Prenatal Exposure: Mandatory Reporting within a Culture of Compassion

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Which statement best describes how you feel about winter starting?

- I'm dreading it!
- Bring it on!
- It is what it is!

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Otto Bremer Trust Center for Safe & Healthy Children

- **C**linical Excellence
  - Comprehensive multidisciplinary evaluations
  - Inpatient and Outpatient services
- **A**dvocacy & Collaboration
  - Prevention: *No Hit Zone*
  - Regional approach to care
- **R**esearch
  - Infant TRAIN, Infant Mortality
  - Trafficking Screening
- **E**ducation
  - Regional – National – International Conferences
  - ACGME accredited CAP fellowship

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Otto Bremer Trust CSHC Program Overview

REFERRAL SOURCES

- Emergency Department
- Inpatient Service
- Trauma Service
- Physicians
- Other Hospitals
- Law Enforcement
- Child Protective Services
- District Attorney
- Parents
- Community

TYPE OF EVALUATIONS

- Sexual Abuse/Assault
- Physical Abuse/Assault
- Neglect/Medical Neglect
- Malnutrition
- Interpersonal Violence
- Drug Exposure
- Medical Child Abuse
- Child Fatality
- Medical Conditions Mistaken for Abuse

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Prenatal Exposure Defined

Prenatal exposure is the ingestion of a controlled substance for non-medical purposes by a woman during pregnancy which includes the use of opium, cocaine, heroin, phencyclidine, methamphetamine, amphetamine, tetrahydrocannabinol or habitual and excessive use of alcohol.

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State Statute

626.556 REPORTING OF MALTREATMENT OF MINORS.
Subdivision 1.**Public policy.**
(a) The legislature hereby declares that the public policy of this state is to protect children whose health or welfare may be jeopardized through physical abuse, neglect, or sexual abuse. While it is recognized that most parents want to keep their children safe, sometimes circumstances or conditions interfere with their ability to do so. When this occurs, the health and safety of the children must be of paramount concern. Intervention and prevention efforts must address immediate concerns for child safety and the ongoing risk of abuse or neglect and should engage the protective capacities of families.

Resource Guide for Mandated Reporters of Child Maltreatment Concerns, Child Safety and Permanency Division
Minnesota Department of Human Services, January 2016
https://edocs.dhs.state.mn.us/lfserver/Public/DHS-2917-ENG

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Prenatal Exposure and Mandatory Reporting

The reporting of prenatal exposure to controlled substances in Minn. Stat., section 626.5561, subd. 1, states a person mandated to report shall immediately report to the local welfare agency if they know or have reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during pregnancy, including but not limited to tetrahydrocannabinol, or has consumed alcoholic beverages during pregnancy in any way that is habitual or excessive.

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Reporting of Maltreatment of Minors Act

The Reporting of Maltreatment of Minors Act, Minn. Stat., section 626.556, subd. 2(g)(6), defines a type of neglect as prenatal exposure to a controlled substance used by a mother for nonmedical purposes, as evidenced by withdrawal symptoms in a child at birth, results of toxicology test performed on the mother at delivery or child at birth, medical effects or developmental delays during a child's first year of life that medically indicate prenatal exposure to a controlled substance, or presence of a Fetal Alcohol Spectrum Disorder.

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Exemption to Reporting

A health care professional or a social service professional who is mandated to report is exempt from reporting a woman's use or consumption of THC or alcoholic beverages during pregnancy if the professional is providing the woman with prenatal care or other healthcare services. However, a voluntary report may be made.

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Exemption: What Does this Mean?

- Even though I'm exempt, should I still report?
- What are the advantages/disadvantages to reporting?
- If I don't report, what conversations should I have with the patient?
- Who is my patient? Mother, baby, or both?

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MN State Statute: Toxicology Test for Mother

A toxicology test must be ordered for pregnant women upon admission and any time up to and including 8 hours after delivery if a pregnant patient has obstetrical complications that indicate possible use during pregnancy of a controlled substance for a non-medical purpose.

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MN Statue Statute: Toxicology Test for Baby

Toxicology testing of a newborn is required if there is reason to believe, based on the assessment of the mother or newborn, that a controlled substance was used by the mother for a non-medical purpose during pregnancy.

- Maternal verbal consent must be obtained.
- Mother may refuse testing for herself, however, she may not refuse testing for her newborn.

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ACOG Recommendation

- Before pregnancy and in early pregnancy, all women should be asked about their use of tobacco, alcohol, and other drugs, including marijuana and other medications used for nonmedical reasons.
- Women reporting marijuana use should be counseled about concerns regarding potential adverse health consequences of continued use during pregnancy.
- Women who are pregnant or contemplating pregnancy should be encouraged to discontinue marijuana use.
- Pregnant women or women contemplating pregnancy should be encouraged to discontinue use of marijuana for medicinal purposes in favor of an alternative therapy for which there are better pregnancy-specific safety data.
- There are insufficient data to evaluate the effects of marijuana use on infants during lactation and breastfeeding, and in the absence of such data, marijuana use is discouraged.

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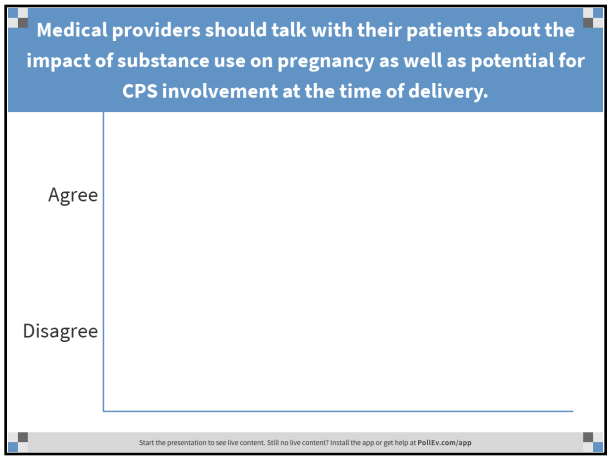

Having the Difficult Conversation

- Whether you make a report or not, it is important to talk with mothers about the potential impact her use could have on her baby.
- If the conversation does not take place, mothers might not have the opportunity to get services and support in place to help them maintain their sobriety and prevent CPS involvement.

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Communicating with Mother

- All women should be informed about planned medical testing.
- Explain and document reasons for testing.
- Provide mother with support in a nonjudgmental and compassionate environment.

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Communicating with Mother

Research indicates that mothers who receive treatment and support during pregnancy have a better prognosis for recovery from addiction, which improves neonate outcomes. Clear and honest communication with the mother regarding drug testing is very important.

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Scripting Suggestions

- "One of my jobs is to make sure that you have a healthy pregnancy and a healthy baby."
- "We both have the same goal: for you to have a healthy pregnancy and baby. Let's work together to make sure that happens."
- "If you or baby test positive at the time of delivery, a CPS report will be made. I want to work with you to make sure that doesn't happen."
- "As a mandated reporter, I am obligated to call Child Protection to let them know our concerns. I know this can be overwhelming and difficult to hear– do you have any questions that I can answer for you?"
- "CPS has resources to help you maintain your sobriety during your pregnancy and after."
- "Is there anything that you would like me to communicate to CPS when I contact them?"

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Documentation Tips

- It is important to document discussions between patient and provider regarding substance use and pregnancy.
- If you make a CPS report, document that a report was made.
- Documentation can be simple and concise: "Child Protection report made due to concerns about substance use during pregnancy/due to positive toxicology test for methamphetamines."
- If you will be doing ongoing drug testing during pregnancy, document that this will occur and explain why: "Ongoing drug testing will occur due to patient's positive toxicology test."
- Document that patient has been made aware of the impact of use on pregnancy, recommendation to abstain, that CPS will be notified at delivery if mom or baby are positive, and need for ongoing drug testing.

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Who Is a Mandatory Reporter?

A professional or professional's delegate who is engaged in the practice of the healing arts, hospital administration, psychological or psychiatric treatment, child care, education, social services, correctional supervision, probation and correctional services, or law enforcement, or employed as a member of the clergy and received the information while engaged in ministerial duties.

Resource Guide for Mandated Reporters of Child Maltreatment Concerns, Child Safety and Permanency Division
Minnesota Department of Human Services, January 2016
https://edocs.dhs.state.mn.us/lfserver/Public/DHS-2917-ENG

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Who Makes the Report?

"If you suspect a child is being abused or neglected, you cannot shift the responsibility of reporting to a supervisor, or to someone else in the office, school, clinic or licensed facility. **You alone are required to make the report to the responsible agency**."

**At UMMCH, Social Workers are available to make the report to CPS.

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How long do you have to make an oral CPS report? Written CPS report?

- You have to make both an oral report and a written report immediately.
- You have to make an oral report within 24 hours and a written report within 48 hours.
- You have to make an oral report immediately or within 24 hours and a written report within 72 hours.
- You have to make an oral report immediately or within 24 hours and a written report within 72 hours, excluding weekends and holidays.

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Timeline for Reporting

"The law requires mandated reporters to make a report if they know of or have reason to believe a child is being neglected or abused, or has been neglected or abused within the preceding three years."

Oral Report

- Immediately, within 24 hours

Written Report

- Within 72 hours, excluding holidays/weekends

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Failure to Report

A mandatory reporter who knows or has reason to believe that a child is neglected or physically or sexually abused, or has been neglected or physically or sexually abused within the preceding 3 years, and fails to report the abuse is guilty of a misdemeanor.

A mandatory reporter who knows or has reason to believe that two or more children not related to the perpetrator have been physically or sexually abused by the same perpetrator within the preceding 10 years and fails to report is guilty of a gross misdemeanor.

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Making the Report: What Will I be Asked?

- Your name, phone number, relationship to family/child
- Name, address, age, and other identifying information regarding the alleged victim, siblings, alleged offender, witnesses, and household members.
- Specific description of allegations (when, where).
- If the child is in immediate danger.
- Description of injuries.
- Family's awareness of report.
- Tribal affiliation.
- NEW: Additional questions about family's protective factors and risk factors, pets in the home.

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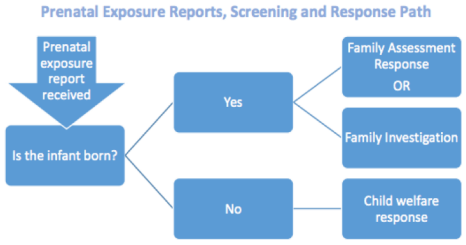
What Happens After I Make a Report?



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What Happens After I Make a Report?

- BEFORE 34 WEEKS: Project Child, Mother's First, etc. Services provided, include chemical health assessments and treatment services, education, support, counseling, community referrals, assistance with basic needs, and parenting education.
- Programs are voluntary.
- All MN counties offer a similar program.

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What Happens After I Make a Report?

- AFTER 34 WEEKS: CPS will likely open as a child welfare case and then as child protection when baby is born.
- Once baby is born, the outcome of CPS involvement is dependent on what substance was used and CPS history. Outcomes could include ongoing chemical dependency support and resources, mental health/parenting services, and removal of baby from mother's care.

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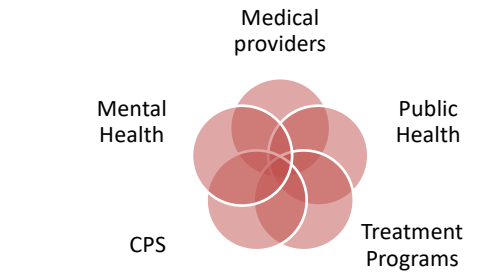
Multidisciplinary Response



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Prenatal Response

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Postnatal Response

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Creating a Positive Reporting Experience

- As a general rule, we recommend telling the patient that you are a mandated reporter and obligated to make a report to Child Protection. There may be times that informing the patient is not possible or ideal. Use your best judgement.
- Talk to patient about your concerns and explain that you are a mandated reporter.
- Maintain a positive, nonjudgmental attitude.
- Focus on the services that will be available for support and the hope that CPS involvement can be prevented.
- Emphasize the importance of having a health pregnancy and healthy baby.
- Answer questions and address concerns.

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Discussion: Provider-Patient Relationship

- Many providers worry that making a CPS report will impact the provider-patient relationship.
- Many providers also worry that a patient might stop seeking prenatal care due to the CPS report.
- How do we balance these with our mandatory obligation and our goal of healthy pregnancy/healthy baby?

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Reminders

- If mother or baby test positive at the time of delivery, a CPS report will be made.
- If mother has CPS history, even THC/alcohol use during pregnancy can lead to larger consequences.
- Mother may question why she was not told about potential consequences during prenatal care.

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What word comes to mind when you think about working with mothers who have used an illicit substance during pregnancy?

"The Trauma Suitcase"

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ADVERSE CHILDHOOD EXPERIENCE (ACE)

An adverse childhood experience (ACE) describes a traumatic experience in a person's life occurring before the age of 18 that the person remembers as an adult.

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What Are the ACEs?

- Physical abuse
- Sexual abuse
- Emotional abuse
- Mental illness of a household member
- Problematic drinking or alcoholism of a household member
- Illegal street or prescription drug use by a household member
- Divorce or separation of a parent
- Domestic violence towards a parent
- Incarceration of a household member

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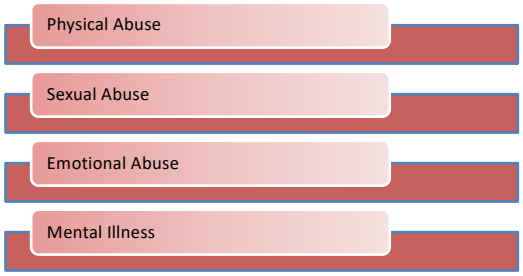
ACEs



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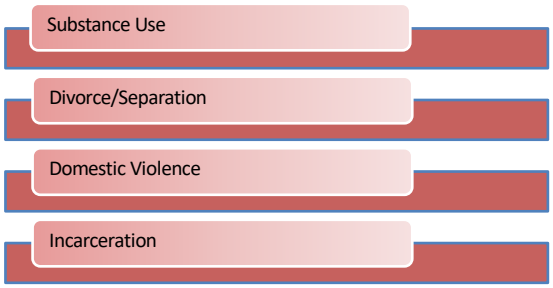
ACEs



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The Relationship Between ACEs and Substance Use

- The early initiation of alcohol use.
- Higher risk of mental and substance use disorders as an older adult (50+).
- Continued tobacco use into adulthood.
- Prescription drug use.
- Lifetime illicit drug use, drug dependency, and self-reported addiction.

SAMHSA's Center for the Application of Prevention Technologies

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Minnesota ACEs

TABLE 1: **PREVALENCE OF ACEs IN MINNESOTA** MINNESOTA 2011

	NUMBER OF ACES (PERCENT)					
	0	1	2	3	4	5+
All Minnesotans	45	22	12	8	5	8
Men	46	23	12	7	5	7
Women	43	22	12	9	6	9

Source: Minnesota Department of Health, Center for Health Statistics, BRFSS *Due to rounding, the numbers may exceed 100%.*

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Trauma Informed Care

- An organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma.
- Emphasizes physical, psychological and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment.
- Is about creating a safe environment based on an understanding of the effects of trauma so that health care encounters are safe and affirming.
- Does not mean probing for trauma stories.

The Trauma Informed Care Project
Browne, et al., 2012; Poole & Greaves, 2012

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Trauma Informed Care

Being trauma-informed and trauma-responsive is about building trust.

Key elements include:

- Thinking about and removing barriers to engagement.
- Attending to a person's immediate needs.
- Being as transparent, consistent, and predictable as possible.
- Respecting healthy boundaries.
- Having clearly communicated program goals.
- Obtaining informed consent and explaining confidentiality and limits to confidentiality.

(BC Center of Excellence for Women's Health, 2013)

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Role of the Psychosocial Assessment

- Build rapport
- Assess trauma history
- Assess psychosocial needs/barriers to care
- Identify risk factors
- Identify protective factors
- Provide support, resources, and education

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My beliefs and attitudes about women who use substances while pregnant impacts the care I provide.

Yes, absolutely.

At times, but I try my best to not let them interfere with my work.

No, never.

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CREATING A CULTURE OF COMPASSION

- We share the same goals as parents: a healthy pregnancy and baby.
- The vast majority of mother's make positive changes during pregnancy.
- Ultimately, these babies usually are discharged or returned to the care of their mothers. Focusing on attachment is in everyone's best interest.
- Because we want what is best for babies, we need to support their mothers.
- Increasing comfort of mothers at the bedside will lead them to spend more time with their babies, increasing attachment.
- The words we use impact our message.
- Our nonverbal communication is important.
- When we provide comfort, families are more likely to ask questions, look for guidance, and be receptive to teaching.

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Questions?

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Referrals are accepted for inpatient and outpatient consultations

- Inpatient consultations at HCMC and UMMCH
- Outpatient consultations at our SAFE CHILD Clinic at UMMCH & CornerHouse
- (612) 273-SAFE (7233) - Referrals & Questions on Child Abuse & Mandatory Reporting
- Email: safechild@fairview.org. Website: z.umn.edu/obtcshc

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