Mandated Reporting in the Perinatal Space

Marj Meyer, MD, MFM, AIM Clinical Lead

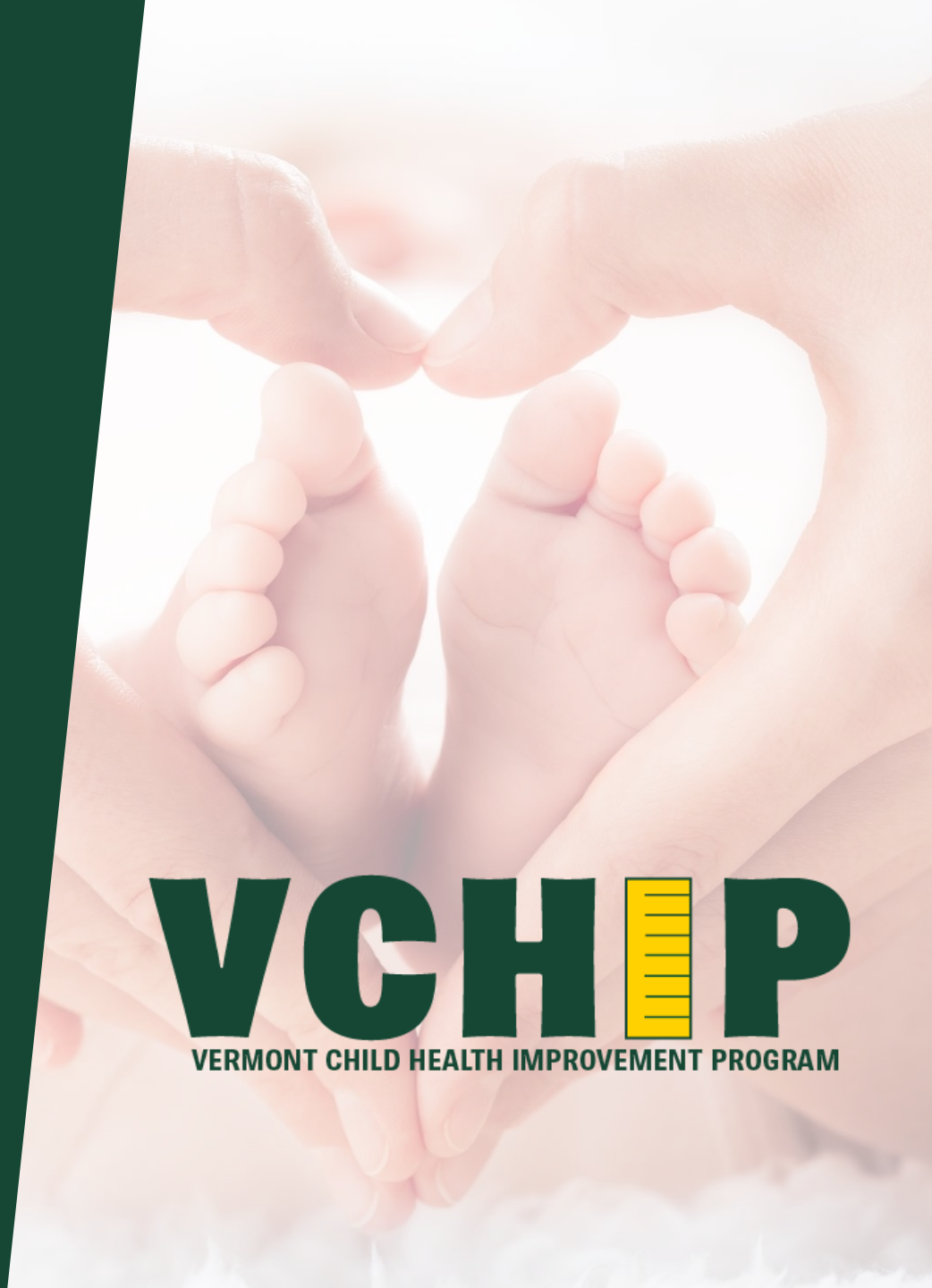
Katy Leffel, RN, BSN, IBCLC, Perinatal Nurse Coordinator, Vermont Department of Health

Shab Cota, MA Training and Coaching Specialist, Vermont Child Welfare Training Partnership

Lindsay Barron, MA, Director of Policy & Planning, DCF, Family Services Division

Kayla Panko, BSN, RNC-MNN, AIM Nurse Educator

June 16, 12:00-1:00PM



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- Use the ***Chat*** panel to ask a question
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VERMONT CHILD HEALTH IMPROVEMENT PROGRAM

AIM
ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

PERINATAL QUALITY COLLABORATIVE VERMONT

Acknowledgements

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Disclosures

- None

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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

Recommendations from American Society of Addition Medicine, American College of OBGYN, and American Academy of Pediatrics all agree:

- The American Society of Addiction Medicine (ASAM) states that child protection agencies ***"should not use evidence of substance use to implement sanctions on parents, especially child removal,"*** and that sanctions should only occur when ***"other risk factors or harms have been assessed or identified, and there is objective evidence of abuse, neglect, or other danger to the child".*** [2]

- ACOG recommends that clinicians "***oppose coercive screening, testing, and treatment interventions"*** and emphasizes that ***a positive drug test is not diagnostic of a substance use disorder or its severity.*** [5-6]

Recommendations from American Society of Addition Medicine, American College of OBGYN, and American Academy of Pediatrics all agree:

- The AAP recommends that a CPS report "***should be considered when the mother has not received or been adherent to treatment of OUD, when there is concern or evidence of polysubstance use during pregnancy, or when there is a concern for infant safety"*** — not based on a positive screen alone. [7]

- ASAM further recommends that **toxicology testing should be obtained with informed, written consent (outside emergencies),** and patients should understand the possible ramifications of a positive result before testing. [2]

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

] *JAMA Network Open*. 2024;7(7):e2420591. doi:10.1001/jamanetworkopen.2024.20591

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

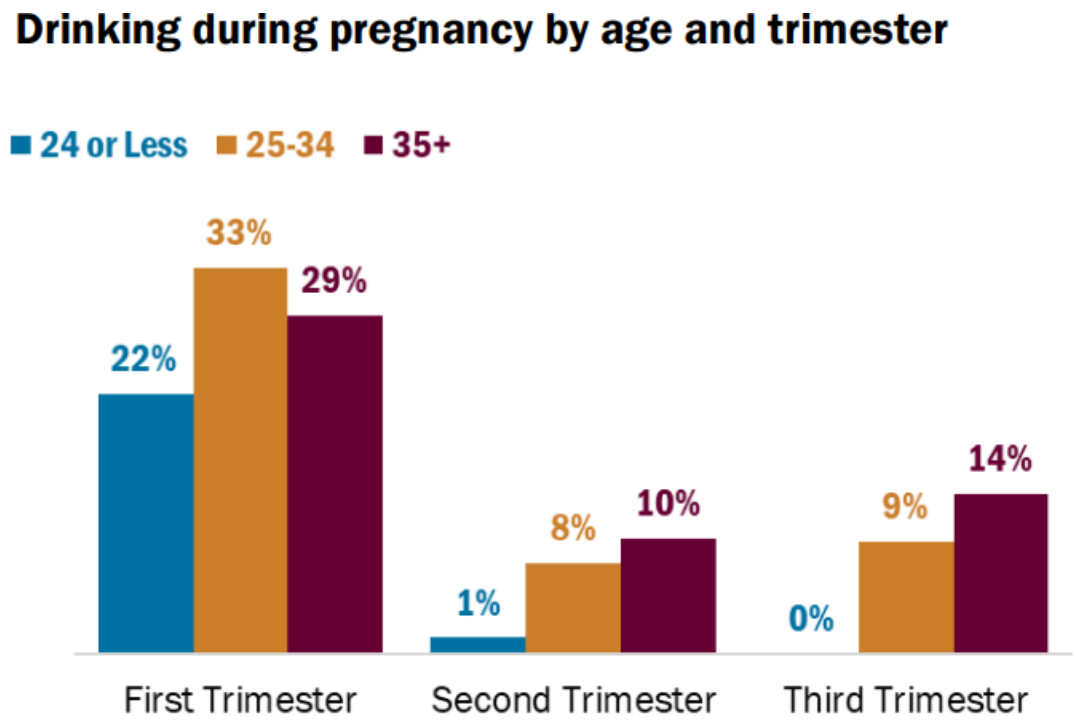
And all six died in the year after birth directly related to their SUD

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.

Other sources of Maternal SU data

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	48%



Connection to Services

Mandated Supporting

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

VT Helplink
Alcohol & drug support center

It is imperative to connect pregnant people with connection to ongoing supports early in pregnancy:

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

Resources

[SFV Nurse Home Visiting Video]

Children's Integrated Services

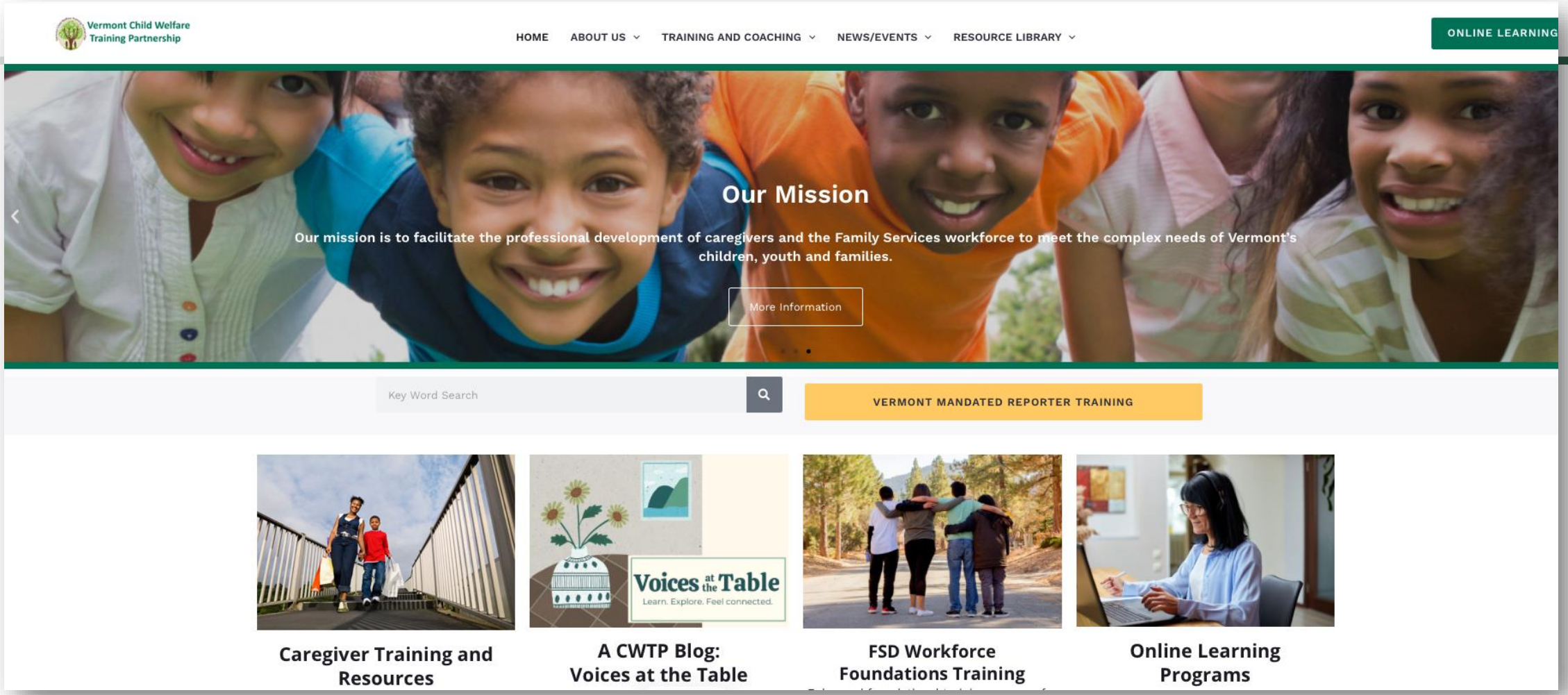
RECOVERING LOUDLY
STORIES OF MOMS IN RECOVERY

"Recover loudly so others don't have to die quietly."
Moms across Vermont are recovering loudly—these are their stories.

Vermont Head Start Association

Recovery Partners of Vermont

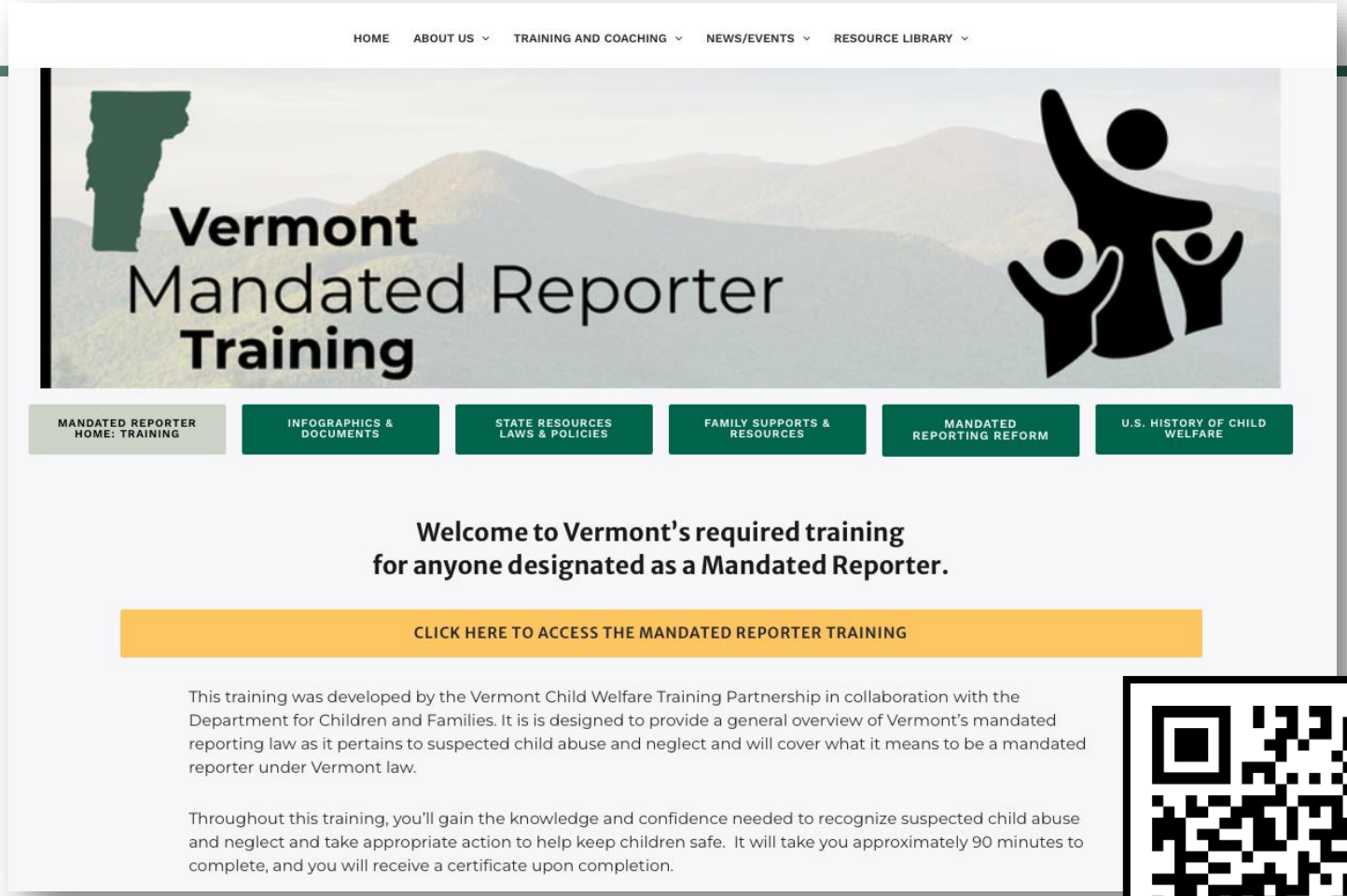
Vermont Child Welfare Training Partnership



Vermont Child Welfare Training Partnership

Vermont Mandated Reporter Training

- Components of the updated training
- Training Audience
- How to access training



Statutory Definitions & Acceptance

33 V.S.A. § 4912(14) states that "**risk of harm**" means a significant danger that a child will suffer serious harm by other than accidental means, which harm would be likely to cause physical injury, or sexual abuse, including as the result of:

(A) a single, egregious act that has caused the child to be at significant risk of serious physical injury;

(B) the production or preproduction of methamphetamines when a child is actually present;

(C) failing to provide supervision or care appropriate for the child's age or development and, as a result, the child is at significant risk of serious physical injury;

(D) failing to provide supervision or care appropriate for the child's age or development due to use of illegal substances or misuse of prescription drugs or alcohol;

(E) failing to supervise appropriately a child in a situation in which drugs, alcohol, or drug paraphernalia are accessible to the child; and

(F) a registered sex offender or person substantiated for sexually abusing a child residing with or spending unsupervised time with a child.

Family Services Division (FSD) Data

Ages Birth to 5 at the Time of Intake Acceptence

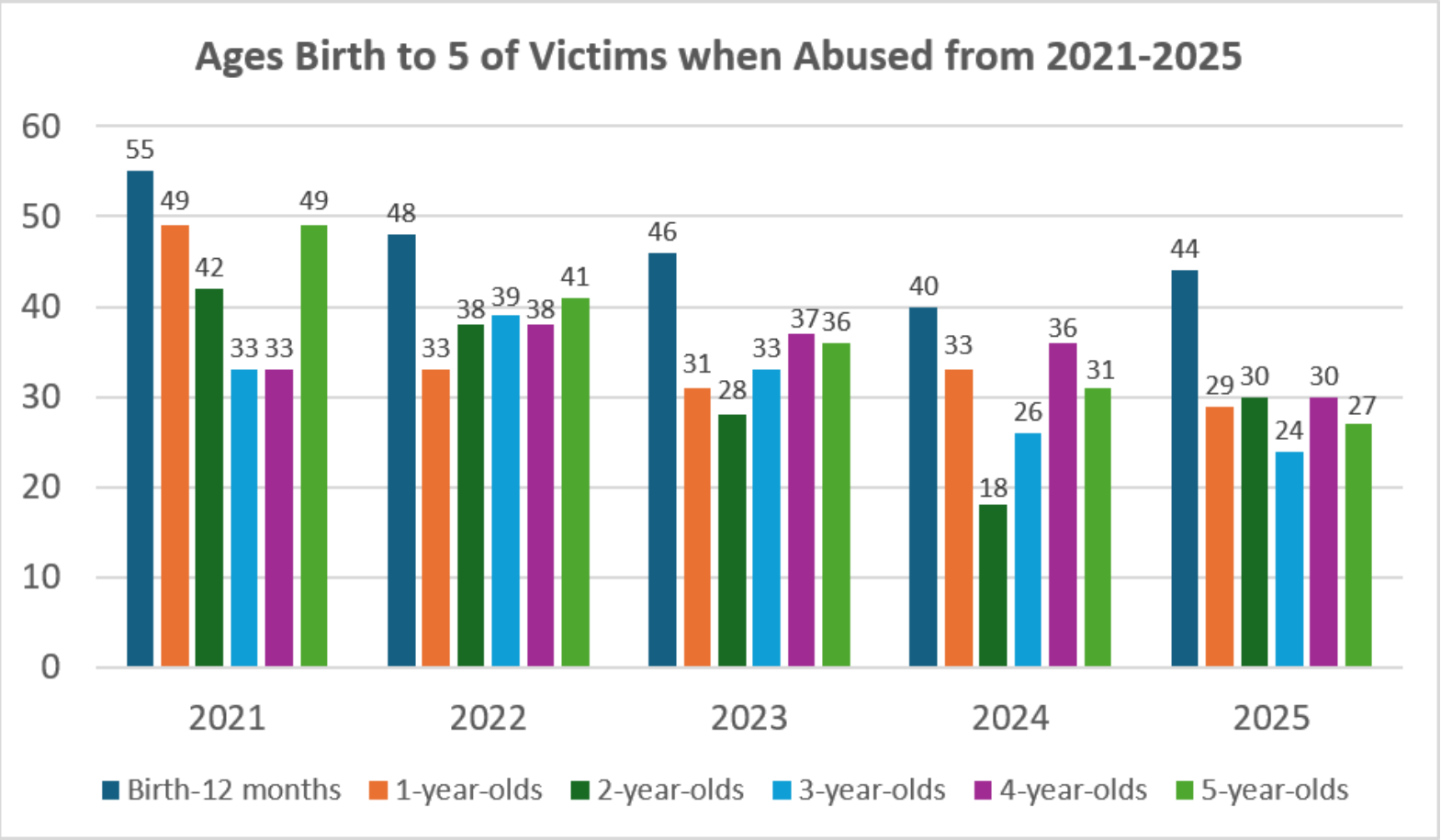
	Birth-12 months	1-year-olds	2-year-olds	3-year-olds	4-year-olds	5-year-olds
2021	275	250	277	278	296	299
2022	296	252	289	314	271	342
2023	286	220	221	289	300	304
2024	256	199	185	224	256	267
2025	233	225	208	187	201	262
Grand Total	1346	1146	1180	1292	1324	1474

Date Source; ADS ticket to pull data from SSMIS for all alleged child victims listed on accepted intakes from 2021-2025

Data Note: Intakes may have more than one alleged child victims.

Data Note: Alleged child victims may be listed multuple times for multiple accepted intakes

Family Services Division (FSD) Data

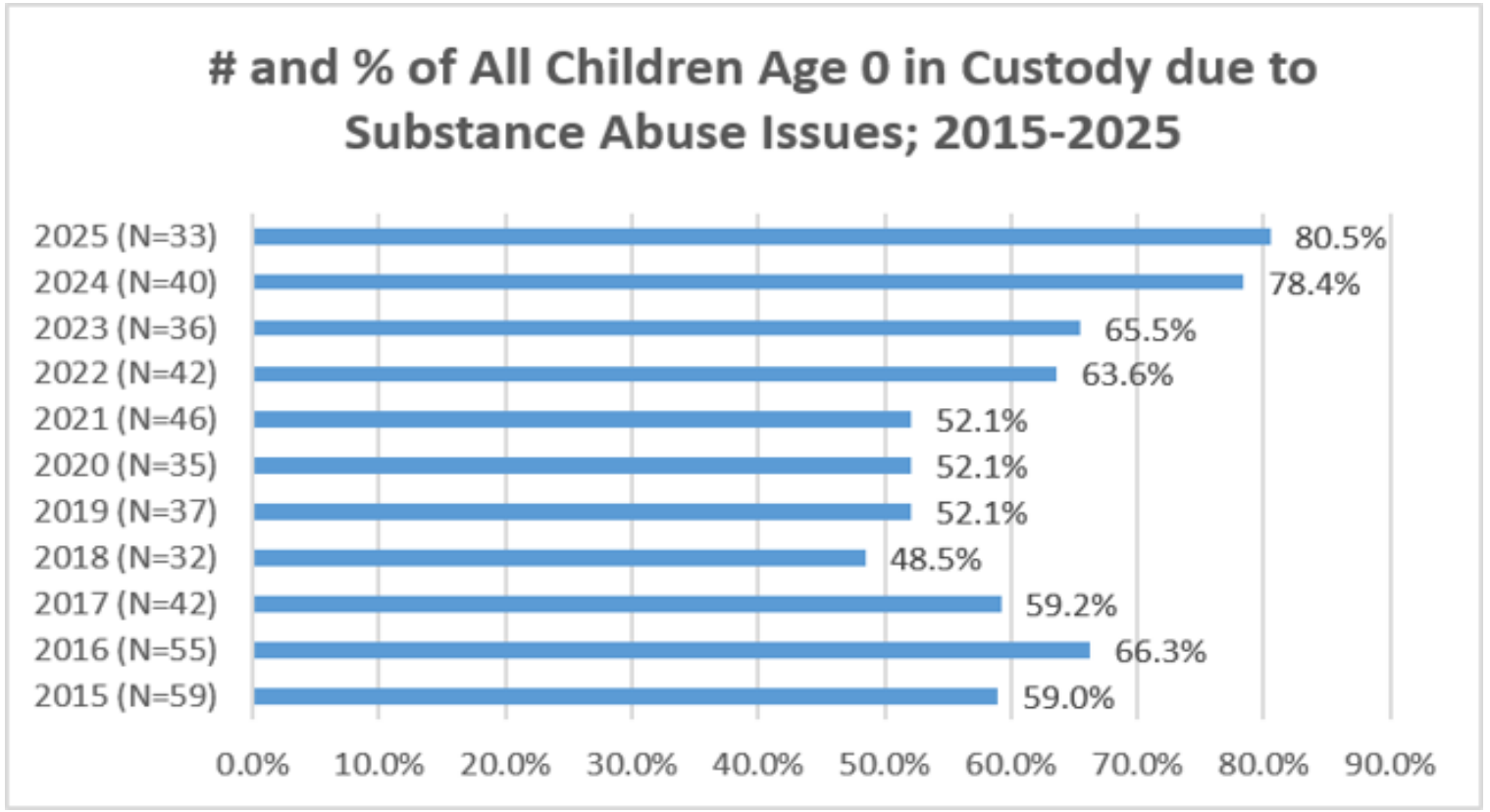


Data Source: 2021-2025 Child Protection Report/Victim Age When Abused report in FSD Report Manager

Data Note: Data within Report Manager is point in time. Totals may vary upon completion of pending reports within a given CY

Data Note: This is a total of victims ages when abused for 0-5 This includes Physical Abuse, Sexual Abuse, Risk of Sexual Abuse, Risk of Harm, Emotional/Neglect

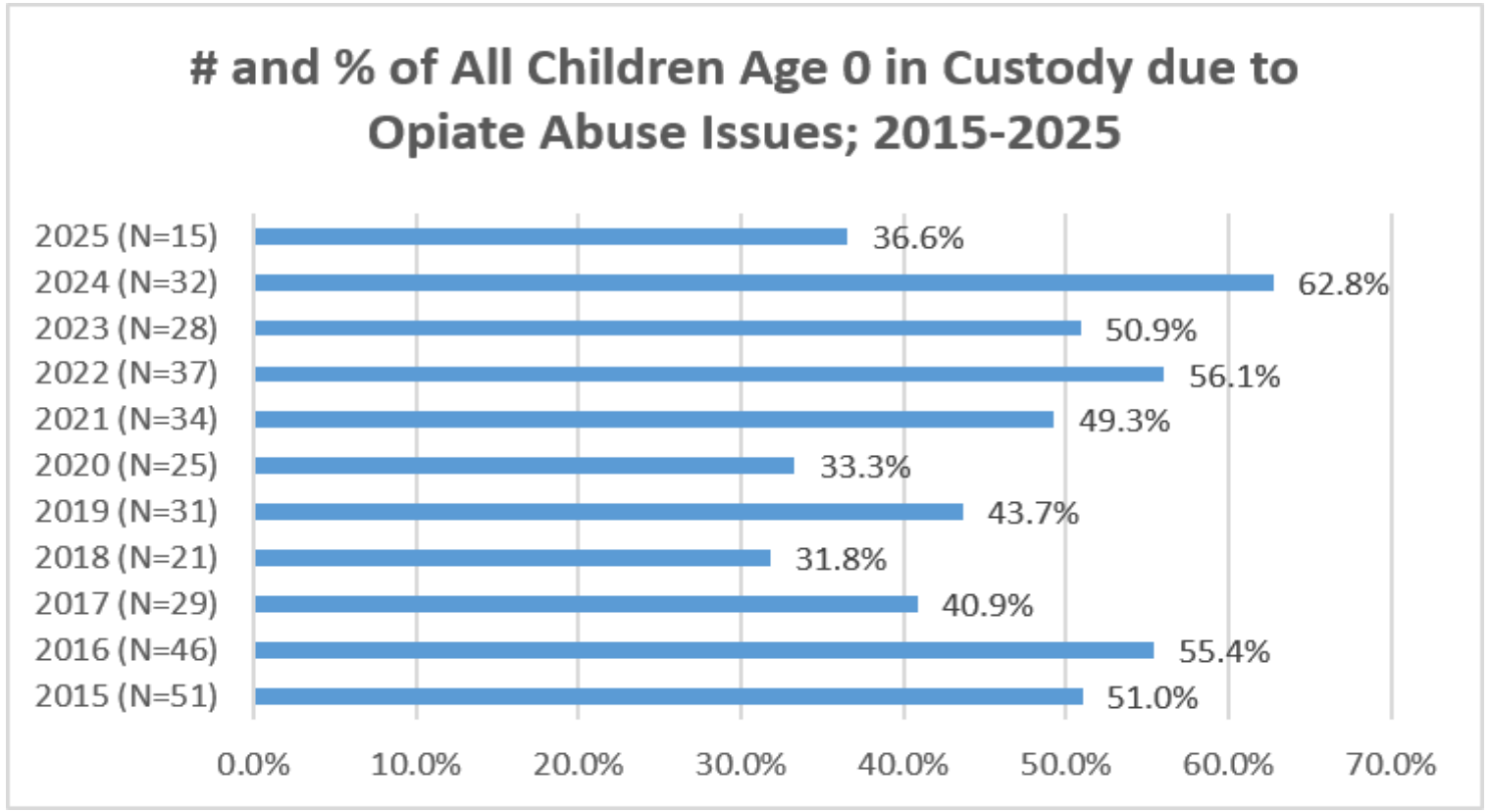
Family Services Division (FSD) Substance Abuse Data



Data Source: AHS Report Catalog; All Open Custody Cases with Case Detail Report for 0-5 Custody population. Annual Substance Abuse Survey.

Data Note: Data is point-in-time as of the day the report is ran; 11/1/XX. Child's age is calculated using the same date.

Family Services Division (FSD) Substance Abuse Data



Data Source: AHS Report Catalog; All Open Custody Cases with Case Detail Report for 0-5 Custody population. Annual Substance Abuse Survey.

Data Note: Data is point-in-time as of the day the report is ran; 11/1/XX. Child's age is calculated using the same date.

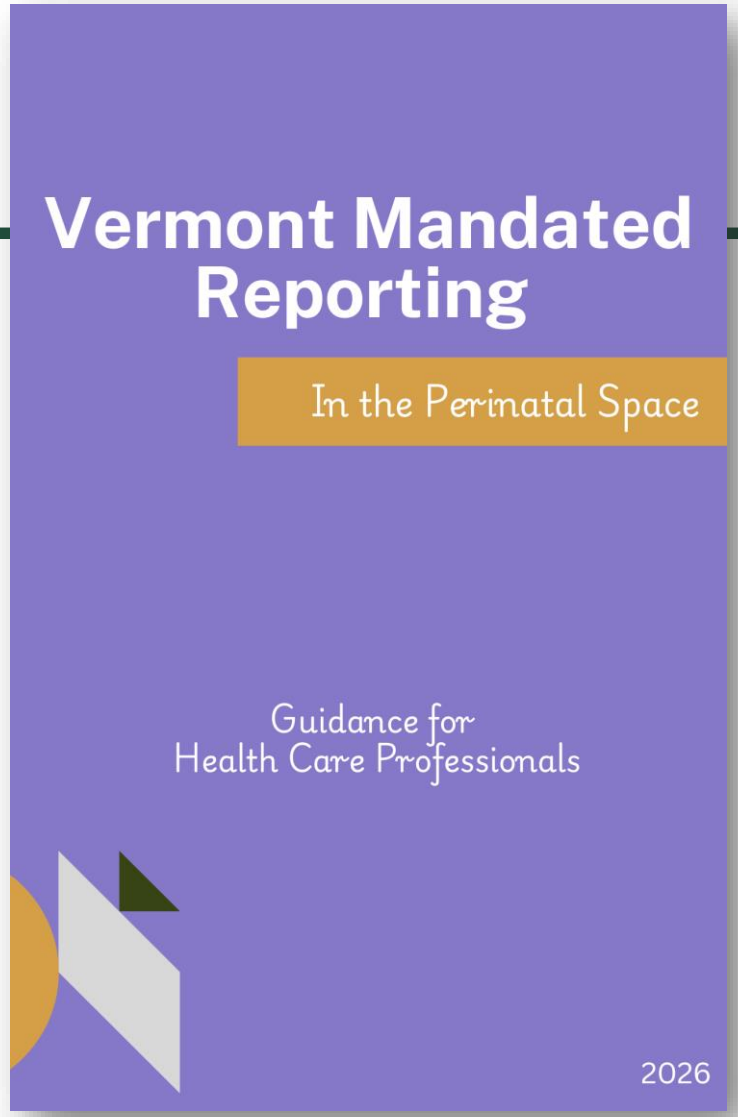
Areas of Consideration & Assessment

- Caregiver's pattern of use, procurement of substances, and impact on functioning and parenting
- Home environment, health risks, and basic needs
- Child and caregiver vulnerabilities
- Family's network of support, including the presence of sober caregivers and willingness to support or intervene
- Parent's perception of their use and the overall situation
- Engagement in treatment, peer recovery supports, and other recovery-oriented services

Care of Pregnant & Postpartum People with Substance Use Disorder Patient Safety Bundle

- Provide clinical and non-clinical staff education on optimal care for pregnant and postpartum people with SUD, including federal, state, and local notification guidelines for infants with in-utero substance exposure and comprehensive family care plan requirements.
  - Develop clear educational resources that address common myths about institutional and state policies for child protection reporting
  - Train clinicians in the actual requirements for reporting SUD and correct misconceptions to prevent unnecessary reporting

Mandated Reporting Guidance



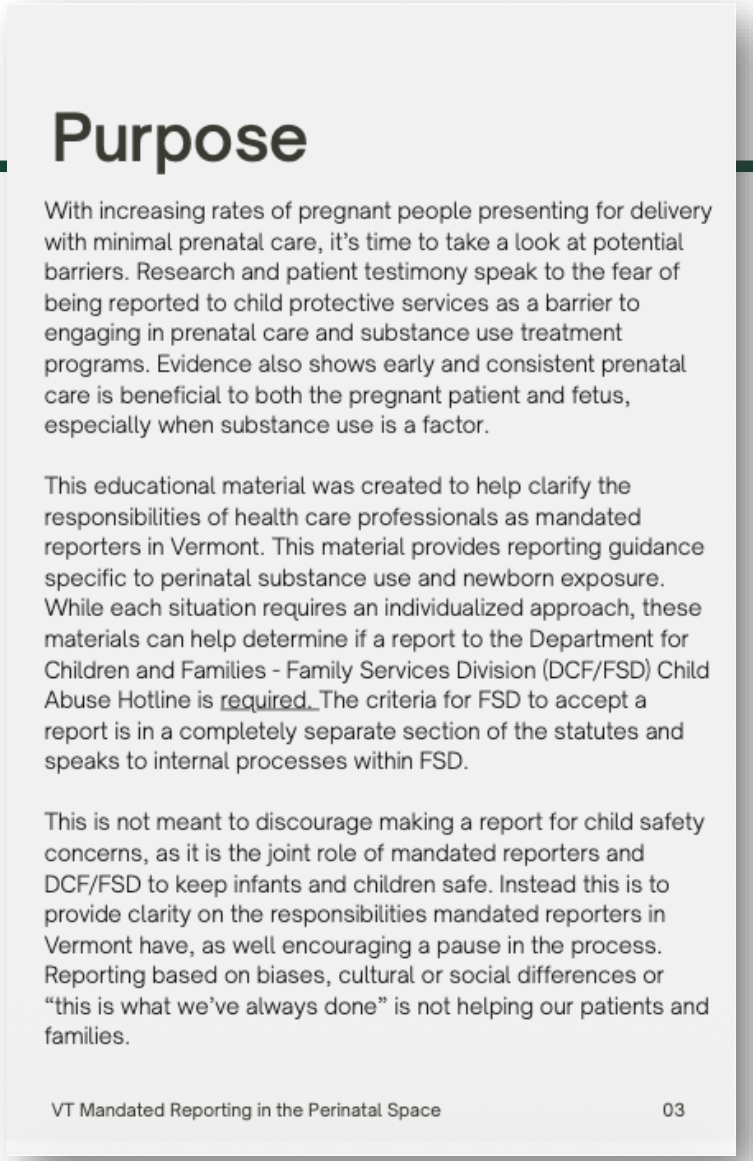
Multi-perspective Approach

- Members of AIM Team
- Family & Child Health Division
- OB/GYNs
- Pediatricians
- Risk Management
- Social Work/Case Management
- Members of the VT Child Welfare Training Partnership
- VT-PQC Patient & Family Advisors (Lived Experience)

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.

Vermont Mandated Reporting

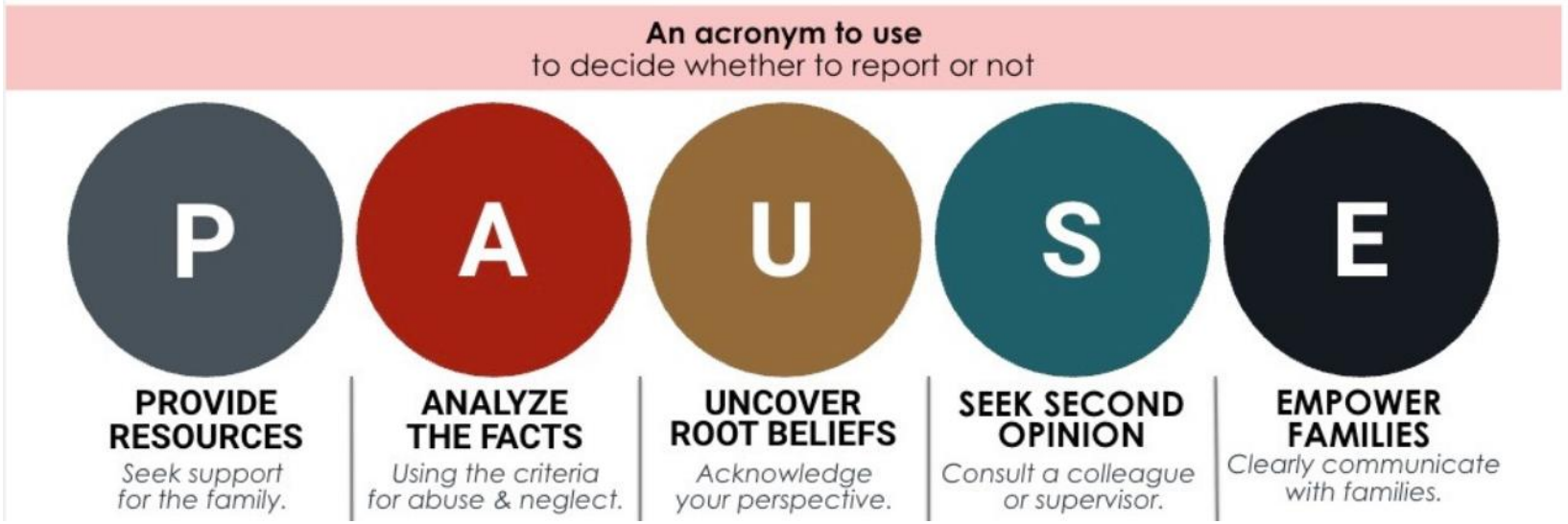
In the Perinatal Space

Guidance for
Health Care Professionals

2026

Content List

PAUSE Strategy



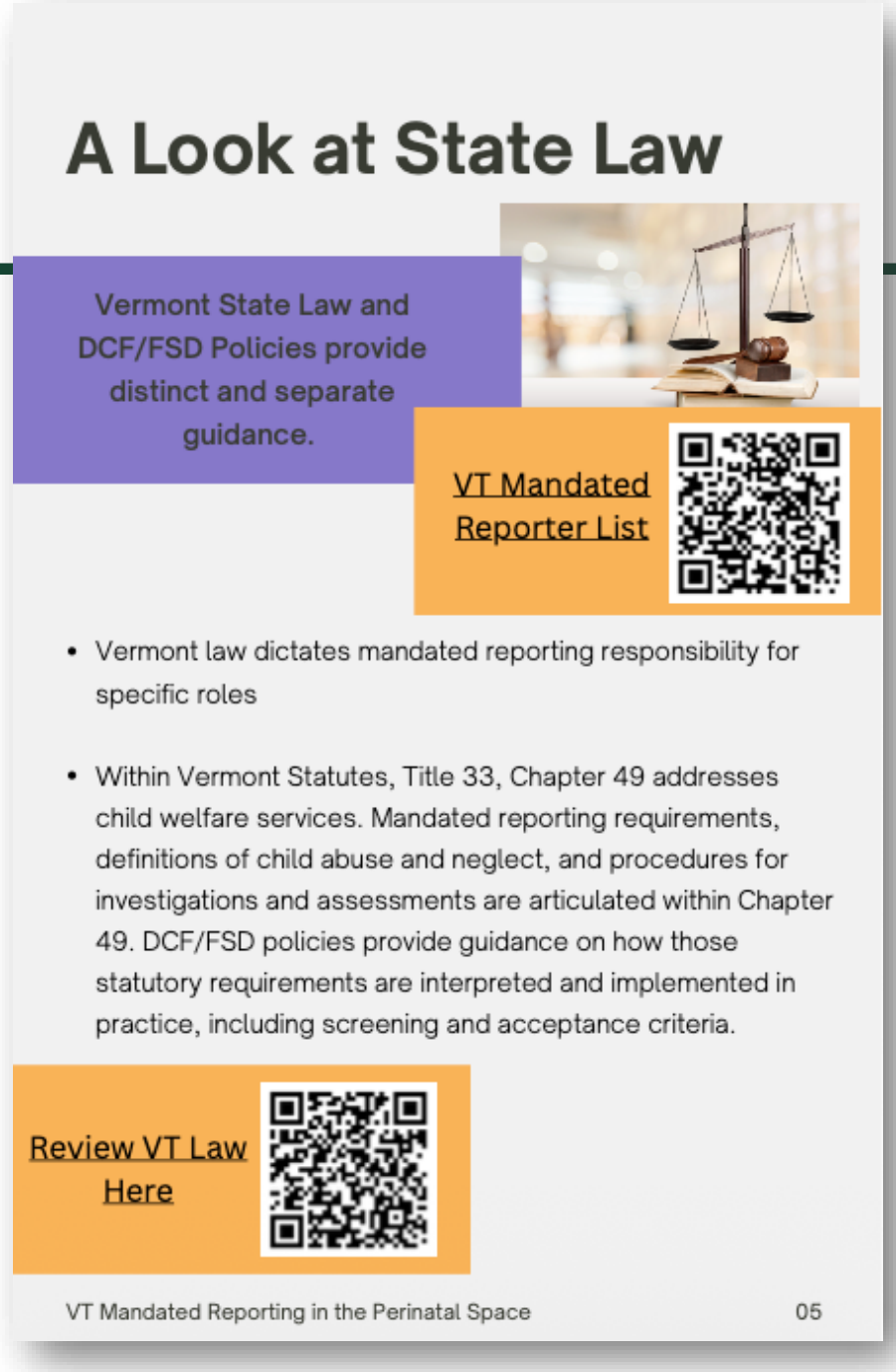
Consider using the PAUSE acronym when you are unsure if you suspect child abuse or neglect.

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

A Look at State Law

- VT Mandated Reporter List

- VT Statutes, Title 33, Chapter 49 → Child Welfare Services
  - Mandated Reporting Requirements
  - Definitions of Child Abuse & Neglect
  - Procedures for investigations & assessments



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.

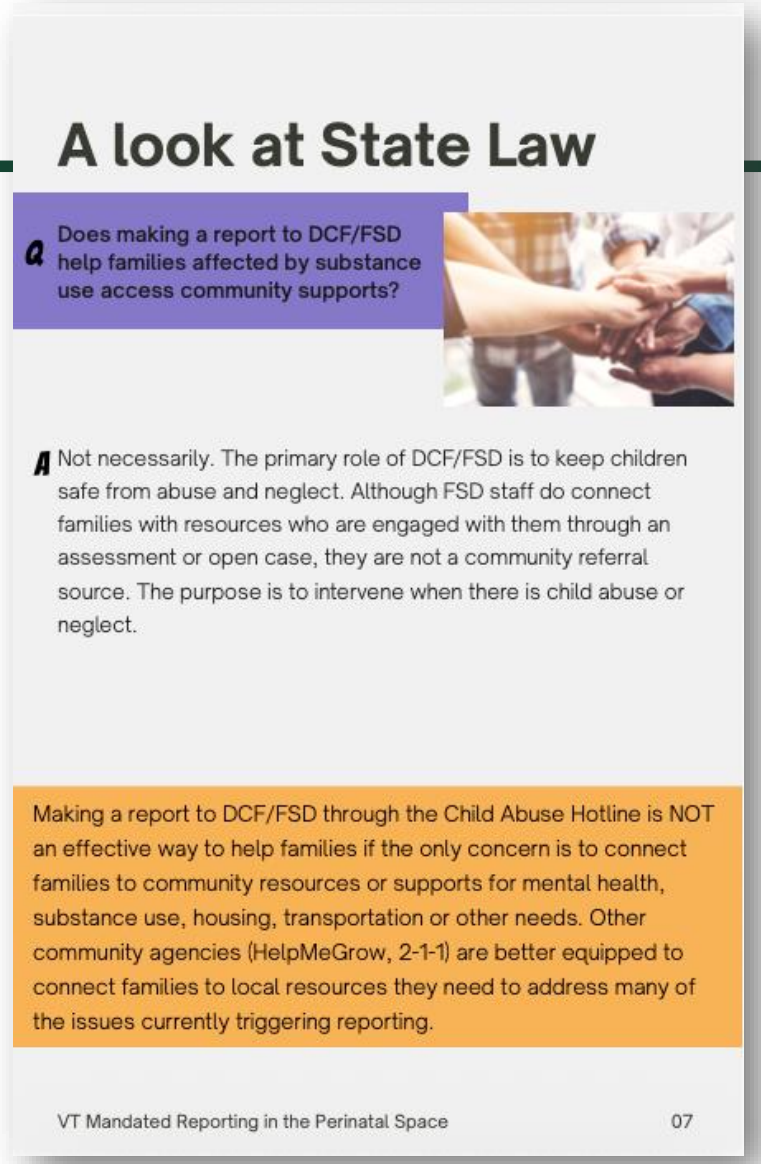
- Substance use in pregnancy or positive toxicology testing of a birthing person or newborn does NOT require a mandatory report to be made.

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.

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.



Vermont law includes a Risk of Harm Statute covering substance use

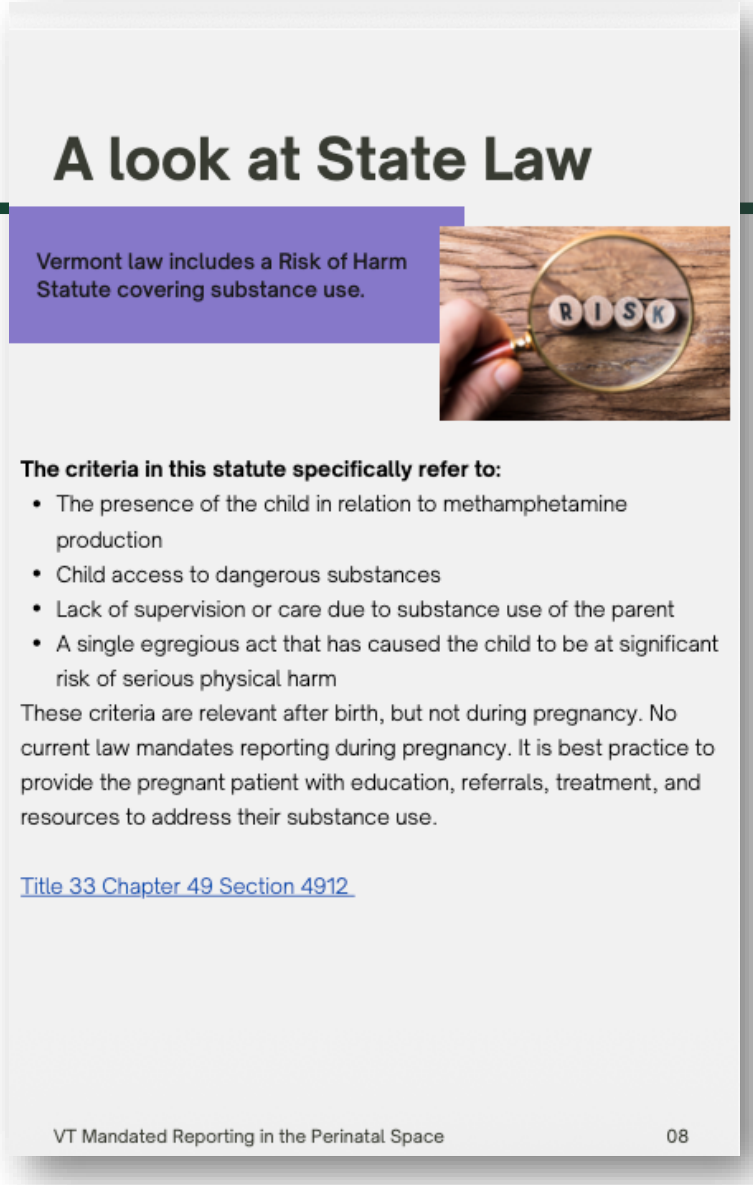
The criteria in this statute specifically refer to:

- 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.

<u>No current law mandates reporting during pregnancy.</u>

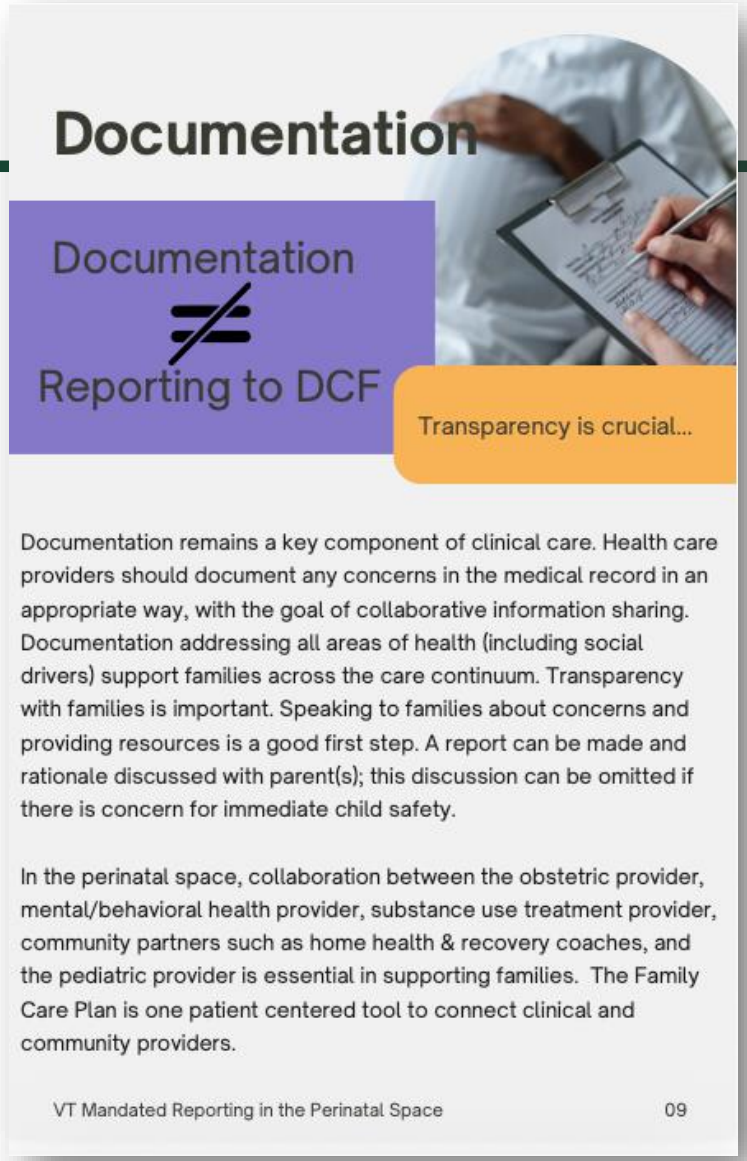
It is best practice to provide the pregnant patient with education, referrals, treatment, and resources to address their substance use.



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.



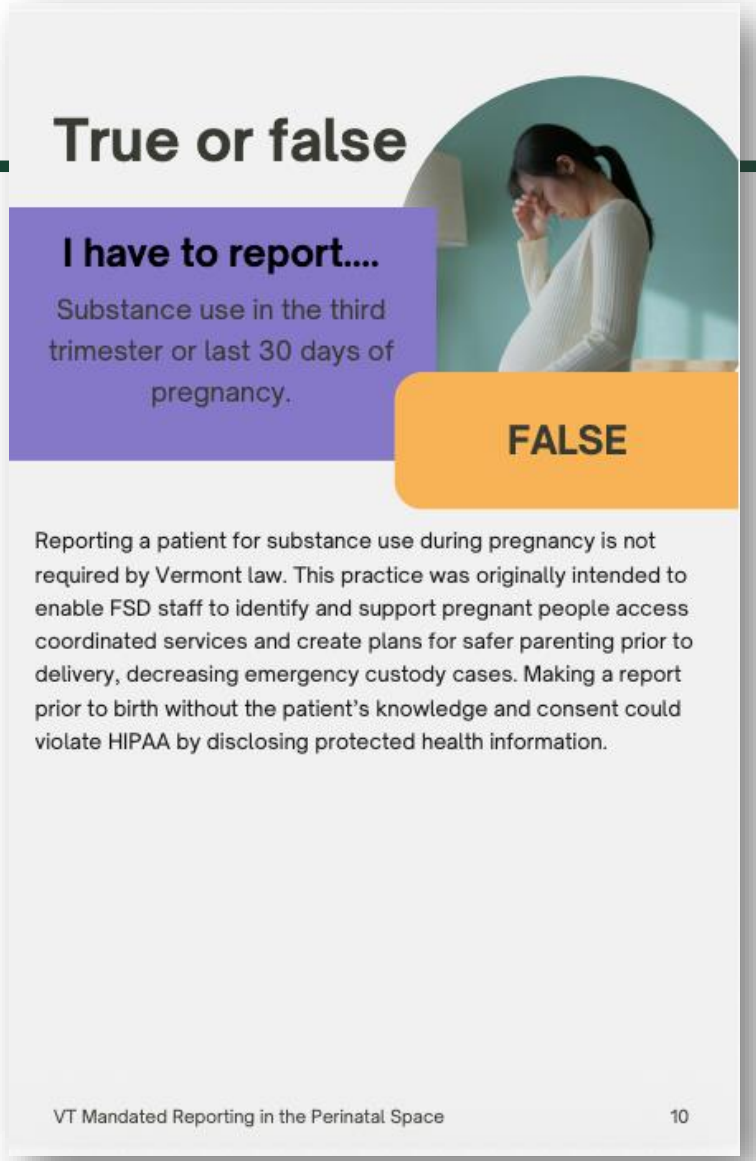
I have to report...
Substance use in the third trimester or last 30 days of pregnancy.

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.



I have to report...
A positive drug test on either birth parent or newborn at time of birth hospitalization

FALSE

Substance use in pregnancy (newborn with substance exposure) alone does not indicate the need for a DCF/FSD report in Vermont, other concerns must also exist.

The presence of child safety concerns in addition to ongoing parental substance use meets reporting criteria.

FSD will accept reports based on substance use alone per their policies, but there is not a mandate in reporting substance use without the reasonable suspicion of harm.

I have to report…
I have no real suspicion of abuse or neglect but I could lose my license if I don’t make a defensive report

FALSE

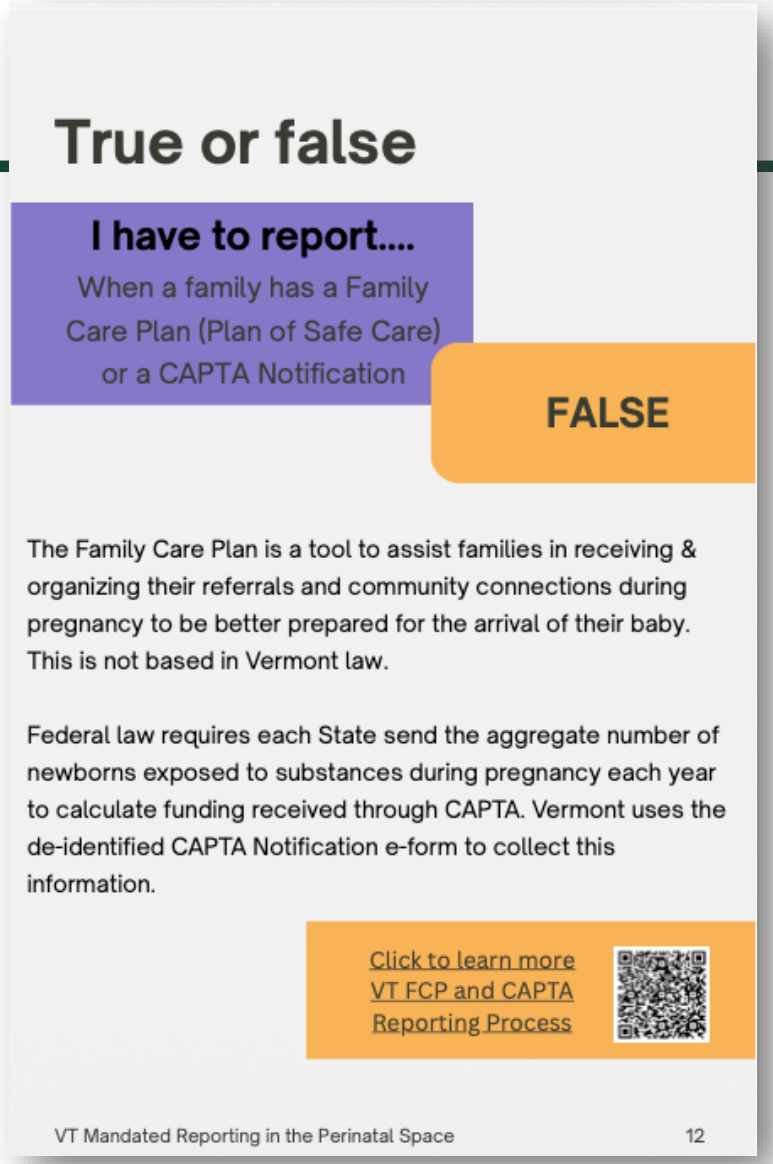
Prosecution of mandated reporters for failing to make a report is exceptionally rare in any state. Vermont law does not criminalize substance use in pregnancy.

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.



Case #1

Your patient at 36 weeks gestation discloses to you that they have been using alcohol throughout pregnancy.

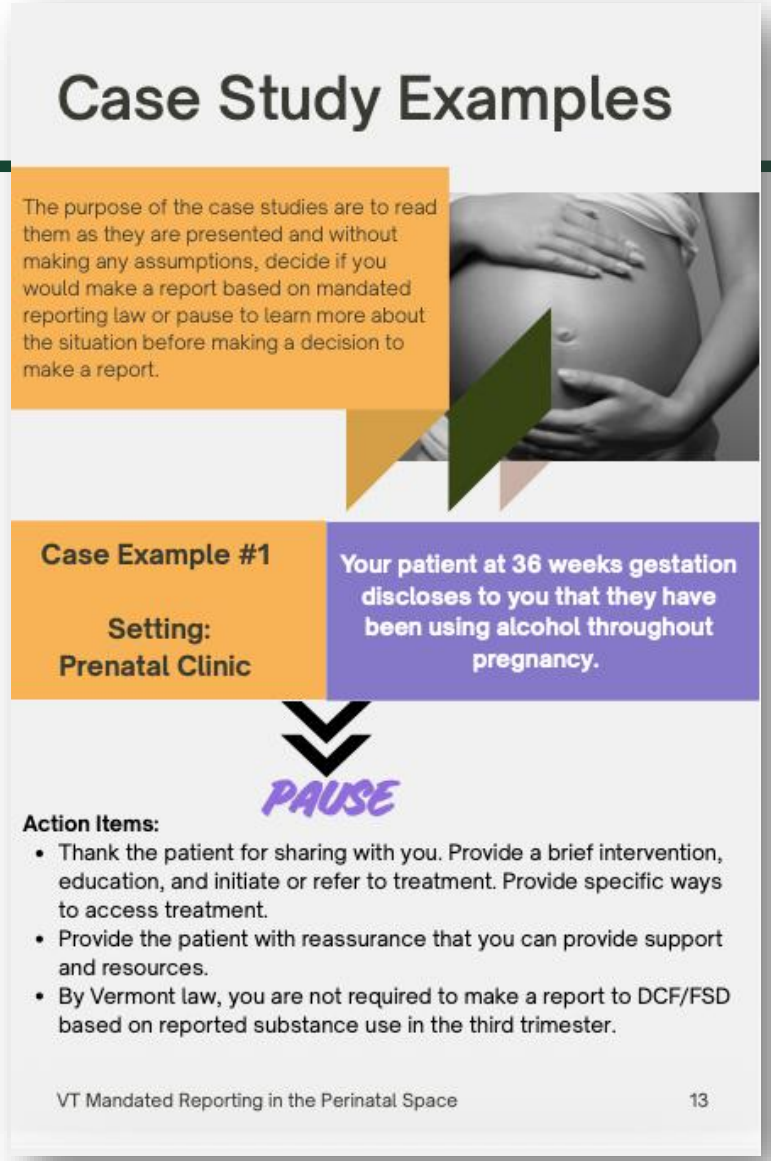
PAUSE

Action Items:

- Thank the patient for sharing with you. Provide a brief intervention, education, and initiate or refer to treatment. Provide specific ways to access treatment.

- Provide the patient with reassurance that you can provide support and resources.

By Vermont law, you are not required to make a report to DCF/FSD based on reported substance use in the third trimester.



Case #2

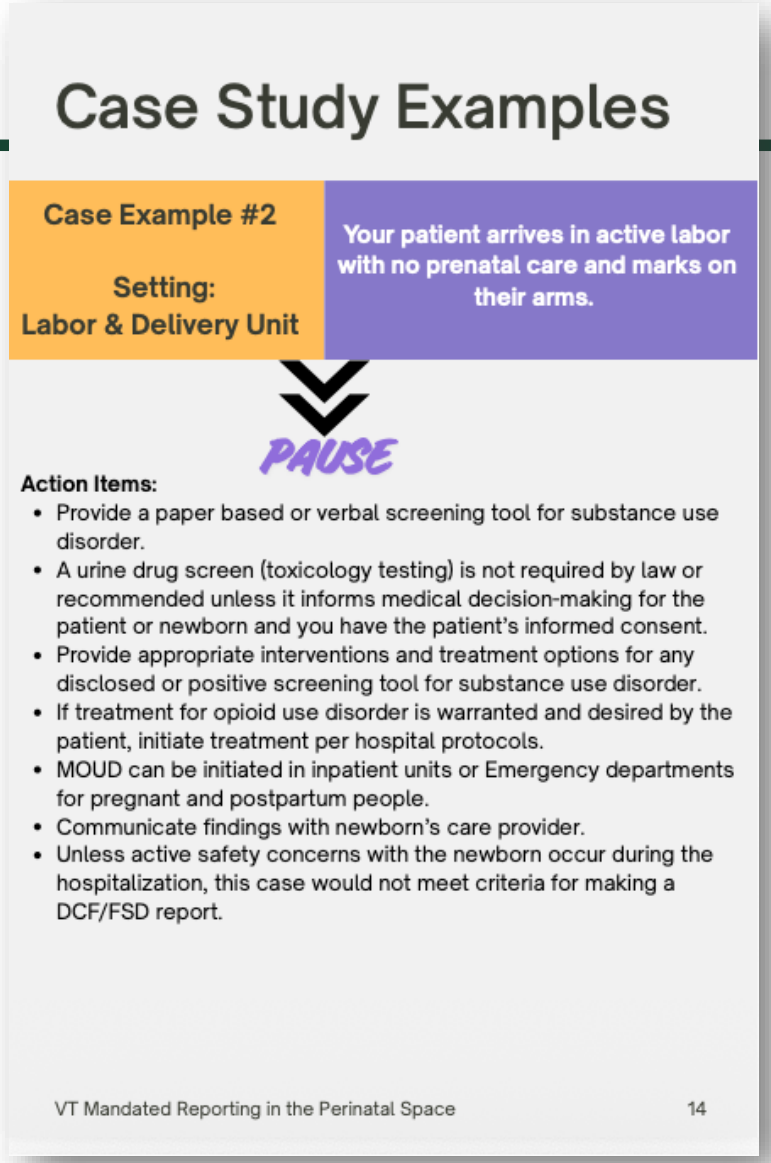
Your patient arrives in active labor with no prenatal care and marks on their arms.

PAUSE

Action Items:

- Provide a paper based or verbal screening tool for substance use disorder.
- A urine drug screen (toxicology testing) is **not required by law or recommended** unless it informs medical decision-making for the patient or newborn and you have the patient's informed consent.
- Provide appropriate interventions and treatment options for any disclosed or positive screening for substance use disorder.
- If treatment for opioid use disorder is warranted and desired by the patient, initiate treatment per hospital protocols.
    - MOUD can be initiated in inpatient units or Emergency departments for pregnant and postpartum people.
- Communicate findings with newborn's care provider.

Unless active safety concerns with the newborn occur during the hospitalization, this case would not meet criteria for making a DCF/FSD report.



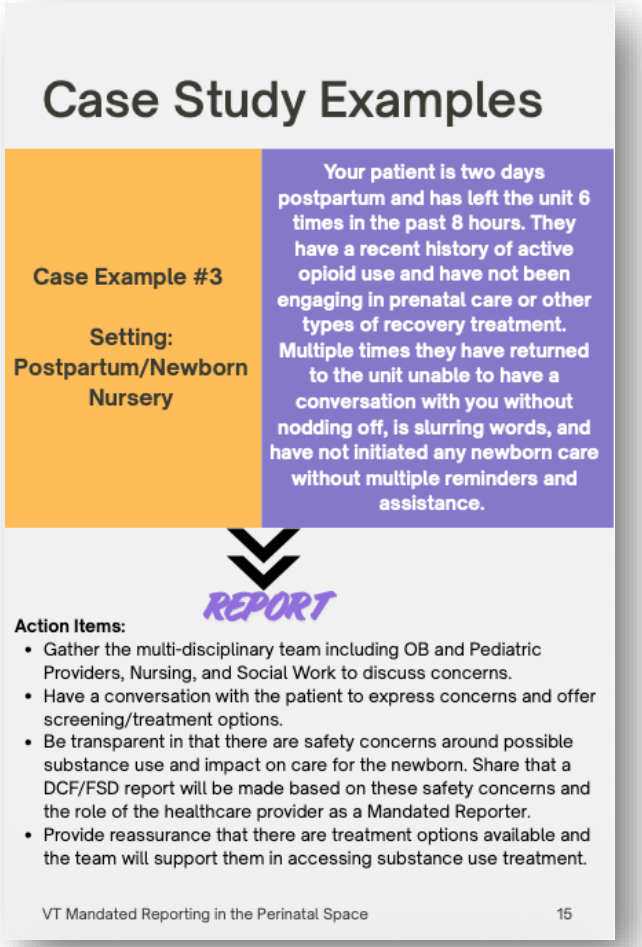
Case #3

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.



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

UVMMC 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

How To Access Resources

Mandated Reporting Guide

- Hard Copies: Samantha.Bellinger@uvmhealth.org
- E-copies: Kayla.Panko@uvmhealth.org

Mandated Reporting Rack Card

- Hard copies: Samantha.Bellinger@uvmhealth.org
- E-copies: Kayla.Panko@uvmhealth.org

And Remember:

We are all responsible for :

- Addressing our bias
- Offering supports
- Helping connect to resources

Questions / Discussion