

Insights

Our Systems Meant to Help Are Hurting Black Families



Mandated reporting is meant to keep children safe. [It requires](#) that those who work with children—health professionals, social workers, and teachers, among others—report any reasonable suspicion of child maltreatment, and gives them the anonymity to do so freely. When done under appropriate circumstances, mandated reporting supports children’s social, emotional and physical health. But, sometimes interventions that are meant to help end up causing unintentional harm.

This is what happens when structural racism gets in the way of intended processes, says Erin Cloud, supervising attorney for [The Bronx Defenders](#) and a member of the [Black Mamas Matter Alliance](#). In these instances, she explains, mandated reporting disrupts the health of black families, ultimately causing harm to the children that providers intend to protect. In honor of Black Maternal Health Week, and in keeping with our strategic vision’s focus on social determinants of health, NICHQ is shining a spotlight on this troubling example of when systems meant to support children’s health end up failing black mothers and children.

Cloud, who’s spent the past seven years advocating for parents in the child welfare system, shares the story of one of her clients, an example of what happens when biased reporting causes unintended harm for mothers and children. [The client’s story, and Cloud’s fight, offer a unique perspective on why mandated reporting is inextricably linked to children’s health](#)

outcomes.

Gloria's Story

Gloria is a black mother of two children. When her second child was born, Gloria was living in safe shelter housing with her first child, a healthy 3-year-old boy. After undergoing a cesarean surgery, doctors chose to drug test both Gloria and her newborn son, Jermaine. This decision was made without notice or consent, and done despite the newborn being healthy at birth. The results of the test showed marijuana metabolite evident in both mother and baby. In response, the doctors immediately reported Gloria to child protective services (CPS). Of note, the health system's guidelines in Gloria's state do not recommend calling CPS at this point.

Gloria, despite just undergoing the trauma of cesarean surgery, was forced to participate in an hour-long interview. During this interrogation, Gloria was forthcoming that she smoked marijuana recreationally. When CPS then told Gloria that she could not take her child home from the hospital, Gloria was furious, brokenhearted and desperate for her baby. In frustration, she yelled at the caseworker. Because of this emotional outburst, she was reported as "rude," "angry" and "uncooperative."

Interested in hearing more from Black Maternal Health Week? Follow the discussion on Twitter with #BMHW18.

When Gloria returned to her shelter that night without her children, she was told that, unless she had her children, she would be forced to leave the shelter in three days. Gloria, who left the hospital in stitches, also had her 3-year-old taken away and now risked losing access to safe housing.

The next day, CPS concluded that the children would be unsafe in Gloria's care due to her "angry outburst" at the hospital and admitted marijuana usage. Gloria begged for her children to stay with her sister but CPS declined the request, concluding that her sister's home was too small. Instead, Gloria's children were sent to live with strangers in a foster home.

Gloria then began a week-long hearing where she had to fight for her children's return. During that time, both her health and her children's health were put at risk. She was denied regular contact with her baby, and not even offered a breast pump to support future breastfeeding habits. The healthy 3-year-old she had raised was taken from her, despite there being no evidence of abuse.

By the hearing's end, the Court agreed that Gloria was a fit mother and returned the children. By then, Gloria had lost her shelter. And, because of the initial report, Gloria's name was placed on a child abuse registry that will restrict her employment options until Jermaine is 28 years old.

Loss of critical mother-child interactions, loss of housing and loss of employment. These are the actual consequences from a report that was intended to help.

Do you have a story to share with us?

We're always interested in hearing from the people our systems seek to help.

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Gloria's story is not an isolated scenario. It is joined by countless other stories from women of color whose children have fallen victim to a process failure in our systems. "I've seen too many black mothers separated from their babies at birth," says Cloud. "And what's even more concerning is that these calls [largely revolve around issues of economic insecurity](#), such as lack of food and stable housing, rather than abuse."

These failures are especially telling when we consider the striking inequities in health outcomes for black mothers and children—black babies are [twice as likely to die](#) before reaching their first birthday than white babies; black mothers are three to four times more [likely to die in childbirth](#) than white women; and black mothers have the lowest rates of breastfeeding initiation and continued breastfeeding among [all ethnic and racial groups](#).

Achieving health equity means looking at children's health through a systems lens," says NICHQ Project Director Zhandra Levesque, MPH. "All of these systems, perhaps especially child protective services, are meant to protect and support children. But when bias gets in the way, and the process fails, children's health suffers."

This bias, Cloud argues, is what causes black children to be [disproportionately](#) overreported, even when maltreatment occurs at equal or greater [rates](#) in white communities. "A number of [published articles](#) exist where white parents openly discuss their marijuana use as casual, fun and something that makes them better parents. No one takes their children away."

And what happens to children's development when they are unnecessarily taken from their families? What happens to maternal and children's health when new mothers aren't taught how to breastfeed their babies? We know these circumstances don't lead to good outcomes. Yet, according to Cloud, these experiences are common place.

For healthcare professionals, addressing this problem starts by understanding what happens when child welfare investigations are initiated, and recognizing when that intervention can cause more harm than good, says Cloud.

When babies and mothers are separated at birth, they both miss out on critical health benefits. Immediate and continuous skin-to-skin contact is shown to empower new mothers, support psychological health and [improve short and long-term outcomes](#) for both mothers and babies. It also helps support future breastfeeding habits, says NICHQ project specialist Avery Desrosiers, MPH, who works on the National Action Partnership to Promote Safe Sleep Improvement and Innovation Network ([NAPPSS-IIN](#)), a NICHQ-led initiative that aims to make safe sleep and breastfeeding the national norm.

"Mothers like Gloria, who have the metabolite in their system, may be advised that they can breastfeed healthily once it is out of their system. However, without being able to feed their baby within the first hour of birth, on-demand and in response to infant feeding cues, they're less

likely to breastfeed later,” says Desrosiers. “As a result, both mother and baby miss out on the critical health benefits that come with breastfeeding: [reduced risks of cancer for mothers, lower obesity rates for children](#), to name just a few.”

A call to child protective services can also [erode](#) the trust between women and their providers. When this happens, women are less likely to seek treatment and share health concerns, often becoming less committed to prenatal and postpartum care,” says Cloud. “For these mothers, the hospital is now a place of trauma rather than a place of support.”

There are also chronic and long-term health risks for children who are removed from their homes; children in foster care suffer from [higher rates of physical and mental problems](#), and often don’t receive adequate healthcare. Meanwhile, Cloud explains, their parents, like Gloria, lose access to housing and job security, which can damage children’s health if they are ever returned.

Ultimately then, this issue’s effect on children’s health begins prenatally and continues throughout the life course, making it a critical concern for all those seeking to improve children’s health outcomes and achieve health equity.

“Everyone has some level of bias,” says NICHQ Analyst, Sherra Lawrence, MA. “But if we have the right systems and processes in place, each with a clear set of checks and balances, we can help ensure that our practices are equitable for all mothers and children.”

And improvement is possible.

“The American College of Obstetricians and Gynecologists has [recommended guidelines](#) for reporting, but there’s a gap between what exists and what occurs, which predominantly affects families of color,” says Cloud. “Training providers on harm-reduction thresholds for drug use and working with policy makers to institutionalize an evidence-based and objective threshold for drug use that prompts reporting—these are just a couple of the opportunities for improvement. If enough people in enough systems work together, we can make this change and help children and families across the country.”