture, sell, give, or distribute methamphetamine in violation of § 18.2-248.03, if the juvenile has been previously adjudicated delinquent on two or more occasions of violating § 18.2-248.03 provided the adjudications occurred after the juvenile was at least 16 years of age; or felonious manufacturing, selling, giving, distributing, or possessing with intent to manufacture, sell, give, or distribute anabolic steroids in violation of § 18.2-248.5 if the juvenile has been previously adjudicated delinquent on two or more occasions of violating § 18.2-248.5 provided the adjudications occurred after the juvenile was at least 16 years of age, the Court shall conduct a preliminary hearing, provided that the Commonwealth gives written notice of his intent to proceed under subsection C. Prior to giving written notice of his intent to proceed pursuant to this subsection, the attorney for the Commonwealth shall submit a written request to the director of the court services unit to complete a report as described in §16.1-269.2(B) unless waived by the juvenile and his attorney or other legal representative. The report shall be filed with the court and mailed or delivered to (i) the attorney for the Commonwealth and (ii) counsel for the juvenile, or, if the juvenile is not represented by counsel, to the juvenile and a parent, guardian, or other person standing in loco parentis with respect to the juvenile, within 21 days of the date of the written request. After reviewing the report, if the attorney for the Commonwealth still intends to proceed pursuant to this subsection, he shall then provide the written notice of such intent, which shall include affirmation that he reviewed the report. **Similar to an adult preliminary hearing, the juvenile is certified to the grand jury if the court finds probable cause.**

Upon motion of the juvenile, the court may conduct a hearing to allow the juvenile to present any evidence that the juvenile was a

victim of felonious criminal sexual assault in violation of Article 7 (Va. Code §18.2-61 *et seq.*) of Chapter 4 of Title 18.2 or trafficking in violation of Article 3 (Va. Code §18.2-344 *et seq.*) of Chapter 8 of Title 18.2 by the alleged victim prior to or during the commission of the alleged offense. If the court finds by a preponderance of the evidence that sufficient evidence exists to believe that the juvenile was a victim and that such alleged offense was a direct result of the juvenile being a victim of such felonious crimininal sexual assault or trafficking, then the court shall proceed as provided in Va. Code § 16.1-269.1 (A) and a motion to transfer is required on behalf of the Commonwealth.

Clerk's Procedures for :

A Juvenile Pursuant to **Va. Code § 16.1-269.1 (A)**

The following procedures are recommended in processing a juvenile pursuant to Va. Code § 16.1-269.1 (A) .

These are proceedings in which the judge is making a determination of whether or not the juvenile should be tried as an adult. The clerk's office will know the Commonwealth is requesting the judge make this determination when notice is filed with the clerk prior to the adjudicatory hearing or if the Commonwealth proceeds under subsection (A) on charges that fall under subsection (C).

STEP	DESCRIPTION
1	The Clerk's office receives a petition or a warrant alleging a juvenile fourteen or older has committed a felony. CCRE and a fingerprint card may accompany the petition/warrant. These documents should be kept with the file until the case is finalized. Additional petitions/warrants may be filed which include ancillary charges. These charges are heard with the felony adjudication and may also be transferred. Definition of Ancillary Charge: Delinquent act, misdemeanor or felony, committed by juvenile as part of a common scheme or plan with a delinquent violent felony.
2	If the juvenile has been detained, the court shall hold a detention hearing as soon as possible, not to exceed seventy-

STEP	DESCRIPTION
	two hours unless the period expires on a Saturday, Sunday or other legal holiday, then the next business day. **If detained**, district court form DC-529, DETENTION ORDER/CAPIAS PURSUANT TO § 16.1-247(K), will be filed. This hearing may be held using video conferencing. **If not detained**, it is recommended that the JDR clerk's office set an attorney advisement as soon as possible and provide proper notice pursuant to Va. Code §§ 16.1-263 and 16.1-264.
3	Enter the petition/warrant in JCMS and schedule for a detention hearing and attorney advisement, if detained, or an attorney advisement, if not detained. The case is assigned a "petition" or "charge" number. Index in JCMS using the following codes: Case type: **DF** delinquent felony Hearing type: **DT** detention hearing **AA** attorney advisement
4	If scheduling a detention hearing: unless the juvenile has retained counsel and he is present at the detention hearing, the Court shall appoint counsel and have him present at the detention pursuant to Va. Code § 16.1-266 (B). The Commonwealth's Attorney should be notified of the date and time of the detention hearing. District court form DC-354, CUSTODIAL TRANSPORTATION ORDER, should be entered if the juvenile is at the detention home and the hearing is not scheduled using video conferencing. Pursuant to Va. Code § 16.1-266 (C)(3), a child who is alleged to have committed an offense that would be a felony if committed by an adult, may waive right to counsel only after he consults with an attorney and the court determines that his waiver is free and voluntary. The waiver shall be in writing, signed by both the child and the child's attorney and shall be filed with the court records of the case. Orders should be charge specific in case certain offenses are certified and others dismissed or reduced.
5	Detention hearing and/or attorney advisement conducted. If held by video conferencing, Va. Code § 16.1-250 applies and requires that at least one of the following parties appears in the jurisdiction in which the offense occurred: the judge, the

STEP	DESCRIPTION
5 *(cont'd)*	juvenile, the commonwealth's attorney, the attorney for the child, or the parent(s), guardian, or legal custodian. If persons listed on the petition or parents, legal custodian, guardian, or persons standing *in loco parentis*, have not been served with petition/warrant(s), a summons and a copy of the charging document should be served on them prior to the commencement of the detention hearing. District court form DC-513, ADVISEMENT AND REQUEST FOR APPOINTMENT OF COUNSEL should be used. At the conclusion of the detention hearing, **if the juvenile remains detained**, the court shall schedule the preliminary hearing within twenty-one days from the date he was first detained pursuant to Va. Code § 16.1-277.1. Parents and witnesses should sign the district court form DC-329, RECOGNIZANCE to return on the date of the preliminary hearing. If not detained, the Court would have the juvenile sign the district court form DC-329, RECOGNIZANCE for the preliminary hearing date, which must be set within 120 days from the date the petition or warrant was filed with the clerk's office pursuant to Va. Code § 16.1-277.1. **If detained**, the Court may set a bond amount and bail conditions. This information can be recorded on Form DC-569, ORDER or an order provided by the court. Prior to trial, the bail decision may be appealed to circuit court. (*See* appendix on "Appeals".) The court granting or denying such bail, ordering any increase or ordering new or additional sureties may, upon appeal thereof, and for good cause shown, stay execution of such order for so long as reasonably practicable for the party to obtain an expedited hearing before the next higher court. No such stay may be granted after any person who has been granted bail has been released from custody on such bail. Va. Code § 19.2-124 A district court form DC-538, PLACEMENT ORDER must be entered by the court to return the juvenile to the detention home if so ordered.

STEP	DESCRIPTION
	The following motions may be filed in conjunction with the felony proceedings: – Competency to Stand Trial – Motion to Suppress – Motion for Testimony Via Closed-Circuit Television
6	Prior to the adjudicatory hearing, the clerk's office receives from the Commonwealth Attorney's office a Motion to Transfer pursuant to Va. Code § 16.1-269.1 (A). The clerk's office sends notice of the motion to counsel for the juvenile, the juvenile and a parent, guardian or other person standing *in loco parentis*. The district court form DC-519, NOTICE OF TRANSFER HEARING should be used to send this required notice. The clerk's office should file the motion and a copy of the notice with the case papers. The Motion for Transfer filed by the Commonwealth Attorney may have the request for a Transfer Report incorporated into the motion with a certified copy of the motion to the Court Service's Unit. The clerk's office should prepare district court form DC-542, ORDER FOR INVESTIGATION AND REPORT ordering the Court Service's Unit to prepare a Transfer Report pursuant to Va. Code § 16.1-269.1 (A)(4). The judge must sign. Keep the original in the file and give a copy to CSU immediately.
7 **7** *(cont'd)*	If the judge orders the hearing closed, district court form DC-501, ORDER TO CLOSE HEARING should be entered. Virginia Code § 16.1-277.1 (D), requires that in cases where the juvenile is detained in a secure facility, the twenty-one day time limitation for the transfer hearing can only be extended by the court for a reasonable period of time based upon good cause shown, AND that the basis for such extension be recorded in writing and filed with the proceedings. Transfer hearing conducted. District court form DC-518, TRANSFER/ RETENTION ORDER should be used to record the court's findings. If the court finds the juvenile should be transferred, the case is tried in Circuit Court. If the court finds the juvenile should remain before the Juvenile Court, the trial may take place in

STEP	DESCRIPTION
	conjunction with the Transfer Hearing, or may be continued for another date. See the following section dealing with Adjudication in the JDR Court. Orders should be charge specific in case certain offenses are certified and others dismissed or reduced. The juvenile may waive jurisdiction of the case. District court form DC-517, WAIVER OF JURISDICTION should be signed by the juvenile and counsel for the juvenile. If remanded to detention, district court form DC-538, PLACEMENT ORDER should be used. If a juvenile is held in secure detention after completion of an adjudicatory hearing or transfer hearing, then the juvenile must be released if the disposition hearing is not completed within thirty days from the adjudicatory or transfer hearing, therefore timely processing is necessary. The juvenile may appeal the decision to transfer the charges or the Commonwealth may appeal the decision not to transfer the charges. District court form DC-580, NOTICE OF APPEAL – CRIMINAL should be used.
8	If transferred finalize the case(s) in JCMS using the following Final Disposition codes: **TA** Transferred as Adult When the juvenile court is notified by the circuit court that the juvenile has been tried as an adult, the **ADULT** field should be flagged with an **X** on the H/D Tab JCMS. **X** will cause a flag on the juvenile name index to display, which will provide a warning to the users that petitions or juvenile summons should no longer be received for the defendant.
8 *(cont'd)*	When a juvenile is transferred to the Circuit Court for trial and is convicted of such offenses, all future criminal and traffic proceedings shall be handled as if the juvenile were an adult. Only those criminal proceedings that would fall under the jurisdiction of the Juvenile and Domestic Relations District Court

STEP	DESCRIPTION
	for an adult shall be filed against the juvenile in a JDR court for processing. However, such an order terminating the juvenile court's jurisdiction shall not apply to any allegations of criminal conduct that would properly be within the jurisdiction of the juvenile and domestic relations district court if the defendant were an adult. Upon receipt of the order terminating the juvenile court's jurisdiction over the juvenile, the clerk of the juvenile court shall forward any pending petitions of delinquency for proceedings in the appropriate general district court. The adjudication as an adult does not affect civil proceedings. Retain a copy of case papers for juvenile file and forward originals to the Circuit Court, including any CCRE documents. District court form DC-575, CONFIDENTIAL MATERIALS – JUVENILE CASE APPEAL/TRANSFER TRANSMITTAL should be used to transmit papers. If juvenile is remanded to detention pending the hearing in Circuit, placement should be noted on the transmittal. If the petition/warrant is dismissed or not guilty, the fingerprints and photographs are to be destroyed within sixty days after final disposition.

Processing a Juvenile, age 16 or older at the time of the offense, pursuant to Va. Code § 16.1-269.1 (B).

The following procedures are recommended in processing a juvenile pursuant to Va. Code § 16.1-269.1 (B). **When the listed charges are filed, a preliminary hearing is mandatory.**

STEP	DESCRIPTION
1	The Clerk's office receives a petition or a warrant alleging a juvenile, age 16 or older at the time of the offense, has committed one of the following offenses: - Capital Murder (§ 18.2-31) - First Degree Murder (§ 18.2-32) - Second Degree Murder (§ 18.2-32) - Murder by Lynching (§ 18.2-40) - Aggravated Malicious Wounding (§ 18.2-51.2)

STEP	DESCRIPTION
	CCRE and a fingerprint card may accompany the petition/warrant. These documents should be kept with the file until the case is finalized. Additional petitions/warrants may be filed which include ancillary charges. These charges are heard with those set for preliminary hearing and may also be certified. Definition of Ancillary Charge – Delinquent act, misdemeanor or felony, committed by juvenile as part of a common scheme or plan with a delinquent violent felony.
2	If the juvenile has been detained, the court shall hold a detention hearing as soon as possible, not to exceed seventy-two hours unless the period expires on a Saturday, Sunday or other legal holiday, then the next business day. **If detained,** a district court form DC-529, DETENTION ORDER/CAPIAS PURSUANT TO § 16.1-247(K) will be filed. It would be unlikely that the juvenile would not be detained if charged with one of the offenses listed. **If not detained,** it is recommended that the JDR clerk's office set an attorney advisement as soon as possible, and provide proper notice pursuant to Va. Code §§ 16.1-263 and 16.1-264. This hearing may be held using video conferencing. Please see STEP 5.
3	Enter the petition/warrant in JCMS and schedule for a detention hearing. The case is assigned a "petition" or "charge" number. Index in JCMS using the following codes: Case type: **DF** delinquent felony Hearing type: **DT** detention hearing
3 *cont'd*	**If the juvenile is not detained,** hearing type **AA** should be used
4	Unless the juvenile has retained counsel and he is present at the detention hearing, the court shall appoint counsel and have him present at the detention pursuant to Va. Code § 16.1-266 (B). The Commonwealth's Attorney should be notified of the date and time of the detention hearing. DC-513, ADVISEMENT AND REQUEST FOR APPOINTMENT OF

STEP	DESCRIPTION
	COUNSEL should be used. A district court form DC-354, CUSTODIAL TRANSPORTATION ORDER should be entered if the juvenile is at the detention home and the hearing is not scheduled using video conferencing. Also pursuant to Va. Code § 16.1-266 (C3), a child who is alleged to have committed an offense that would be a felony if committed by an adult, may waive right to counsel only after he consults with an attorney and the court determines that his waiver is free and voluntary. The waiver shall be in writing, signed by both the child and the child's attorney and shall be filed with the court records of the case. Orders should be charge specific in case certain offenses are certified and others dismissed. **Comments:** If the charge is a capital offense, please see the COURT APPOINTED COUNSEL GUIDELINES & PROCEDURES MANUAL on the intranet regarding appointment of counsel in capital cases.
5 5 *cont'd*	Detention hearing and attorney advisement conducted. If persons listed on the petition or parents, legal custodian, guardian, or persons standing *in loco parentis*, have not been served with petition/warrant(s), a summons and a copy of the charging document should be served on them prior to the commencement of the detention hearing. At the conclusion of the detention hearing, if the juvenile remains detained, the court shall schedule the preliminary hearing within twenty-one days from the date he was first detained pursuant to Va. Code § 16.1-277.1. Parents and witnesses should sign the district court form DC-329, RECOGNIZANCE, to return on the date of the preliminary hearing. If not detained, the Court would have the juvenile sign district court form DC-329, RECOGNIZANCE for the preliminary hearing date, which must be set within 120 days from the date the petition or warrant was filed with the clerk's office pursuant to Va. Code § 16.1-277.1. **If detained**, the Court may set a bond amount and bail conditions. This information can be recorded on district court form DC-569, Order.

STEP	DESCRIPTION
	Prior to trial, the bail decision may be appealed to circuit court. (See appendix on "Appeals".) The court granting or denying such bail, ordering any increase, or ordering new or additional sureties may, upon appeal thereof, and for good cause shown, stay execution of such order for so long as reasonably practicable for the party to obtain an expedited hearing before the next higher court. No such stay may be granted after any person who has been granted bail has been released from custody on such bail. Va. Code § 19.2-124 A district court form DC-538, PLACEMENT ORDER must be entered by the court to return the juvenile to the detention home if so ordered. If held by video conferencing, Va. Code § 16.1-250 applies and requires that at least one of the following parties appears in the jurisdiction in which the offense occurred: the judge, the juvenile, the commonwealth's attorney, the attorney for the child, or the parent(s), guardian, or legal custodian. The following motions may be filed in conjunction with the felony proceedings: - Competency to Stand Trial - Motion to Suppress - Motion for Testimony Via Closed-Circuit Television
6	If the judge orders the hearing closed, district court form DC-501, ORDER TO CLOSE HEARING should be entered. Preliminary hearing conducted. If the court finds that probable cause exists, the case is certified, along with any ancillary charges, to the grand jury. District court form DC-520, CERTIFICATION OF JUVENILE FELONY CHARGE is used to record the certification of the charges. Virginia Code § 16.1-277.1 (D), requires that in cases where the juvenile is detained in a secure facility, the twenty-one day time limitation for the preliminary hearing can only be extended by the court for a reasonable period of time based upon good cause shown, AND that the basis for such extension be recorded in writing and filed with the proceedings.

STEP	DESCRIPTION
	The juvenile may waive his right to a preliminary hearing. District court form DC-521, WAIVER OF PRELIMINARY HEARING AND CERTIFICATION should be used. If remanded to detention, district court form DC-538, PLACEMENT ORDER should be used. The juvenile may appeal the decision to certify the charges. District court form DC-580, NOTICE OF APPEAL – CRIMINAL should be used. Orders should be charge specific in case certain offenses are certified and others dismissed.
7	If certified or dismissed, finalize the cases(s) in JCMS using the following Final Disposition codes: **GJ** Grand Jury **D** Dismissed Retain a copy of case papers for juvenile file in accordance to local policy, and forward originals to the Circuit Court, including any CCRE documents. District court form DC-575, CONFIDENTIAL MATERIALS – JUVENILE CASE APPEAL/TRANSFER TRANSMITTAL should be used to transmit papers. If juvenile is remanded to detention pending the hearing in Circuit, placement should be noted on the transmittal. When the juvenile court is notified by the circuit court that the juvenile has been tried as an adult, the **ADULT** field should be flagged with an **X** on the H/D tab in JCMS. **X** will cause a flag on the juvenile name index to display, which will provide a warning to the users that petitions or juvenile summons should no longer be received for the defendant. Virginia Code § 16.1-271 states "Conviction of a juvenile as an adult pursuant to the provisions of this chapter shall preclude the juvenile court from taking jurisdiction of such juvenile for subsequent offenses committed by that juvenile." When a juvenile is certified to the Circuit Court for trial and is convicted of such offenses, all future criminal and traffic proceedings shall be handled as if the juvenile were an adult. Only those criminal proceedings that would fall under the jurisdiction of the Juvenile and Domestic Relations District Court for an adult shall be filed against the juvenile in a JDR court for processing.

STEP	DESCRIPTION
7 *cont'd*	The adjudication as an adult does not affect civil proceedings. If the court does not find probable cause to believe that the juvenile has committed the violent juvenile felony as charged in the petition or warrant or if the petition or warrant is terminated by dismissal in the juvenile court, the attorney for the Commonwealth may seek a direct indictment in the circuit court. If the petition or warrant is terminated by *nolle prosequi* in the juvenile court, the attorney for the Commonwealth may seek an indictment only after a preliminary hearing in juvenile court. Regardless of the disposition of the case, the fingerprints and photographs are to be forwarded to the CCRE at final disposition.

A Juvenile, age 16 or older at the time of the offense,pursuant to Va. Code § 16.1-269.1 (C).

The following procedures are recommended in processing a juvenile pursuant to Va. Code § 16.1-269.1 (C):

The clerk's office will know the Commonwealth is proceeding under this code section when notice is filed with the clerk at least seven days prior to the preliminary hearing.
Note: The court will receive a report from the Court Services Unit at least twenty-one days prior to the Commonwealth's written notice of his intent to proceed under this code section.

STEP	DESCRIPTION
1 1 *cont'd*	The Clerk's office receives a petition or a warrant alleging a juvenile, age 16 or older at the time of the offense, has committed one of the following offenses: - Murder (§ 18.2-33), - Injury by mob (§ 18.2-41), Abduction (§ 18.2-48), - Mal. wounding(§ 18.2-51), - Mal. wounding of law enforcement (§ 18.2-51.1), - Poisoning (§ 18.2-54.1), - Adulteration of products (§ 18.2-54.2), - Robbery (§ 18.2-58), - Carjacking (§ 18.2-58.1), - Rape (§ 18.2-61), - Forcible sodomy (§ 18.2-67.1), - Object sexual penetration (§ 18.2-67.2),

STEP	DESCRIPTION
	- Manufacturing, selling, giving, distributing, or possessing with intent to manufacture, sell, give, or distribute a controlled substance or an imitation controlled substance in violation of § 18.2-248, - Manufacturing, selling, giving, distributing, or possessing with intent to manufacture, sell, give, or distribute methamphetamine in violation of § 18.2-248.03, - Felonious manufacturing, selling, giving, distributing, or possessing with intent to manufacture, sell, give, or distribute anabolic steroids in violation of § 18.2-248.5. A CCRE and a fingerprint card may accompany the petition/warrant. These documents should be kept with the file until the case is finalized. Additional petitions/warrants may be filed which include ancillary charges. These charges are heard with those set for preliminary hearing and may also be certified. Definition of Ancillary Charge: Delinquent act, misdemeanor or felony, committed by juvenile as part of a common scheme or plan with a delinquent violent felony.
2	If the juvenile has been detained, the court shall hold a detention hearing as soon as possible, not to exceed seventy-two hours unless the period expires on a Saturday, Sunday or other legal holiday, then the next business day. If detained, a district court form DC-529, DETENTION ORDER/CAPIAS PURSUANT TO § 16.1-247(K), will be filed. It would be unlikely that the juvenile would not be detained if charged with one of the offenses listed. **If not detained,** it is recommended that the JDR clerk's office set an attorney advisement as soon as possible, and provide proper notice pursuant to Va. Code §§ 16.1-263 and 16.1-264. This hearing may be held using video conferencing.
3	Enter the petition/warrant in JCMS and schedule for a detention hearing. The case is assigned a "petition" or "charge" number. Index in JCMS using the following codes: Case type: **DF** delinquent felony Hearing type: **DT** detention hearing **If the juvenile is not detained**, hearing type **AA** should be used.

STEP	DESCRIPTION
4	Unless the juvenile has retained counsel and he is present at the detention hearing, the court shall appoint counsel and have him present at the detention pursuant to Va. Code § 16.1-266 (B). The Commonwealth's Attorney should be notified of the date and time of the detention hearing. A district court form DC-354, CUSTODIAL TRANSPORTATION ORDER should be entered if the juvenile is at the detention home and the hearing is not scheduled using video conferencing. Pursuant to Va. Code § 16.1-266 (C)(3), a child who is alleged to have committed an offense that would be a felony if committed by an adult, may waive right to counsel only after he consults with an attorney and the court determines that his waiver is free and voluntary. The waiver shall be in writing, signed by both the child and the child's attorney and shall be filed with the court records of the case. Orders should be charge specific in case certain offenses are certified and others dismissed or reduced.
5	Detention hearing and attorney advisement conducted. If persons listed on the petition or parents, legal custodian, guardian, or persons standing *in loco parentis*, have not been served with petition/warrant(s), a summons and a copy of the charging document should be served on them prior to the commencement of the detention hearing.

5 *cont'd*	The district court form DC-513, ADVISEMENT AND REQUEST FOR APPOINTMENT OF COUNSEL should be used. At the conclusion of the detention hearing, **if the juvenile remains detained**, the court shall schedule the preliminary hearing within twenty-one days from the date he was first detained pursuant to Va. Code § 16.1-277.1. Parents and witnesses should sign the DC-329, Recognizance to return on the date of the preliminary hearing. **If not detained**, the Court would have the juvenile sign the district court form DC-329, RECOGNIZANCE for the preliminary hearing date, which must be set within 120 days from the date the petition or warrant was filed with the clerk's office pursuant to Va. Code § 16.1-277.1. **If detained**, the Court may set a bond amount and bail conditions. This information can be recorded on a DC-569, ORDER or an order provided by the court. Prior to trial, the bail decision may be appealed to circuit court. (*See* appendix on "Appeals".) The court granting or denying such bail, ordering any increase or ordering new or additional sureties may, upon appeal thereof, and for good cause shown, stay execution of such order for so long as reasonably practicable for the party to obtain an expedited hearing before the next higher court. No such stay may be granted after any person who has been granted bail has been released from custody on such bail. Va. Code § 19.2-124 If held by video conferencing, Va. Code § 16.1-250 applies and requires that at least one of the following parties appears in the jurisdiction in which the offense occurred: the judge, the juvenile, the commonwealth's attorney, the attorney for the child, or the parent(s), guardian, or legal custodian. A district court form DC-538, PLACEMENT ORDER must be entered by the court to return the juvenile to the detention home if so ordered. The following motions may be filed in conjunction with the felony proceedings: - Competency to Stand Trial

STEP	DESCRIPTION
	- Motion to Suppress - Motion for Testimony Via Closed-Circuit Television
6	At least seven days prior to the preliminary hearing, the Clerk's office receives from the Commonwealth Attorney's office a notice of intent to proceed under Va. Code § 16.1-269.1 (C). It is the Commonwealth Attorney's responsibility to provide the notice by delivery or mail to counsel for the juvenile, or if not represented, the juvenile and a parent, guardian or other person standing *in loco parentis*. The clerk's office should file the notice with the case papers.
7	If the judge orders the hearing closed, DC-501, ORDER TO CLOSE HEARING should be entered. Preliminary hearing conducted. Virginia Code § 16.1-277.1 (D) requires that in cases where the juvenile is detained in a secure facility, the twenty-one day time limitation for the preliminary hearing can only be extended by the court for a reasonable period of time based upon good cause shown, AND that the basis for such extension be recorded in writing and filed with the proceedings. At this hearing or prior to this hearing, the Commonwealth Attorney may elect to withdraw his motion under Va. Code § 16.1-269.1 (C) and proceed under (A), which states the court shall conduct a transfer hearing. If this occurs, please see steps for proceeding under Va. Code § 16.1-269.1 (A). If the Court finds that probable cause exists, the case is certified, along with any ancillary charges, to the grand jury. DC-520, CERTIFICATION OF JUVENILE FELONY CHARGE is used to record the certification of the charges. The juvenile may waive his right to a preliminary hearing. Form DC-521, WAIVER OF PRELIMINARY HEARING AND CERTIFICATION should be used. If remanded to detention, district court form DC-538, PLACEMENT ORDER should be used. The juvenile may appeal the decision to certify the charges. District court form DC-580, NOTICE OF APPEAL-CRIMINAL should be used.

STEP	DESCRIPTION
	Regardless of the disposition of the case, the fingerprints and photographs are to be forwarded to the CCRE at final disposition Orders should be charge specific in case certain offenses are certified and others dismissed or reduced.

A Juvenile Felony when Adjudication Takes Place in J&DR Court.

The following procedures are recommended in processing a juvenile felony when the adjudication takes place in the J&DR Court.

STEP	DESCRIPTION
1	The Clerk's office receives a petition or a warrant alleging a juvenile fourteen or older has committed a felony. CCRE and a fingerprint card may accompany the petition/warrant. These documents should be kept with the file until the case is finalized.
2	**If the juvenile has been detained,** the court shall hold a detention hearing as soon as possible, not to exceed seventy-two hours unless the period expires on a Saturday, Sunday or other legal holiday, then the next business day. This hearing may be held using video conferencing. **If not detained,** it is recommended that the JDR clerk's office set an attorney advisement as soon as possible and provide proper notice pursuant to Va. Code §§ 16.1-263 and 16.1-264. **If detained,** district court form DC-529, DETENTION ORDER/CAPIAS PURSUANT TO § 16.1-247(K) will be filed.
3	Enter the petition/warrant in JCMS and schedule for a detention hearing, if detained, or an attorney advisement, if not detained. The case is assigned a "petition" or "charge" number. Index in JCMS using the following codes: Case type: **DF** delinquent felony Hearing type: **DT** detention hearing **AA** attorney advisement
4	If scheduling a detention hearing: unless the juvenile has retained counsel and he is present at the detention hearing, the

STEP	DESCRIPTION
	court shall appoint counsel and have him present at the detention pursuant to Va. Code § 16.1-266 (B). The Commonwealth's Attorney should be notified of the date and time of the detention hearing. District court form DC-354, Custodial Transportation Order should be entered if the juvenile is at the detention home and the hearing is not scheduled using video conferencing. Pursuant to Va. Code § 16.1-266 (C)(3), a child who is alleged to have committed an offense that would be a felony if committed by an adult, may waive right to counsel only after he consults with an attorney and the court determines that his waiver is free and voluntary. The waiver shall be in writing, signed by both the child and the child's attorney and shall be filed with the court records of the case. Orders should be charge specific in case certain offenses are certified and others dismissed or reduced.
5	Detention hearing and attorney advisement conducted. If held by video conferencing, Va. Code § 16.1-250 applies and requires that at least one of the following parties appears in the jurisdiction in which the offense occurred: the judge, the juvenile, the commonwealth's attorney, the attorney for the child, or the parent(s), guardian, or legal custodian. If persons listed on the petition or parents, legal custodian, guardian, or persons standing *in loco parentis*, have not been served with petition/warrant(s), a summons and a copy of the charging document should be served on them prior to the commencement of the detention hearing. District court form DC-513, ADVISEMENT AND REQUEST FOR APPOINTMENT OF COUNSEL should be used. At the conclusion of the detention hearing, **if the juvenile remains detained**, the court shall schedule the adjudicatory hearing within twenty-one days from the date he was first detained pursuant to Va. Code § 16.1-277.1. Parents and

STEP	DESCRIPTION
	witnesses should sign the DC-329, RECOGNIZANCE to return on the date of the preliminary hearing. Virginia Code § 16.1-277.1 (D), requires that in cases where the juvenile is detained in a secure facility, the twenty-one day time limitation for the preliminary hearing can only be extended by the court for a reasonable period of time based upon good cause shown, AND that the basis for such extension be recorded in writing and filed with the proceedings. **If not detained**, the court would have the juvenile sign the district court form DC-329, RECOGNIZANCE for the preliminary hearing date which must be set within 120 days from the date the petition or warrant was filed with the clerk's office pursuant to Va. Code § 16.1-277.1. **If detained**, the Court may set a bond amount and bail conditions. This information can be recorded on district court form DC-569, ORDER. Prior to trial, the bail decision may be appealed to circuit court. (*See* appendix on "Appeals".) The court granting or denying such bail, ordering any increase or ordering new or additional sureties may, upon appeal thereof, and for good cause shown, stay execution of such order for so long as reasonably practicable for the party to obtain an expedited hearing before the next higher court. No such stay may be granted after any person who has been granted bail has been released from custody on such bail. Va. Code § 19.2-124 District court form DC-538, PLACEMENT ORDER must be entered by the court to return the juvenile to the detention home if so ordered. The following motions may be filed in conjunction with the felony proceedings: – Competency to Stand Trial – Motion to Suppress – Motion for Testimony Via Closed Circuit Television

STEP	DESCRIPTION
6	Trial on charges held in Juvenile Court. District court form DC-569, ORDER may be used to record findings and orders. The court may adjudicate and move directly to disposition at the same hearing. District court form DC-572, ORDER should be used. Please note that this commitment to DJJ must be reviewed in thirty days. Pursuant to Va. Code § 16.1-278.8, a juvenile can be committed to DJJ only if he is eleven years of age or older and the current offense is (i) an offense that would be a felony if committed by an adult, (ii) an offense that would be a Class 1 misdemeanor if committed by an adult and the juvenile has previously been found to be delinquent based on an offense that would be a felony if committed by an adult, or (iii) an offense that would be a Class 1 misdemeanor if committed by an adult and the juvenile has previously been adjudicated delinquent of three or more offenses that would be a Class 1 misdemeanor if committed by an adult, and each such offense was not a part of a common act, transaction or scheme.
7	In the **PUB** field, an entry of **Y** indicates that the case is open to the public and an entry of **N** means the case is not open to the public. When a **Y** is entered, "**PUBLIC**" will display on the name index. (Mandatory) If guilty, circuit court form CC-1390, ORDER FOR DNA OR HIV TESTING AND/OR FOR PREPARATION OF REPORTS TO CENTRAL CRIMINAL RECORDS EXCHANGE must be entered ordering a buccal swab be conducted to collect DNA from the juvenile, and fingerprints, if not previously completed. Please see Section IV Post Trial Procedures for fingerprinting and DNA processing instructions. Enter a **Y** in the **DNA** field on the H/D Tab. (Mandatory). When adjudicated delinquent of a felony in the JDR court, the juvenile is still treated as a juvenile for subsequent delinquency and traffic matters, however, subsequent charges, if found delinquent or guilty, are open to the public, pursuant to Va. Code § 16.1-305 (B1). If the petition/warrant is dismissed or not guilty, the fingerprints and photographs are to be destroyed within sixty

STEP	DESCRIPTION
	days after final disposition. If the felony is deferred and dismissed, fingerprints are still required.

Reporting to U.S. Immigration and Customs Enforcement (ICE)

Pursuant to Va. Code §16.1-309.1 when a juvenile is detained, adjudicated delinquent of a violent juvenile felony, and there is evidence the juvenile is in the United States illegally, the Clerk of the Court shall report this information to the Bureau of Immigration and Customs Enforcement. The court utilizes the DC-569 ADJUDICATION AND DISPOSITION ORDER – DELINQUENCY to facilitate the reporting of this information. The clerk will fax a copy of the DC-511, PETITION and the DC-569, ADJUDICATION AND DISPOSITION ORDER to ICE.

Time Limitations

Va. Code § 16.1-277.1

There are certain time limitations within which the adjudicatory hearing in a delinquency proceeding must be held.

- Juveniles in secure detention must be released from confinement if no transfer or adjudicatory hearing is held within twenty-one days from the date when he or she is first detained.
- For juveniles not in secure detention or who have been released, an adjudicatory or transfer hearing must be held within 120 days from filing of the petition.

The time limitations above are tolled during any period in which:

- the whereabouts of the child are unknown
- the child has escaped from custody
- the child has failed to appear pursuant to a court order

In addition, the time limits may be extended for a reasonable period for good cause shown if the basis for extension is recorded in writing in the case papers.

Motions and Other Subsequent Pleadings

After the case has been filed in the clerk's office as described in "Case Initiation", above, all motions and other subsequent pleadings shall be filed directly with the clerk. Clerks may provide information, but not advice, to parties on how to prepare forms used as subsequent pleadings. *See* RULES OF SUPREME COURT, Part 6, § 1. Unauthorized Practice Rules and Considerations (Introduction, paragraph B (2)).

Miscellaneous Pre-Trial Proceedings

Some of the additional pre-trial proceedings that may occur in these cases include:

- Motions to suppress illegally seized evidence.
- Sanity at the time of the offense. The Supreme Court of Virginia has held that a juvenile under fourteen years of age did not have either a statutory right or a due process right to assert an insanity defense at the adjudicatory phase of a delinquency proceeding. Commonwealth v. Chatman, 260 Va. 562, (November 3, 2000), rev'g. Chatman v. Commonwealth, 30 Va. App. 593 (1999).
- Testimony of child witness via closed-circuit television. Va. Code §§ 18.2-67.2 through 18.2-67.9. Request to disclose identity of juvenile charged with certain crimes. Va. Code § 16.1-309.1. See "Confidentiality of Records" later in this chapter.
- Use of a certified facility dog to aid a testifying witness. Va.Code § 18.2-67.9:1.
- Request for pre-trial examination and treatment. Va. Code § 16.1-275. See "Trial Procedures" later in this chapter.
- Motions pursuant to Va. Code § 22.1-254 to require juveniles charged with certain offenses to attend a statutorily authorized alternative educational program.
- Certificates of analysis for drug related cases. *See* "Adult Criminal Procedures-Certificate of Analysis".
- Notice of, Motion and Order for Chemical Analysis of Alleged Plant Material. See "Adult Criminal Procedures-Notice, Motion and Order for Chemical Analysis of Alleged Plant Material".

These actions are part of the pending case and do not get indexed as subsequent actions.

Trial Procedures

Adjudicatory Hearing

For cases heard in court, the clerk's office must perform several functions to assure that cases are processed efficiently. The clerk's office is responsible for assuring that:

- All parties and witnesses involved have been notified of the hearing through the juvenile district court form DC-510, SUMMONS. If a new trial date is set, use district court form DC-329, RECOGNIZANCE (WITNESS), district court form DC-346, NOTICE OF NEW TRIAL DATE or DC-512, NOTICE OF HEARING, as appropriate.
- All other case-related paperwork is complete and accounted and attached to the case including:
    - The original petition and summons or warrant.

- District court form DC-325, REQUEST FOR WITNESS SUBPOENA, and subsequent district court form DC-326, SUBPOENA FOR WITNESS.
- Personal recognizance, bond, or other bail conditions.
- Other pleadings and evidence filed with the court.
- The docket sheet is printed by JCMS; the cases pending are prepared for court.
- Witnesses and other parties are notified of continuances or pre-trial resolution of a case.
- Other court actions are recorded in JCMS and on the case papers:
- Guilty plea to a reduced charge.
- Continuances, including deferred adjudication. Va. Code §§ 16.1-278.8(5) or 16.1-278.9 (*See* "Disposition Hearing" below).

At the commencement of the adjudicatory hearing, the court shall determine whether or not the juvenile is represented by a lawyer (privately retained or court appointed) or has waived counsel. If this matter has not been previously handled in a hearing prior to the adjudicatory hearing, it must be done at the beginning of the adjudicatory hearing.

The juvenile may request a waiver of her/his right to a public hearing. Any hearing in a proceeding where a juvenile fourteen years or older is charged with an offense which would be a felony if committed by an adult shall be open, unless the court closes the hearing for good cause. Va. Code § 16.1-302 (C). If the judge decides to close such a hearing, he must state in writing his reasons for closing the hearing. District court form DC-501, ORDER TO CLOSE HEARING should be used to record this decision.

Once these matters have been completed, the court should commence the proceeding. District court form DC-569, ORDER can be used to memorialize the courts findings and order.

If the child is adjudicated delinquent, the court may order an investigation and the submission of a pre-disposition report using district court form DC-542, ORDER FOR INVESTIGATION AND REPORT. Va. Code § 16.1-273. The investigation shall include a drug screening and may include a social history of the child's physical, mental and social condition, including an assessment of any affiliation with a youth gang, the child's personality and the facts and circumstances surrounding the violation of the law.

A drug screening is required in the case of any juvenile adjudicated delinquent on the basis of an act committed on or after January 1, 2000:

- that would be a felony if committed by an adult, or

- that would be a Class 1 or Class 2 misdemeanor drug offense under Article 1 or Article 1.1 of Chapter 7 of Title 18.2 (§§ 18.2-247 through 265.5) if committed by an adult.

If the drug screening indicates that the juvenile has a substance abuse or dependence problem, a substance abuse counselor employed by the Department of Juvenile Justice or by the locally operated court services unit shall then complete an assessment.

The court shall, on motion of the Commonwealth's attorney and with the consent of the victim, or may, in its discretion, order a victim impact statement if the court determines that the victim may have suffered significant physical, psychological or economic injury as a result of the violation of law. *See* Va. Code § 19.2-299.1 for details regarding a victim impact statement.

If the judge found sufficient facts to find the juvenile guilty of certain offenses listed in Va. Code § 16.1-278.9 at clauses (i), (ii), (v), (vi) and (vii)(such as DUI, possession of alcoholic beverages, or unlawful use or possession of a handgun or other described weapons), the judge must defer adjudication and treat the juvenile pursuant to Va. Code § 16.1-278.9, including denial of driving privileges with limited restricted driving privileges using district court form DC-576, DRIVER'S LICENSE DENIAL ORDER (JUVENILE)/DRIVER'S LICENSE SUSPENSION ORDER (UNDERAGE ALCOHOL VIOLATIONS). There is no initial conviction. If the offense involves a DWI and the child was transporting a person seventeen years of age or younger, the court shall impose the additional fine and order community service as provided in Va. Code § 18.2-270.

A violation of driving after illegally consuming alcohol is a Class 1 misdemeanor. Punishment shall include forfeit of license for a period of one year (if the offense was committed before July 1, 2010 or on or after July 1, 2011) or six months (if the offense occurred between July 1, 2010 and June 30, 2011) from the date of conviction and a mandatory minimum fine of $500 or performance of a mandatory minimum of 50 hours of community service. Va. Code § 18.2-266.1. The juvenile shall be eligible for a restricted license and participation in a VASAP Program. The license forfeiture and any restricted license issued under Va. Code § 18.2-266.1 should be entered on district court form DC-260, DRIVER'S LICENSE FORFEITURE/SUSPENSION AND RESTRICTED DRIVING ORDER.

A juvenile may be detained following adjudication, even if he or she was not previously detained, if the criteria set forth in subsection A of Va. Code § 16.1-248.1 are met. *See* criteria above in "Case Initiation, Processing of a Child Taken into Immediate Custody".

Transfer of Venue-Except in custody, visitation and support cases, if the child resides in a city or county of the Commonwealth and the proceeding is commenced in a court of another city or county, that court may at any time, on its own motion or a motion of a party for good cause shown, transfer the proceeding to the city or county of the child's residence for such further action or proceedings as the court receiving the transfer may

deem proper. However, such transfer may occur in delinquency proceedings only after adjudication, which shall include, for the purposes of this section, a finding of facts sufficient to justify a finding of delinquency. Va. Code § 16.1-243.

Disposition Hearing

A disposition hearing is held separate from and after the adjudicatory hearing in many juvenile cases to allow time for the preparation of reports ordered by the court. See discussion of the reports that may or must be ordered by the court above.

If a child has been adjudicated as being in need of supervision, an evaluation must be conducted by the appropriate public agency using an interdisciplinary team approach, and a report of such evaluation is to be filed with the court. The report is prepared by the court services unit or other entity ordered by the court, is filed with the clerk's office, and is furnished to counsel for the parties involved at least seventy-two hours prior to the hearing.

In some instances, the entity providing the services must calculate a fee for the services based on costs incurred and the child's parents' ability to pay for services. The judge must assess the fees, but is also empowered to waive all or part of the payment of the fees pursuant to Va. Code § 16.1-274 by using district court form DC-533, ASSESSMENT/PAYMENT ORDER. If a guardian *ad litem* has been appointed, the judge must determine if the parents are capable of paying the fee of the guardian *ad litem*. The judge's decision should be noted on district court form DC-533, ASSESSMENT/PAYMENT ORDER. Also, if court-appointed counsel represented the juvenile, the judge should determine if the parents were financially able to retain a lawyer and refused to do so. If so, then the parents should be ordered to pay by using district court form DC-533, ASSESSMENT/ PAYMENT ORDER and if the amounts are unpaid, a separate case should be created for the parents using certified copies of district court form DC-533, ASSESSMENT/PAYMENT ORDER as the initiating case papers.

In addition to those detailed under the discussion of the adjudicatory hearing, two types of examinations pursuant to Va. Code § 16.1-275 between adjudication and disposition are available:

- Physical examination and treatment by a physician or mental examination and treatment by a local mental health center, if there is no appropriate local center, then examination and treatment by a physician or psychiatrist or examination by a clinical psychologist. Upon written recommendation by the person examining the juvenile that adequate evaluation of the juvenile's treatment needs can only be performed in an inpatient hospital setting, the court may order the juvenile

transferred to a state mental hospital for up to ten days for a recommendation for treatment.

- Placement in the custody of the Department of Juvenile Justice for up to thirty days for diagnostic assessment services if the juvenile would be eligible for commitment pursuant to subdivision A 14 of Va. Code § 16.1-278.8 or Va. Code § 16.1-285.1.
- If a juvenile is held in secure detention after completion of an adjudicatory hearing or transfer hearing, then the juvenile must be released if the disposition hearing is not completed within thirty days from the adjudicatory or transfer hearing.
- The time limitations above are tolled during any period in which:
    - the whereabouts of the child are unknown
    - the child has escaped from custody
    - the child has failed to appear pursuant to a court order.

In addition, the time limits may be extended for a reasonable period for good cause shown if the basis for extension is recorded in writing in the case papers.

The dispositional alternatives in delinquency cases, which are available to the court, depend on the charges, the conditions noted in the social history, physical, and mental examinations, and the statutory provisions. Following conviction, the court may make the following dispositions, pursuant to Va. Code §§ 16.1-278.8 and 16.1-278.9 and other various dispositional statutes:

Traffic

- In traffic infractions, impose only those penalties that may be imposed on adults for the same offense. Va. Code § 16.1-278.10. This restriction does not bar the Department of Motor Vehicles from requiring participation in driver improvement programs.
- A violation of a provisional driver's license restriction is a traffic infraction. Va. Code § 46.2-334.01.
- With regard to the restrictions to be imposed upon juvenile drivers, especially those restrictions imposed by DMV, the age of the offender at the date of the violation, not the conviction, determines the applicability of the juvenile restrictions. Va. Code § 46.2-334.01.

- *See* also section on "Juvenile Traffic Procedures".

Provision of Services and Treatment

- Order a government agency to render such services to the juvenile that such agency may be required to provide under the law pursuant to Va. Code § 16.1-278.
- Order a parent, guardian, legal custodian or other person, whether or not they reside with the child, to participate in programs, cooperate in treatment and be subject to conditions ordered by the court.
- Require the juvenile to participate in gang-activity prevention program when a juvenile has been found delinquent of:
    - shooting, stabbing cutting, wounding or by any means causing a person bodily injury with the intent to maim, disfigure, disable or kill. Va. Code § 18.2-51.
    - malicious bodily injury to law enforcement officer. Va. Code § 18.2-51.1.
    - malicious bodily injury by means of any caustic substance or agent or use of any explosive or fire. Va. Code § 18.2-52.
    - shooting, stabbing, cutting or wounding a person during the commission or attempted commission of a felony. Va. Code § 18.2- 53.
    - bodily injury caused by prisoners, probationers or parolees. Va. Code § 18.2-55.
    - hazing causing bodily injury. Va. Code § 18.2-56.
    - assault and battery. Va. Code § 18.2-57.
    - assault and battery against a law enforcement officer. Va. Code § 18.2-57.
    - assault and battery against a family or household member. Va. Code § 18.2-57.2..
    - entering property of another for purpose of damaging it. Va. Code § 18.2-121.
    - injuries to churches, church property, cemeteries, burial grounds, etc. Va. Code § 18.2-127.
    - trespass upon church or school property. Va. Code § 18.2-128.
    - destroying, defacing, damaging or removing with the intent to steal a monument. Va. Code § 18.2-137.
    - damaging public buildings. Va. Code § 18.2-138.
    - breaking, injuring, defacing, destroying or preventing the operation of a vehicle, aircraft or boat. Va. Code § 18.2-146.

  - entering or setting in motion vehicle, aircraft, boat, locomotive or rolling stock of railroad without consent of owner or person in charge. Va. Code § 18.2-147.
  - any violation of a local ordinance adopted pursuant to Va. Code § 15.2-1812.2 (willful and malicious damage or defacement of public facilities).
- Order a first-time drug offender to undergo substance abuse screening, and to submit to periodic drug testing and to undergo an appropriate substance abuse education/treatment program. Va. Code § 16.1-278.8:01.

Probation and Deferred Dispositions

- Allow the juvenile to remain with a suitable person under conditions and limitations that the court deems proper.
- Defer disposition for a specific period of time established by the court with due regard for the gravity of the offense and the juvenile's history, after which time the charge may be dismissed by the judge if the juvenile is of good behavior during the period for which disposition is deferred.
- Defer disposition for a specific period of time established by the court with due regard for the gravity of the offense and the juvenile's history and place the child on probation on terms and conditions set by the court without the entry of an adjudication of guilt and with the consent of the child and his attorney. Upon fulfillment of the terms and conditions of probation, the court shall discharge the child and dismiss the proceedings against him without an adjudication of guilt.
- Place the juvenile on probation with conditions and limitations as determined by the court. The costs may be imposed where disposition is deferred and the juvenile is placed on probation. Costs are imposed only if a charge is brought on a warrant or summons and not a petition.
- Place the juvenile on probation and order treatment for substance or alcohol abuse in a program licensed by the Department of Behavioral Health and Developmental Services for the treatment of juveniles for substance abuse, provided that (i) the juvenile has received a substance abuse screening and assessment pursuant to Va. Code § 16.1-273 and the assessment reasonably indicates that the commission of the offense was motivated by, or closely related to, the habitual use of alcohol or drugs and indicates that the juvenile is in need of treatment for this condition; (ii) the juvenile has not previously been and is not currently being adjudicated for a

violent juvenile felony; and (iii) such a facility is available. Upon the juvenile's withdrawal, removal, or refusal to comply with the conditions of participation in the program, he shall be brought before the court for a hearing at which the court may impose any other disposition authorized by this section. The court shall review such placements at thirty-day intervals.

Driver's License Actions

– For a second or subsequent violation of the provisional driver's license restrictions, the court may suspend the juvenile's privilege to drive for a period not to exceed six months in addition to any other penalty. Va. Code § 46.2-334.01.

– Suspend the juvenile's driver's license with or without issuance of a restricted license, or impose a curfew on the operation of a motor vehicle (except for traffic offenses, see below, or for violations of Va. Code §§ 4.1-305; 18.2-248, 18.2-248.1,18.2-250, , 18.2-266, or 18.2-268.2). If a restricted license is authorized, the juvenile surrenders the driver's license to the court and the court enters district court form DC-577, DRIVER'S LICENSE SUSPENSION ORDER AND ENTRY INTO SERVICES PROGRAM (JUVENILE). A copy of the order with the license is transmitted to the Department of Motor Vehicles (DMV) for re-issuance of the license as a restricted license.

– The court shall order that the juvenile be denied a driver's license as provided pursuant to Va. Code § 16.1-278.9 and issue a district court form DC-576, DRIVER'S LICENSE DENIAL ORDER (JUVENILE)/DRIVER'S LICENSE SUSPENSION ORDER (UNDERAGE ALCOHOL VIOLATIONS) if the court finds facts that would justify a finding that the child is delinquent, and the finding involves:

  - a violation of Va. Code §§ 18.2-248, 18.2-248.1, 18.2-250, , 18.2-266 or a similar local ordinance or of Va. Code § 18.2-388, or
  - refusal to take a blood or breath test in violation of Va. Code § 18.2-268.2, or
  - the unlawful purchase, possession or consumption of alcohol in violation of Va. Code § 4.1-305, unlawful drinking or possession of alcoholic beverages in or on school grounds in violation of Va. Code § 4.1-309, the unlawful use or possession of a handgun or a "streetsweeper" (or a violation of Va. Code § 18.2-83 (making a bomb threat).

  That same statute and order allows the judge to grant a restricted driving permit upon entry into a treatment program except in cases of violation of Va. Code §§ 18.2-248, 18.2-248.1, 18.2-250 or and second or subsequent violations of any of the offenses listed in Va. Code § 16.1-278.9. The

juvenile surrenders his driver's license to the court, which holds such license while the order is in effect. The original of the order is given to the juvenile, and a copy is sent to DMV. This process does not create a suspension of the juvenile's driver's license and is the exclusive remedy for issuance of a restricted driver's license for juveniles for violations involving Va. Code §§ 18.2-266 and 18.2-268.2, because the statute authorizes discharge of the juvenile and dismissal of the case without an adjudication of guilt upon fulfillment of all terms and conditions prescribed by the court (unless the violation involved injury or death), thereby not permitting the use of Va. Code § 18.2-271.1 and district court form DC-265, RESTRICTED DRIVER'S LICENSE AND ENTRY INTO ALCOHOL SAFETY ACTION PROGRAM (which requires a finding of guilt) with juveniles.

If the juvenile is less than sixteen years and three months old, then the juvenile may not apply for a driver's license for a period of six months after he reaches the age of sixteen years and three months.

Fines, Restitution and Community Service

- Impose a fine not to exceed $500.
- Order restitution or participation in a "public service project" as defined in Va. Code § 16.1-278.1. The court must require that the juvenile make at least partial restitution or reparation for any property damage, for loss caused by the offense or for actual medical expenses incurred by the victim as a result of the offense when the court finds the juvenile delinquent of:

  - shooting, stabbing cutting, wounding or by any means causing a person bodily injury with the intent to maim, disfigure, disable or kill. Va. Code § 18.2-51.
  - malicious bodily injury to law enforcement officer. Va. Code § 18.2-51.1.
  - malicious bodily injury by means of any caustic substance or agent or use of any explosive or fire. Va. Code § 18.2-52.
  - shooting, stabbing, cutting or wounding a person during the commission or attempted commission of a felony. Va. Code § 18.2- 53.
  - bodily injury caused by prisoners, probationers or parolees. Va. Code § 18.2-55.
  - hazing causing bodily injury. Va. Code § 18.2-56.
  - assault and battery. Va. Code § 18.2-57.

- assault and battery against a family or household member. Va. Code § 18.2-57.2.
- entering property of another for purpose of damaging it. Va. Code § 18.2-121.
- injuries to churches, church property, cemeteries, burial grounds, etc. Va. Code § 18.2-127.
- trespass upon church or school property. Va. Code § 18.2-128.
- destroying, defacing, damaging or removing with the intent to steal a monument. Va. Code § 18.2-137.
- damaging public buildings. Va. Code § 18.2-138.
- breaking, injuring, defacing, destroying or preventing the operation of a vehicle, aircraft or boat. Va. Code § 18.2-146.
- entering or setting in motion vehicle, aircraft, boat, locomotive or rolling stock of railroad without consent of owner or person in charge. Va. Code § 18.2-147.
- any violation of a local ordinance adopted pursuant to Va. Code § 15.2-1812.2 (willful and malicious damage or defacement of public facilities).

- If the juvenile is required to pay restitution based on being found delinquent for one of these offenses, participation in a community service project must also be ordered.
- Require the juvenile to participate in a public service project (community service). If the juvenile was found delinquent of one of the offenses for which it is required that the juvenile pay restitution. The juvenile must also be required to participate in a community service project.
- Pursuant to § 19.2-305.1, at the time of sentencing, the court shall enter the amount of restitution to be repaid by the juvenile, the date by which all restitution is to be paid, and the terms and conditions of such repayment on a form prescribed by the Office of the Executive Secretary of the Supreme Court of Virginia, namely the Order for Restitution (Juvenile), DC-579. If the attorney for the Commonwealth participated in the prosecution of the juvenile, the attorney for the Commonwealth or his designee shall complete, to the extent possible, all portions of the form excluding the amount of restitution to be repaid by the juvenile and the terms and conditions of such repayment. If the attorney for the Commonwealth did not participate in the prosecution of the juvenile, the court or the clerk shall complete the form. A copy of the form, excluding contact information for the victim, shall be

provided to the juvenile at sentencing. A copy of the form shall be provided to the attorney for the Commonwealth and to the victim, his agent, or his estate upon request and free of charge.

Transfer of Custody

Transfer custody to a proper person (*see* Va. Code § 16.1-278.8 (13)(a)), welfare agency, or local board of public welfare or social services. Transfers to local boards of public welfare or social services require a finding in the order whether reasonable efforts to prevent removal were made and that continued home placement would be contrary to the child's welfare. The local board shall accept the care and custody of the child if it has been given reasonable notice of the pendency of the case and an opportunity to be heard. In an emergency, the local department of public welfare may be required to accept a child for a period not to exceed 14 days without prior notice or an opportunity to be heard if the judge entering the order describes in the order the emergency and the need for such temporary placement. If the child cannot be dealt with in the child's locality or with the locality's resource, the court may take custody, make other placements, and may enter and enforce a payment order for such placement against the parents or other persons who are legally obligated to provide support and are financially able to contribute support. Va. Code § 16.1-286.

Commitment and Incarceration

- Commit the juvenile to an appropriate state institution if the mental competency examination indicates that a juvenile is mentally ill or intellectually disabled.
- Only a juvenile who is *(i)* adjudicated ~~as a~~ delinquent *of an act enumerated in subsection B or C of §* ***16.1-269.1*** and is 11 years of age or older *or (ii) 14 years of age or older* may be committed to the Department of Juvenile Justice.
- Place the juvenile in a secure local facility, pursuant to Va. Code § 16.1-284.1:
- Confinement only for up to thirty days inclusive of time served in a detention home or other secure facility if the juvenile:
  - is at least fourteen years old, and
  - has committed an offense for which an adult could be punished by incarceration in jail or the penitentiary, and

The court determines that:

- the juvenile has not been found guilty previously and is not now found guilty of a violent juvenile felony
- the juvenile has not been released from the Department of Juvenile Justice within the previous eighteen months, and
- the interests of the child and the community require that the child be placed under legal restraint or discipline, and
- other placements will not serve the best interest of the child.

Confinement in a Detention Home or Other Secure Facility

for up to six months.

If the period of confinement is to exceed thirty calendar days, and the juvenile is eligible for commitment pursuant to subdivision A 14 of Va. Code § 16.1-278.8, the court shall order the juvenile committed to the Department of Juvenile Justice but suspend the commitment. As a condition of the suspension, the court shall specify conditions for the completion of one or more community-based or facility-based treatment programs.

for up to twelve months.

If the single offense or multiple offenses, which if committed by an adult would be punishable as a felony or a Class 1 misdemeanor, caused the death of any person, then the court may order the juvenile confined in a detention home or other secure facility for juveniles for a period not to exceed 12 months from the date the order is entered.

A review hearing must be held at least once during each thirty-day period of confinement. The appearance of the juvenile before the court for a hearing may be by (i) personal appearance before the judge or (ii) use of two-way electronic video and audio communication. If two-way electronic video and audio communication is used, a judge may exercise all powers conferred by law and all communications and proceedings shall be conducted in the same manner as if the appearance were in person, and any documents filed may be transmitted by facsimile process. A facsimile may be served or executed by the officer or person to who sent, and returned in the same manner, and with the same force, effect, authority, and liability as an original document. All signatures thereon shall be treated as original signatures. Any two-way electronic video and audio communication system used for an appearance shall meet the standards as set forth in subsection B of § 19.2-3.1.If it appears at this hearing that the purpose of a confinement has been achieved, the juvenile shall be released on probation but be subject to the order suspending commitment to the

Department. If the juvenile is consistently failing to comply with the conditions set by the court or the facility, the court shall order that the juvenile be committed to the Department.

Commitment to the Department of Juvenile Justice for a determinate period of time stated in the order, pursuant to Va. Code § 16.1-285.1, if the juvenile is **at least fourteen years old**, and the juvenile has been **found guilty of an offense which would be a felony if committed by an adult**, and one of the following applies:

- the juvenile is on parole for an offense which would be a felony if committed by an adult, or
- within the last twelve months the juvenile was committed to the state by court order in a previous delinquency proceeding arising from commission of an offense that would be a felony if committed by an adult, or
- where the felony offense would be punishable by confinement for more than twenty years if committed by an adult or
- the juvenile was previously adjudicated delinquent for a felony punishable for more than twenty years or more if committed by an adult, and
- the court finds that commitment under this section is necessary to meet the rehabilitative needs of the juvenile and would serve the best interests of the community, and
- the judge determines that the interests of the juvenile and community require placing the juvenile under legal restraint and discipline and that the juvenile is not amenable to treatment or rehabilitation through other programs or facilities. In making this determination, the judge shall consider the juvenile's age, the present offense(s), the juvenile's history, and the Department's estimated length of stay. Va. Code § 16.1-285.1 (B)

The court shall specify a determinate period of commitment, not to exceed seven years or the juvenile's twenty-first birthday, whichever comes first. The court may also order a period of determinate or indeterminate parole supervision. The total period of commitment and probation cannot exceed seven years or the juvenile's twenty-first birthday, whichever comes first. The Department may petition for an earlier release for good cause. The commitment shall be reviewed, pursuant to petition by the Department, on the second anniversary of the commitment and annually thereafter. Va. Code § 16.1-285.1 (F).

Impose penalties applicable to adults not to exceed twelve months in jail if the juvenile is over eighteen at time of sentencing but was a juvenile at the time that the offense(s) was committed and the offense(s) would be a crime if committed by an adult.

Contempt Penalties

Take enforcement action permitted by Va. Code § 16.1-292 for violation of court orders, including punishing summarily for contempt with confinement of juveniles in a juvenile secure facility (or, if the juvenile is eighteen years of age or older when the order of disposition is entered, in jail) for up to ten consecutive days. In contempt cases where the underlying order involved a child in need of services or a child in need of supervision, confinement of juveniles shall not exceed seven days.

NOTE: Some of the dispositions provided above can or should be ordered in conjunction with other dispositions in the list.

Appeals

Any final order or conviction of the juvenile and domestic relations district court affecting the rights or interests of any person coming within its jurisdiction or any order entered under Va. Code § 16.1-292 (E) may be appealed to the circuit court within ten days of entry of the conviction. Va. Code § 16.1-296.

No costs, taxes or fees are to be assessed on appeals in delinquency cases because Va. Code § 16.1-296 only permits such assessments if a trial fee could have been assessed in the juvenile and domestic relations district court and no trial fees in delinquency cases are statutorily provided.

When a case is transferred to another jurisdiction for disposition and an appeal is noted, the appeal is noted in the court which disposed of the case. The case is then sent back to the circuit court where the case was initiated.

For step-by-step procedures for the appeal process, *see* the "Appeals" appendix.

Post-Trial Actions When a Juvenile Committed to the Department of Juvenile Justice

Va. Code §§ 16.1-293, 16.1-290

When a court commits a juvenile to the Department of Juvenile Justice, the court services unit shall maintain contact with the juvenile. Juveniles paroled after having been committed to the Department are returned to the custody of the local court service unit. Placement in foster care paid by the Department of Juvenile Justice while on parole can

only be ordered by the court after an investigation and a finding that the child should not be returned home and that local funds for foster care are not available.

In the event that the person was in the custody of the local department of social services immediately prior to his commitment to the Department and has not attained the age of eighteen years, the local department of social services shall resume custody upon the person's release from commitment, unless an alternative arrangement for the custody of the person has been made and communicated in writing to the Department. The court services unit shall consult with the local department of social services four weeks prior to the person's release from commitment on parole supervision concerning return of the person to the locality and the placement of the person. The court services unit will be responsible for supervising the person's terms and conditions of parole.

When a person is ordered to participate in therapy, counseling or similar continuing programs, a motion may be filed with the court to reconsider the order or the terms or conditions of participation at any time after entry of the order. The motion must be heard within thirty days, and the order disposing of the motion shall be deemed to be a final order for appeal purposes.

Whenever a juvenile is placed in temporary custody of the Department pursuant to Va. Code § 16.1-278.8 (A)(4a) or committed to the Department pursuant to Va. Code § 16.1-278.8 (A)(14) or (17), the Department shall apply for child support with the Department of Social Services. The parents shall be responsible for child support from the date the Department receives the juvenile. If the parent fails or refuses to pay the support, the court may proceed against them for contempt.

Post-Trial Procedures

As juvenile cases are completed in juvenile and domestic relations district court, there are several post-trial procedures that must be completed to assure that cases are properly recorded and disposed of. Thus, the clerk's office will:

- Ensure that the disposition is recorded in the JCMS system and filed with the case papers.
- Collect fines and court costs ordered by the court, if any.
- Scan and assign all court documents to the case in the court's records management system.
- Send district court form DC-533, ASSESSMENT/PAYMENT ORDER if parents are ordered to pay for court-appointed attorney or investigative services.
- Prepare the court order (if a separate order is used) as per the court's instructions and attach to appropriate case(s). Do not batch different children's names on the order.

- Prepare the district court form DC-572, JUVENILE COMMITMENT ORDER if the juvenile is to be committed to the Department of Juvenile Justice or a local facility.
- Prepare CCRE report and order for withdrawal of DNA sample for analysis where applicable. A juvenile convicted of a felony or adjudicated delinquent on the basis of an act which would be a felony if committed by an adult shall have his blood, saliva or tissue taken for DNA analysis provided the juvenile was 14 years of age or older at the time of the commission of the offense. Send copies of the juvenile's fingerprints and a report of the disposition to Central Criminal Records Exchange if the juvenile is adjudicated delinquent or found guilty of an offense that would be a felony if committed by an adult or any other offense for which a report to the CCRE is required.

  NOTE: An order to collect DNA should not be entered upon the conviction or deferral of juvenile misdemeanor cases.

- Prepare district court form DC-573, ORDER FOR CUSTODY/PARENTING TIME/VISITATION ORDER GRANTED TO INDIVIDUAL(S) if the custody of the child was in dispute.
- Prepare district court form DC-628, ORDER FOR SUPPORT (CIVIL) if the court orders the parents to pay for child support during court-ordered commitment.
- Prepare bond forfeiture for those bonded defendants who failed to appear in court.
- Refund appearance bonds to those bonded defendants who appeared in court.
- Prepare district court form DC-352, COMMITMENT ORDER where applicable, and forward to jail.
- Complete district court form DC-538, PLACEMENT ORDER for juveniles placed in shelter care or a detention facility pending transfer or as ordered by the court.
- Prepare district court form DC-539, RELEASE ORDER for juveniles to be released from shelter care or a detention facility as ordered by the court.
- Send appealed case files to circuit court.

If no appeal is noted, the clerk shall provide written notice of a conviction for those offenses specified in Va. Code § 16.1-305.1 to the superintendent of the school division in which the juvenile was enrolled within fifteen days of the expiration of the appeal period. For dispositions other than conviction, deferred disposition, nolle prosequi, withdrawal, or dismissal, the court shall provide written notice to the superintendent of the school division in which the juvenile was enrolled within fifteen days of such action.

Bond Forfeitures

See Chapter "Miscellaneous-Bond Forfeiture"

The same procedure used to forfeit bonds in adult criminal cases (Va. Code § 19.2-143) is also used in forfeiting bonds in juvenile cases.

Payment of Counsel

If an attorney is appointed to represent a juvenile at a detention hearing, however, is not appointed to represent the juvenile for the preliminary, transfer or adjudication hearing, he may be paid for representing the juvenile at the detention hearing, an amount not to exceed $120.00. The district court form DC-40, List of Allowances should indicate that the appointment was pursuant to Va. Code § 16.1-266 (B).

Likewise, if an attorney is appointed to on a juvenile felony charge and the juvenile chooses to waive counsel, the attorney may be paid for representing the juvenile at the detention/advisement hearing, an amount not to exceed $120.00. The district court form DC-40, LIST OF ALLOWANCES should indicate that the appointment was pursuant to Va. Code § 16.1-266 (C)(3).

The DC-40, LIST OF ALLOWANCES should be filed with the court for payment of services regarding representation of a juvenile for the preliminary, transfer or adjudication hearing in the JDR Court. The maximum allowed is $120.00 per charge. The Judge may enter district court form DC-533, ASSESSMENT/PAYMENT ORDER requiring the parents pay attorney fees.

Violations of Court Orders

In addition to or instead of revoking a suspended sentence upon violation of the terms of the dispositional order, the court may proceed by a show cause proceeding, by contempt, or by both. Va. Code § 16.1-292. For purposes of contempt proceedings, a juvenile and an adult are treated the same except that a juvenile can only be sentenced for contempt to a secure juvenile facility, not a jail, except in certain situations, for up to ten days per offense and may be sentenced otherwise for no more than he could have been sentenced originally for the delinquent offense. Special provisions apply to the dispositional alternatives when the underlying order involves a child in need of services or a child in need of supervision.

CCRE/Fingerprinting

Virginia Code § 16.1-299. All duly constituted police authorities having the power of arrest shall take fingerprints and photographs of any juvenile who is taken into custody and charged with a delinquent act at arrest for which, if committed by an adult, is required to be reported to the Central Criminal Records Exchange (CCRE), pursuant to subsection A of Va. Code § 19.2-390.

Preparation of fingerprint cards and CCRE's is the responsibility of the chief law enforcement officer or designee, who may be the arresting officer. It is the court's responsibility to inform the chief law enforcement officer, upon conviction of applicable charges, that fingerprinting and photographs are required.

Case dispositions for juveniles will electronically transmit to CCRE upon final disposition, meaning case closed in JCMS. The program will automatically transmit cases that are reportable using the case type, code section and/or final disposition as the determining factors.

Juvenile delinquency dispositions should be reported to the CCRE in the following instances:

- Adjudications of delinquency on all felonies (**regardless of the age**), treason, Title 54.1 violations punishable as a misdemeanor, and any misdemeanors punishable by confinement in jail under Title 18.2, Title 19.2 or similar local ordinances. Exception is: family desertion or nonsupport Va. Code § 20-61.
- Charges, **regardless of disposition,** which are defined as violent juvenile felonies for **minors 14 and older** in subsection B and C of Va. Code § 16.1-269 1 and ancillary charges are reported to CCRE. Violent juvenile felonies are:

§ 18.2-31	Capital murder defined; punishment.
§ 18.2-32	First and second-degree murder defined; punishment.
§ 18.2-33	Felony homicide defined; punishment.
§ 18.2-40	Lynching deemed murder.
§ 18.2-41	Shooting, stabbing, etc., with intent to maim, kill, etc., by mob.
§ 18.2-48	Abduction with intent to extort money or for immoral purpose.
§ 18.2-51.1	Malicious bodily injury to law-enforcement officers, firefighters, search and rescue personnel
§ 18.2-51	Shooting, stabbing, etc., with intent to maim, kill, etc.
§ 18.2-51.2	Aggravated malicious wounding; penalty.
§ 18.2-54.1	Attempts to poison.
§ 18.2-54.2	Adulteration of food, drink, drugs, cosmetics, etc.; penalty.
§ 18.2-58.1	Carjacking; penalty.
§ 18.2-58	Robbery by strangulation.
§ 18.2-61	Rape.
§ 18.2-67.1	Forcible sodomy.
§ 18.2-67.2	Object sexual penetration; penalty.

"Ancillary crime" or "ancillary charge" means any delinquent act committed by a juvenile as a part of the same act or transaction as, or which

constitutes a part of a scheme or plan with, a delinquent act that would be a felony if committed by an adult.

- Felonies in which deferred disposition is ordered and the charges are later dismissed.

  With the Juvenile State Police Interface, explained in more detail in the JCMS User's Guide, the court does not have to mail the CCRE form on cases that successfully transmit to state police, however, the fingerprint card will be received by the clerk's office and must be mailed to the state police if the charge is reportable to CCRE. The fingerprint card is mailed upon final disposition and should only list the charges that are required to be reported.

- Forms

CC-1390	ORDER FOR DNA OR HIV TESTING AND/OR FOR PREPARATION OF REPORTS TO CCRE
SP 180	MANUAL FINGERPRINT FORM
SP 222	AUTOMATED FINGERPRINT FORM
DC-360	SHOW CAUSE SUMMONS
DC-511	PETITION

- References

  DMV/State Pre-Payable Table

Clerk's Procedure for CCRE Received Without Documents

The following procedures are recommended when the fingerprint form is received without charging documents.

- All copies of the fingerprints, and all photographs shall be destroyed by the clerk sixty days after fingerprints were taken if a petition or warrant is not filed against the juvenile pursuant to Va. Code § 19.2-390. The court should enter an order directing the law enforcement agency to destroy their fingerprint card and photographs related to the charge. The clerk destroys the fingerprint card received by the court.
- To prevent destruction of any fingerprint forms and/or photographs that may have been sent in error to the court, the clerk may choose to return the form and/or photographs to the issuing agency for corrected distribution

Clerk's Procedure for CCRE Received at the Time of Charging Documents

The following procedures are recommended when the fingerprint form is received at the time of the charging documents.

STEP	DESCRIPTION
1	If fingerprint form is attached to the charging document, enter fingerprint form number in JCMS in **DOCUMENT NUMBER** field upon data entry of charge.
2	Upon adjudication, for a juvenile whose case is being transferred to another court for disposition, the clerk enters the appropriate disposition code, and forwards the fingerprint form with the case papers. Clerk enters **TR** for transfers to another court or **TA** for cases where the juvenile is fourteen years or older charged with an offense that if charged as an adult would be considered a felony and is transferred to Circuit Court.
3	If reportable, after fifteen days, the dispositional information will electronically be sent to state police. (*CASES WITH FINAL DISPOSITION OF TR, FF, TA OR AN EXISTING APPEAL DATE WILL NOT TRANSMIT TO CCRE.*) The fingerprint card must be mailed to CCRE. Upon a finding of not guilty or in a case resulting in a disposition for a charge in which fingerprints are not required, the clerk completes the disposition code, and court will destroy all court copies of the fingerprint form within six months of disposition of case pursuant to Va. Code § 19.2-390. The court should enter an order directing the law enforcement agency to destroy their fingerprint card and photographs related to the charge. The clerk destroys the fingerprint card received by the court. For finalized cases transferred as part of disposition to another court, clerk shall forward fingerprint card as part of the case papers. The court receiving the transferred file shall forward the fingerprint card to CCRE, at the electronic disposition will transmit to CCRE from their court.
4	For a juvenile case that has a "fugitive" status, the clerk enters a FF disposition code, and retains the fingerprint form with the case papers.

Clerk's Procedure for CCRE not Received with Documents

The following procedures are recommended when the fingerprint form is not received at the time of the charging documents.

NOTE: In cases where the **DOCUMENT NUMBER** is required for case entry, the clerk may check the **DOCUMENT NUMBER** Unknown checkbox and enter the **AGENCY NUMBER** until the fingerprint form is received.

STEP	DESCRIPTION
1	Upon adjudication of the charge, the clerk may issue the CC-1390, ORDER FOR DNA OR HIV TESTING AND/OR FOR PREPARATION OF REPORTS TO CCRE to facilitate fingerprinting and photographing of juveniles.
2	Upon receipt of the CC-1390, ORDER FOR DNA OR HIV TESTING AND/OR FOR PREPARATION OF REPORTS TO CCRE showing compliance with court order, the clerk may file form with case papers. Upon notice of noncompliance with court order, the clerk shall notify the judge for the required action requested upon the Court's motion. Clerk may issue DC-360, SHOW CAUSE SUMMONS or Court Service Unit may file DC-511, PETITION for failure to comply with or violation of court order based on Judges decision at notification of noncompliance.
3	Upon adjudication, for a juvenile whose case is being transferred to another court for disposition, the clerk enters the appropriate disposition code, and forwards the fingerprint form with the case papers. Clerk enters **TR** for transfers to another court or **TA** for cases where the juvenile is fourteen years or older charged with an offense that if charged as an adult would be considered a felony and is transferred to Circuit Court. For finalized cases transferred as part of disposition to another court, clerk shall complete and forward fingerprint form as part of the case papers. The court receiving the transferred file shall forward the fingerprint form to CCRE, as the electronic disposition will transmit to CCRE from their court.
4	If reportable, after fifteen days, the dispositional information will electronically be sent to state police. (*CASES WITH FINAL DISPOSITION OF TR, FF, TA OR AN EXISTING APPEAL DATE WILL*

STEP	DESCRIPTION
	NOT TRANSMIT TO CCRE.) The fingerprint card must be mailed to CCRE, if reportable. Retain SP 180 in case file. Upon a finding of not guilty or in any case resulting in a disposition for a charge for which fingerprints are not required, the clerk completes the disposition code and the court will destroy all court copies of the fingerprint form within six months of disposition of case pursuant to Va. Code § 19.2-390. The court should enter an order directing the law enforcement agency to destroy their fingerprint card and photographs related to the charge. The Clerk destroys the fingerprint card received by the court.
5	For a juvenile case that has a "fugitive" status, the clerk enters **FF** as the disposition code, and retains the fingerprint form with the case papers.
6	If fingerprint form is received in less than twenty days after disposition, the clerk shall enter the **DOC#** in JCMS, and the information will transmit electronically. If the fingerprint form is received after twenty days from disposition, the clerk shall enter the **DOC#** and forward the fingerprint form manually to the CCRE.

CCRE Report Review Procedures

Each Friday, the Supreme Court of Virginia complies and extracts eligible records and electronically processes them for the Interface. Reports are generated and placed in the courts print file. See the JCMS User's Guide, Virginia Department of State Police Interface for more information regarding the State Police Report.

References

§ 16.1-299	Fingerprints and photographs of juveniles
§ 18.2-119	Trespass
§ 18.2-415	Disorderly conduct
§ 18.2-390	Reports to be made by local law-enforcement officers
§ 19.2-391	When authorized to take prints
§ 19.2-392.01	Certain misdemeanor cases
§ 20-61	Family desertion and nonsupport

Petition for Payment Agreement For Fines and Costs or Request to Modify Existing Agreement

The court shall offer any defendant who is unable to pay in full the fines and costs within 180 days of sentencing the opportunity to enter into a deferred, modified deferred or installment payment agreement.

The court shall not deny a defendant the opportunity to enter into a payment agreement solely (i) because of the category of offense for which the defendant was convicted or found not innocent, (ii) because of the total amount of all fines and costs, (iii) because the defendant previously defaulted under the terms of a payment agreement, (iv) because the fines and costs have been referred for collections pursuant to § 19.2-349, (v) because the defendant has not established a payment history or (vi) because the defendant is eligible for a restricted driver's license under subsection E of § 46.2-395.

In determining the length of time to pay under a deferred, modified deferred, or installment payment agreement and the amount of the payments, a court shall take into account the defendant's financial resources and obligations, including any fines and costs owed by the defendant in other courts. In assessing the defendant's ability to pay, the court shall use a written financial statement, DC-211, PETITION FOR PAYMENT AGREEMENT FOR FINES AND COSTS OR REQUEST TO MODIFY EXISTING AGREEMENT, setting forth the defendant's financial resources and obligations or conduct an oral examination of the defendant to determine his financial resources and obligations. The length of a payment agreement and the amount of the payments shall be reasonable in light of the defendant's financial resources and obligations and shall not be based solely on the amount of fines and costs. The court may offer a payment agreement combining an initial period during which no payment of fines and costs is required followed by a period of installment payments.

A court may not require a down payment as a condition of a defendant entering a deferred, modified deferred, or installment payment agreement.

All fines and costs that a defendant owes for all cases in any single court may be incorporated into one payment agreement, unless otherwise ordered by the court in specific cases. A payment agreement shall include only those outstanding fines and costs for which the limitations period set forth in § 19.2-341 has not run.

At any time during the duration of a payment agreement, the defendant may request a modification of the agreement in writing on a form provided by the Executive Secretary of the Supreme Court, and the court may grant such modification based on a good faith showing of need.

A court shall consider a request by a defendant who has defaulted on a payment agreement to enter into a subsequent payment agreement. In determining whether to approve the request for a subsequent payment agreement, the court shall consider any change in the defendant's circumstances. A court shall not require a down payment to enter into a subsequent payment agreement.

The filing of a DC-211, PETITION FOR PAYMENT AGREEMENT FOR FINES AND COSTS OR REQUEST TO MODIFY EXISTING AGREEMENT does not require a hearing by statute. The court should not index the motion. If local policy requires a hearing for initial or additional time-to-pay, the following apply:

- If the case is still pending, enter a hearing with the hearing type of 'MO- Motion'.
- If the case is finalized, use an **AH** hearing type.

Constitutionality of Statutes

Va. Code § 16.1-131.1

In any criminal or traffic case in a court not of record, if the court rules that a statute or local ordinance is unconstitutional, it shall upon motion of the Commonwealth, stay the proceedings and issue a written statement of its findings of law and relevant facts, if any, in support of its ruling, and shall transmit the case, together with all papers, documents and evidence connected therewith, to the circuit court for a determination of constitutionality. If the Circuit court rules that the statute or local ordinance is constitutional; it shall remand the case to the court not of record for trial.

The Clerk should update the case using **F** as hearing result and **TR** as final disposition. In remarks it is suggested to put "appealed pursuant to Va. Code § 16.1-131.1. DO NOT PLACE A DATE IN THE **APPEAL DATE** FIELD. Keep a copy of the original summons or warrant. Immediately transfer original to Circuit court along with DC-322, ORDER - TRANSFER OF JURISDICTION.

Registration on the Sex Offender and Crimes against Minors Registry

Va. Code § 9.01-902

Juveniles adjudicated delinquent shall not be required to register; however, where the offender is a juvenile over the age of 13 at the time of the offense who is tried as a juvenile and is adjudicated delinquent on or after July 1, 2005, of any offense for which registration is required, the court may, in its discretion and upon motion of the attorney for the Commonwealth, find that the circumstances of the offense require offender registration. In making its determination, the court shall consider all of the following factors that are relevant to the case: (i) the degree to which the delinquent act was

committed with the use of force, threat or intimidation, (ii) the age and maturity of the complaining witness, (iii) the age and maturity of the offender, (iv) the difference in the ages of the complaining witness and the offender, (v) the nature of the relationship between the complaining witness and the offender, (vi) the offender's prior criminal history, and (vii) any other aggravating or mitigating factors relevant to the case. The attorney for the Commonwealth may file such a motion at any time during which the offender is within the jurisdiction of the court for the offense that is the basis for such motion. Prior to any hearing on such motion, the court shall appoint a qualified and competent attorney-at-law to represent the offender unless an attorney has been retained and appears on behalf of the offender or counsel has already been appointed.

Miscellaneous Procedures

Possession of Marijuana

The Juvenile and Domestic Relations District Court has the authority to punish juveniles who possess marijuana pursuant to Va. Code § 4.1-1105.1 with a civil penalty up to $25.00 penalty, however, the court may also enter a disposition pursuant to Va. Code § 16.1-278.9.

The following procedures are recommended in processing a juvenile simple possession of marijuana case in the Juvenile and Domestic Relations District Court.

STEP	DESCRIPTION
1	The Clerk's office receives a summons. Summons should be stamped with date received.
2	Enter the summons as new case number in the delinquency division of the JCMS and schedule adjudication hearing. Index in JCMS with the following codes: Case Type: **CI** – Civil Violation Hearing Type: **AJ** – adjudication
3	At the adjudicatory If the juvenile is found not guilty, finalize the case in JCMS. Case finalized as **NG** – not guilty. - If the juvenile is found guilty without further disposition, finalize the case in JCMS. Case finalized as **G** – guilty.
4	If the Court finds defers the matter, continue for a period of time to be set by the Court.

STEP	DESCRIPTION
	The clerk should place a **DD** in the hearing result field and a **DS** in the new hearing type with the deferred disposition date. If the court so orders, the clerk shall complete the district court form DC-576, DRIVER'S LICENSE DENIAL ORDER (JUVENILE)/DRIVER'S SUSPENSION ORDER (UNDERAGE ALCOHOL VIOLATIONS) **for the OL suspension. If the clerk's office enters the suspension time into** JCMS, place an **M** in the DMV field to indicate manual transmission of the suspension to DMV. A copy of the district court form DC-576 is sent to DMV. Juvenile may be required to undergo a substance abuse assessment pursuant to Va. Code § 18.2-251.01 or Va. Code § 19.2-299.2 as appropriate, and enter a treatment and/or education program, if available, such as in the opinion of the court, may be best suited to the needs of the accused based upon consideration of the substance abuse assessment as well as license suspension. (District JCMS Forms 200 Series - Restricted Driver's License Form)
5	The Court shall review the case on the deferred disposition review date. If there have been no further charges, the case shall be dismissed. If there have been further charges, the case is reset on the docket, and the juvenile is subpoenaed back to court. If the matter is reset, please refer to the steps above for final disposition, but the OL suspension is not ordered again.

Diversion –Underage Possession of Alcohol

Virginia Code § 16.1-260 provides that when a violation of §4.1-305 is charged by summons, the juvenile shall be entitled to have the charge referred to intake for consideration of informal proceedings pursuant to subsection B, provided such right is exercised by written notification to the clerk not later than 10 days prior to trial. At the time such summons alleging a violation of §4.1-305 is served, the officer shall also serve upon the juvenile written notice of the right to have the charge referred to intake on district court form DC-524, NOTICE OF RIGHT TO CONSIDERATION OF DIVERSION make return of such service to the court. If the officer fails to make such service or return, the court shall dismiss the summons without prejudice.

References

§4.1-305	Underage possession of alcohol
§ 16.1-260	Diversion provisions
§ 16.1-277.1	Time limitation

§ 16.1-278.9	Delinquent children; loss of driving privileges for alcohol, firearm and drug offenses; truancy
§ 18.2-251	Persons charged with first offense may be placed on probation; conditions; screening, assessment and education programs; drug tests; costs and fees; violations; discharge.

TRANSFER TO CIRCUIT COURT

- VA Code §16.1-269.1(A)

- The juvenile must be 14 years old and charged with a felony offense.
- This is discretionary. The CW must file a motion to transfer requesting the juvenile to be tried as an adult, as well as the appropriate notices pursuant to §§ 16.1-263 and 16.1-264.
- The court must find by a preponderance of the evidence that the juvenile is not a proper person to remain within the jurisdiction of the juvenile court.
- The Court will consider:
    - Juvenile's age
    - Seriousness and number of offenses
    - Was the offense committed in a violent, premediated, or willful manner?
    - Was the offense committed against persons or property?
    - Whether the maximum punishment for such offense is greater than 20 years.
    - Did the offense involve a firearm or dangerous weapon?
    - The nature of the juvenile's participation in the offense
    - Can the juvenile be retained in the juvenile justice system long enough for effective rehabilitation?
    - The record and previous history of the juvenile
    - Whether the juvenile previously absconded from juvenile correctional entity (i.e., detention)
    - The extent of the juvenile's intellectual disability or mental illness, if any
    - The juvenile's school record and education
    - The juvenile's mental and emotional maturity
    - The juvenile's physical condition and physical maturity

HOW DOES THE CW EFFECTUATE TRANSFER?

- File motion requesting transfer
- Comply with various notice requirements
- Hold Preliminary hearing to establish probable cause in JDR
- If PC established, the judge holds a transfer hearing and considers various factors (VA Code §16.1-269.1(A))- see above

CERTIFICATION

- Virginia Code 16.1-269.1 (B) & (C)
  - The juvenile must be 16 years old
  - (B) The CW **shall** certify a juvenile if he is charged w/ capital murder, first or second degree murder, lynching, or aggravated malicious wounding.
  - (C) The CW **may** certify a juvenile if we provide notice of intent to certify and the juvenile is charged with felony homicide, malicious wounding by mob, abduction, malicious wounding, poisoning, robbery, carjacking, rape, sodomy, object sexual penetration, or certain distribution offenses.
- How does the CW Effectuate Certification?
  - CW files notice of intent to certify
  - JDR court holds a probable cause hearing
  - If the court finds PC, then the case is certified to the grand jury
  - If the court does not find PC, then the CW may seek a direct indictment in the Circuit Court

§ 16.1-248.1. Criteria for detention or shelter care.

A. A juvenile taken into custody whose case is considered by a judge, intake officer or magistrate pursuant to § 16.1-247 shall immediately be released, upon the ascertainment of the necessary facts, to the care, custody and control of such juvenile's parent, guardian, custodian or other suitable person able and willing to provide supervision and care for such juvenile, either on bail or recognizance pursuant to Chapter 9 (§ 19.2-119 et seq.) of Title 19.2 or under such conditions as may be imposed or otherwise. However, at any time prior to an order of final disposition, a juvenile may be detained in a secure facility, pursuant to a detention order or warrant, only upon a finding by the judge, intake officer, or magistrate, that there is probable cause to believe that the juvenile committed the act alleged, and that at least one of the following conditions is met:
1. The juvenile is alleged to have (a) violated the terms of his probation or parole when the charge for which he was placed on probation or parole would have been a felony or Class 1 misdemeanor if committed by an adult; (b) committed an act that would be a felony or Class 1 misdemeanor if committed by an adult; or (c) violated any of the provisions of § 18.2-308.7, and there is clear and convincing evidence that:
a. Considering the seriousness of the current offense or offenses and other pending charges, the seriousness of prior adjudicated offenses, the legal status of the juvenile and any aggravating and mitigating circumstances, the liberty of the juvenile, constitutes a clear and substantial threat to the person or property of others;
b. The liberty of the juvenile would present a clear and substantial threat of serious harm to such juvenile's life or health; or
c. The juvenile has threatened to abscond from the court's jurisdiction during the pendency of the instant proceedings or has a record of willful failure to appear at a court hearing within the immediately preceding 12 months.
2. The juvenile has absconded from a detention home or facility where he has been directed to remain by the lawful order of a judge or intake officer.
3. The juvenile is a fugitive from a jurisdiction outside the Commonwealth and subject to a verified petition or warrant, in which case such juvenile may be detained for a period not to exceed that provided for in § 16.1-323 while arrangements are made to return the juvenile to the lawful custody of a parent, guardian or other authority in another state.
4. The juvenile has failed to appear in court after having been duly served with a summons in any case in which it is alleged that the juvenile has committed a delinquent act or that the child is in need of services or is in need of supervision; however, a child alleged to be in need of services or in need of supervision may be detained for good cause pursuant to this subsection only until the next day upon which the court sits within the county or city in which the charge against the child is pending, and under no circumstances longer than 72 hours from the time he was taken into custody. If the 72-hour period expires on a Saturday, Sunday, legal holiday or day on which the court is lawfully closed, the 72 hours shall be extended to the next day that is not a Saturday, Sunday, legal holiday or day on which the court is lawfully closed.
5. The juvenile failed to adhere to the conditions imposed upon him by the court, intake officer or magistrate following his release upon a Class 1 misdemeanor charge or a felony charge.

However, no juvenile younger than 11 years of age shall be placed in secure detention unless such juvenile is alleged to have committed one or more of the delinquent acts enumerated in subsection B or C of § 16.1-269.1.

When a juvenile is placed in secure detention, the detention order shall state the offense for which the juvenile is being detained, and, to the extent practicable, other pending and previous charges.

B. Any juvenile not meeting the criteria for placement in a secure facility shall be released to a parent, guardian or other person willing and able to provide supervision and care under such conditions as the judge, intake officer or magistrate may impose. However, a juvenile may be placed in shelter care if:
1. The juvenile is eligible for placement in a secure facility;
2. The juvenile has failed to adhere to the directions of the court, intake officer or magistrate while on conditional release;
3. The juvenile's parent, guardian or other person able to provide supervision cannot be reached within a reasonable time;
4. The juvenile does not consent to return home;
5. Neither the juvenile's parent or guardian nor any other person able to provide proper supervision can arrive to assume custody within a reasonable time; or
6. The juvenile's parent or guardian refuses to permit the juvenile to return home and no relative or other person willing and able to provide proper supervision and care can be located within a reasonable time.
C. When a juvenile is detained in a secure facility, the juvenile's probation officer may review such placement for the purpose of seeking a less restrictive alternative to confinement in that secure facility.

D. The criteria for continuing the juvenile in detention or shelter care as set forth in this section shall govern the decisions of all persons involved in determining whether the continued detention or shelter care is warranted pending court disposition. Such criteria shall be supported by clear and convincing evidence in support of the decision not to release the juvenile.
E. Nothing in this section shall be construed to deprive the court of its power to punish a juvenile summarily for contempt for acts set forth in § 18.2-456, other than acts of disobedience of the court's dispositional order which are committed outside the presence of the court.
F. A detention order may be issued pursuant to subdivision A 2 by the committing court or by the court in the jurisdiction from which the juvenile fled or where he was taken into custody.
G. The court is authorized to detain a juvenile based upon the criteria set forth in subsection A at any time after a delinquency petition has been filed, both prior to adjudication and after adjudication pending final disposition subject to the time limitations set forth in § 16.1-277.1.
H. If the intake officer or magistrate releases the juvenile, either on bail or recognizance or under such conditions as may be imposed, no motion to revoke bail, or change such conditions may be made unless (i) the juvenile has violated a term or condition of his release, or is convicted of or taken into custody for an additional offense, or (ii) the attorney for the Commonwealth presents evidence that incorrect or incomplete information regarding the factors in subsection A was relied upon by the intake officer or magistrate establishing the initial terms of release. If the juvenile court releases the juvenile, either on bail or recognizance or under such conditions as may be imposed, over the objection of the attorney for the Commonwealth, the attorney for the Commonwealth may appeal such decision to the circuit court. The order of the juvenile court releasing the juvenile shall remain in effect until the circuit court, Court of Appeals or Supreme Court rules otherwise.

16.1-228. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Abused or neglected child" means any child:

1. Whose parents or other person responsible for his care creates or inflicts, threatens to create or inflict, or allows to be created or inflicted upon such child a physical or mental injury by other than accidental means, or creates a substantial risk of death, disfigurement or impairment of bodily or mental functions, including, but not limited to, a child who is with his parent or other person responsible for his care either (i) during the manufacture or attempted manufacture of a Schedule I or II controlled substance, or (ii) during the unlawful sale of such substance by that child's parents or other person responsible for his care, where such manufacture, or attempted manufacture or unlawful sale would constitute a felony violation of § 18.2-248;

2. Whose parents or other person responsible for his care neglects or refuses to provide care necessary for his health; however, no child who in good faith is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination shall for that reason alone be considered to be an abused or neglected child. Further, a decision by parents who have legal authority for the child or, in the absence of parents with legal authority for the child, any person with legal authority for the child who refuses a particular medical treatment for a child with a life-threatening condition shall not be deemed a refusal to provide necessary care if (i) such decision is made jointly by the parents or other person with legal authority and the child; (ii) the child has reached 14 years of age and is sufficiently mature to have an informed opinion on the subject of his medical treatment; (iii) the parents or other person with legal authority and the child have considered alternative treatment options; and (iv) the parents or other person with legal authority and the child believe in good faith that such decision is in the child's best interest. No child whose parent or other person responsible for his care allows the child to engage in independent activities without adult supervision shall for that reason alone be considered to be an abused or neglected child, provided that (a) such independent activities are appropriate based on the child's age, maturity, and physical and mental abilities and (b) such lack of supervision does not constitute conduct that is so grossly negligent as to endanger the health or safety of the child. Such independent activities include traveling to or from school or nearby locations by bicycle or on foot, playing outdoors, or remaining at home for a reasonable period of time. Nothing in this subdivision shall be construed to limit the provisions of § 16.1-278.4;

3. Whose parents or other person responsible for his care abandons such child;

4. Whose parents or other person responsible for his care, or an intimate partner of such parent or person, commits or allows to be committed any act of sexual exploitation or any sexual act upon a child in violation of the law;

5. Who is without parental care or guardianship caused by the unreasonable absence or the mental or physical incapacity of the child's parent, guardian, legal custodian, or other person standing in loco parentis;

6. Whose parents or other person responsible for his care creates a substantial risk of physical or mental injury by knowingly leaving the child alone in the same dwelling, including an apartment as defined in § 55.1-2000, with a person to whom the child is not related by blood or marriage and who the parent or other person responsible for his care knows has been convicted of an offense against a minor for which registration is required as a Tier III offender pursuant to § 9.1-902; or

7. Who has been identified as a victim of sex trafficking or severe forms of trafficking as defined in the federal Trafficking Victims Protection Act of 2000, 22 U.S.C. § 7102 et seq., and in the federal Justice for Victims of Trafficking Act of 2015, 42 U.S.C. § 5101 et seq.

If a civil proceeding under this chapter is based solely on the parent having left the child at a hospital or emergency medical services agency, it shall be an affirmative defense that such parent safely delivered the child within 30 days of the child's birth to (i) a hospital that provides 24-hour emergency services, (ii) an attended emergency medical services agency that employs emergency medical services personnel, or (iii) a newborn safety device located at and operated by such hospital or emergency medical services agency. For purposes of terminating parental rights

pursuant to § 16.1-283 and placement for adoption, the court may find such a child is a neglected child upon the ground of abandonment.

§ 16.1-251. Emergency removal order.

A. A child may be taken into immediate custody and placed in shelter care pursuant to an emergency removal order in cases in which the child is alleged to have been abused or neglected. Such order may be issued ex parte by the court upon a petition supported by an affidavit or by sworn testimony in person before the judge or intake officer which establishes that:
1. The child would be subjected to an imminent threat to life or health to the extent that severe or irremediable injury would be likely to result if the child were returned to or left in the custody of his parents, guardian, legal custodian or other person standing in loco parentis pending a final hearing on the petition.
2. Reasonable efforts have been made to prevent removal of the child from his home and there are no alternatives less drastic than removal of the child from his home which could reasonably protect the child's life or health pending a final hearing on the petition. The alternatives less drastic than removal may include but not be limited to the provision of medical, educational, psychiatric, psychological, homemaking or other similar services to the child or family or the issuance of a preliminary protective order pursuant to § 16.1-253.

If the petitioner fails to obtain an emergency removal order within four hours of taking custody of the child, the affidavit or sworn testimony before the judge or intake officer shall state the reasons therefor.

When a child is removed from his home and there is no reasonable opportunity to provide preventive services, reasonable efforts to prevent removal shall be deemed to have been made.

The petitioner shall not be required by the court to make reasonable efforts to prevent removal of the child from his home if the court finds that (i) the residual parental rights of the parent regarding a sibling of the child have previously been involuntarily terminated; (ii) the parent has been convicted of an offense under the laws of the Commonwealth or a substantially similar law of any other state, the United States, or any foreign jurisdiction that constitutes murder or voluntary manslaughter, or a felony attempt, conspiracy, or solicitation to commit any such offense, if the victim of the offense was a child of the parent, a child with whom the parent resided at the time such offense occurred, or the other parent of the child; (iii) the parent has been convicted of an offense under the laws of the Commonwealth or a substantially similar law of any other state, the United States, or any foreign jurisdiction that constitutes felony assault resulting in serious bodily injury or felony bodily wounding resulting in serious bodily injury or felony sexual assault, if the victim of the offense was a child of the parent or a child with whom the parent resided at the time of such offense; or (iv) on the basis of clear and convincing evidence, the parent has subjected any child to aggravated circumstances or abandoned a child under circumstances that would justify the termination of residual parental rights pursuant to subsection D of § 16.1-283.

As used in this section:

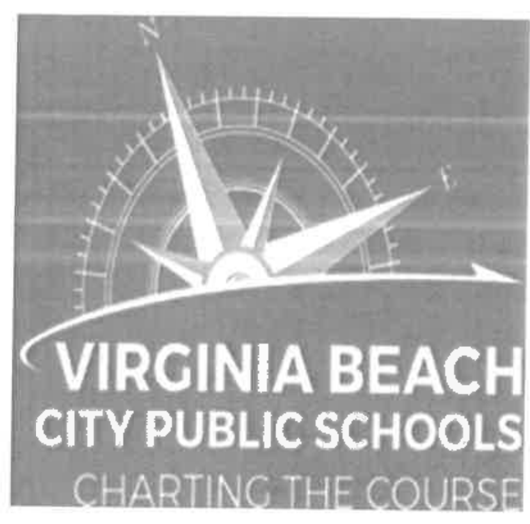
"Aggravated circumstances" means torture, chronic or severe abuse, or chronic or severe sexual abuse, if the victim of such conduct was a child of the parent or child with whom the parent resided at the time such conduct occurred, including the failure to protect such a child from such conduct, which conduct or failure to protect (i) evinces a wanton or depraved indifference to human life or (ii) has resulted in the death of such a child or in serious bodily injury to such a child.

"Chronic abuse" or *"chronic sexual abuse"* means recurring acts of physical abuse that place the child's health, safety and well-being at risk.

"Serious bodily injury" means bodily injury that involves substantial risk of death, extreme physical pain, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member, organ or mental faculty.

"Severe abuse" or *"severe sexual abuse"* may include an act or omission that occurred only once but otherwise meets the definition of "aggravated circumstances."

B. Whenever a child is taken into immediate custody pursuant to an emergency removal order, a hearing shall be held in accordance with § 16.1-252 as soon as practicable, but in no event later than five business days after the removal of the child.
C. In the emergency removal order the court shall give consideration to temporary placement of the child with a person with a legitimate interest under the supervision of the local department of social services, until such time as the hearing in accordance with § 16.1-252 is held.
D. The local department of social services having "legal custody" of a child as defined in § 16.1-228 (i) shall not be required to comply with the requirements of this section in order to redetermine where and with whom the child shall live, notwithstanding that the child had been placed with a natural parent.



Virginia Beach City Public Schools

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The Truancy/Parent Participation Docket

The Hon. Adrianne L. Bennett

The Hon. James P. Normile

Kami Lannetti, Deputy Schools Attorney

Danielle Hall-McIvor, Associate Schools Attorney

Simone Boothe, Associate Schools Attorney

§ 22.1-279.3. Parental responsibility and involvement requirements.

A. Each parent of a student enrolled in a public school has a duty to assist the school in enforcing the standards of student conduct and compulsory school attendance in order that education may be conducted in an atmosphere free of disruption and threat to persons or property, and supportive of individual rights.

B. A school board shall provide opportunities for parental and community involvement in every school in the school division.

C. Within one calendar month of the opening of school, each school board shall, simultaneously with any other materials customarily distributed at that time, send to the parents of each enrolled student (i) a notice of the requirements of this section; (ii) a copy of the school board's standards of student conduct; and (iii) a copy of the compulsory school attendance law. These materials shall include a notice to the parents that by signing the statement of receipt, parents shall not be deemed to waive, but to expressly reserve, their rights protected by the constitutions or laws of the United States or the Commonwealth and that a parent shall have the right to express disagreement with a school's or school division's policies or decisions.

Each parent of a student shall sign and return to the school in which the student is enrolled a statement acknowledging the receipt of the school board's standards of student conduct, the notice of the requirements of this section, and the compulsory school attendance law. Each school shall maintain records of such signed statements.

D. The school principal may request the student's parent or parents, if both parents have legal and physical custody of such student, to meet with the principal or his designee to review the school board's standards of student conduct and the parent's or parents' responsibility to participate with the school in disciplining the student and maintaining order, to ensure the student's compliance with compulsory school attendance law, and to discuss improvement of the child's behavior, school attendance, and educational progress.

E. In accordance with the due process procedures set forth in this article and the guidelines required by § 22.1-279.6, the school principal or his designee shall notify the parents of any student who violates a school board policy or the compulsory school attendance requirements when such violation is likely to result in the student's suspension or the filing of a court petition, whether or not the school administration has imposed such disciplinary action or filed a petition. The notice shall state (i) the date and particulars of the violation; (ii) the obligation of the parent to take actions to assist the school in improving the student's behavior and ensuring compulsory school attendance compliance; (iii) that, if the student is suspended, the parent may be required to accompany the student to meet with school officials; and (iv) that a petition with the juvenile and domestic relations district court may be filed under certain circumstances to declare the student a child in need of supervision.

F. No suspended student shall be admitted to the regular school program until such student and his parent have met with school officials to discuss improvement of the student's behavior, unless the school principal or his designee determines that readmission, without parent conference, is appropriate for the student.

G. Upon the failure of a parent to comply with the provisions of this section, the school board may, by petition to the juvenile and domestic relations district court, proceed against such parent for willful and unreasonable refusal to participate in efforts to improve the student's behavior or school attendance, as follows:

1. If the court finds that the parent has willfully and unreasonably failed to meet, pursuant to a request of the principal as set forth in subsection D, to review the school board's standards of student conduct and the parent's responsibility to assist the school in disciplining the student and maintaining order, and to discuss improvement of the child's behavior and educational progress, it may order the parent to so meet; or

2. If the court finds that a parent has willfully and unreasonably failed to accompany a suspended student to meet with school officials pursuant to subsection F, or upon the student's receiving a second suspension or being expelled, it may order the student or his parent, or both, to participate in such programs or such treatment, including, but not limited to, extended day programs, summer school, other educational programs and counseling, as the court deems appropriate to improve the student's behavior or school attendance. The order may also require participation in a parenting, counseling, or mentoring program, as appropriate, or that the student or his parent, or both, shall be subject to such conditions and limitations as the court deems appropriate for the supervision, care, and rehabilitation of the student or his parent. In addition, the court may order the parent to pay a civil penalty not to exceed $500.

H. The civil penalties established pursuant to this section shall be enforceable in the juvenile and domestic relations district court in which the student's school is located and shall be paid into a fund maintained by the appropriate local governing body to support programs or treatments designed to improve the behavior of students as described in subdivision G 2. Upon the failure to pay the civil penalties imposed by this section, the attorney for the appropriate county, city, or town shall enforce the collection of such civil penalties.

I. All references in this section to the juvenile and domestic relations district court shall be also deemed to mean any successor in interest of such court.

1995, c. 852; 1996, c. 771; 2000, c. 538; 2001, cc. 688, 820; 2004, c. 573; 2023, c. 523.

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§ 16.1-241.2. Proceedings against certain parents.

A. Upon the failure of a parent to comply with the provisions of § 22.1-279.3, the school board may, by petition to the juvenile and domestic relations court, proceed against such parent for willful and unreasonable refusal to participate in efforts to improve the student's behavior as follows:

1. If the court finds that the parent has willfully and unreasonably failed to meet, pursuant to a request of the principal as set forth in subsection D of § 22.1-279.3, to review the school board's standards of student conduct and the parent's responsibility to assist the school in disciplining the student, maintaining order, or ensuring the child's school attendance, and to

discuss improvement of the child's behavior, school attendance, or educational progress, it may order the parent to so meet; or

2. If the court finds that the parent has willfully and unreasonably failed to accompany a suspended student to meet with school officials pursuant to subsection F of § 22.1-279.3, or upon the student receiving a second suspension or being expelled, it may order (i) the student or his parent to participate in such programs or such treatment as the court deems appropriate to improve the student's behavior, including, but not limited to, extended day programs and summer school or other education programs and counseling, or (ii) the student or his parent to be subject to such conditions and limitations as the court deems appropriate for the supervision, care, and rehabilitation of the student or his parent; in addition, the court may order the parent to pay a civil penalty not to exceed $500.

The court may use its contempt power to enforce any order entered under this section.

B. The civil penalties established pursuant to this section shall be enforceable in the juvenile and domestic relations court or its successor in interest in which the student's school is located and shall be paid into a fund maintained by the appropriate local governing body to support programs or treatments designed to improve the behavior and school attendance of students as described in subdivision 2 of subsection G of § 22.1-279.3. Upon the failure to pay any civil penalties imposed by this section and § 22.1-279.3, the attorney for the appropriate county, city, or town shall enforce the collection of such civil penalties.

C. For the purposes of this section and § 22.1-279.3, "parent" or "parents" means any parent, guardian, legal custodian, or other person having control or charge of a child.
1994, c. 813; 1995, c. 852; 1996, c. 771; 2004, c. 573.

A Child in Need of Services is defined in the Code of Virginia, Section 16.1-228, as:

A child whose behavior, conduct or condition presents or results in a serious threat to the well-being and physical safety of the child; however, no child who in good faith is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination shall for that reason alone be considered to be a child in need of services, nor shall any child who habitually remains away from or habitually deserts or abandons his family as a result of what the court or the local child protective services unit determines to be incidents of physical, emotional or sexual abuse in the home be considered a child in need of services for that reason alone.

However, to find that a child falls within these provisions, (i) the conduct complained of must present a clear and substantial danger to the child's life or health, or (ii) the child or his family is in need of treatment, rehabilitation or services not presently being received, and (iii) the intervention of the court is essential to provide the treatment, rehabilitation or services needed by the child or his family.

A Child in Need of Supervision is defined in the Code of Virginia, Section 16.1-228, as:

A child who, while subject to compulsory school attendance, is habitually and without justification absent from school, (i) and the child has been offered an adequate opportunity to receive the benefit of any and all educational services and programs that are required to be provided by law and which meet the child's particular educational needs, and (ii) the school system from which the child is absent or other appropriate agency has made a

reasonable effort to effect the child's regular attendance without success; or

A child who, without reasonable cause and without the consent of his parent, lawful custodian, or placement authority, remains away from or habitually deserts or abandons his family or lawful custodian or escapes or remains away without proper authority from a residential care facility in which he has been placed by the court, and (i) such conduct presents a clear and substantial danger to the child's life or health, (ii) the child or his family is in need of treatment, rehabilitation or services not presently being received, and (iii) the intervention of the court is essential to provide the treatment, rehabilitation or services needed by the child or his family.

Examples of CHINS Issues Include

- Curfew
- **Truancy**
- Not following household rules
- Runaway

Code of Virginia, Section 16.1-260, further states that CHINS problems should be resolved through the use of community resources before court intervention can take place.

Regarding CHINS matters, the goal of the Virginia Beach Court Services Unit is to divert the juvenile and his/her family from the

court process whenever possible. The Intake Unit can assist families in finding available community resources to address an adolescent's acting-out behavior.

When a parent requests assistance with a child exhibiting negative behaviors, an Intake Officer instructs the parent to initiate individual/family counseling. If the child refuses to attend two scheduled appointments, refuses to take prescribed medication, or refuses to comply with a recommended course of treatment, the parent is instructed to provide written documentation of the non-compliance from the therapist.

A CHINS petition is then filed and a court date is scheduled for the child and a parent/legal guardian to appear before a judge. The judge may then issue an order of compliance.

 Form DC-560

PETITION AND ORDER FOR PARENTAL PARTICIPATION

Using this Revisable PDF Form

1. Copies

    a. Original - to the court.

    b. First copy - parent who is subject to the order.

    c. Second copy - school board/petitioner.

    d. Other copies as determined by local practice..

2. Petition signed by petitioner and by intake officer. Order signed by judge.

3. Attachments - none required.

4. Preparation details:

    a. This form is to be used for petitions filed by school boards against a parent pursuant to Virginia Code §§ 16.1-241.2 and 22.1-279.3.

    b. This petition must be filed through the intake office unless filed by an attorney. An attorney may file the petition in the clerk's office.

 Form DC-560

PETITION AND ORDER FOR PARENTAL PARTICIPATION

Data Elements, ***front***

1. Case number.
2. Hearing date and time.
3. Name of court.
4. Name of petitioning school board.
5. Address of petitioning school board.
6. Telephone number of petitioning school board.
7. Name and address of student.
8. Student's date of birth.
9. Student's social security number.
10. Name, address and telephone number of respondent/parent (or guardian).
11. Respondent's date of birth.
12. Respondent's social security number.
13. Name of petitioning school board.
14. Relief sought by petitioner.
15. Date of petition.
16. Signature of representative of petitioner.

To be completed by intake officer:

17. Space for intake officer's signature and date.

Form DC-560

Petition and Order for Parental Participation

Data Elements, *reverse*

Completed by the judge at the hearing:

1. Petitioner's name.
2. Respondent/Parent's name
3. Check box(es) reflecting disposition.
4. Date of order.
5. Signature of judge.

PETITION AND ORDER FOR PARENTAL PARTICIPATION

Case No. .... 1 ....

Commonwealth of Virginia   Va. Code §§ 16.1-241.2, 22.1-279.3

.... 2 ....
DATE OF HEARING

.... 3 .... Juvenile and Domestic Relations District Court

.... 4 ....
PETITIONER/SCHOOL BOARD

v.

.... 10 ....
RESPONDENT/PARENT/GUARDIAN/LEGAL CUSTODIAN

.... 5 ....
ADDRESS

....
ADDRESS

.... 6 ....
TELEPHONE NUMBER

....
TELEPHONE NUMBER

....
NAME OF STUDENT

.... 11 ....
RESPONDENT'S DATE OF BIRTH

.... 7 ....
ADDRESS

.... 12 ....
RESPONDENT'S SOCIAL SECURITY NUMBER

8 .... 9 ....
STUDENT'S DATE OF BIRTH   STUDENT'S SOCIAL SECURITY NUMBER

The school board for .... 13 .... hereby petitions this court to proceed against the parent named above for willful and unreasonable refusal to participate in efforts to improve the student's behavior. The school board specifically requests that:

4

[ ] The court order the parent to meet with school officials to discuss the student's improvement in behavior, school attendance or educational progress, the school board's standards of student conduct, and the parent's responsibility to assist the school in disciplining the student, maintaining order, or ensuring the child's school attendance.

[ ] The court impose a civil penalty not to exceed $500.00 for the parent's failure to meet with school officials due to the student's suspension or expulsion.

[ ] The court order the student or parent to participate in such programs or such treatment as the court deems appropriate to improve the student's behavior.

....
SUGGESTED PROGRAM NAME AND ADDRESS

....

[ ] The court order the student or parent to be subject to the conditions and limitations as the court deems appropriate for the supervision, care, and rehabilitation of the student or his parents.

....
SUGGESTED CONDITIONS AND LIMITATIONS

....

....

.... 15 ....
DATE

16
PETITIONER'S SIGNATURE

Sworn/Affirmed and signed before me on ....

17
INTAKE OFFICER

ORDER

1

PETITIONER/SCHOOL BOARD

V.

2

RESPONDENT/PARENT/GUARDIAN/LEGAL CUSTODIAN

The court hereby orders:

3

[ ] a civil fine of $ .... to be paid to ....

[ ] The parent(s) to meet with school officials;

[ ] The [ ] student and/or [ ] parent to participate in the following program or treatment:

....

PROGRAM NAME AND ADDRESS

....

[ ] The [ ] student and/or [ ] parent to be subject to the following conditions and limitations:

....

CONDITIONS AND LIMITATIONS

....

....

4

....

DATE

5

____

JUDGE

Absences/Truancy/Parental Notification 5-17

School Board of the City of Virginia Beach
Policy 5-17

STUDENTS

Absences/Truancy/Parental Notification

A. Absences

1. Generally

   Students of school age shall attend their assigned schools during school hours in accordance with state law. Students are considered absent if they are not present on days that school is in session as determined by the School Board approved calendar or during make-up days determined by the Superintendent or School Board. The Superintendent through the principals shall be responsible for maintaining accurate records of attendance and for closely monitoring all excused and unexcused absences.

2. Excused Absences

   a. Documented absences are defined as absences for personal illness, serious illness or death in the family, exposure to contagious disease, extremely inclement weather, school-sponsored activity or observance of a recognized religious

holiday. The eligible student or parent or legal guardian of a minor student will provide written notice to the school of the reason for the absence or tardiness.

b. Preapproved absences are defined as absences for cause and absences that occur with the full knowledge and consent of the eligible student or the parents/legal guardian of the minor student. The principal, at the principal'shis/her or designee's discretion, may accept as valid the reasons for these absences.

c. Other verifiable reasons may be deemed excused at the discretion of the principal or designee.

B. Truancy

Truancy is defined as the absence of a student for other than a legitimately recognized reason for all or part of a day when school is in session. The Superintendent or designee shall develop regulations for monitoring truant students and may establish reasonable disciplinary measures based upon the frequency of truancy and the age of the student.

C. Notification of Parents of Absent Students

As required by state law and regulation, each principal or designee shall make a reasonable effort to see that parents/legal guardians of a minor student be contacted when the student is absent. Parents/legal guardians of minor students will provide a number to be called or an email address. This may be the main contact phone number, work number, email address, or emergency contact number.

Legal Reference

Code of Virginia § 22.1-253.13:7, as amended. Standard 7. Policy manual.

Code of Virginia § 22.1-258, as amended. Appointment of attendance officers; notification when pupil fails to report to school.

Code of Virginia § 22.1-259, as amended. Teachers to keep daily attendance records.

Code of Virginia § 22.1-260, as amended. Report of children enrolled and not enrolled.

Code of Virginia § 22.1-261, as amended. Division Superintendent to make list of children not enrolled; duties of attendance officer.

Code of Virginia § 22.1-262, as amended. Complaint to court when parent fails to comply with law.

Code of Virginia § 22.1-267, as amended. Proceedings against habitually absent child.

Adopted by School Board: October 21, 1969
Amended by School Board: February 15, 1977
Amended by School Board: August 15, 1978
Amended by School Board: August 4, 1983
Amended by School Board: August 21, 1990
Amended by School Board: July 16, 1991
Amended by School Board: July 13, 1993 (Effective August 14, 1993)
Amended by School Board: June 20, 1995
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Amended by School Board: August 27, 2018
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Absences/Truancy School and Class Attendance - Grades K-12 5-17.1

School Board of the City of Virginia Beach
Regulation 5-17.1

STUDENTS

Absences/Truancy School and Class Attendance - Grades K-12

Students are expected to be in school, in class, and ready for instruction. Daily and punctual school attendance is essential to each student's academic development. Absence from school is detrimental to student achievement. A student is counted present for Virginia Department of Education (VDOE) reporting purposes if present for any portion of the day.

As required under the provisions of law, each parent/guardian is responsible for regular and punctual attendance of any minor child in the parent/legal guardian's custody within the compulsory age for school attendance. Emancipated students are responsible for their own regular and punctual attendance. Parents/legal guardians of minor students and emancipated students are expected to work cooperatively with school personnel to correct attendance problems, including meetings with teachers, counselors, or administrators.

When students are in a virtual environment, schools will not follow the prescribed guidelines as noted below as it would not be practical to have these requirements. To take and track attendance in the virtual setting, staff are to adhere to the procedures provided by the VDOE as communicated by the Department of School Leadership.

Each member of a school's faculty is expected to avoid causing a student to be tardy or absent from a colleague's class. If a student is tardy or

absent because of being detained by a faculty member, the student will be considered excused and the absence will not be included in the count for excessive absences.

Students shall not be in an unauthorized area of the school without prior permission, and shall not leave a classroom, building, or assigned area without proper permission. Students who do not comply with this section will be subject to disciplinary action in accordance with the Code of Student Conduct and Discipline Guidelines.

A. Absence Defined

1. At the elementary and middle school level, if a student does not attend school for at least a portion of the day, the student is counted absent.

2. At the high school level, absences are computed for each class. At the middle school level, absences are computed for each credit course. A student who misses more than fifteen (15) minutes of any class will be counted absent for that class.

B. Excused Absences

1. Personal illness, illness or death in the family, exposure to contagious disease, religious holidays, extremely inclement weather, or school-sponsored/related activities will be considered legitimate excuses for a student's absence. The parent/legal guardian of a minor student will provide written notice to the school of the reason for the absence or tardiness.

2. Requests for pre-approved excused absences should be made in writing by the parent/legal guardian and should state the reasons for absence and the time of absence. Such requests must be approved in advance by the principal.

3. One day-long excused absence shall be permitted per school year for any middle school or high school student who is absent from school to engage in a political or civic event.

4. Other verifiable reasons may be deemed excusable at the discretion of the principal. Such requests should be made in writing by the parent or legal guardian and should state the reasons for absence and the time of absence.

C. Unexcused Absences

Absences for reasons other than those listed above, including out-of-school suspension, are unexcused absences.

D. Parental/Guardian Notification of Absences

A documented attempt will be made to contact the parent/legal guardian of a minor student if a student is absent without administrative approval or knowledge.

E. Recordkeeping for Absences

1. Each principal is responsible for establishing a school recordkeeping system for all student absences.

2. Each teacher is responsible for recording as excused or unexcused school or class absence and tardiness. Excused absences for school-sponsored/related activities, authorized visits of students with school personnel, and recognized religious holidays should be noted as such.

3. All absences require written confirmation from the parent/legal guardian of a minor student. All absence notes will be preserved until the close of the school term, and the principal will be the judge of the signature validity.

F. Make-up Work

Students who receive excused absences will be allowed to make up all assignments that affect the course grade and will be made aware of these assignments. It is the student's responsibility to make up assignments within a reasonable amount of time.

Students who receive unexcused absences may make up assignments at the discretion of the teacher, subject to the requirements communicated (provided) by the teacher at the beginning of the course. It is the student's responsibility to be aware of established guidelines and to follow those guidelines to make up the assignment. Students who are under the penalty of Out-of-School Suspension (OSS) will be able to access and complete graded work during and after the suspension, so the student may remain current with school instruction as long as enrolled in school.

G. Excessive Absences-Virginia Beach City Public Schools

1. Definition

   a. All excused and unexcused absences will be included in computing excessive absences except as follows:

      1. 1) School-sponsored/related activities
      2. 2) Authorized visits of students with school personnel
      3. 3) Recognized religious holidays
      4. 4) Political or civic event

   b. In the high schools, students having more than twelve (12) absences from a class (excused or unexcused) within a given semester will be considered as having excessive absences. This

guideline will also apply to credit courses taken at the middle school level.

c. In high schools with alternate day schedules (i.e. block scheduling), students having more than six (6) class absences from a class (excused or unexcused) within a given semester will be considered as having excessive absences. This guideline will also apply to credit courses at the middle school level.

d. In elementary and middle schools, students having more than eighteen (18) absences for the school year will be considered as having excessive absences.

2. Resulting Actions

a. When a student's absences equal two-thirds of the number for excessive absences, the school will notify the parent/legal guardian of a minor student in writing of the number of absences and will be responsible for working with the student and, if applicable, the minor student's parent/legal guardian in developing a plan of corrective action as appropriate. Such intervention may include, but is not limited to, the following: parent/legal guardian of a minor student conference; scheduled contact with parent; referral to the guidance counselor or school social worker; loss of privileges and/or restricted participation in school activities; referral to alternative learning program; and recommendation to the administration for other consequences.

b. When a student's absences are excessive, the teacher will notify the principal. The principal or designee will advise the parent/legal guardian by United States mail of the appropriate following action:

1. 1) In the elementary and middle schools (grades K-8), students having excessive absences will participate in a corrective action plan with intervention strategies to improve attendance. At the end of the school year, on the authority of the principal, the student could be denied promotion as appropriate.

2. 2) In high schools, students having excessive absences within a given semester will receive a failing grade (63/N) for that semester or the actual class grade, whichever is lower. At the middle school level, this guideline will also apply to credit courses.

3. <u>Waiver of Grade Reduction/Retention</u>

a. A parent/legal guardian of a minor student may request a waiver of the attendance regulation for extenuating circumstances beyond the parent's and/or student's control. Each school shall have available in the main office and/or guidance office the Virginia Beach Attendance Waiver Request Form.

b. A waiver may be submitted to the principal prior to the close of a semester or nine-week course, but no later than ten (10) days after the

close of a semester or nine-week course. Teachers will provide attendance records and documentation of absences to the principal for review with the waiver request. Additional documentation may be provided in conjunction with the waiver request.

c. Each waiver request will be considered on an individual basis taking into consideration documentation provided and extenuating circumstances beyond the parent's and/or student's control. The principal may request additional documentation from a medical professional when absences due to illness are excessive and/or a pattern appears to exist.

d. The principal shall act upon a waiver request within ten (10) administrative days after receiving it. The parent/legal guardian of a minor student shall be notified of the decision in writing within five (5) administrative days after the administrative decision has been made.

4. Appeal of Waiver Decision

A parent/legal guardian of a minor student may appeal the decision of the principal by submitting to the Coordinator of Student Services a written appeal within three (3) days of receipt of the decision from the principal. A parent/legal guardian of a minor student may appeal the decision of the Coordinator of Student Services to the appropriate Senior Executive Director in the Department of School Leadership. The decision of the appropriate Senior Executive Director is final.

5. Notification Procedures

a. **Excused and Unexcused Absences**

For all absences, the school will contact the home each day of the student's absence from school using the automatic dialing system.

b. **Unexcused Absences (excluding suspensions)**

1. 1) **Each unexcused absence** - the principal or designee will make a reasonable effort to notify the parent of the student's absence and to obtain an explanation for the absence.

2. 2) **Fifth unexcused absence** - the principal or designee shall:

    1. a) Make a reasonable effort to ensure that direct contact is made with the parent/legal guardian by the principal or designee, to obtain an explanation for the absences, and to explain the consequences of non-attendance.

    2. b) The principal or designee and the student's parent/legal guardian are required to jointly develop a plan to resolve the student's non-attendance.

3. 3) **Sixth unexcused absence**

    1. a) Within ten school days, the principal or designee shall

schedule a conference with the Student Support Team (SST), the student, the student's parent/legal guardian, and school personnel. The conference may include other community service providers to resolve issues related to non-attendance.

2. b) The conference shall be held no later than 15 school days after the sixth absence.
3. c) The SST may appoint a case manager to follow the case.
4. d) The SST can make recommendations, for intervention within the classroom or for services within the school.
5. e) The case manager will provide regular contact with the parent/legal guardian and student.

4. 4) **Seventh Unexcused Absence**
    1. a) The principal or designee shall refer the student to Juvenile Intake for an interview.
    2. b) A copy of the letter sent to the parent/legal guardian will be faxed to Court Services,

along with written documentation of the efforts made to resolve the non-attendance.

3. c) If the truancy continues, the Social Worker or principal or designee shall file a CHINS Petition.

4. d) If the parent/legal guardian refuses to cooperate with the school division, the case manager, with the knowledge and support of School Administration and in consultation with Court Services, should institute proceedings against the parent/legal guardian pursuant to § 18.2-371, as amended or § 22.1-262, as amended. In the event that more than one parent/legal guardian have been awarded joint physical custody pursuant to § 20-124.2, as amended, and the school has received such notice of such order, all parents/legal guardians shall be notified at the last known address of the parents/legal guardians. (Please note that should a CHINS petition be filed, the court is obligated to notify all parents/legal guardians of the

court hearing, regardless of the custody status of a child).

5. e) In filing a complaint against the student, the principal or designee shall provide written documentation of the efforts to comply with the provisions of section 22.1-258, as amended.

Legal Reference

Code of Virginia § 22.1-258, as amended. Appointment of attendance officers; notification when pupil fails to report to school.

Approved by Superintendent: July 16, 1991
Revised by Superintendent: August 18, 1992
Revised by Superintendent: June 20, 1995
Revised by Superintendent: December 19, 1995 (effective January 29, 1996)
Revised by Superintendent: August 6, 1996
Revised by Superintendent: October 8, 1998
Revised by Superintendent: July 31, 2001
Revised by Superintendent: March 17, 2006
Approved by School Board: April 20, 2010
Approved by School Board: August 27, 2018
Amended by School Board: September 9, 2020
Revised by the Superintendent August 23, 2021
Revised by Superintendent: April 15, 2024

Absences/Truancy/Parental Notification 5-17

School Board of the City of Virginia Beach
Policy 5-17

STUDENTS

Absences/Truancy/Parental Notification

A. Absences

1. Generally

   Students of school age shall attend their assigned schools during school hours in accordance with state law. Students are considered absent if they are not present on days that school is in session as determined by the School Board approved calendar or during make-up days determined by the Superintendent or School Board. The Superintendent through the principals shall be responsible for maintaining accurate records of attendance and for closely monitoring all excused and unexcused absences.

2. Excused Absences

   a. Documented absences are defined as absences for personal illness, serious illness or death in the family, exposure to contagious disease, extremely inclement weather, school-sponsored activity or observance of a recognized religious

holiday. The eligible student or parent or legal guardian of a minor student will provide written notice to the school of the reason for the absence or tardiness.

b. Preapproved absences are defined as absences for cause and absences that occur with the full knowledge and consent of the eligible student or the parents/legal guardian of the minor student. The principal, at the principlal'shis/her or designee's discretion, may accept as valid the reasons for these absences.

c. Other verifiable reasons may be deemed excused at the discretion of the principal or designee.

B. Truancy

Truancy is defined as the absence of a student for other than a legitimately recognized reason for all or part of a day when school is in session. The Superintendent or designee shall develop regulations for monitoring truant students and may establish reasonable disciplinary measures based upon the frequency of truancy and the age of the student.

C. Notification of Parents of Absent Students

As required by state law and regulation, each principal or designee shall make a reasonable effort to see that parents/legal guardians of a minor student be contacted when the student is absent. Parents/legal guardians of minor students will provide a number to be called or an email address. This may be the main contact phone number, work number, email address, or emergency contact number.

Legal Reference

Code of Virginia § 22.1-253.13:7, as amended. Standard 7. Policy manual.

Code of Virginia § 22.1-258, as amended. Appointment of attendance officers; notification when pupil fails to report to school.

Code of Virginia § 22.1-259, as amended. Teachers to keep daily attendance records.

Code of Virginia § 22.1-260, as amended. Report of children enrolled and not enrolled.

Code of Virginia § 22.1-261, as amended. Division Superintendent to make list of children not enrolled; duties of attendance officer.

Code of Virginia § 22.1-262, as amended. Complaint to court when parent fails to comply with law.

Code of Virginia § 22.1-267, as amended. Proceedings against habitually absent child.

Adopted by School Board: October 21, 1969
Amended by School Board: February 15, 1977
Amended by School Board: August 15, 1978
Amended by School Board: August 4, 1983
Amended by School Board: August 21, 1990
Amended by School Board: July 16, 1991
Amended by School Board: July 13, 1993 (Effective August 14, 1993)
Amended by School Board: June 20, 1995
Amended by School Board: August 21, 2001
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Transgender Issues in Practice (1-hour)

Speakers:

1. The Honorable Jennifer B. Shupert, Presiding Judge of Virginia Beach Juvenile & Domestic Relations District Court
2. Sarah Nelson, associate attorney at Phillips & Peters, PLLC in Norfolk, Virginia
3. Madison Wagner, associate attorney at Rice & Gregg, P.C. in Norfolk, Virginia
4. Lawren Burroughs, owner/ partner of Burroughs Law Office, P.C. (d/b/a Frugal Legal Services) in Virginia Beach, Virginia

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Topics:

1. Perspective from the Bench

2. Perspective from Counsel

3. Perspective from a Guardian *ad litem* (and issues related to minors as parties)

4. Perspective on the Emergence of (and need for) New Legal Authority

I. Perspective from the Bench

a. General Tips:

i. If counsel is aware that the appearance of a party or witness might cause confusion as to their identity, advise the clerk and/or court ahead of time.

ii. Identify clearly what pronouns would be preferred.

1. In your pleadings: you will need to use legal names but can add an "aka" or define the names at the beginning.

2. In the courtroom: clarify the preferred pronouns. For example, if two parties are the same gender and same last name, can we refer to them by first names? This is something counsel should discuss before the hearing.

iii. Don't be afraid to ask to modify pleadings or orders if the forms do not reflect the applicable pronouns.

b. Examples of where Transgender issues have arisen:

c. Example 1:

High school sophomore missed an extensive number of school days. Conferences between the school and the child's guardian

were not successful in remedying the situation. A CHINS petition was filed. The Court was advised that the child was male by birth but identified as a female and preferred to be called by a nickname rather than their birth name.

After some inquiry, the juvenile identified several issues that were said to be barriers to continued school attendance. First, the juvenile alleged that using the bathroom was an issue. Second, the juvenile alleged that she did not have appropriate clothing to wear to school.

d. Example 2:

Custody/Visitation case. Father was a naval officer nearing retirement, who recently transitioned. The two teenage daughters did not have a great relationship with dad prior to the litigation. Father filed a petition for custody.

Counsel advised the Court prior to the start of the case that father had transitioned, had a new name and that her pronouns were

she/her. Counsel also advised that the parties were OK with being called "mother" and "father". In the end, the 17yr old daughter, who identified herself as transgender, became interested in living with father after getting to know father as her transitioned self.

e. Example 3:

Juvenile delinquency petition filed alleging the juvenile assaulted a classmate. The facts ended up being that the classmate was verbally bullying the juvenile about their gender identity and had been targeting the juvenile on several prior occasions. The juvenile finally snapped and tried to physically attack the bully.

II. Perspective from Counsel

a. Addressing pronouns/ name preference/ legal changes

i. With Your Own Client

1. Ensure you are correctly addressing your client. Do not take a case in which the parties face these issues if you are

unwilling to have these types of discussions with your client.

Example 1: Party was transgender and had long identified with they/them pronouns. Party changed their name to a male name. I inquired if the name was legally changed and if he/him pronouns were preferred. Party's counsel advised that she was too afraid to broach this subject with her client so she "honestly does not know."

Example 2: Party was transgender and a settlement agreement was proposed honoring party's preferred name and pronouns. Party's counsel had not conferred with the party about this issue and sent a responsive letter that such modifications to the settlement agreement were offensive based on his opinion of the transgender subject rather than his client's subjective preferences.

2. Make sure you are not taking a legal position that hinges on gender issues while mistaking your own client's facts.

Example: Counsel filed a pleading arguing importance of cis-gender pronouns in the statute for the outcome while simultaneously failing to recognize her client was beginning to transition from female to male.

ii. With Opposing Parties

1. Ask and listen to your client but this is not a hill to die on if the opposing party has a preference so long as your document is legally accurate and clear.

2. Be respectful and accurate in all communications and writings.

iii. With Opposing Counsel

1. Openly communicate to ensure this is harmoniously addressed and a non-issue for the parties amongst the actual contested issues.

2. Be respectful and patient when you encounter counsel with prejudices or biases.

b. Property Settlement Agreements and Pleadings

i. Stylistic

1. Be legally correct but do not harm your client by being dismissive of their transition

2. Legal name changes versus preferred name changes can be handled by small stylistic changes to your standard documents such as:

   a. Plaintiff, Sarah Nelson (also known as Samuel Nelson (hereinafter "Samuel")

   b. Plaintiff, Sarah Nelson (also known as Samuel Nelson (hereinafter "Plaintiff")

ii. Legal Accuracy and Practice/Drafting Tips

1. Norfolk Divorce in which both parties transitioned after marriage and prior to divorce (i.e., Husband at the time of marriage was Wife at the time of divorce and Wife at the time of marriage was Husband at the time of divorce). If unclear, you risk problems with enforcement.

2. Practice tip: Ensure a judge (current and any future judge enforcing orders) understands parties clearly who you are referring to in an Agreement or Pleading. You may know now, but take fresh eyes to ensure someone later would clearly understand.

3. Practice/ Drafting tip: common practice to only state parties names once but if pronouns (he/ she/ him/ her/ they/ them/ husband/ wife) cause any confusion it is worth your time to change your typical drafting style. Agreements can refer to first names instead of Husband or Wife. Pleadings can refer to Plaintiff or Defendant. Use technology tools to quickly replace all in template documents but be sure to double check.

4. Practice/ Drafting tip: take fresh eyes to double check all pronoun replacements clearly. With these issues, a typographical error is easy and could make a catastrophic

difference that is difficult to unravel. Use technology tools to search all use of such terms.

III. Perspective from a Guardian *ad litem* (and issues related to minors as parties)

a. Vocabulary and why this topic is important

  i. Use the proper terms when speaking with your client and the Court.

   1. Gender Dysphoria: The Mayo Clinic defines gender dysphoria as “the feeling of discomfort or distress that might occur in people whose gender identity differs from their sex assigned at birth or sex-related physical characteristics”

    a. It is included in the DSM-5.

    b. https://www.mayoclinic.org/diseases-conditions/gender-dysphoria/symptoms-causes/syc-20475255

   2. Cisgender: The person identifies with the same gender that they were assigned at birth

a. https://www.thetrevorproject.org/resources/guide/a-guide-to-being-an-ally-to-transgender-and-nonbinary-youth/

3. Transgender: The person identifies as a gender other than what they were assigned at birth

    a. https://www.thetrevorproject.org/resources/guide/a-guide-to-being-an-ally-to-transgender-and-nonbinary-youth/

4. Nonbinary: The person does not identify with a specific gender

    a. https://www.thetrevorproject.org/resources/guide/a-guide-to-being-an-ally-to-transgender-and-nonbinary-youth/

ii. Know the statistics

1. In 2022 UCLA School of Law Williams Institute published a report that estimated that there are three hundred thousand children between the ages of 13 and 18 that identify as transgender

a. https://williamsinstitute.law.ucla.edu/publications/trans-adults-united-states/

2. "39% of LGBTQ+ young people seriously considered attempting suicide in the past year", if you look specifically at transgender and nonbinary young people, that number increases to 46%
   a. 12% actually attempted suicide
   b. Youth of color reported higher numbers than white youth
   c. https://www.thetrevorproject.org/survey-2024/
3. LGTBQ+ young people who live in accepting communities attempted suicide at less than half the rate of those who reported living in very unaccepting communities
4. Resources for youth and their family
   a. The Trevor Project
      i. https://www.thetrevorproject.org/resources/category/gender-identity/
   b. GLAAD
      i. https://glaad.org/transgender/

b. Speaking with your client

   i. Start the conversation with the child by asking what their preferred pronouns are and what name they would like to be called

      1. The child may not be sure how they identify

         a. Example: Prior to speaking with the child, one of the parties explained that at one point their child was identifying as another gender and was wanting to go by another name. I saw the child and simply asked what they liked to be called and their pronouns. The child told me to call her by her legal name and to use the pronouns that aligned with her sex.

      2. Does their gender identity impact their life?

         a. How is their mental health?

         b. Do they have issues in school?

         c. How is their relationship with their parents?

c. Speaking with parties to the case

   i. For custody and visitation cases, ask the parents how they handle the situation and what they say to their child

1. When parents disagree about their approach to their child who questions their gender:
    a. Try to put your political leanings to the side and focus on the best interest factors:
        i. 1) The age and physical and mental condition of the child, giving due consideration to the child's changing developmental needs
        ii. 3) The relationship existing between each parent and each child, giving due consideration to the positive involvement with the child's life, the ability to accurately assess and meet the emotional, intellectual, and physical needs of the child
        iii. 4) The reasonable preference of the child

ii. For criminal or CHINS cases, ask the parents or other potential placements about how those influence the dynamics of the household
    1. Example:

a. Child is charged with Assault and Battery of their parent. I spoke with the child's adult sibling who was a potential placement. She explained that the parents were "old school" and did not know how to deal with their child's gender dysphoria. Additionally, that person told me gender dysphoria was something that the child struggled with internally.

iii. Your GAL Report

1. Explain how the child identifies right away
    a. Refer to the child using the proper names and pronouns throughout the report
2. Include the parent's behavior surrounding their child's gender identity and how it may influence the relationship the child has with their parents
3. Focus on the best interest of the child factors.
4. If a party to the case is transgender or identifies as nonbinary

a. The medical procedures they have done for their transition are not relevant

b. How long the person has identified the way they identified and if it impacts their relationship with the child may be relevant

IV. Perspective on the Emergence of (and need for) New Legal Authority

a. New legislative changes

b. What legislative changes are still needed

c. How is this area of law working to improve

d. Emergence of Case Law

e. Examples

August/September 2024: The Current State of the Law Regarding Transgender Youth in Virginia

The following provides a framework for discussing the legal and practical aspects of handling cases involving transgender youth in Virginia. It covers relevant laws, policies, resources, and considerations that family law attorneys need to be aware of.

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1. Introduction

1.1. Growing visibility and legal recognition of transgender individuals.

The visibility and legal recognition of transgender individuals, particularly children, have significantly increased in recent years. This growing awareness has led to important advancements in rights and protections, ensuring that transgender individuals can live authentically and with dignity. For children, this recognition is crucial as it affects their development, mental health, and overall well-being.

However, the issue of transgender rights, especially concerning children, has become highly politicized and weaponized in public discourse. On one hand, advocates emphasize the importance of affirming and supporting transgender youth, highlighting the positive impact of acceptance on their mental health and quality of life. On the other hand, opponents often frame the issue as a threat to traditional values and parental rights, leading to heated debates and legislative battles.

This politicization has resulted in a patchwork of laws and policies across the United States, with some states enacting protections for transgender youth while others impose restrictions. In Virginia, recent policy changes reflect this contentious landscape, emphasizing parental involvement in decisions about a child's gender identity and rolling back some earlier accommodations.

Understanding the legal framework, current policies, and the role of parents—especially in cases of conflict—is essential for family law attorneys. This knowledge equips them to navigate the complexities of these cases and advocate effectively for the best interests of transgender children.

1.2. **Impact on family law practice in Virginia.** The growing visibility and legal recognition of transgender individuals, especially children, and the politicization of this issue have significant implications for family law attorneys and their clients. Family law attorneys must navigate a more complex legal landscape, with varying state and federal laws and policies on transgender rights. This requires staying updated on the latest legal developments and understanding how they affect custody, visitation, and other family law matters. Attorneys must develop a deep understanding of transgender issues, including medical, psychological, and social aspects, to effectively advocate for the best interests of transgender children and address the unique challenges they face.

Balancing the rights of parents with the welfare of the child, especially in cases where parents disagree about their child's gender identity, involves understanding and applying legal standards that prioritize the child's best interests while respecting parental involvement. Additionally, family law attorneys play a key role in advocating for transgender clients and educating judges, opposing counsel, and other stakeholders about transgender issues, ensuring fair and informed decision-making in family law cases.

For clients, understanding their legal rights and protections under state and federal laws is crucial. This includes knowing how recent legal developments, such as the **Bostock** decision, affect their rights in areas like education, healthcare, and employment. Transgender children and their families must navigate school policies that may vary widely between districts, ensuring that transgender students receive proper

support and accommodations. Access to resources and support services, including legal assistance, counseling, and advocacy organizations, is essential for families to navigate the challenges associated with raising a transgender child and ensure their child's well-being. In cases where parents disagree about their child's gender identity, clients need guidance on resolving conflicts through mediation, counseling, or court intervention. Attorneys can help clients understand their options and advocate for solutions that prioritize the child's best interests.

The evolving legal landscape and the politicization of transgender issues present both challenges and opportunities for family law attorneys and their clients. By staying informed, developing specialized knowledge, and advocating effectively, attorneys can play a crucial role in supporting transgender children and their families, ensuring that their rights and well-being are protected.

2. Legal Framework in Virginia

2.1. State Laws and Policies

2.1.1. 2020 law requiring model policies for transgender students.

§ 22.1-23.3. Treatment of transgender students; policies

https://law.lis.virginia.gov/vacode/title22.1/chapter3/§22.1-23.3/

2.1.2. Model Policies: In 2020, Virginia passed a law requiring the Department of Education to develop model policies for the treatment of transgender students. These policies cover various aspects, including compliance with nondiscrimination laws, maintaining a safe learning environment, and protecting student privacy.

2.1.3. In the news:

2.1.3.1. Virginia finalizes guidance on transgender students, including rolling back accommodations.

https://apnews.com/article/virginia-transgender-students-schools-youngkin-ba073a1e8a9286456a7509688f40115b

2.1.3.2. Virginia finalizes guidance on trans students, rolling back some accommodations for transgender students.

https://www.nbcnews.com/nbc-out/out-politics-and-policy/virginia-finalizes-guidance-trans-students-rolling-back-accommodations-rcna95086

2.1.3.3. Virginia Education Department releases new model policies on treatment for student's gender identity.

https://www.jacksonlewis.com/insights/virginia-education-department-releases-new-model-policies-treatment-student-gender-identity

2.1.3.4. Showing Up for Trans Students in Virginia | ACLU

https://www.aclu.org/news/lgbtq-rights/showing-up-for-trans-students-in-virginia

2.1.4. 2023 guidelines emphasizing parental notification and use of official records for names and pronouns. In July 2023, Governor Glenn Youngkin's administration finalized new guidelines that roll back some earlier accommodations. These new policies emphasize parental notification and require that students be referred to by the names and pronouns in their official records unless a parent approves otherwise.

2.1.5. Participation in school activities based on sex assigned at birth. The new guidelines state that participation in certain school programs and the use of facilities like bathrooms should be based on the sex assigned at birth, with modifications only as required under federal law.

2.2. Federal Protections

2.2.1. Title IX and its extension to gender identity and sexual orientation. This is a key federal law that prohibits discrimination based on sex in any education program or activity receiving federal financial assistance. In 2021, the U.S. Department of Education clarified that Title IX's protections extend to discrimination based on gender identity and sexual orientation.

2.2.2. Equal Protection Clause under the Fourteenth Amendment. Under the Fourteenth Amendment of the U.S. Constitution, the Equal Protection Clause ensures that no state shall deny any person within its jurisdiction the equal protection of the laws. This has been interpreted to protect transgender students from discrimination in schools.

2.2.3. First Amendment rights related to gender identity. This amendment protects the rights of students to express their gender identity, including the use of preferred names and pronouns.

The following is a link to an article that discusses the reality that there is no such thing as a "legal name." It "seeks to highlight the legal, moral, and philosophical wrongness of the notion that people have one uniquely identifying legal name."

There is No Such Thing As a 'Legal Name': A Strange, Shared Delusion by Austin A. Baker, J. Remy Green

https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3840603

2.2.4. Due Process Clause protections. Part of the Fourteenth Amendment, this clause protects individuals from being deprived of life, liberty, or property without due process of law. This has been used to argue for the rights of transgender students to be treated fairly and with dignity.

These laws collectively aim to ensure that transgender students can learn in a safe and supportive environment, free from discrimination and harassment.

[https://www.ed.gov/news/press-releases/us-department-education-confirms-title-ix-protects-students-discrimination-based-sexual-orientation-and-gender-identity]

3. **Custody and Visitation Considerations**

3.1. **Best Interests of the Child (§ 20-124.3).** In Virginia, the juvenile and domestic relations district court considers the best interests of the child when determining custody and visitation arrangements, as outlined in § 20-124.3 of the Virginia Code. The court evaluates several factors, including the child's needs, the parents' ability to meet those needs, and the child's relationship with each parent.

https://law.lis.virginia.gov/vacode/title20/chapter6.1/§20-124.3/

A child's status as transgender can impact the court's considerations in the following ways:

3.1.1. **Child's needs, including mental and emotional well-being.** The court will consider the specific needs of the transgender child, including their mental and emotional well-being. This may involve evaluating the support each parent provides for the child's gender identity.

https://law.lis.virginia.gov/vacode/title20/chapter6.1/§20-124.3/

3.1.2. **Parental support for the child's gender identity.** The court will assess each parent's willingness and ability to support the child's gender identity. This includes respecting the child's preferred name and pronouns and providing access to appropriate medical and psychological care.

https://law.lis.virginia.gov/vacode/title20/chapter6.1/§20-124.3/

3.1.3. **Safe and supportive environment.** Ensuring a safe and supportive environment is crucial. The court will consider whether each parent can provide a home environment free from discrimination, bullying, or harassment related to the child's transgender status.

https://law.lis.virginia.gov/vacode/title20/chapter6.1/§20-124.3/

3.1.4. **Expert testimony and child's preference.** The court may also consider testimony from medical and psychological experts who can provide insights into the child's needs and the impact of their transgender status on their well-being.

The court's primary focus is on the best interests of the child, and they will take into account how each parent's actions and attitudes towards the child's transgender status affect their overall well-being.

https://law.lis.virginia.gov/vacode/title20/chapter6.1/§20-124.3/

3.2. **Resolving Parental Disagreements.** When two parents disagree about their child's transgender status and how to parent them, Virginia courts will weigh their respective positions based on the best interests of the child, as outlined in § 20-124.3 of the Virginia Code. Here are some key considerations:

3.2.1. **Mediation and counseling.** Parents can seek mediation to try to reach an agreement with the help of a neutral third party. This process can help facilitate communication and find a mutually acceptable solution.

Engaging in family counseling or therapy can provide a supportive environment for parents and the child to discuss their feelings and concerns. A professional therapist can help mediate the discussion and offer guidance.

3.2.2. **Court intervention and specific issue orders.** If mediation and counseling do not resolve the disagreement, either parent can file a

petition in the juvenile and domestic relations district court. The court will consider the best interests of the child, as outlined in § 20-124.3 of the Virginia Code, and make a determination on custody and visitation.

3.2.3. **What are prohibited steps orders?** In other countries (UK), parents can apply for an order prohibiting steps by one parent from taking certain actions regarding the child's gender identity without the court's permission. Virginia relies on best interest of the child standards in § 20-124.3.

https://www.wiselaw.co.uk/parents-disagree-child-gender/

3.2.4. **Importance of legal representation.** Seeking legal representation from an attorney experienced in family law and LGBTQ+ issues can help parents navigate the legal process and advocate for their position effectively.

These steps aim to ensure that the child's best interests are prioritized while addressing the parents' concerns and disagreements.

4. The Role of the United States Supreme Court and the Executive Branch on Transgender Rights

4.1. Impact of Bostock v. Clayton County, 590 U.S. 644 (2020)

4.1.1. **Employment protections and broader legal implications.** The ruling established that discrimination based on gender identity or sexual orientation is a form of sex discrimination under Title VII of the **Civil Rights Act of 1964**. This means that transgender individuals are protected from employment discrimination in workplaces with fifteen or more employees.

https://www.aclu.org/news/civil-liberties/how-the-impact-of-bostock-v-clayton-county-on-lgbtq-rights-continues-to-expand

4.1.2. **Title IX protections for transgender students.** The **Bostock** decision, which ruled that discrimination based on gender identity or sexual orientation is a form of sex discrimination under Title VII, has been extended to Title IX. This means that transgender students are protected from discrimination in federally funded educational institutions.

https://www.aclu.org/news/civil-liberties/how-the-impact-of-bostock-v-clayton-county-on-lgbtq-rights-continues-to-expand

4.1.3. **Encouraging inclusive practices in schools.** The clear federal ban on employment discrimination has encouraged employers to adopt more inclusive practices and policies to prevent discrimination and support transgender employees.

https://www.aclu.org/news/civil-liberties/how-the-impact-of-bostock-v-clayton-county-on-lgbtq-rights-continues-to-expand

4.1.4. **Questionable legal precedent?** The **Bostock** decision has set a precedent for numerous lawsuits involving transgender rights. Courts have cited **Bostock** in cases challenging discriminatory practices in schools, healthcare, and other areas, reinforcing the protection of transgender individuals under federal law.

https://www.aclu.org/news/civil-liberties/how-the-impact-of-bostock-v-clayton-county-on-lgbtq-rights-continues-to-expand

Overall, the **Bostock** decision has significantly strengthened the legal protections for transgender students, ensuring they are safeguarded against discrimination in educational settings.

4.2. **United States v. Jonathan Skrmetti.** This case involves a challenge to Tennessee's law banning gender-affirming care for minors. The law restricts access to puberty blockers, hormone therapy, and surgery for transgender individuals under. The Supreme Court will hear arguments during its 2024-2025 term.

https://www.newsweek.com/supreme-court-case-transgender-rights-gender-affirming-care-1916571

4.3. **Biden Administration's Anti-discrimination Rules.** Following the **Bostock** decision, the Biden administration directed federal agencies to incorporate the ruling into their policies. This has led to broader protections for transgender individuals in various areas, including education, healthcare, and housing.

https://www.aclu.org/news/civil-liberties/how-the-impact-of-bostock-v-clayton-county-on-lgbtq-rights-continues-to-expand

The Supreme Court recently blocked the Biden administration's new anti-discrimination rules for transgender students in certain states. These rules, which are in effect in some states, aim to protect LGBTQ+ students from discrimination under Title IX. The vote was 5-4.

https://www.scotusblog.com/2024/08/supreme-court-blocks-temporary-enforcement-of-expanded-protections-for-transgender-students/

4.4. **Gender-affirming care bans.** The Supreme Court will also hear a major case that could determine whether states can block transgender youth from receiving gender-affirming healthcare. This case addresses the broader issue of state-level restrictions on gender-affirming treatments.

https://www.newsweek.com/supreme-court-case-transgender-rights-gender-affirming-care-1916571

5. **Ongoing legal challenges related to transgender student rights under Title IV following the Bostock decision.**

5.1. **Bathroom Policies:** Federal appellate courts are divided on whether school policies that prohibit transgender students from using bathrooms consistent with their gender identity violate Title IX. The

Fourth and Seventh Circuits have ruled that such policies can violate Title IX, while the Eleventh Circuit has rejected this view.

https://crsreports.congress.gov/product/pdf/LSB/LSB10953

5.2. **Biden Administration's Title IX Rules:** The Biden administration issued new Title IX regulations that add protections for LGBTQ+ students, including transgender students. However, more than a dozen Republican-led states have sued the administration over these regulations, leading to a legal battle over their enforcement.

https://crsreports.congress.gov/product/pdf/LSB/LSB10953

5.3. **Temporary Injunctions:** Some states have obtained temporary injunctions that prevent the U.S. Department of Education from enforcing the new Title IX regulations. As of now, 26 states have challenged these regulations in court, and seven temporary injunctions have been granted.

https://crsreports.congress.gov/product/pdf/LSB/LSB10953

5.4. **Transgender Student Athletes:** The Biden administration initially planned to include a policy forbidding schools from enacting outright bans on transgender athletes, but this provision was put on hold. This delay has led to ongoing debates and potential legal challenges regarding the participation of transgender athletes in school sports.

These legal challenges highlight the ongoing disputes and evolving nature of transgender rights under Title IX, with significant implications for transgender students across the United States.

https://crsreports.congress.gov/product/pdf/LSB/LSB10953

6. Current Public-School Policies in Virginia

6.1. Key Points of Recent Policies

6.1.1. **Parental notification requirements.** Schools must notify parents about any discussions involving a student's gender identity. This policy emphasizes the role of parents in making decisions about their child's gender identity.

6.1.2. **Use of names and pronouns from official records.** Students must be referred to by the names and pronouns listed in their official records unless a parent approves the use of different names or pronouns.

6.1.3. **Participation in school activities and use of facilities based on sex assigned at birth.** Participation in certain school programs and the use of facilities like bathrooms and locker rooms should be based on the sex assigned at birth. Modifications are only made as required under federal law.

These public school policies do not reflect the best interests of all students, but rather impose a narrow and exclusionary view of gender. Instead of creating barriers based on hypothetical scenarios, the state should seek to address the real challenges faced by transgender youth and their inclusion in the public school population. A more balanced and respectful solution is possible and necessary.

7. Policy Changes and Legal Challenges

7.1. **Comparison with other states.** Virginia's approach is more restrictive compared to some states but less so than others that have enacted outright bans on gender-affirming care for minors. The state's policies are still evolving, and ongoing legal and political developments will continue to shape the landscape for transgender children in Virginia.

https://www.nbcnews.com/nbc-out/out-politics-and-policy/virginia-finalizes-guidance-trans-students-rolling-back-accommodations-rcna95086

7.2. A Closer Look at Virginia Beach City Public Schools: Treatment of Transgender Students 5-7.1. The Virginia Beach School Board recently adopted revised transgender model policies that align with Governor Youngkin's administration. Here are the key points of these policies. The policy states that school personnel must respect students' variations in sexuality, gender identity, expression, and/or presentation, and provide them with a safe and positive learning environment.

https://schoolboard.vbschools.com/policies/§-5/5-7-1

The policy also states that school personnel must adhere to legal standards of confidentiality regarding a student's gender identity, legal name, or sex assigned at birth, and not disclose such information to other students or parents without a legitimate educational interest or written consent from the student or the parent.

The policy further states that school personnel must refer to each student using only the name and pronoun that appear in the student's official record, or that the student or the parent has designated in the official record, unless instructed otherwise in writing. The recognized pronouns are he, she, or they.

The policy also states that student records that require the student's legal name and sex will reflect those as designated in the official record unless a legal document substantiates a change in the student's legal name or sex.

The policy also states that sex and gender-based practices should be limited to serve legitimate, educational goals or for otherwise non-discriminatory purposes, and that sex and gender grouping for class activities or school events should not be used unless necessary. The policy also states that for any school program, event, or activity that are separated by sex, the appropriate participation of students will be

determined by sex rather than gender or gender identity, unless a reasonable modification is provided by law.

The policy also provides a legal reference to the Virginia Human Rights Act and the Virginia law that requires school boards to adopt policies on the treatment of transgender students.

The policy is similar to those adopted by other local cities, such as Chesapeake and Norfolk, that also require parental notification and consent for using names and pronouns different from those in official records, and that also base participation in sex-specific activities and use of facilities on the sex assigned at birth.

The policy document from Virginia Beach Public Schools outlines comprehensive guidelines for the treatment of transgender students, emphasizing respect for variations in sexuality, gender identity, expression, and presentation. It mandates that school personnel provide a safe and positive learning environment while adhering to legal standards of confidentiality regarding a student's gender identity, legal name, or sex assigned at birth. School staff must use the names and pronouns listed in the student's official records unless otherwise instructed in writing, recognizing pronouns such as he, she, or they. Student records must reflect the legal name and sex as designated in official documents unless legally changed.

The policy limits sex and gender-based practices to legitimate educational goals and non-discriminatory purposes, determining participation in sex-separated activities based on sex rather than gender identity unless legally modified. It references the Virginia Human Rights Act and state laws requiring school boards to adopt policies for transgender students.

Like policies in Chesapeake and Norfolk, it requires parental notification and consent for using names and pronouns different from official

records and bases participation in sex-specific activities and facility use on the sex assigned at birth. The policy includes adoption and revision dates by the superintendent and school board.

Legal References:

Code of Virginia § 2.2-3900, *et seq.*, as amended. Virginia Human Rights Act.

Code of Virginia § 22.1-23.3, as amended. Treatment of transgender students; policies.

Adopted by Superintendent: September 28, 2021, Revised by School Board: October 10, 2023.

7.3. Other local cities in Southeastern Virginia:

7.3.1. Chesapeake Public Schools: Like Virginia Beach, Chesapeake has adopted policies that require parental notification and consent for using names and pronouns different from those in official records. Students must use facilities that correspond to their sex assigned at birth.

7.3.2. Norfolk City Public Schools: Norfolk has also implemented policies that emphasize parental involvement and require students to use names and pronouns listed in their official records unless a parent approves otherwise. Participation in sex-specific activities and use of facilities are based on the sex assigned at birth.

7.3.3. Portsmouth Public Schools: Portsmouth follows the state guidelines, requiring parental consent for changes in names and pronouns and mandating the use of facilities based on the sex assigned at birth.

7.3.4. Hampton City Schools: Hampton's policies are consistent with the state model, emphasizing parental rights and requiring students to use names and pronouns in their official records unless a parent

approves otherwise. Facilities and activities are also based on the sex assigned at birth.

Broadly speaking, the policies in these neighboring districts are quite similar, reflecting the state's emphasis on parental involvement and the use of official records for names and pronouns. These policies have sparked significant debate and varying levels of acceptance across different communities.

8. Resources for Transgender Students

8.1. Support Organizations

8.1.1. Virginia Department of Health's Transgender Resource and Referral List. The Virginia Transgender Resource and Referral List provides information on legal, medical, and mental health resources across different regions in Virginia. This list is updated regularly to ensure accuracy.

https://www.vdh.virginia.gov/content/uploads/sites/10/2019/04/TransRRList.pdf

8.1.2. Equality Virginia. This organization offers information, referrals to community resources, and advocacy for LGBTQ+ individuals. They also provide community education and outreach.

https://equalityvirginia.org/

8.1.3. He She Ze and We. A statewide non-profit offering weekly support meetings for parents, caregivers, and adult family members of transgender and gender-diverse individuals. They provide both virtual and in-person meetings.

https://heshezewe.org/

8.1.4. PFLAG. This organization provides resources specifically for transgender and nonbinary youth in Virginia, including support hotlines and connections to local partner organizations.

https://pflag.org/

8.1.5. U.S. Department of Education's toolkit. They offer a toolkit for supporting LGBTQI+ youth and families in schools, which includes information on student-led groups and other federal resources.

https://www2.ed.gov/about/offices/list/ocr/docs/lgbtqi-student-resources-toolkit-062023.pdf

These resources aim to create a supportive and inclusive environment for transgender students in Virginia schools.

8.2. Legal Support for Transgender Youth

8.2.1. ACLU of Virginia. The American Civil Liberties Union (ACLU) of Virginia offers legal assistance and advocacy for transgender youth facing discrimination. They work on various issues, including school policies and access to gender-affirming care.

https://www.aclu.org/news/lgbtq-rights/showing-up-for-trans-students-in-virginia

8.2.2. Equality Virginia. This organization provides information, referrals, and advocacy for LGBTQ+ individuals. They focus on creating inclusive environments and protecting the rights of transgender youth.

https://equalityvirginia.org/

8.2.3. Transgender Legal Defense & Education Fund (TLDEF). "Leveraging decades of experience on the frontlines of power, we shift government and society towards a future where we are no less than equal. A4TE was founded in 2024 as the National Center for

Transgender Equality (NCTE) and Transgender Legal Defense and Education Fund (TLDEF), two long-time champions for the trans community, merged together as one organization. A4TE builds on their successes to boldly imagine a world where trans people live our lives joyfully and without barriers."

https://transequality.org/

8.2.4. **Lambda Legal.** This national organization provides legal support and advocacy for LGBTQ+ individuals, including transgender youth. They have resources and can offer assistance to those in Virginia.

https://www.aclu.org/news/lgbtq-rights/showing-up-for-trans-students-in-virginia

These organizations aim to protect the rights and well-being of transgender youth through legal support and advocacy.

8.2.5. **National LGBTQ+ Bar Association.** The National LGBTQ+ Bar cannot provide any legal counsel or advice; however, they can provide you with resources on how to find an LGBTQ+ welcoming and affirming attorney.

https://lgbtqbar.org/

8.2.6. **LGBT Family Law Institute.** "The LGBT Family Law Institute is a joint venture of the LGBTQ_ Bar and the National Center for Lesbian Rights, allowing experienced LGBTQ+ family law practitioners to share collective wisdom and to discuss cutting-edge legal strategies for representing members of the LGBTQ+ community."

https://lgbtqbar.org/programs/member-practice-area-groups/family-law-institute/

9. Beyond Sports, Restrooms, and Locker Rooms

9.1. Parental involvement and privacy. Transition does not equal medical/surgical intervention. Every child's journey and, as such, every parent's journey, is unique. In addition to the possibility of medical and surgical transitions, there are a number of ways in which children transition.

Many begin by socially transitioning in some form or fashion. All humans evolve in their social interactions as they mature, but there is an added layer of complexity to a child wrestling with a need to transition socially. This typically involves how the child presents themselves in everyday life. It can include adopting a new name, using different pronouns, changing hairstyles, and wearing clothing that matches their gender identity. It is often, but not always, the first step and can be particularly important for children.

Some children transition legally, by name and congruent sex/gender recognition. This includes updating their legal documents to reflect the child's gender identity and can involve changing their name and gender marker on birth certificates, school records, and other official documents. This process and the requirements to achieve such a transition vary state by state. Please note that Virginia no longer requires medical or surgical transitions as component of a legal transition.

Most importantly, children and their parents should seek psychological support from counselors or therapists. This type of support is crucial to helping the family navigate the emotional and social aspects of transitioning.

Compassion, kindness, and patience are crucial during any transition for both children and their parents or guardians. All decisions should remain confidential until the child and their parents choose to share.

9.2. **The age at which a child might begin medical transition can vary, but here are some general guidelines:**

9.2.1. **Puberty Blockers:** These are often the first step in medical transition for transgender youth. Puberty blockers can be prescribed at the onset of puberty, which typically occurs around ages 10-12 for girls and 11-13 for boys. These medications temporarily halt the physical changes of puberty, giving the child more time to explore their gender identity without the added stress of unwanted physical changes. These medications are commonly used, without objection or protest, with cisgender children experiencing early onset puberty.

9.2.2. **Hormone Therapy:** The World Professional Association for Transgender Health (WPATH) recommends that hormone therapy can begin around age 14. This involves taking estrogen or testosterone to develop secondary sex characteristics that align with the individual's gender identity. Parental consent and a thorough psychological evaluation are usually required.

9.2.3. **Gender-Affirming Surgeries:** Some surgeries, such as chest surgery, may be considered around age 15-17 (although, not commonly conducted until the individual is eighteen or older), depending on the individual's needs and circumstances. Other surgeries, like genital surgery, are typically not performed until the individual is eighteen or older.

9.3. **Psychological Support:** Throughout the transition process, ongoing psychological support from counselors or therapists is crucial. This support helps children and their families navigate the emotional and social aspects of transitioning.

These steps are tailored to each individual's needs and circumstances, and decisions are made in consultation with healthcare professionals, the child, and their family.

9.4. **§ 54.1-2409.5. Conversion therapy prohibited.** As used in this section, "conversion therapy" means any practice or treatment that seeks to change an individual's sexual orientation or gender identity, including efforts to change behaviors or gender expressions or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same gender. "Conversion therapy" does not include counseling that provides acceptance, support, and understanding of a person or facilitates a person's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, as long as such counseling does not seek to change an individual's sexual orientation or gender identity.

No person licensed pursuant to this subtitle or who performs counseling as part of his training for any profession licensed pursuant to this subtitle shall engage in conversion therapy with a person under 18 years of age. Any conversion therapy efforts with a person under 18 years of age engaged in by a provider licensed in accordance with the provisions of this subtitle or who performs counseling as part of his training for any profession licensed pursuant to this subtitle shall constitute unprofessional conduct and shall be grounds for disciplinary action by the appropriate health regulatory board within the Department of Health Professions. 2020, cc. 41, 721.

10. Debunking the Desistence Myth

10.1. **80% of young people diagnosed with gender dysphoria grow out of it by the time they're 18.** The origin of this desistance myth is a study conducted by Keneth J. Zucker and Susan J. Bradley, where they found that out of the 45 *gender non-conforming* children of their study, 80% were found not to be transgender after a follow up in their high school years. Since this study was conducted in 1995, none of these children were diagnosed with gender dysphoria, a diagnosis that was not

established until in the DSM-5. The now defunct diagnosis of gender identity disorder from the DSM-4 required only four (or more) of the following:

1. Repeatedly stated desired to be, or insistence that he or she is, the other sex
2. In boys, preference for cross-dressing or simulating female attire; in girls; insistence on wearing only stereotypical masculine clothing
3. Strong and persistence preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex
4. Strong prefer for playmates of the other sex

Although included as an option, the first criterion was not required for an official diagnosis.

The DSM-5 now defines gender dysphoria in adolescents as a marked incongruence between one's experienced/expressed gender and their assigned gender, lasting at least 6 months, as manifested by at least six of the following (one of which must be the first criterion):

1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender)
2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to wearing of typical feminine clothing
3. A strong preference for cross-gender roles in make-believe play or fantasy play
4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender
5. A strong preference for playmates of the other gender
6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-

tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities

7. A strong dislike of one's sexual anatomy
8. A strong desire for the physical sex characteristics that match one's experienced gender

To meet criteria for the diagnosis, the condition must also be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

To put it plainly, a diagnosis is something that should only be rendered by a professional, and any treatments by the parents or legal guardian and the children and their medical/psychological professionals, not politicians or other policy makers. To quote Virginia's own Attorney General, Steve Miyares, "parents, not government, are in the best position to work with their children on important life decisions, and no parent signs up to co-parent with the government. In fact, the rights of parents are one of our oldest and most fundamental liberty interests."

"The [Zucker Bradley] study sample represented a broad spectrum of gender non-conformity, not just those who actually desired to be or insisted they were a different sex or gender. This was not exclusively a sample of transgender or gender dysphoric children by today's accepted standards."

In 2013, the infamous Thomas Steensma study, stated in its introduction that "[a]t the time of follow-up in adolescence or adulthood, ... studies showed that, for the majority of the children (84.2%; n=207), the GD desisted" The citation for this reference is another of Steensma's studies from 2011, which, itself, references the same statistic in its introduction, stating that "[f]eelings of gender dysphoria persisted into adolescence in only 39 out of 246 of the children (15.8%)." Steensma calculated this number by combining the numbers from a number of different studies, where 7 out of 10 of the studies were dated before there was even a

diagnosis for gender dysphoria and a few dating back to the 1960s and 1970s when there wasn't even a proper clinical understanding of gender identity. Even the most recent four studies relied upon predated the replacement of the now-defunct diagnosis of gender identity disorder. These studies could not have properly identified adolescents that may be diagnosed with gender dysphoria applying today's standards. Further, the Amsterdam study referenced in the Steensma's study stated, that "the Amsterdam clinic is the only gender identity service in the Netherlands where psychological and medical treatment is offered to adolescents with gender dysphoria, so they "*assumed* that for the 80 adolescents (56 boys and 24 girls), who did not return to the clinic, that their gender dysphoria had desisted, and that they no longer had a desire for gender reassignment." Any conclusions from this type of flawed methodology are invalid.

The Steensma study stated that "explicitly asking children with gender dysphoria with which sex they identify seems to e of great value in predicting a future outcome for both boys and girls with gender dysphoria. This falls directly in line with current diagnostic criteria for gender dysphoria and contradicts the narrative that we should not listen to young people who persistently identify as another gender, because they will most likely stop doing so in the future. The most popular source cited for this myth fails to support and even contradicts the myth itself.

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https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf

https://www.erininthemorning.com/p/debunked-no-80-of-trans-youth-do

Video of Montana hearing on SB 99:
https://sg001-harmony.sliq.net/00309/Harmony/en/PowerBrowser/PowerBrowserV2/20230127/-1/45413

11. Positions of Key Virginia Officials

11.1. Governor Glenn Youngkin

11.1.1. **Emphasis on parental rights and involvement.** Governor Youngkin's stance on transgender youth in Virginia emphasizes parental rights and involvement in decisions regarding their children's gender identity. Here are some key points, which are in line with most parents of transgender youth, whereby decisions should be made in consultation with healthcare professionals, the child, and their family:

https://apnews.com/article/virginia-transgender-students-schools-youngkin-ba073a1e8a9286456a7509688f40115b

11.1.2. **Parental Notification:** Governor Youngkin's administration has implemented policies that require schools to notify parents about any discussions or changes related to a student's gender identity. This policy aims to ensure that parents are involved in these decisions.

11.1.3. Names and Pronouns: The policies mandate that students be referred to by the names and pronouns listed in their official records unless a parent approves otherwise.

11.1.4. Use of Facilities: The guidelines state that students should use restrooms and locker rooms that correspond to the sex assigned at birth, with modifications only as required under federal law.

11.1.5. Emphasis on Privacy and Dignity: Governor Youngkin has said that these policies are designed to protect the privacy, dignity, and respect of all students and parents in the school system.

These policies have been met with mixed reactions, with some advocating for increased parental rights and others expressing concern about the potential impact on transgender students' well-being.

11.2. Attorney General Jason Miyares

11.2.1. Support for Parental Rights: Miyares has consistently supported policies that prioritize parental involvement in decisions about their children's gender identity. He has said that parents, not the government, are best positioned to make important life decisions for their children.

https://www.wusa9.com/article/news/local/virginia/miyares-weighs-in-on-virginia-transgender-model-policies/65-a351877d-1779-41ad-9e1e-9298e8427a55

11.2.2. Backing Youngkin's Policies: Miyares has backed Governor Glenn Youngkin's model policies for transgender students, which require parental notification and consent for changes in names and pronouns and mandate the use of facilities based on the sex assigned at birth.

11.2.3. Legal Actions: Miyares has led coalitions and filed amicus briefs in support of parental rights in cases involving transgender students. For example, Miyares led a sixteen-state coalition asking the Supreme Court to hear a case challenging school guidelines that allow students to change their gender identity without parental consent.

https://www.wusa9.com/article/news/local/virginia/miyares-weighs-in-on-virginia-transgender-model-policies/65-a351877d-1779-41ad-9e1e-9298e8427a55

11.2.4. Opposition to Certain Legislation: Miyares has voiced opposition to legislation that he believes infringes on parental rights, such as bills that would criminalize a parent's disagreement with their child's stated gender identity.

https://www.wusa9.com/article/news/local/virginia/miyares-weighs-in-on-virginia-transgender-model-policies/65-a351877d-1779-41ad-9e1e-9298e8427a55

Overall, Miyares's position focuses on ensuring that parents have a central role in decisions about their children's gender identity and that schools work in partnership with parents.

12. Summary

12.1. Importance of Understanding and Supporting Transgender Children. Understanding and supporting transgender children is crucial due to the significant impact on their development, mental health, and overall well-being. The growing visibility and legal recognition of transgender individuals, especially children, have led to advancements in rights and protections, ensuring they can live authentically and with dignity. However, this issue has become highly politicized, resulting in a patchwork of laws and policies across the United States. Family law

attorneys must navigate these complexities to advocate effectively for transgender children.

12.2. **Role of Family Law Attorneys in Advocating for the Best Interests of Transgender Children.** Family law attorneys play a vital role in advocating for the best interests of transgender children. They must stay updated on the latest legal developments and understand how they impact custody, visitation, and other family law matters. Attorneys need to develop a deep understanding of transgender issues, including medical, psychological, and social aspects, to address the unique challenges these children face. Balancing the rights of parents with the welfare of the child, especially in cases where parents disagree about their child's gender identity, involves applying legal standards that prioritize the child's best interests while respecting parental involvement.

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Lawyer Wellness?????????

Navigating Occupational Risks to Practicing Law and Cultivating Attorney Well-being

Presented by:

The Virginia Judges and Lawyers Assistance Program

In this presentation, JLAP briefly describe the studies/surveys that gave rise to the well-being movement in the legal profession, define well-being and its dimensions, review the occupational risks identified by the National Task Force, discuss the reasons the legal profession needs to change, cover some of the ethical rules and identify coping skills.

Report of the Virginia State Bar
President's Special Committee
on Lawyer Well-Being

The Occupational Risks of the Practice of Law

Update
June 2022

INTRODUCTION

In the mid-2010s, lawyer well-being became a focal point of the legal profession. Lawyers had long anecdotally known that their profession suffered from wellness deficiencies, but the National Task Force on Lawyer Well-Being's landmark 2017 report elevated the discussions of lawyer well-being to a national level. Prompted by this report, the profession as a whole began a period of self-examination and evaluation. Other studies, reports, and initiatives focusing on lawyer wellness followed, but few attempted a detailed study of the reasons why lawyers experience wellness issues at a disproportionate rate compared to the general public.

In 2018, Virginia State Bar President Leonard C. Heath, Jr. sought to remedy this omission by convening the President's Special Committee on Lawyer Well-Being to identify specific aspects or characteristics of the practice of law that might serve as a risk to a lawyer's well-being. After an intensive year of research, study, discussions, and drafting, that Committee in May 2019 published a first-of-its-kind Report[1] identifying twenty occupational risks of the practice of law.

To maximize its usefulness to lawyers and other legal professionals, the Report adopted a novel structure by sorting the risks into four categories and presenting them in a digestible matrix format followed by more in-depth discussions of each risk and how individuals and organizations can combat them. The four categories are:

- **Physical Risks** that directly affect a lawyer's bodily health;
- **Mental and Emotional Risks**, which refer to conditions of law practice that harm psychological well-being;
- **Adaptation Risks** related to the changing nature of law practice in the twenty-first century; and
- **Self-Actualization Risks**, which borrowing from the final tier of Maslow's hierarchy of needs, refer to situations that prevent lawyers from flourishing or reaching a state of contentment.

1 The Occupational Risks of the Practice of Law: Report of the Virginia State Bar President's Special Committee on Lawyer Well-Being, May 2019, https://www.vsb.org/docs/VSB_wellness_report.pdf.

Since the Report's publication, the legal profession has endured the COVID-19 pandemic, which upended the practice of law more than any other single event in living memory. Depending on the month and ever-evolving virus, the pandemic disrupted the delivery of legal services. Observing this, in 2021, Virginia State Bar President Jay B. Myerson convened a second, smaller Special Committee on Lawyer Well-Being with a narrow mission: review the changes to the legal profession since May 2019 particularly with regard to those caused by the pandemic, and provide an update to the Report to address the ways the occupational risks of the practice of law have changed. President Myerson's goal was to keep lawyer well-being at the forefront of discussions within our profession and to build upon the Virginia State Bar's May 2019 report.

Seven individuals, including veterans of the original 2018–19 Special Committee on Lawyer Well-Being and new members representing a broad cross-section of the legal profession, were selected to carry out this update to the original 2019 Report. The members of the Committee are as follows:

Leonard C. Heath, Jr., Esq., Chair
Heath, Old & Verser , P.L.C.
Newport News, VA

Graham K. Bryant, Esq., Editor
Office of the Attorney General of Virginia
Richmond, VA

Hon. Manuel A. Capsalis
Fairfax County General District Court
Fairfax, VA

Hetal Challa, Esq.
Challa Law, P.C.
Virginia Beach, VA

Margaret E. Hannapel, Esq.
Supreme Court of Virginia
Richmond, VA

Macel H. Janoschka, Esq.
Frith Anderson & Peake, P.C.
Roanoke, VA

Dean Laura Shepherd
William & Mary Law School
Williamsburg, VA

Crista Gantz
Virginia State Bar Staff Liaison

After reviewing the changes to lawyer well-being wrought in the years since the 2019 Report, the Committee determined that the 20 occupational risks identified in that report continued to accurately reflect the primary occupational risks to lawyers. The Committee was unable to identify any additional risks that were meaningfully distinct from the 20 risks previously recognized. The Committee believed, however, that many of those risks were exacerbated by the pandemic. As an example, the risk designated "Business Management of the Practice of Law" saw new challenges. Lawyers managing their firms were confronted with implementing safety precautions, reacting to mandatory shutdowns, working with PPP loan applications and loan forgiveness forms, managing layoffs or reductions in force, setting up work-from-home infrastructure, and deciding when employees could safely return to the office. Similar examples could be provided for most of the previously identified risks.

As the Committee's work progressed this year, the country moved from COVID-19 pandemic phase to a COVID-19 endemic phase. Fortunately, with the arrival of vaccines and treatments, and a better understanding of the virus, society as a whole, and the profession in particular, returned to a somewhat "normal" routine. Nevertheless, the Committee believes that the pandemic has changed the profession. Rather than focusing its report on how the occupational

risks of the practice of law were impacted during the pandemic, the Committee decided to focus on those previously identified occupational risks that were impacted most by *lasting and continuing changes.* With this new and more focused scope, the Committee recognized that significant developments in the practice of law had affected in particular three occupational risks: Individual Work, Changing Legal Paradigms, and Lack of Diversity in the Legal Profession.

As the Report was being written, Committee members also decided to draft it in such a way as to document and memorialize for posterity's sake at least part of the struggles endured during the COVID-19 pandemic and the creative and effective means by which lawyers continued to provide much needed legal services.

This 2022 Report is designed to supplement the 2019 Report. Accordingly, this Report includes updated discussion and matrix entries for these three previously identified occupational risks.[2]

Goals of the Committee

This Committee shares two of the goals of the 2018–19 President's Special Committee on Lawyer Well-Being. The first goal is for this Report to serve as an accessible resource for all those participating in the legal community, including lawyers, judges, law students, legal assistants, law office staff, and clerks of court and their staff. The second goal is for the Report to help those who, despite lacking familiarity with the legal profession, may nonetheless be most keenly aware of lawyers' or judges' wellness issues: the spouse, significant other, and family members of an affected legal professional. In addition, while the Committee was performing its work, the members came to the realization that this Report may also serve as a historical prospective of the impact of the pandemic on the legal profession. We are hopeful that with the passage of time, memories of the hardship inflicted on our profession, and that of society as a whole, may fade. This Report will hopefully serve as a small historical observation of the impact of the pandemic and the resilience of the legal profession. Let this Report be a remembrance that in the worst of times, members of our great profession found a way to continue to serve society and promote the Rule of Law.

Dedication

This Report is dedicated to Lawyers Helping Lawyers, the organization established in 1985 to assist impaired lawyers across the Commonwealth of Virginia. In 2019, Lawyers Helping Lawyers became the Virginia Judges and Lawyers Assistance Program. Prior to this transformation, Lawyers Helping Lawyers relied substantially upon charitable donations and the work of its core volunteers to provide a much-needed service to the legal profession and to protect the public. These volunteers were able to support Lawyers Helping Lawyers through difficult times and keep it operational long enough for its vision, utility, and value to be recognized during the Virginia Lawyers Initiative. As part of the Virginia Lawyers Initiative, Lawyers Helping Lawyers became the Virginia Judges and Lawyers Assistance Program, a fully, reliably, and permanently funded program dedicated to providing services to Virginia's judges, lawyers, legal staff, clerks of court, and law students.

2 In addition, the Committee recommends that readers interested in a broader discussion of how the COVID-19 pandemic affected the legal profession beyond wellness considerations read the 2022 Future of Law Practice Report prepared by the VSB Special Committee on Technology and the Future of Law Practice and issued on May 24, 2022.

Supplemental Matrix of Occupational Risks to Lawyer Well-Being

MENTAL AND EMOTIONAL RISKS			
Risk Description	**Potential Effects**	**Practice Pointers for Individuals**	**Practice Pointers for Organizations**
Individual Work	The individual nature of a lawyer's profession can lead to feelings of isolation. In fact, legal work in general has been considered the loneliest kind of work. The COVID-19 pandemic only exacerbated the loneliness problem by preventing in-office and in-person social interactions while increasing lawyers' stress.	• Proactively reach out to colleagues, even if working from home. • If feasible, go into the office several times a week to maintain relationships. • Go outside for your lunch break. • Intentionally schedule participation in bar association activities, conferences, and seminars. • Proactively schedule social time with friends and family.	• Recognize the importance of facilitating professional relationships and adjust office-attendance policies accordingly. • Develop a system to maintain regular contact with employees working from home to monitor their well-being — not to surveil them. • Redouble efforts to provide mentorship programs recognizing that prevalent work-from-home schedules inhibit professional interaction. • Create an environment that facilitates serendipitous interactions.

ADAPTATION RISKS			
Risk Description	**Potential Effects**	**Practice Pointers for Individuals**	**Practice Pointers for Organizations**
Changing Legal Paradigms	In addition to disruption caused by the digital revolution, pandemic-era innovations like working from home and the rise of videoconferencing have created new challenges for lawyers, including home office syndrome (stress and exhaustion associated with blurred boundaries between work and home life) and Zoom fatigue (burnout associated with overuse of virtual communication platforms).	**Home Office Syndrome** • Cultivate psychological boundaries between "work" and "home." • Create dedicated work spaces. • Establish fixed start and end time for workday. • Follow a routine to replicate the rhythms of an in-office work day. • Wear different clothing for work and home time. • Establish routine that helps you transition from home mode to work mode, and vice versa. **Zoom Fatigue** • Avoid videoconferencing in full-screen and instead use a smaller window relative to the monitor size. • Maintain distance from screen and web cam. • Avoid multitasking and build in breaks for longer video calls. • Build in breaks for longer videoconferences. • Use speaker only view. • Appoint facilitator to run virtual meetings. • Avoid continuous use of videoconferencing by employing mix of communication methods (phone calls, emails, in-person conversations). • Use the 20-20-20 rule—focus on something 20 feet away for 20 seconds every 20 minutes of screen time.	**Home Office Syndrome** • Promote an organizational culture that encourages separating work from home, such as by permitting attorneys to turn off phones and computers after hours. • Provide those working from home with the resources they need to succeed, like standing desks, multiple monitors, blue-light/computer glasses, and laptop docks. • Implement software to minimize harms from extended use of screens. • Encourage in-person meetings when safe, including meetings outdoors. **Zoom Fatigue** • Implement software to minimize harms from extended use of screens.

LACK OF DIVERSITY IN THE LEGAL PROFESSION			
Risk Description	**Potential Effects**	**Practice Pointers for Individuals**	**Practice Pointers for Organizations**
Lack of Diversity in the Legal Profession	Diverse and inclusive working environments foster lawyer wellness. A lack of diversity, however, can lead to isolation, a sense of exclusion, and ultimately poor performance and a lack of autonomy. The COVID-19 pandemic caused a mass transition to remote work, leaving many diversity initiatives behind.	• Intentionally seek out colleagues with different backgrounds, particularly when working remotely or in times of limited office exposure. • Consider implicit biases and how working from home may have changed or exacerbated them.	• Consider diversity when establishing remote work policies to ensure diverse employees have opportunities to participate even if not in the office. • Evaluate organizational priorities as altered by pandemic disruption and reassess the role of diversity in organizational goals and culture. • Virtual communications should be evaluated to ensure diverse participation, not only as to attendees but also as to organizers and presenters.

MENTAL AND EMOTIONAL RISKS

Individual Work

The Risk

The COVID-19 pandemic made the legal profession even lonelier. Much of the legal profession experienced a work transformation between Friday, March 13 and Monday, March 16, 2020. During those four days, as a nation, we watched basketball tournaments canceled — sometimes mid-game. Phone calls were made from long-term care facilities to loved ones letting them know that the facilities would go on lockdown and that visitors would no longer be allowed. And, over the weekend, we went from a country that commuted to work every day to one that worked at home (if we were lucky).

At the beginning of the pandemic, there was a sense that we were all working together for the common good. People increased the frequency of calls to colleagues, friends, and neighbors to ensure that they were all right. Some people even reported feeling more engaged than before the pandemic.[1] But as weeks turned into months, a true sense of isolation and loneliness set in for many. Isolation was an important public health measure, but that isolation took its toll on mental health.

Law was already a lonely profession. The pandemic simply exacerbated the problem. A survey conducted by the American Bar Association between September 30 and October 11, 2020, in which over 4,200 ABA members responded, revealed the true extent of the transformation of the legal profession. Of all lawyers responding, 54% reported working from home close to 100% of the time. About 25% of respondents reported working from home between 25% and 75% of the time. Another 22% reported working from home close to 0% of the time. Beyond these figures, 60% of lawyers reported working on a flexible schedule. When focusing on those respondents with dependent children at home, that number increased to 65%.

1 Kira M. Newman, *Seven Ways the Pandemic Is Affecting Our Mental Health*, GREATER GOOD MAGAZINE, (Aug. 11, 2020), https://greatergood.berkeley.edu/article/item/seven_ways_the_pandemic_is_affecting_our_mental_health.

The same survey reported that over 90% of lawyers were spending more time on videoconference calls. About 55% reported spending less time developing business or reaching out to clients. About 70% of lawyers reported spending more time with the people they lived with than the previous year.[2]

In the legal profession, just like society as a whole, the effect was more severe on the young and the old. Young lawyers noticed a drop in billable hours due to partners holding onto more work.[3] There was no "clocking out" for young lawyers because many felt the need to be available 24/7.[4] Younger lawyers who had not had an opportunity to create connections with coworkers and mentors struggled more than most lawyers. Lawyers with children at home faced additional hurdles. Over time, younger lawyers reached out for assistance with increasing frequency. Many commentators started to observe a "lost generation of lawyers."[5]

> "There was no 'clocking out' for young lawyers because many felt the need to be available 24/7."

Bar associations, both mandatory and voluntary, ended all in-person activities. Like law firms, these organizations had to quickly adapt from working in a brick-and-mortar office to operating in a virtual world, with everyone working from home. For most, this involved immediate upgrades in technology and installation of software that was never needed before. While bar associations adapted to this new environment, their members were cut off from vital services. And as pointed out by the Committee that drafted the 2019 Report, many of the identified occupational risks of the practice of law could be minimized by associating with professional organizations and attending bar meetings. This was particularly true with the Individual Work risk, where the 2019 Report recommended that lawyers "[a]ctively participate in bar functions and organizations and develop relationships with legal colleagues."

The impact of the pandemic was even more severe on law students. Law students tend to learn just as much from interaction with classmates as with professors, and the personal connections created at law school often form lifelong professional bonds. But during the pandemic, structured virtual sessions replaced lively classroom discussions. The inability to get to know classmates in a meaningful way hampered the usual organic development of study groups. And, as the pandemic eased, law schools had to be creative and institute new orientation programs for second-year law students who had never physically been present in the law school building.

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2 Stephanie A. Scharf et al., Practicing Law in the Pandemic and Moving Forward: Results and Best Practices from a Nationwide Survey of the Legal Profession, Am. Bar Ass'n. (2021), https://www.americanbar.org/content/dam/aba/administrative/digital-engagement/practice-forward/practice-forward-survey.pdf.

3 Debra Cassens Weiss, *More Work Shifted to Law Partners as Demand for Legal Services Dropped, New Report Says*, ABA Journal (Aug. 13, 2020), https://www.abajournal.com/news/article/more-work-shifted-to-law-partners-as-demand-for-legal-services-dropped-report-says (ABA news article describing findings of 2020 Thomson Reuters Peer Monitor Index report).

4 Stacey A. Whiteley & Robin Belleau, *Supporting Associates Amid Pandemic's Mental Health Toll*, Law360, (Mar. 15, 2021) https://www.kirkland.com/publications/article/2021/03/supporting-associates-amid-pandemic.

5 Weiss, *supra*.

Fortunately, from this Committee's perspective, the worst of the exacerbation of this particular occupational risk appears to be temporary as society returns to a normal and robust way of life. Certain pandemic accommodations, however, likely will remain an integral part of the practice of law. As discussed elsewhere in this supplemental Report, working from home and videoconferencing have become embedded in the legal community. Working from home provides flexibility, eliminates unproductive commute time, is better for the environment, and is viewed as an employee benefit. Virtual meetings, when used correctly, can be effective and eliminate the time and expense associated with travel. Used in the court system, virtual appearances can decrease the expenses associated with litigation, making the courts more accessible. Although working from home and employing virtual conferencing provide great work benefits and may promote work efficiency, they can contribute to a sense of loneliness and being isolated.[6]

Practice Pointers

Several tips may help to avoid feeling lonely when working remotely. First, be proactive in reaching out to colleagues.[7] Although working from home may require more work in scheduling interactions with others, initiating an impromptu video or audio call to communicate and brainstorm with others will help you feel included and less lonely. These types of unplanned encounters regularly occur when attorneys work within the confines of a physical office, sometimes running into others in the hallway or popping into a colleague's office to bounce ideas off them.

Second, if possible, actually go into the office a day or two each week to help maintain work relationships. Third, go outside for your lunch break. Getting outside for a break can keep your body moving, clear your head, and help maintain perspective. An added bonus may be encountering others while on your walk to provide human connectivity. Fourth, purposefully include opportunities to attend bar association meetings, conferences, and seminars in your schedule. When deciding whether to attend such functions virtually or in person, be cognizant that in-person meetings are important to your social and mental well-being. Finally, be proactive in making plans after work that involve being with family and friends. Knowing that you will have a chance to socialize later will help you feel less lonely throughout your workday.[8] Such plans will also force you to separate your workday from your personal day.

Legal organizations must be mindful of evolving lawyer well-being problems associated with working remotely. Simply stated, people who feel lonely cannot do their best work, and legal teams staffed with lonely attorneys cannot operate at peak levels.[9] Some organizations have discovered a need to return to the office to refresh and perpetuate the culture of the organiza-

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6 Matthew Pears et al., , *The Impact of Sitting Time and Physical Activity on Mental Health During COVID-19 Lockdown*, Sports Sciences for Health, June 10, 2021, https://link.springer.com/content/pdf/10.1007/s11332-021-00791-2.pdf.

7 Benjamin Rojas, *Five Tips to Avoid Feeling Lonely When Working Remotely*, Forbes (Aug. 26, 2021), https://www.forbes.com/sites/theyec/2021/08/26/five-tips-to-avoid-feeling-lonely-when-working-remotely/?sh=71fd6fc54f88/.

8 *Id.*

9 Constance N. Hadley & Mark Mortensen, *Are Your Team Members Lonely?*, MIT Sloan Mgmt. Rev. (Winter 2021), https://sloanreview.mit.edu/article/are-your-team-members-lonely/.

tion.[10] A 2022 LinkedIn poll conducted by Fortune surveyed 2,800 workers. A top motivation factor for returning to the office was a desire to socialize with colleagues. Organizations that allow for remote work must also be aware of lost informal mentoring activities. To counter these lost mentoring opportunities, the organization may need to build into its organizational structure alternatives to promote mentoring.

Additionally, organizations should enact procedures to reach out to employees who work remotely to monitor employee well-being. This is particularly true for younger lawyers. As observed by the National Task Force on Lawyer Well-Being, to be a good lawyer, one has to be a healthy lawyer. Add to this the new challenges created by remote work and an evolving realization that, while productivity has increased as a result of remote working, innovation has shown signs of decreasing due to reduced serendipitous interactions.[11]

10 John M. Bredehoft, VBA Practice Management Advisor Live Chat (April 15, 2022).

11 Jeffrey Sanchez-Burks & Maxim Sytch, *Reimagining the Office for Immensely Human Interactions*, MIT Sloan Mgmt. Rev. (June 07, 2021), https://sloanreview.mit.edu/article/reimagining-the-office-for-immensely-human-interactions/.

ADAPTATION RISKS

Changing Legal Paradigms

The Risk

The "Changing Legal Paradigms" section of the 2019 Report focused on, among other things, the digital revolution and how evolving technologies affected the practice of law. The COVID-19 pandemic made the decades-long digital revolution look like it occurred on a geologic time scale. In a matter of weeks, the pandemic upended nearly every aspect of the legal profession and ushered in an entirely new form of law practice. Mandatory shutdowns and isolation required law firms, which traditionally have relied upon physical offices, to transform into virtual firms consisting of attorneys working from home connected by technology. Prior to the arrival of COVID-19, only a small portion of lawyers worked remotely. With the arrival of the pandemic, virtually every lawyer and legal staff member had to work from home.

With this forced changing legal paradigm came new challenges to lawyer well- being which were not recognized prior to the arrival of the pandemic. The two most prominent challenges can best be categorized as home office syndrome and Zoom fatigue. The Committee determined that these two new challenges warranted inclusion in this report, not as new risks, but being products of the previously identified Changing Legal Paradigms risk.

Home Office Syndrome

The COVID-19 pandemic upended nearly every aspect of the legal profession, but perhaps the most significant change — and the change most likely to remain a permanent part of law practice — has been the rise of working from home. Before any vaccines or other treatments for COVID-19 were available, the most reliable way to mitigate the disease's spread was to social distance. As a result, spring 2020 saw a forced abandonment of the office.

Workspaces with efficient multi-monitor setups, accessible law libraries, and ample copying, printing, and mailing resources were replaced by whatever nook would accommodate a laptop

at home. As working from home transitioned from a necessary novelty to a routine fact of life, many attorneys upgraded their home office spaces to accommodate the new norm of remote law practice. In order to efficiently and effectively provide legal services compliant with the Rules of Professional Conduct, law firms invested in hardware and software to promote and support home offices. In a matter of weeks, the legal profession was forced to advance technologically in what would have normally taken years to accomplish. Even though many firms have now returned to the office, many lawyers are resisting that return. Practicing law from home, then, is likely to be a longstanding part of our profession.

Working from home has many upsides — it can be convenient (especially for working parents), offers flexibility, and eliminates the time loss and environmental impact of a commute. But it also has downsides, which are the focus of this discussion.

"Home office syndrome" is the name penned by some psychologists for the feelings of stress, loneliness, exhaustion, and being overwhelmed resulting from a blurring of boundaries between work and home life.[1] Lawyers working from home will often find themselves not fully working, but not fully relaxing either. They strive to accomplish tasks that absolutely must be done and meet their billable-hour requirements, but their time is often interrupted by spouses and children, a dog that needs to be taken outside, a household repair that comes up, or countless other distractions. In addition, a lack of routine can result in lawyers working even longer hours at home because work time melds into personal time.

Worsening the blur between work and home is the fact that many lawyers' at-home workspaces are in locations intimately associated with feelings of being off the clock. The kitchen table is where family meals, not conference calls, are supposed to happen. The living room is for socializing, not for billing. Injecting aspects of law practice into these sacred spaces — spaces that traditionally have recharged lawyers so that they can be better grounded and more resilient — cause lawyers to experience cognitive dissonance that exacerbates the already difficult balance of work and life.

Not to be ignored is the fact that going to the office also provides respite from the rigors of home life, especially for parents. For many lawyers during the pandemic, there was no sanctuary from work life or home life because both existed simultaneously in the "home office."

1 Alex Dimitriu, *Home Office Syndrome*, PSYCHOL. TODAY, Apr. 13, 2020, https://www.psychologytoday.com/us/blog/psychiatry-and-sleep/202004/home-office-syndrome.

Practice Pointers

Lawyers and their employers should recognize that working from home and home office syndrome are now facts of life in the legal profession. Most strategies for coping with home office syndrome involve establishing boundaries between work life and home life.

For individual lawyers, one of the most effective ways to separate work from home is to designate a home office space solely for business, eliminating the "but-I'm-at-home" mental fog.[2] Of course, this approach may not be feasible for lawyers who live in smaller spaces or who have to share the only available office space with a spouse or child also working from home or attending school virtually.

Another step is to cultivate psychological boundaries between work and home by adopting routines that replace the rhythms of an in-office workday. For instance, the office commute—though often reviled for good reasons—functions as a ritual to transition from being at home to being at work. Establishing a fixed starting and ending time for the workday, as well as standard wake-up and lunch times, and then sticking to that routine, can help create a psychological barrier between work and home in much the same way as the office commute once did. Ending work at a consistent time also ensures you allow time for interacting with family and friends, as well as time for relaxation.

In addition, wearing professional clothing—or at least something a touch more formal than sweatpants and a hoodie—can help put your mind in work mode. Slipping into something more comfortable at your designated end time can equally switch your mind back to being at home, helping you leave work behind. Any routine that helps you transition from home mode to work mode, and vice versa, should be recognized, honored, and employed. Something as simple as taking a walk around the block before work to prepare for your business day and then a walk around the block at the end of your workday to decompress can provide a method to transition from home life to work life and vice-versa.

> "Organizations can encourage their attorneys to set aside their phones and not feel obligated to check email after working hours."

Organizations also have a role to play in easing home office syndrome. Recognizing that the best way to combat the mental and emotional downsides of working from home is to create psychological barriers between home and office, employers should intentionally develop a culture that promotes such barriers. Organizations can encourage their attorneys to set aside their phones and not feel obligated to check email after working hours. Of course, lawyers will always have times when they need to be available after hours. Litigators have stressful filing or trial days and transactional attorneys have down-to-the wire closings. But outside of days like those, organizations should ensure their members feel comfortable not being on call. It is all but impossible to establish a meaningful separation between work and home when lawyers are expected by their firms to monitor their phones and emails at all hours at home.

2 Adam Dachis, *How to Craft the Perfect Home Office*, Lifehacker (Nov. 4, 2013), https://lifehacker.com/how-to-craft-the-perfect-home-office-1455516163.

Organizations should also strive to make sure attorneys who regularly work from home have the resources they need to be successful. Preparing a home office checklist for necessary and recommended furnishings, equipment, devices, and programs should promote well-being at an institutional level. Providing standing desks, webcams, laptop docks, and extra monitors go a long way to ensuring a home workspace is as productive as the office. Employers have a vested interest in taking this step: a well-equipped attorney working from home will likely be more effective, efficient, and productive than a similar attorney making do with just a laptop and a dining room table.

Zoom Fatigue[3]

Prior to the pandemic, business and social relationships were conducted by various means, including in person, over the phone, and via email. Lawyers used computers, tablets, and smartphones a great deal, but meetings still primarily occurred in conferences rooms, hearings were in courtrooms, and social events were anywhere but on the computer.

With the COVID-19 lockdowns, all that changed. Social-distancing requirements and stay-at-home orders limited lawyers' personal interactions almost exclusively to computer screens. While email remained an effective means of communication, telephone communication was hampered because people were no longer stationed at the desk where the office phone was situated. The pandemic intensified lawyers' prior reliance on email, online legal research, word processing, and other computer-intensive activities essential to law practice. Virtual platforms rapidly became an accepted alternative to face-to-face interactions, professional and social. Virtual hearings, negotiations, meetings, and even happy hours became an integral part of legal life.

Although widespread vaccination and effective mitigation measures have now reduced the pandemic's effect and have allowed most attorneys to resume many in-person activities, the concept of staying at home and working virtually is likely here to stay as many professionals have appreciated the flexibility and cost efficiency that virtual meetings provide.

However, this convenience — and during the pandemic a life-line — has come with a price. Prolonged usage and dependence on virtual meetings, and its accompanying deleterious effects, have become known as "Zoom fatigue"—tiredness, worry, or burnout associated with the overuse of virtual platforms of communication, particularly videoconferencing.[4] Zoom fatigue became a familiar term during the pandemic when use of videoconferencing software skyrocketed due to people working from home.

3 "Zoom fatigue" refers to fatigue induced by excessive audiovisual conferencing. The term does not apply solely to the audiovisual platform known as Zoom. Instead, just like the word "Band-Aid," which is the name of a specific product, became synonymous for self-adhering bandages, the term "Zoom" became synonymous with audiovisual conferencing. The members of this Committee were all grateful to discover the existence of the Zoom platform during the pandemic, as was most of the legal profession. The term "Zoom" became both a noun and a verb over the course of the pandemic, e.g., "let's Zoom today at 2:00 p.m."

4 Carolyn Reinach Wolf, *Virtual Platforms Are Helpful Tools but Can Add to Our Stress*, PSYCHOL. TODAY, May 14, 2020, https://www.psychologytoday.com/us/blog/the-desk-the-mental-health-lawyer/202005/virtual-platforms-are-helpful-tools-can-add-our-stress.

While videoconferencing can be effective and is often necessary, it also can be exhausting. Virtual meetings require structure and hierarchy. Individuals have to wait their turn to participate. In an in-person conference, several conversations may take place among sub-groups. In virtual meetings, however, more than one person talking creates a cacophony, rendering the virtual meeting useless.

In remote meetings we must intently listen to each speaker because we do not have the luxury of asking the person next to us about information that might have been missed.[5] Add to this the unusual social dynamic of observing an individual face close up, and also wondering who might be watching you in a similar fashion. If you look away, will you appear to be distracted or not listening?[6] Many of us may be more obsessed with our own appearance when our own video image is staring back at us. Having to engage in a constant gaze makes us uncomfortable and tired. Then there is the temptation to turn off the video camera so we can do other things, which is something we might rarely do in an in-person meeting.

Relatedly, "computer vision syndrome" is a condition in which prolonged working on a computer causes the user headaches, eye strain, eye watering, eye redness, or blurred vision. Other physical effects associated with screen use include decreased attention, sleep disorders, depression, and depletion of mental or physical capacity and inertia.[7]

Professor Jeremy Bailenson, founding director of the Stanford Virtual Human Interaction Lab, explained the physical mechanism behind why extensive videoconferencing can be harmful to the eyes and increase overall fatigue.[8] Rather than looking around, people engaged in videoconferencing fix their eyes at an individual for an extended period. Depending upon the size of the monitor, faces can appear quite large, which affects not only individual comfort levels with respect to personal space, but also the amount of strain being placed on the eye.

Practice Pointers

A solution suggested by Bailenson to reduce screen fatigue associated with videoconferences is to avoid videoconferencing in full-screen and instead use a smaller window relative to the monitor size. Doing so minimizes face size on screen and its associated physical and psychological discomfort. Bailenson also suggested laptop users to connect an external keyboard to further increase personal space rather than hunching near an integrated webcam.

Other simple steps can help minimize Zoom fatigue. First, avoid multitasking while in a virtual meeting. When you multitask, you simply cannot remember things as well as when you are more singularly focused on your peers. Avoid emailing or texting others, particularly when

5 Liz Fosslien & Mollie West Duffy, *How to Combat Zoom Fatigue*, Harvard Business Review (Apr. 29, 2020), https://hbr.org/2020/04/how-to-combat-zoom-fatigue.

6 *Id.*

7 Jon Johnson, *Negative Effects of Technology: What to Know*, Medical News Today, Feb. 25, 2020, https://www.medicalnewstoday.com/articles/negative-effects-of-technology.

8 Jeremy N. Bailenson, *Nonverbal Overload: A Theoretical Argument for the Causes of Zoom Fatigue*, Technology, Mind, and Behavior, https://assets.pubpub.org/3xtduwvl/21614092702823.pdf.

unrelated to the virtual meeting.[9] Second, build in breaks for longer calls.[10] And schedule 10 to 15 minute breaks between separate virtual meetings. Third, reduce your onscreen stimuli. Research shows that if you are on a video, you are more likely to spend time gazing at your own face. This is easily avoided by hiding yourself from view. Also, consider using the speaker only view, so you are not watching others not actively speaking.[11]

Fourth, make sure that a facilitator is appointed to run the meeting. The facilitator should open the meeting by stating the order in which people should participate, so everyone gets to speak. This will eliminate anxiety for participants trying to figure out when they should or should not chime into the conversation. Fifth, incorporate phone calls and emails into your communications. In this world of high tech, many folks will welcome the opportunity to take a break from a videoconference and simply talk by phone. Sixth, along the same lines, for communications outside of your office, avoid defaulting to video, especially if you do not know the other participants well. A video call is fairly intimate for many and can even feel invasive. From a different perspective, limiting video conferencing initiated by others is also appropriate. For example, if a client or opposing attorney Facetimes without warning, it is acceptable to decline and suggest an old-fashioned phone call instead.[12]

Consider using the 20-20-20 rule to limit screen fatigue. This rule suggests that for every 20 minutes spent looking at a screen, one should take a 20 second break and focus on an object at least 20 feet away, which relaxes the eye muscles for 20 seconds and gives the brain much-needed respite. Some people find it helpful to set an alarm for every 20 minutes when using a computer as a reminder to get up and change focus. The rationale behind the rule is that it takes 20 seconds for the eyes to fully relax. Every 20 minutes for 20 seconds, walk around the room, rest the eyes by closing them, or focusing on another object.

Others have found improvement in screen fatigue by implementing the following techniques:

1. Blinking often,
2. Using artificial tears or eye drops,
3. Increasing the text on the computer to prevent squinting,
4. Getting regular eye checkups to ensure that prescriptions are up to date,
5. Using an anti-glare screen filter, and
6. Sitting at least 25 inches from the screen (at arm's length)

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9 Fosslien & Duffy, *supra*.

10 *Id.*

11 *Tip Sheet: Avoiding Zoom and Screen Fatigue*, Georgetown University: Instructional Continuity (2022), https://instructionalcontinuity.georgetown.edu/pedagogies-and-strategies/avoiding-zoom-and-screen-fatigue/.

12 Fosslien & Duffy, *supra*.

Ultimately, the main issue appears to be the extent that lawyers rely on screens. This reliance is unlikely to change even as attorneys return to the office and resume face-to-face meetings again.

Organizations can help ease their lawyers' screen fatigue by encouraging in-person meetings when safe, including meetings outdoors. In addition, implementing interface changes and providing users with software that reduce the screen fatigue may be beneficial. These apps include Night Shift, Awareness, and F.lux that reduce contrast and make screens less harsh. Finally, individuals may consider purchasing—and organizations may want to provide—computer glasses designed to reduce eye strain caused by blue light,[13] which can reduce eye irritation from light sensitivity.

Lack of Diversity in the Legal Profession

The Risk

The 2019 Report recognized the lack of diversity in the legal profession as a well-established risk. It noted that diversity and wellness had a "symbiotic" relationship such that a lack of diversity in the legal profession was a cause of isolation, stress, anxiety, depression, and a feeling of lack of self-empowerment or professional achievement — in short, a wellness impairment.

Since the Report's publication, the COVID-19 pandemic profoundly affected all aspects of life — including diversity in the legal field. The results have been mixed and indicate that, for all the efforts to advance the cause of diversity and in turn wellness, more needs to be done.[14]

COVID-19 roiled all aspects of society in the summer 2020. The killing of George Floyd and other events led to a national examination of racial injustice, including whether and to what extent structural injustice existed and perpetuated a barrier to racial progress. Diversity within the legal profession was necessarily a part of this examination. The Supreme Court of Virginia, as well as other courts across Virginia, issued statements, and in some cases plans of action, addressing the inherent imperative of equal justice, access to justice, and due process under the law.[15] Bar associations, law schools and other law-related entities undertook similar examinations.

The pandemic created an upheaval in the traditional practice of law, including the necessity of shutting down many brick and mortar law offices and requiring working from home. Law firm viability, priorities, and projects all had to be reexamined. Bar associations, law schools, and other law-related entities were similarly affected. The upheaval's effects were felt in, among other areas, diversity and corresponding wellness in the legal profession. As law firm

13 Mark Smirniotis & Leigh Krietch Boerner, *What Are Computer Glasses (and Do They Work)?*, N.Y. Times, Apr. 27, 2017, https://www.nytimes.com/wirecutter/blog/what-are-computer-glasses-and-do-they-work/.

14 *Id.*; *see generally* Jamillah Bowman Williams, *COVID-19 Widens Disparities for Workers of Color*, 35 ABA J. Labor & Emp. L. 1 (2020), https://www.americanbar.org/content/dam/aba/publications/aba_journal_of_labor_employment_law/v35/number-1/covid-19-widens.pdf.

15 See *Statement to Members of the Judiciary and the Bar of Virginia*, Supreme Court of Virginia, June 16, 2020, https://www.vacourts.gov/news/items/2020_0616_scv_%20statement.pdf.

hiring and promotions were necessarily (although thankfully temporarily) reduced, efforts to promote diversity fell behind.

Along with the advent of remote law practice and attendant virtual communication, a concept referred to as "distance bias" began to emerge, recognizing a disproportionate impact on legal professionals of color and other diverse backgrounds.[16] Many positive aspects of diversity that thrived in normal settings became challenging when working remotely replaced in-person law practice. Diverse professionals who had attained the proverbial seat at the conference table, or hoped to someday gain a seat, instead found themselves sitting at home. Not only were their voices less able to be heard, but they also lost the benefits of daily in-person professional interactions.

The pandemic and the necessity of working from home also disproportionately impacted women attorneys, and in particular those who are parents, as the line between professional career and home life often disappeared. These attorneys found themselves simultaneously performing as lawyer, parent, and teacher while sitting at the kitchen table with their children. Many women attorneys faced unique challenges and struggled with burnout as multi-tasking without a clearer separation of work and home became significantly more challenging.[17]

"As the pandemic's effects may forever change how legal organizations operate, they should reevaluate how to promote diversity in their work."

Practice Pointers

As Margaret Ogden, Wellness Coordinator in the Supreme Court of Virginia's Office of the Executive Secretary and a member of this Committee observed in The Weekly Wellnote email on January 24, 2022: "One of the best ways to build inclusivity is to listen to the voices of our colleagues who come from under-represented backgrounds." A group consisting of those with similar backgrounds is less likely to be able to consider a broader spectrum of views and, in turn, offer innovative solutions to the issues before them. Diversity of individuals engenders diversity of ideas and ideals. It makes inclusion possible, and inclusion makes a law firm better able to serve its clients. Diversity offers a wider scope of knowledge and a fuller understanding of the realities of life that are presented in the challenges of each client's wants and needs.

As the pandemic's effects may forever change how legal organizations operate, they should reevaluate how to promote diversity in their work. For example, virtual communications should be evaluated in the context of ensuring appropriate diverse participation, not only as attendees

16 Nelson D. Schwartz, *Working From Home Poses Hurdles for Employees of Color*, N.Y. Times, Sept. 6, 2020, https://www.nytimes.com/2020/09/06/business/economy/working-from-home-diversity.html.

17 Liane Jackson, *How Pandemic Practice Left Lawyer-Moms Facing Burnout*, ABA Women in the Law, ABA J., Aug. 1, 2021, https://www.abajournal.com/magazine/article/how-pandemic-practice-left-lawyer-moms-on-the-verge; *see also* Liane Jackson, *Female Lawyers Face Unique Challenges During the COVID-19 Pandemic*, ABA J., Oct. 1, 2020, https://www.abajournal.com/magazine/article/female-lawyers-face-pandemic-challenges; Gabriele C. Pelura, *COVID-19 and Its Effect on Gender Diversity in the Law*, ABA J., Feb. 9, 2021, https://www.americanbar.org/groups/litigation/committees/woman-advocate/practice/2021/covid19-and-its-effect-on-gender-diversity-in-the-law/.

but also as organizers and presenters in audio-visual conferences. Just as diversity and inclusion at the conference table is a goal, opportunities for diverse interaction and particularly the ability to participate meaningfully in virtual spaces should be provided.

The events of the last couple of years have also illuminated the need to understand and address unconscious or implicit bias. Recognizing biases can help address their impact on perceptions, promote understanding of others, and facilitate effective and creative solutions. A goal of diversity and inclusion initiatives should always be the creation of a more positive and productive environment. And luckily a by-product of this is the promotion of lawyer well-being.

By: Bretta Lewis, Esq.

Pender & Coward

Hypotheticals and Questions Virginia Rules of Professional Responsibility: 1.1, 1.3, 1.4 3.3, 3.4, 4.2, 4,3

FACT PATTERN – GAL REPORT AND RECOMMENDATIONS (1.1, 1.3, 1.3, 3.3)

You are the GAL in a custody/DHS case. You are appointed after the ex-parte ruling but before the 5 day hearing. CASA is also involved. The child is a very young infant and has been remved from an uninhabitable home. The parents are young and not married. They have had trauma in the past and seem basically clueless, but they are not violent and drug tests performed by DHS show that they are not on drugs. There is no requirement for a report for the 5 day hearing, but you decide to get involved right away. You interview the relatives that have offered themselves as placement options. You don't have a chance to interview the parents before the 5 day, but you see them in court and observe them at the 5 day hearing. By the adjudicatory hearing, you have still not met the parents, because they are difficult to find. They seem transient and confused. CASA, DHS, and the relatives have personally spent time with the parents and all agree and assure you that the parents are both unfit. For the adjudicatory/dispositional combined hearing, you decide to file a report. You state in the report that the parents are transient, and that you recommend that the child remain placed in the home that DHS recommends, which is a relative. You have not interviewed the relative, but DHS, CASA and the City Attorney assure you that they have, and that the relative is better than the parents. You have not met with either of the parents.

QUESTIONS:

1. Have you committed any ethical violations by representing to the court that you have conducted an independent investigation in this matter?
2. Have you committed any ethical violations by not speaking to the parents before making a recommendation?
3. Have you violated the GAL standards in this case?
4. Do you have a duty under the applicable rules to inform the Court of anything?
5. What if the case goes on a year? Can you alter your recommendation without losing credibility?
6. What if one of the parents completes ALL services? Do you have a duty to re-interview him or her?
7. What is the difference between a recommendation and a bias?
8. How does a GAL remain independent without being neutral… or how does a GAL remain professional and also offer a recommendation that may not be what one or more party wants to hear?

9. How does the rule about Communication relate to this fact pattern?

FACT PATTERN FOR ALL OTHER QUESTIONS (3.3, 3.4, 8.4)

You have a new client - Olivia. She claims that her "narcissistic" husband, Tyler, is abusive, totally self-absorbed, and a terrible parent. Olivia says Tyler has all kinds of issues that make living with him intolerable. She and Tyler have recently separated, and she wants to file for divorce. Tyler is staying with a buddy but wants to get back into the house. He also told her that he wants 50/50 custody of their child, a 9-year-old son named Alvin. She says Alvin has straight A's and is in the gifted program at the public school near the marital residence.

Olivia wants sole custody, as she believes he is an inappropriate influence, but she says she may wait until Alvin finishes third grade to leave her husband. She says that does not believe that her husband intends to leave her or file for divorce, but she says she has evidence that he is having an affair.

Olivia says that Alvin confided in her that one night when Olivia was out of town for work, Tyler brought over a lady. Alvin was supposed to be in bed, but he snuck out to see what they were doing, and he saw them going into mom and dad's room. He didn't see her again and he didn't ask his dad any questions, because he sensed that he'd get in trouble for spying and not being in bed. Alvin has been mad at his dad ever since. Olivia did not confront Tyler, because she wanted to save this information for Court and confront him before he has a chance to lie.

Olivia retains you, paying $20,000 in advance. She signs a representation agreement stating she will follow your advice and keep you informed… with other typical agreement items included. After she leaves, you look on her social media pages and see several hundred photos of her, her husband, and their child. They look like a happy family on social media. She has some questionable posts, some photos of herself wearing revealing outfits, and some photos you make a note to yourself are not ideal in terms of how they will look in a custody trial.

Meanwhile, you look up her husband and see some of what she's talking about: selfies after workouts, selfies in the bathroom, lots of pics of his tats, political rants, posts about how much he loves partying, selfies outdoors, selfies indoors, long exchanges with his pals about their excessive nights out, clubbing, lots of photos of him and a woman who fits the description of the lady Alvin says he saw, with the caption "I have the best 'work wife" ever!"

On the dad's social media, you also see a photo of Alvin riding his bike, with dad cheering in the background. You also see that Tyler, in response to congratulatory messages from his friends, has posted comments that Alvin was a "sissy" and a "momma's boy" because he took a while to learn to ride without training wheels, but ultimately, the post says he is proud of him for "the eventual W after a so many painful L's." You print the posts and save them for presentation at a later date. These posts give you some confidence that your client is telling you the truth about Tyler, but they look happy in the pictures… but then again.. who posts photos of sad times?

Once you and Olivia file the complaint for divorce, you file a *Pendente Lite* Motion asking for exclusive use and possession of the home, as well as primary custody of Alvin. Tyler's lawyer has filed an answer, denying all allegations and accusing Olivia of constructive desertion and alienation of the child. His counterclaim states that Olivia has a habit of falling asleep in Alvin's room when she tucks him in, and that she has created a situation in which Alvin is too dependent on her for his age, which is making him "soft and antisocial." Tyler has asked for the appointment of a GAL and for 50/50 custody. He has also asked that Olivia be ordered into counseling to address her "helicopter mom issues."

Just before the *Pendente Lite* hearing, Olivia comes to your scheduled meeting to prepare her testimony… and, to your surprise, she brings Alvin. You are dismayed, and you say only "hello" to him. You ask your assistant to set Alvin up in a conference room with some markers, a puzzle, and a TV tuned to cartoons.

Once Alvin is situated and you are alone with your client, you ask Olivia what is going on. She says Alvin WANTED to come, that he WANTS to talk to you, and that Alvin will have a terrible reaction if he is forced to spend more than two nights per month with his dad. You are irritated, because why did she even tell him she was seeing you? How does he know there's a divorce pending? And why is he expressing an opinion about visitation? You sense that she has been discussing this with him and it makes you uncomfortable. You tell her that you don't think Alvin should be so wise to the situation and that you want her to stop talking to him about all adult issues including this case.

Undaunted, Olivia says Alvin talked about not wanting to see his dad the whole way to the office and that once he said it, she secretly recorded it to prove she's telling the truth. She plays the recording. You hear this:

Olivia: Sorry, son, I didn't hear you because of the radio, can you repeat that?
Alvin: Sure, mom… I said I don't want to see dad and I want to talk to the judge about it. I want to tell the judge that I am super mad at him. I want him and that stupid, mean lady to just go live together and then you and me can stay together forever and we don't have to talk to him ever again.

Olivia: Aw, sweetie, you are such a good boy. I love you for being so loyal to me, always, but I am sure you will meet a prettier girl and marry her and leave me all alone someday!
Alvin: Impossible! There is nobody prettier than you, mom!

<u>A. QUESTIONS:</u>

1. At this point, after you clean up your vomit, what do you do with Alvin? Do you interview him?

A: Yes B: No C: Maybe

2. If yes, does the fact that he does not yet have a GAL influence your decision?

A: Yes B: No

3. If no, does the fact that there's a PL Motion in which one of the attorneys has asked for a GAL influence your decision?

A. Yes B: No

4. At the *Pendente Lite* hearing, do you have an obligation to tell the Court that you met Alvin and that he was at your office?

A: Yes B: No C: Only if you interviewed him D: Only if a GAL is appointed

E: Only if you interviewed him AND a GAL is appointed

5. Has Olivia done anything wrong by recording Alvin's car comments?

A. Yes B. No

6. Do you save the car recording for evidence?

A. Yes B. No C. Maybe D. Only If the dad disputes the child's preference

7. Your client wants you to object to the appointment of a GAL. She wants you to offer the child's testimony and argue that his interests are adequately represented since she believes that he has a preference that he's mature enough to tell both parents in court. Do you make that argument?

A. Yes B. No C. Yes, but only in a pro forma way D. Yes, this course of action is best for my client and achieves her goals, so it's the right thing to do.

ADDITIONAL FACTS FOR NEXT QUESTIONS:

Assuming you DO interview Alvin, the interview reveals that Alvin does, in fact, want to tell you and anyone who will listen that he is sad for his mom and angry at his dad because Alvin did, in fact, see his dad with the other lady, and he did confide in his mom unprompted.

He says he's not sure what they were doing, or why it was such a secret, but that he knows that since dad was sneaking her in and told him to go to bed and not come out until morning and not to tell mom that he had to go to bed early, he knows whatever they were doing was not ok.

He says he thinks maybe mom doesn't want other ladies in her room trying on her clothes or jewelry. He also says he loves his dad but knows he isn't very nice to mom, who deserves someone to be nice to her because she's the best mom ever.

You instantly know that he's compassionate and pretty mature for 9, but still very innocent. You see that Alvin is very articulate, sad his parents aren't getting along, and clearly aligned with his mom.

Finally, Alvin closes by telling you that it will be super fun after the case is over because they can do whatever they want, maybe even get a puppy, since dad will be gone and he's allergic and that's why they never had a dog before. He says he feels a lot better after talking to you, and that if you could please just tell the Judge so that he can go to school that day, he would really appreciate it.

B. QUESTIONS

1. Does the child's statement about the puppy worry you?

A. No, it's fine because it wasn't me.
B. Yes, I worry that she gave him an incentive and it influenced his preference.
C. OTHER

2. If a GAL is appointed, do you tell the GAL about your talk with Alvin?

A. Yes
B. No
C. It depends on what the GAL says Alvin said. If Alvin tells the GAL the same thing, I do not need to disclose.
D. It depends on what the GAL says Alvin said. If Alvin says something different to the GAL, I will want to play the recording and/or tell what Alvin said to me to combat the conflicting information.

3. How do you counsel your client after this meeting?

A. Keep doing what you're doing!
B. You may want to dial back the intensity about custody
C. Please stop talking to Alvin about custody, even if he wants to and please don't promise him any more puppies or anything like that.
D. Depends on whether the GAL is appointed.

ADDITIONAL FACTS FOR NEXT QUESTIONS:

Your client brings Alvin to the PL hearing. Surprisingly, the Judge wants to hear from him in chambers. In chambers, Alvin tells the judge EXACTLY what he told you. The Judge awards primary custody to Olivia, with every other weekend to Tyler. Olivia is ecstatic. The GAL is appointed (the judge said it was important to make sure Alvin had a neutral advocate in case he changed his mind and missed his dad), and trial is set.

Six months later, the trial rolls around. The day of the GAL's final meeting with Alvin, Olivia mentions to Alvin on his way out the door that the GAL will probably be visiting him, and adds that "if things stay just like this, we will be able to get the puppy!" The GAL visits Alvin a few hours later at school. Alvin sticks to his stated preference to be with mom all the time, reiterating that "dad seems to like his lady friend better than me and mom." Olivia calls you after the Gal report comes out, super happy. She mentions that she was worried because Alvin told her a few days ago that he might want to see dad more often. She is relieved when the GAL report says that Alvin's preference has been "consistent and unwavering" and that she is confident that Alvin's preference is reasonable, since the mother has always been his primary care provider and that dad seems more interested in himself and his girlfriend that in Alvin. The GAL did not interview the child's counselor, but you did. You know that Alvin has told his therapist that he misses his dad and that he wishes his dad would pay more attention to him. He has told the counselor that he feels alone a lot, because dad used to do fun things with him that mom tries to do, but she isn't good at them and "it's just not the same without dad." He lists basketball, frisbee, and fishing as things that he used to do with dad "before the lady showed up." The counselor wants dad to engage with the counseling, but he has not responded to the requests sent by email and text. The counselor told you that there were requests to dad's lawyer, but still no response.

C. QUESTIONS

1. **Do you have any obligation to disclose to the court any of the information about the child's preference possibly being to see dad more?**
   A: Yes B: No C. No, but you should tell the GAL

2. **Does your answer change if the child testifies in court that he doesn't want to see dad and that he never wants to see him again?**

   A. Yes B. No C. I cant! The GAL was supposed to figure this out and didn't … but I can't work against my client by disclosing it.

3. Do you call the therapist as a witness, even though the GAL didn't?

A. No way. The therapist may say that the child misses dad, which is not good for my client!
B. Yes! The therapist will testify that the dad has ignored requests to participate, so it's good for my client!
C. Yes. I have a duty to present accurate evidence to the court and I cannot allow my client to mislead the court that the child has no interest in seeing dad. This child is hurt, and I do not want it to be on my conscience that the child's emotional issues may get worse as he gets older if this case goes the way it's going and I don't offer this evidence as to the child's emotional state and attachment to dad.

END OF PROGRAM MATERIALS