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Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

MATERNAL MENTAL HEALTH AND CPS

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Integrated Care Training Program
UW Psychiatry & Behavioral Sciences

project ECHO

GENERAL DISCLOSURES

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GENERAL DISCLOSURES

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SPEAKER DISCLOSURES

PAL for Moms phone consultation line for providers
State of Washington Health Care Authority
206-685-2924 or 1-877-PAL4MOM, M-F 9-5

PLANNER DISCLOSURES

The following series planners have no relevant conflicts of interest to disclose:

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OUTLINE

1. Prevalence and impact of child abuse and neglect
2. Reporting to CPS
3. Maternal mental health and child abuse and neglect
4. Preventing child abuse

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PREVALENCE AND IMPACT

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PREVALENCE

- Analysis of state CPS agency data (2018)
  - 678,000 children were determined to be victims of maltreatment, (up from 674,000 in 2017)
  - 60.8 % of victims were neglected
  - 10.7 % were physically abused
  - 7 % were sexually abused
  - > 15 % were victims of two or more maltreatment types.
  - 1,770 children died from abuse and neglect
- NIS data:
  - > 1.25 million children experienced maltreatment during the NIS–4 study year (2005–2006)
  - This corresponds to one child in every 58 in the United States.

Child Maltreatment Report, 29th edition; National Incidence Study

PREVALENCE

- Parent involved: Mother – 41%; Father – 21%
- Type of injury: Bruises (25% of cases)
- Mean age of the patients was 6.4 years old.
- Significantly more victims (89%) had Medicaid or no insurance compared with other patients (71%).
- Result of CPS report:
  - 46% ‘indicated,’ 20% ‘unfounded,’ and for the remaining 34% follow-up information could not be determined.

CHILD MALTREATMENT AND HEALTH OUTCOMES

Table 8. Summary of the strength of the evidence for related health outcomes.

Robust Evidence	Weak/Inconsistent Evidence	Limited Evidence
Physical abuse		
Depressive disorders	Cardiovascular diseases	Allergies
Anxiety disorders	Type 2 diabetes	Cancer
Eating disorders	Obesity	Neurological disorders
Childhood behavioural/conduct disorders	Hypertension	Underweight/malnutrition
Suicide attempt	Smoking	Uterine leiomyoma
Drug use	Ulcers	Chronic spinal pain
STIs/risky sexual behaviour	Headache/migraine	Schizophrenia
	Arthritis	Bronchitis/emphysema
	Alcohol problems	Asthma
Emotional abuse		
Depressive disorders	Eating disorders	Cardiovascular diseases
Anxiety disorders	Type 2 diabetes	Schizophrenia
Suicide attempt	Obesity	Headache/migraine
Drug use	Smoking	
STIs/risky sexual behaviour	Alcohol problems	
Neglect		
Depressive disorders	Eating disorders	Arthritis
Anxiety disorders	Childhood behavioural/conduct disorders	Headache/migraine
Suicide attempt	Cardiovascular diseases	Chronic spinal pain
Drug use	Type 2 diabetes	Smoking
STIs/risky sexual behaviour	Alcohol problems	
	Obesity	

Source: Norman et al, 2012

INTERGENERATIONAL MALTREATMENT

A simplified diagram of intergenerational transmission: Maltreatment by the parent (G1) of the child (G2) in the first generation leads to maltreatment by the parent (G2) of the child (G3) in the second generation.

Theories to explain IGM

Social Learning theory
Attachment theory
Trauma based models
Ecological or transactional models

Increased risk of IGM

Maternal social isolation
Maternal substance use
Parental mental illness
Young parental age
Parents living with another violent adult
Maternal life stress
Parents' experience of IPV

Source: Child Welfare Information Gateway. (2016). *Intergenerational patterns of child maltreatment: What the evidence shows.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

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IGM – CONTEXT IS CRITICAL

- Depression and trauma symptoms may be potential pathways for intergenerational maltreatment
- But at least one study found that, in the case of child physical abuse, depression and posttraumatic stress disorder reduced the likelihood of intergenerational abuse
- Parents with histories of neglect were at increased risk for IGM, but parents with histories of physical abuse were not
- Authoritarian parenting attitudes, which have been linked to poor child outcomes in Caucasian-American families, were found to protect against intergenerational patterns of abuse by African-American mothers

Source: Child Welfare Information Gateway. (2016). *Intergenerational patterns of child maltreatment: What the evidence shows.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

REPORTING TO CPS

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MANDATED REPORTERS

- Medical practitioners (licensed health service providers, including: podiatrists, optometrists, chiropractors, registered or licensed nurses, dentists, osteopaths, surgeons, physicians and religious healing practitioners)
- Professional school personnel (including, but not limited to, teachers, counselors, administrators, child care facility personnel and school nurses)
- "Social services counselor" (anyone engaged in a professional capacity during the regular course of employment in encouraging or promoting the health, welfare, support or education of children, or providing social services to adults or families, including mental health, drug and alcohol treatment, and domestic violence programs)
- Registered pharmacists
- Licensed or certified child care providers or their employees
- Department of Early Learning employees
- …many more

- **1-866-EndHarm (1-866-363-4276)**

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WHAT HAPPENS AFTER A CPS REPORT?

Meets criteria

CPS INVESTIGATION
(Reports of serious physical abuse and all reports of sexual abuse)

CPS FAMILY ASSESSMENT

Does not meet criteria for abuse / neglect:
Information only referral

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PARENTAL INVOLVEMENT

- Not required to tell the parents about your CPS report.
- If you choose to inform the parents, explain that you are required by law to report all situations of neglect or injury to children caused by questionable or other-than-accidental means.
- Instances in which you may not want to inform the parents of your report to CPS:
  - a situation when the child's safety would be jeopardized by the parent's knowing the child has disclosed information to you
  - when a child is in imminent danger and you believe the parent might run away with the child.

SERVICES PROVIDED

- CPS provides services to abused/neglected children and their families without regard to income.
- Services to children and families may include:
  - Home support specialist services
  - Day care
  - Foster family care
  - Financial and employment assistance
  - Parent aides
  - Mental health services, such as counseling, for parents, children, and families
  - Psychological and psychiatric services
  - Parenting and child management classes
  - Self-help groups

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MATERNAL MENTAL HEALTH AND CPS

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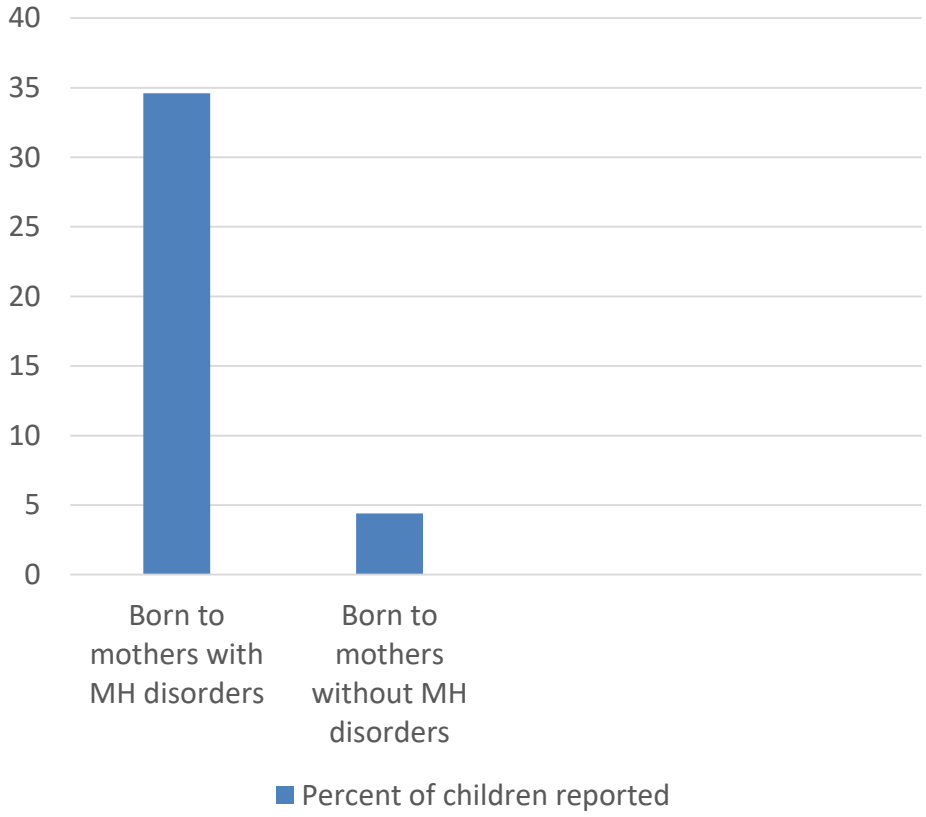
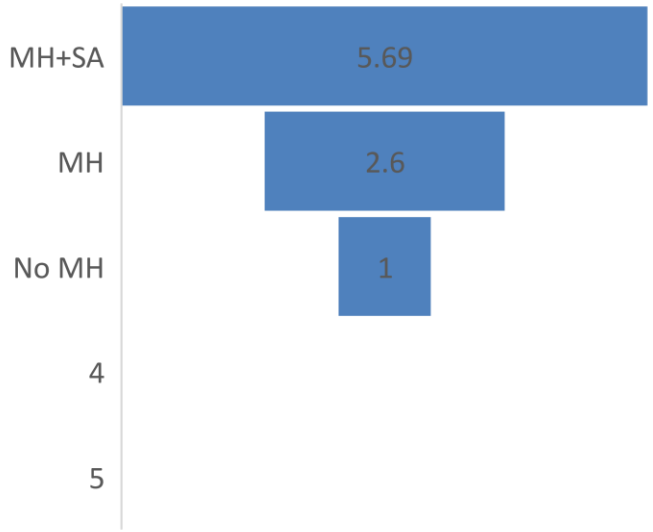
MATERNAL MENTAL HEALTH DISORDERS AND REPORTS TO CPS





The proportion of children with foster placements is more than double for children of mothers with mental illness

Hammond et al, 2017

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SERIOUS MENTAL ILLNESS

- Mothers with SMI are less responsive and emotionally involved with their children than depressed mothers and mothers without mental illness
- Barriers to helping moms with SMI:
  - Fear of losing child custody or access is always uppermost in the minds of severely mentally ill women, leading to barriers to disclosure of parenting difficulties
  - Lack of training among mental health professionals re assessing parenting
- Parents with SMI approximately eight times more likely to have CPS contact and 26 times more likely to have a change in living arrangements; Approximately 50 percent of mothers who suffer from schizophrenia lose custody of their children

Kaplan et al, 2019

SUPPORTING MOTHERS WITH SMI

- Ensure family health
- Prevent psychotic relapse
- Take advantage of available parenting resources
- Prepare in advance for crisis
  - Document daily parenting activities
  - Become knowledgeable about legal issues that pertain to mental health and custody

Seeman, 2011

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MATERNAL DEPRESSION

- Depression elevates the risk of coercive or hostile parenting, and corporal punishment
- Depressed mothers engage less in safety practices
- Compared to nondepressed mothers, moderately but not severely depressed women are more likely to be physically violent
- Both moderately and severely depressed women are at increased risk for high frequencies of verbal/symbolic aggression.

Zuravin, 1989

MATERNAL MENTAL HEALTH AND CPS: ADDITIONAL RISK FACTORS TO CONSIDER

- Level of functioning
- Quality of parenting
- Presence of a supportive partner or extended family
- Presence of mental health problems in the father
- Presence of stress and adversity such as domestic violence
- Financial and housing status

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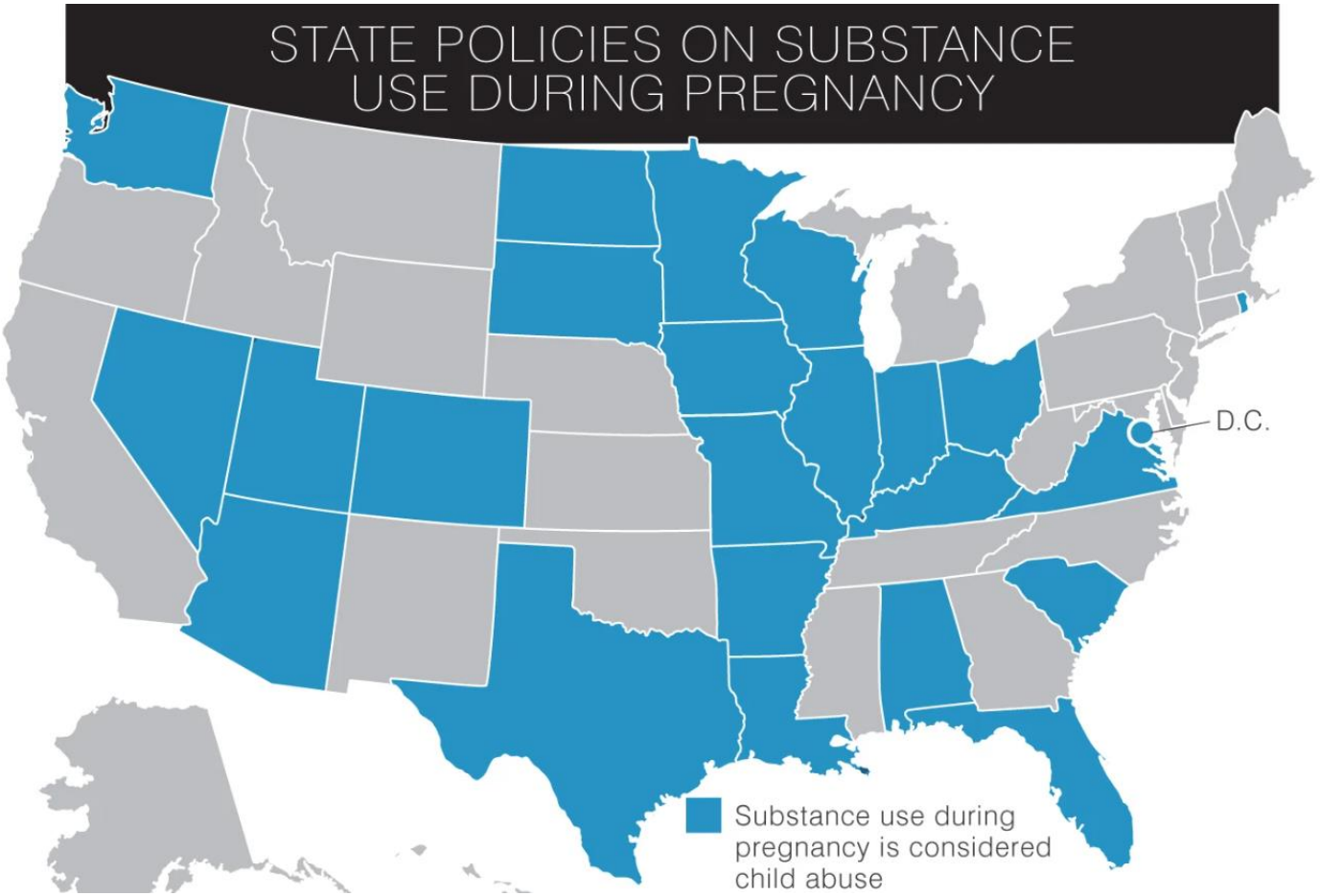
MATERNAL SUBSTANCE USE AND CPS

- Among children placed in the US foster care system parental substance abuse is a concern in approximately 16 to 79% of investigated reports of child maltreatment
- Among 551,232 infants born alive in 2006, 1.45% (n = 7994) were diagnosed with prenatal substance exposure at birth; 61.2% of those diagnosed were reported to CPS before age 1 and nearly one third (29.9%) were placed in foster care.
  - Variation in likelihood and level of CPS involvement by substance type: Cocaine-exposed infants more likely to be reported than those prenatally exposed to marijuana.
  - Infants exposed to alcohol and marijuana reported at lower rates, despite evidence of harmful impact of both substances on child outcomes

MATERNAL SUBSTANCE USE AND CPS



Source – women's mental health.org

MATERNAL SUBSTANCE ABUSE: WHAT ARE THE RISKS?

Low birth weight, preterm birth, hypoxia due to maternal malnutrition or impaired placental functioning

Congenital and neurological abnormalities, heart problems, and seizures resulting from neonatal abstinence or withdrawal

Exposure to domestic violence, tobacco and other toxic drugs, unsafe postnatal home environment, co-occurring maternal mental illness

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SCREENING FOR MATERNAL SUBSTANCE ABUSE

- ACOG recommends universal screening for substance abuse at the first prenatal visit
- 4Ps, NIDA Quick Screen, or CRAFFT (for women 26 years or younger)
- Women may not give honest answers regarding their uses of drugs while pregnant
- Non-consensual drug testing of mothers is unconstitutional

REPORTING REQUIREMENTS IN WA

Prenatal

- Women testing positive for drugs should be assessed for other risk factors (e.g. single parent status, no prenatal visits in first trimester) and referred to early intervention programs, with higher-risk cases referred to CPS
- RCW 26.44.020 (16) specifically states that the role of a parent's substance abuse should be "given great weight" in assessing neglect
- Prenatal CPS involvement and dependency cases

Postpartum

- No uniform policy or State law regarding consent for newborn drug testing.
- Familiarize yourself with regional practice standards
- Women with confirmed histories of drug use, or women and infants exhibiting signs of drug exposure, can be tested under the general consent because results of the test influence medical care and follow up.
- If intent of the testing is to bring legal action against the woman, a consent containing specific language defining possible consequences is needed.
- If a patient refuses testing, this should be documented and testing not performed
- All positive toxicology tests (maternal or child) should be reported to CPS

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MATERNAL SUBSTANCE USE

- Federal Child Abuse Prevention and Treatment Act (CAPTA) requires states receiving CAPTA grants to develop a plan for medical workers to notify CPS of infants identified at birth as affected by prenatal drug exposure
- This referral, in and of itself, is not grounds for a child abuse and/or neglect determination and cannot be used for criminal prosecution
- It is intended to provide a safety screening and to link the mother to voluntary community services
- The law also requires that CPS develop a safe plan for infants in this situation

MORE THAN SUBSTANCE USE

Exhibit 1
Summary of Maternal Characteristics Affecting the Newborn

Characteristics of Substance Abusing Pregnant Women	Percent in Washington State*
Victims of Domestic Violence	73%
One or More Children Under 18 Not Living With Them	69%
Unstable Living Environment	
Unemployed	84%
Rely on Public Assistance	70%
Have Not Completed High School	52%
Lack a Regular Home	32%
Criminal Justice Involvement	
Involvement at Time of Admission to Treatment	58%
History of Arrest One Year Prior to Treatment	65%
Long-Term and/or Poly-Drug Substance Abuse	
Poly-Drug Users	66%
Cigarette Smokers	82%
Lack of Prenatal Care	
Began Prenatal Care in 1st Trimester	<50%
Began Prenatal Care in 3rd Trimester or Had No Prenatal Care	>10%
Mental Health Problems	
History of Mental Health Treatment One Year Prior to Admission	26%
One or More Inpatient Hospitalization Days in Prior Year	14%

* Women receiving specialized PPW residential treatment (Rodriquez 1999)

Many of these characteristics affect the health of the baby, the health of the mother, the delivery process, and the mother's ability to succeed in treatment. These same factors also present significant barriers to treatment recruitment, retention, and completion.

Source:Services for Pregnant, Postpartum, and Parenting Women Sylvie McGee Linda Rinaldi Debby Peterman December 2002

OTHER MH / PERSONALITY DISORDERS

- Mothers with borderline personality disorder are less sensitive to their children's needs, and experience more distress in their parenting role
- Mothers with antisocial personality disorder also tend to engage in lower quality parenting
- Anxious mothers demonstrate less warmth, more criticism, and higher levels of control toward their children
- Anxious mothers are also more disengaged from their children than non-anxious mothers

CHILD CUSTODY TO IMPROVE TREATMENT ADHERENCE

- Child protective workers, family court judges, or family members may impose compliance with treatment recommendations as a condition for parents to maintain caregiving responsibility, to visit, or to reunite with children.
- A double-edged sword:
  - The preservation of relationships with children may be a powerful motivator to participate in treatment
  - Fear of custody loss is, in fact, a significant deterrent to treatment seeking
  - Evidence-based parenting interventions for adults with mental illnesses may not be available
  - Opportunities for failure to achieve parenting goals in a 12-month timeline are great.
  - Relationships between treatment adherence, reduction in symptoms, and improved parental functioning have not been clearly demonstrated.
  - Doubly stigmatizing: mental illness and failing as a parent.

CASE EXAMPLE 1

- Ms. A. was admitted to hospital for a postpartum psychotic episode. She had never been ill before. While she was in hospital, her infant was looked after at home by her parents. The baby's father was also involved in the child's care. Before the patient's hospital discharge (she had recovered and was functioning well at the time of discharge), the psychiatric resident contacted CPS, as a preventive measure, that Ms. A. might need help with parenting. Would you make a CPS report in this case?

CASE EXAMPLE 2

- 32 yo single mother, preterm baby in NICU for the past week with seizures. Mother treated for major depression through pregnancy with sertraline 200 mg, continues to engage in MH treatment. Has disability due to her own birth injury. Victim of IPV in the past, unstable housing, applying for section 8 housing. Is not present at infant's bedside during the day, only comes in at night. Is seen asleep at the bedside, not rousing to baby's crying. Baby is ready for discharge. Would you report this to CPS?

CASE EXAMPLE 3

- 10 yo boy with severe obsessive-compulsive disorder presenting to child psychiatrist for follow up. Mother, who has anxiety disorder, usually brings him in, but father is present at this appointment and reports that last week mother was infuriated at child's checking behaviors and slapped him across the face, leading to finger marks on his cheek which lasted an hour. Would you report this to CPS?

CASE EXAMPLE 4

- 19 yo with major depression and PTSD reports dissociative episodes for the past two years. She has a one year old daughter. She reports accidentally locking herself out on her patio one afternoon, with her phone and baby inside the house. The next thing she remembers is she is standing inside the house, having shattered the window of her bedroom using a planter, and climbed in through the window. FOB visits 1 -2 / week, but she is mostly parenting alone. Would this incident prompt you to make a CPS referral?

CASE EXAMPLE 5

- S is 2 weeks away from her 18th birthday, at 24 weeks gestation, FOB not involved, she is living with her father who has offered to support her and her baby. You notice bruising across her upper arm at her prenatal visit and she admits that her father had been “a little rough” with her when she questioned his excessive alcohol consumption. She begs you not to report him as he is undocumented. Would you report to CPS?

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PREVENTION

Home visiting programs

Parent education programs

Building protective factors

Nurturing and supportive relationships: parents or caregivers and peers

Safe and stable environments: stable housing, adequate nutrition, quality learning opportunities, and physical activities

Social engagement and a sense of connectedness: e.g., schools, recreational facilities, faith communities

Social and emotional competencies: Ability to expresses feelings and understand others' emotional states

Mikton et al, 2009

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HOME VISITING AND CHILD ABUSE PREVENTION

18-month randomized controlled trial in which intact families (N = 122) with at least one CPS report

Facilitated connection to a paraprofessional evidence-based HV program or usual care services from child protection.

No significant changes were found in maternal outcomes (maternal stress, depression, and social support outcomes) by group.

Among nondepressed mothers or families without multiple CPS reports prior to study enrollment, HV was associated with a significantly lower likelihood of CPS report recidivism.

HV can prevent maltreatment recidivism but higher intensity intervention may be warranted for mothers exhibiting significant depressive symptoms or families with extensive CPS histories.

Jonson-Reid et al, 2018

PARENT TRAINING AND CHILD ABUSE PREVENTION

- Components associated with effectiveness:
  - Both home and office settings
  - Inclusion of behavioral components
  - Some training in individual as opposed to group training
  - More than transmitting knowledge about child development and child management skills
  - Supplemental components such as anger and stress control

Lindahl et al, 2006

SYSTEM LEVEL PREVENTION

Pediatric Primary Care to Help Prevent Child Maltreatment: The Safe Environment for Every Kid (SEEK) Model

- special training for residents
- systematic screening for parents
- social work support

SEEK resulted in

- fewer child protective services reports
- fewer instances of possible medical neglect documented as treatment nonadherence
- fewer children with delayed immunizations
- less harsh punishment reported by parents.

Dubowitz et al, 2009

QUESTIONS/CONTACT INFORMATION

Feel free to contact me at:
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