

Vermont Family Care Plan

and

Mandated Reporting for Substance Use in Pregnancy



Vermont Mandated Reporting

In the Perinatal Space

Guidance for
Health Care Professionals

2026

Let's take a moment...

This is difficult content and many of us have either personal experience of substance use or have family and friends impacted by substance use and other co-occurring issues including: Maternal death, suicide, intimate partner violence, and trauma

Please take the time you need and/or feel free to step away if the content presented today is difficult.

I'd like to take a moment to acknowledge Vermont residents who died during and after pregnancy, their loved ones, and the community who cares for them.

Maternal Mortality

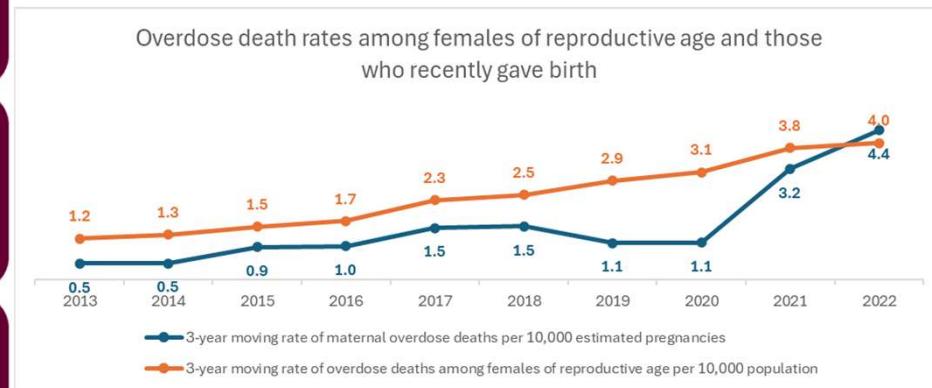
Accidental overdose is Vermont's leading cause of maternal death

48% of the cases reviewed were directly caused by accidental overdose or endocarditis related to IV drug use. In 55%, substance use impacting decedents even when not a direct cause of death

Most accidental overdose deaths involved polysubstance use. Many of the cases reviewed from other causes were heavily impacted by IPV, SU, MH and the child welfare system

More than 90% of perinatal deaths in Vermont occurred among people with a diagnosis of a mental health disorder; 13% of deaths were identified as being caused by suicide.

Odds of overdose death among those who experienced pregnancy are 1.5 times the odds of overdose among females of reproductive age who did not experience pregnancy



Source: [Vermont Maternal Mortality Review Panel Report to the Legislature, 2025](#)

Maternal Mortality in Vermont

Two disclosed use and
were stable on MOUD



Two disclosed use and
were unstable



Two had no diagnosis of
SUD, didn't disclose use



And all six died in the
year after birth directly
related to their SUD

Our Maternal Mortality is heavily impacted by substance use, with most death occurring in the post partum period.

We need to address our bias, consistently de-stigmatize, and universally let our clients know about supports.

In Depth Technical Assistance

From 2023-2025 the National Center on Substance Abuse and Child Welfare (NCSACW), supported focused on perinatal substance use and the child welfare system.

Vermont In-Depth Technical Assistance Initiative



National Center on Substance Abuse and Child Welfare

Key Partners

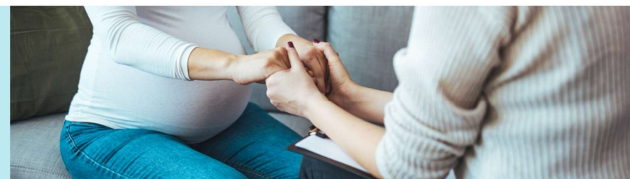
- Department for Children and Families
- Department of Health / Family and Child Health
- Department of Health / Substance Use Programs
- KidSafe Collaborative
- Division of Planning & Court Services, Court Administrator's Office
- University of Vermont Medical Center
- UVM Larner College of Medicine: Vermont Child Health Improvement Program (VCHIP)
- Lund
- Families with lived experience



Current IDTA Sites

Connecticut	Texas
Louisiana	Vermont
Massachusetts	Wyoming
Michigan	Orange County, CA
New Jersey	Riverside County, CA
Oklahoma	

The map is from the National Center on Substance Abuse and Child Welfare.



Vermont Work Plan Goals

Goal 1: Map existing clinical and community-based services and supports across the state that work with pregnant individuals and families experiencing substance use and identify barriers and gaps in care.

Goal 2: Ensure integration among existing (and new) clinical and community-based services/supports.

Goal 3: Apply a health equity approach to the issue of substance use in pregnancy and in families, including a review of policy and structural factors that contribute to health disparities.

Goal 4: Improve data collection as a strategy to apply quality improvement methods in clinical and community care towards the goal of increased care coordination and systems integration.

Goal 5: Address gaps and concerns related to the current process of developing plans of safe care and CAPTA notifications.



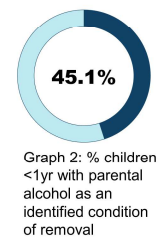
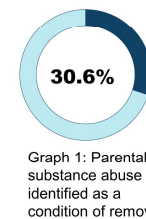
Current Cohort Themes

- Wider dissemination and uptake of currently implemented POSC policies and practices
- Alternative notification pathways for infants with prenatal substance exposure
- Need for environmental scan/community mapping to understand gaps and opportunities
- Moving beyond pilots or regional policy and practice to state-wide services
- Establish evaluation framework to assess what works for all families

Vermont Key Data Points

Substance Use and Child Welfare Involvement

2020 Data from the Adoption and Foster Care Analysis and Reporting System (AFCARS)



Prepared by Michelle Shepard, MD, PhD, Angela Zinno, MA, Katy Leffel, RN, BSN, IBCLC, and Julie Parent, MSW on behalf of the Vermont IDTA team.



How it all comes together



Created from a Centers for Disease Control, Division of Reproductive Health source

PFAC Contributions



Useful
links:

<https://www.uvm.edu/lernermed/vchip/pqc-vt-patient-and-family-advisory-committee-pfac>

[Interest in PQC-VT Patient and Family Advisor Support Request Form](#)

Vermont Family Care Plan – 2026 Revision

What is a Family Care Plan?

A care planning document to support pregnant people in consolidating their medical, community, and social supports throughout pregnancy and the postpartum period.

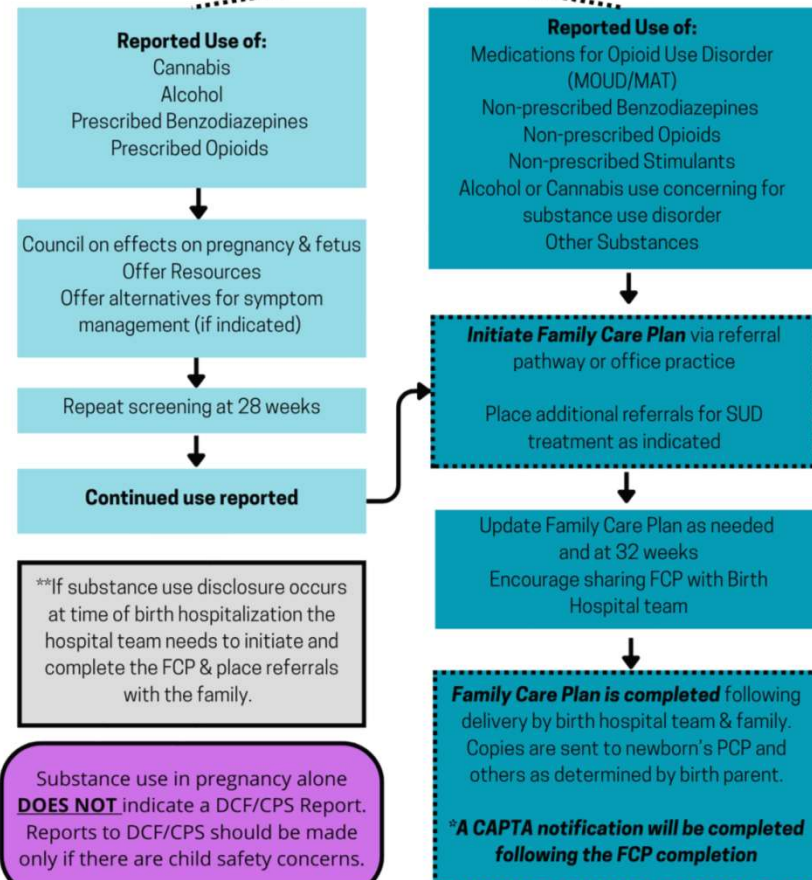
Pregnant patients with substance use in pregnancy is the primary population but this VT-specific tool was created to be used universally as a care planning tool for all pregnant patients.



FCP Initiation Process Map

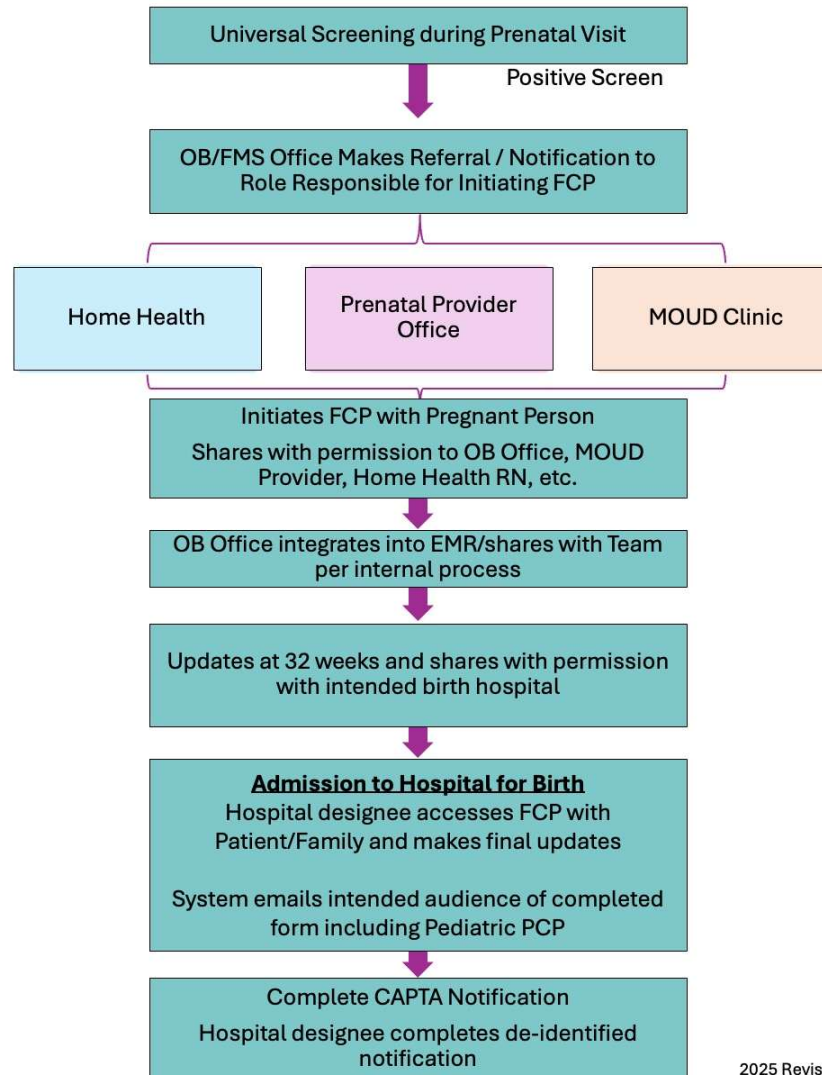
Vermont Family Care Plan (FCP)

Pregnant person reports substance use during universal screening in OB/Midwifery office



FCP related questions → Email AHS.VDHFCPCAPTA@vermont.gov

Vermont Family Care Plan Process



2025 Revision

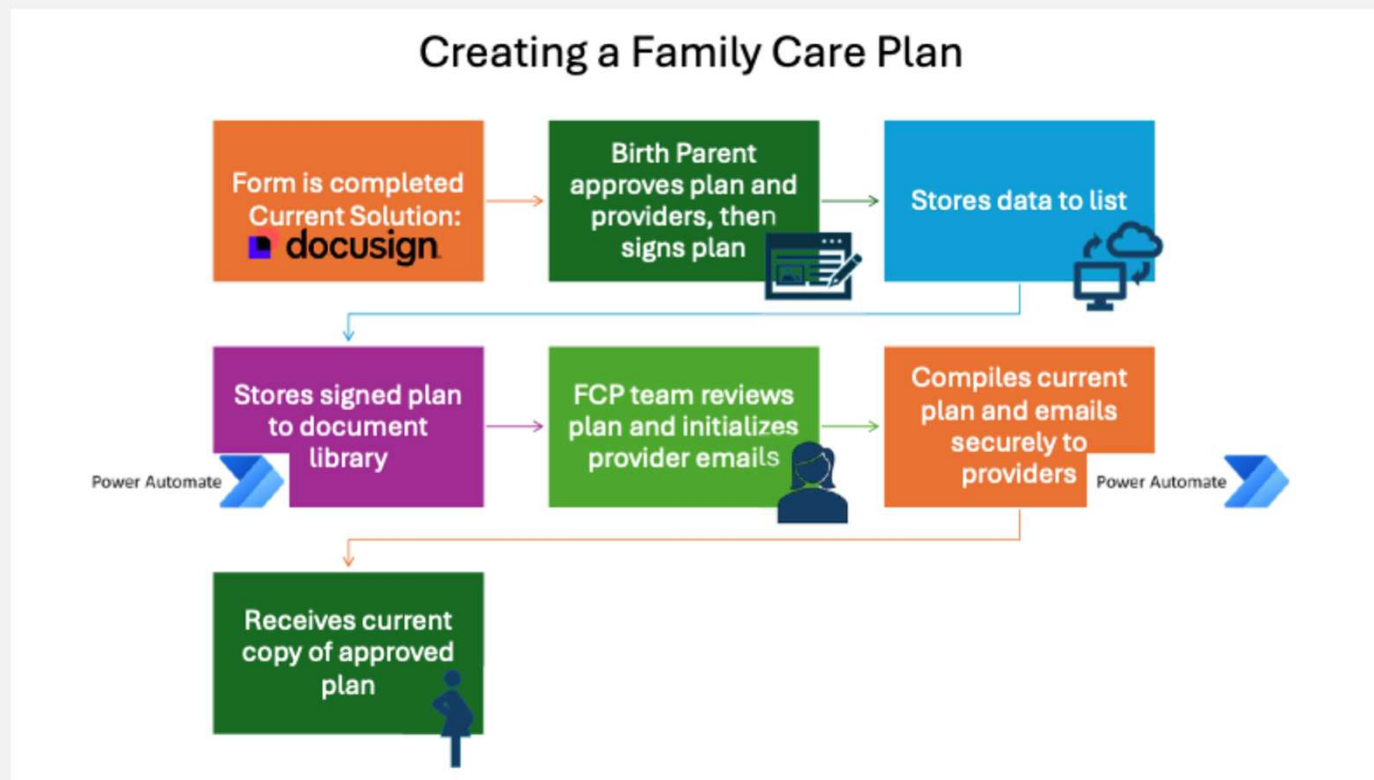
Family Care Plan Pilot

3 Tracks:

1. Home Health Referral for initiation of FCP **
2. OB office personnel initiates FCP
3. HUB personnel initiates FCP

Home Health is the preferred route to support long term connection to supportive perinatal and early childhood community-based systems for families

FCP Form Process Map



Links to test the FCP

[To Initiate the FCP](#)



[To update or complete the FCP](#)



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Things To Know About DCF Reports

Thank you for trusting us with the care of you and your growing baby. We are honored.

Transparency

We realize it can be scary to disclose substance use, mental health concerns, domestic violence, homelessness, or other challenges during pregnancy and postpartum. We are here to help.

The best thing for a healthy baby is a healthy birthing parent. Treatment and accepting referrals for resources is best for you and your baby. We can help connect you to these services during pregnancy so you are prepared to parent once your baby arrives.

As medical professionals we are mandated reporters to the Family Services Division and we want to be up front on situations that would cause us to make a report. A report made does not mean automatically losing custody of a child or that a case will be opened by DCF.

Setting the Stage

- There is uniform concern for and support of parent-child safety and well being by all providers-all want best for the family
- Our collective understanding of substance use, treatment, and parenting has evolved over the last decade with effective treatment
- No one wants to hear a child came to harm from abuse or neglect
- Indications for mandatory reporting are confusing; what happens with FSD reporting and how that helps a family is confusing
- Substance use alone is not an indication for FSD mandated reporting but can be confusing



Reporting before documented child maltreatment does not prevent maltreatment and causes harm

Special Communication | Pediatrics

Evidence From the USPSTF and New Approaches to Evaluate Interventions to Prevent Child Maltreatment

Laura C. Hart, MD; Meera Viswanathan, PhD; Wanda K. Nicholson, MD, MPH, MBA; Michael Silverstein, MD, MPH; James Stevermer, MD, MSPH; Sheena Harris, MD, MPH; Rania Ali, MPH; Roger Chou, MD; Emma Doran, MD, MPH; Kesha Hudson, PhD; Caroline Rains, MPH; Nila Sathe, MA, MLIS; Adam J. Zolotor, MD, DrPH

Future research:

- Studies of risk factors for child maltreatment that include adversity faced by families in the form of access to childcare, access to health care (particularly substance use and mental health treatment), housing insecurity, and food insecurity may be beneficial.
- Solutions to these kinds of challenges in social determinants of health that families face are likely to require multisystem involvement, with contributions from schools, health care facilities, public health, policymakers, and the community at large.
- Research assessing these kinds of solutions should consider clearly delineating the roles of each system and potential synergies so that each contributor (including primary care clinicians) can then understand their role within the multisystem solution and understand where their efforts might be enhanced by the work of others

CAPTA Revision

Approximately 180 submissions in first 6 months of 2026

Substance	Percentage of CAPTA Reports
MOUD	24%
Nicotine	30%
Cannabis	74%
Cocaine	11%
Alcohol	2.7%
Opioids	2.7% nonprescribed; 2.7% prescribed
Stimulants	1 report
Benzodiazepine	2 reports
Polysubstance Use	

35% of pregnant patients were engaged in services prior to delivery

79% Medicaid patients

85% patients did NOT have a DCF report indicated

Mandated Supporting

- Primary Care
- Substance Use Treatments
- Mental Health supports
- Nurse Home Visiting
- Recover Coaches
- Community resources

Connection to Services



SFV Nurse Home Visiting Video



Children's Integrated Services



Transparency

- Goal: to provide health care professionals who work with pregnant and postpartum people with the knowledge of Vermont Statute and their legal requirements to their role as a mandated reporter
 - In the perinatal space as related to substance use
- Not to tell people they shouldn't make reports to the DCF – Family Services Hotline when appropriate

Purpose

With increasing rates of pregnant people presenting for delivery with minimal prenatal care, it's time to take a look at potential barriers. Research and patient testimony speak to the fear of being reported to child protective services as a barrier to engaging in prenatal care and substance use treatment programs. Evidence also shows early and consistent prenatal care is beneficial to both the pregnant patient and fetus, especially when substance use is a factor.

This educational material was created to help clarify the responsibilities of health care professionals as mandated reporters in Vermont. This material provides reporting guidance specific to perinatal substance use and newborn exposure. While each situation requires an individualized approach, these materials can help determine if a report to the Department for Children and Families - Family Services Division (DCF/FSD) Child Abuse Hotline is required. The criteria for FSD to accept a report is in a completely separate section of the statutes and speaks to internal processes within FSD.

This is not meant to discourage making a report for child safety concerns, as it is the joint role of mandated reporters and DCF/FSD to keep infants and children safe. Instead this is to provide clarity on the responsibilities mandated reporters in Vermont have, as well encouraging a pause in the process. Reporting based on biases, cultural or social differences or "this is what we've always done" is not helping our patients and families.

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PAUSE Strategy

An acronym to use
to decide whether to report or not



Consider using the PAUSE acronym when you are unsure if you suspect child abuse or neglect.

If you reasonably suspect child abuse or neglect you must report within 24 hours, even if using the PAUSE approach.

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The PAUSE acronym is utilized in the Mandated Reporter Training created by the Vermont Child Welfare Training Partnership in collaboration with Family Services Division and other partners. All Mandated Reporters in Vermont can access this training.

To Access the Training
[Click HERE](#)



What are the Vermont Laws for obtaining toxicology (drug) testing when there is known or suspected substance use in pregnancy or following delivery?

- A toxicology (urine drug) test on a pregnant or postpartum person with a history of substance use is **NOT** required by law. If toxicology testing is needed for medical care, providers should discuss the risks and benefits of testing with the patient and get informed consent prior to sending any test.
- Toxicology testing (urine, meconium, or cord) on a newborn is **NOT** required by law. Informed parental consent should be obtained if testing is required for a medical reason.
- Substance use in pregnancy or positive toxicology testing of a birthing person or newborn does **NOT** require a mandatory report to be made.

Prior to the birth, the law does not require a report but DCF policy would allow DCF to accept a report for a family assessment.

A look at State Law

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Neonatal Toxicology
Article



Does making a report to DCF/FSD help families affected by substance use access community supports?

Not necessarily. The primary role of DCF/FSD is to keep children safe from abuse and neglect. Although FSD staff do connect families with resources who are engaged with them through an assessment or open case, they are not a community referral source. The purpose is to intervene when there is child abuse or neglect.

Making a report to DCF/FSD through the Child Abuse Hotline is NOT an effective way to help families if the only concern is to connect families to community resources or supports for mental health, substance use, housing, transportation or other needs. Other community agencies (HelpMeGrow, 2-1-1, VT HelpLink) are better equipped to connect families to local resources they need to address many of the issues currently triggering reporting.

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Vermont law includes a Risk of Harm Statute covering substance use

The criteria in this statute specifically refer to:

- The presence of the child in relation to methamphetamine production
- Child access to dangerous substances
- Lack of supervision or care due to substance use of the parent
- A single egregious act that has caused the child to be at significant risk of serious physical harm

These criteria are relevant after birth, but not during pregnancy.

No current law mandates reporting during pregnancy.

It is best practice to provide the pregnant patient with education, referrals, treatment, and resources to address their substance use.

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[Title 33 Chapter 49 Section 4912](#)

Documentation ≠ Reporting to DCF

Documentation remains a key component of clinical care. Health care providers should document any concerns in the medical record in an appropriate way, with the goal of collaborative information sharing. Documentation addressing all areas of health (including social drivers) support families across the care continuum. Transparency with families is important. Speaking to families about concerns and providing resources is a good first step. A report can be made and rationale discussed with parent(s); this discussion can be omitted if there is concern for immediate child safety.

In the perinatal space, collaboration between the obstetric provider, mental/behavioral health provider, substance use treatment provider, community partners such as home health & recovery coaches, and the pediatric provider is essential in supporting families. The Family Care Plan is one patient centered tool to connect clinical and community providers.



Documentation

Documentation
≠
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Transparency is crucial...

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VT Mandated Reporting in the Perinatal Space

09

I have to report...
Substance use in the third trimester or last 30 days of
pregnancy.

FALSE

Reporting a patient for substance use during pregnancy is not required by Vermont law.

This practice was originally intended to enable FSD staff to identify and support pregnant people access coordinated services and create plans for safer parenting prior to delivery, decreasing emergency custody cases.

Making a report prior to birth without the patient's knowledge and consent could violate HIPAA by disclosing protected health information.

True or false

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I have to report...
When a family has a Family Care Plan (Plan of Safe
Care) or a CAPTA Notification

FALSE

The Family Care Plan is a tool to assist families in receiving & organizing their referrals and community connections during pregnancy to be better prepared for the arrival of their baby. This is not based in Vermont law.

Federal law requires each State send the aggregate number of newborns exposed to substances during pregnancy each year to calculate funding received through CAPTA. Vermont uses the de-identified CAPTA Notification e-form to collect this information.

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[Click to learn more
VT FCP and CAPTA
Reporting Process](#)



Your patient is two days postpartum and has left the unit 6 times in the past 8 hours. They have a recent history of active opioid use and have not been engaging in prenatal care or other types of recovery treatment. Multiple times they have returned to the unit unable to have a conversation with you without nodding off, is slurring words, and have not initiated any newborn care without multiple reminders and assistance.



REPORT

Action Items:

- Gather the multi-disciplinary team including OB and Pediatric Providers, Nursing, and Social Work to discuss concerns.
- Have a conversation with the patient to express concerns and offer screening/treatment options.
- **Be transparent in that there are safety concerns around possible substance use and impact on care for the newborn.** Share that a DCF/FSD report will be made based on these safety concerns and the role of the healthcare provider as a Mandated Reporter.
- Provide reassurance that there are treatment options available and the team will support them in accessing substance use treatment.

Case Study Examples

Case Example #3

Setting:
Postpartum/Newborn
Nursery

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- Provide reassurance that there are treatment options available and the team will support them in accessing substance use treatment.

Take Home Message

Substance use alone **is not indicative of a mandated report during pregnancy or following the birth** WITHOUT the presence of other factors that suggest risk of harm to the newborn.

Substance use in pregnancy is **not illegal nor defined as child abuse in Vermont.**

Birthing people **should be supported in disclosing substance use during pregnancy** so they can receive the supports they need and desire.

Toxicology testing should only be used **if it changes clinical management and informed consent** has been obtained from the birth parent.

If concerns are noted, **connect families** with the identified services and determine a follow-up plan. **If safety concerns are reasonably expected it is your responsibility to make a DCF hotline report.**

Resources

Learn More

UVMHC Grand Rounds 10/14/25 - Presented by Dr. Mishka Terplan
"Birth, Drugs, and Pregnancy Criminalization: History and Praxis"

Recording Link: [Click HERE](#)
Passcode: Pdd1W.cy



Doing Right By Birth - Educational Modules and Webinars focused on anti-bias and child welfare reporting training for health care professionals.

Website: [Learn More Here](#)



Substance Use in Pregnancy - Vermont Dept. of Health Resources
One More Conversation Materials, Updated CAPTA Notification Process,
Revised Family Care Plan

Website: [Learn More Here](#)



Academy of Perinatal Harm Reduction -
Free resources for Patients & Providers on goal setting, legal matters,
pain management, birth planning

Website: [Learn More Here](#)



References

If When How Lawyering for Reproductive Justice:

"Prenatal Drug Exposure: CAPTA Reporting
Requirements for Medical Professionals"



Vermont Laws

- Reporting Child Abuse Definitions - [CLICK HERE](#)
- Mandated Reporter List - [CLICK HERE](#)

*See page 5 for QR codes

Department for Children & Families - Family Service Division

Report Child Abuse in Vermont - [CLICK HERE](#)
DCF Policies - [CLICK HERE](#)



Need to Make A Report?

- DCF/FSD Hotline: 1-800-649-5285

Thank you!

Let's stay in touch.

Email: AHS.VDHFCPCAPTA@vermont.gov; Katy.Leffel@vermont.gov

Web: [Perinatal Quality Collaborative of Vermont](#)

Social: @HealthVermont

