Supporting Pregnant and Parenting Teens in Michigan Schools

MICHIGAN ASSOCIATION OF SCHOOL NURSES SUPPORTING PREGNANT AND PARENTING TEENS

Original Date of Issue: 2016
Foreword

These guidelines contain current best practice recommendations for the health service topic addressed. The guidelines have been reviewed by the School Nurse Practice Subcommittee of the Michigan Statewide School Nurse Task Force as a means to provide consistent and safe care to students. Specific laws and regulations that direct school nursing practice or other health services are identified in the guidelines. There is no guarantee that the use of guidance in this document will lead to any particular result or outcome. The information in this document was researched in February, 2016.

Purpose

This document will provide guidelines and resources for the prevention and management of pregnant and parenting teens in schools.

Overview

The United States has one of the highest teen pregnancy rates among industrialized countries (National Campaign to Prevent Teen and Unplanned Pregnancy, 2016a). The Centers for Disease Control and Prevention (CDC) (2016) reported that pregnancy and childbirth are significant contributors for drop-out rates among girls. Furthermore, children of teenage mothers are more likely to have lower school achievement, drop out of high school, have more health problems, be incarcerated at some time during adolescence, give birth as a teenager, and face unemployment as a young adult. The cost of teen pregnancy has also been evaluated and in 2010, teen pregnancy and childbirth accounted for at least $9.4 billion in costs to U.S. taxpayers for increased health care, foster care, incarceration rates among children of teen parents, and lost tax revenue because of lower educational attainment and income among teen mothers (CDC, 2016). The cost of teen pregnancy in Michigan during the same year was $283 million (Campaign to Prevent Teen and Unplanned Pregnancy, 2016).

Medical conditions associated with adolescent pregnancy include poor maternal weight gain, anemia, and pregnancy induced hypertension (American Academy of Pediatrics [AAP] Committee on Adolescence and Committee on Early Childhood, 2012). The committee also found that intimate partner violence is more common among pregnant adolescents than non-pregnant adolescents and that the infants of adolescent mothers have an increased risk of adverse outcomes (higher perinatal mortality, low birth weight, preterm birth, developmental disabilities, and poorer developmental outcomes). Hodgkinson, Beers, Southammakosane and Lewin (2014) provided an overview of the mental health challenges associated with teen parenthood and found that adolescent mothers experience significantly higher rates of depression, both prenatally and postpartum, than adult mothers and their non-pregnant peers. In addition, they also found that teen mothers were at risk for developing symptoms of posttraumatic stress disorder because of their high risk for community and interpersonal violence exposure.

Although the prevalence of repeat teen birth has declined in recent years, nearly one in five teen births is a repeat birth. Large disparities exist in repeat teen births and use of the most effective contraceptive methods postpartum, which was reported by fewer than one out of four teen mothers. Rates of preterm and low birth weight are higher in teens with repeat birth, compared with first births (CDC, 2013).
Michigan and National Data

In 2014, U.S. teens aged 15 - 19 had a birth rate of 24.2 per 1000, a drop of 9% from 2013. The birth rate for women aged 15 – 17 dropped 11% (CDC, 2016a). The CDC (2016) continued to report that the teen birth rate declined for all races and Hispanics in 2014 from 2013. Non-Hispanic black youth, Hispanic/Latino youth, American Indian/Alaska Native youth, and socioeconomically disadvantaged youth of any race or ethnicity experience the highest rates of teen pregnancy and childbirth. Together, black and Hispanic teens comprised 57% of U.S. teen births in 2013.

The Michigan Department of Health and Human Services (MDHHS) (2016a) reported that in 2014, the pregnancy rate for teens aged 15 – 19 was 34.8 per 1000. The pregnancy rate for black females aged 15 – 19 was 73.5 per 1000 and white females were 25.3 per 1000. In Michigan, black females have a pregnancy rate nearly three times higher in this age group. Michigan ranks 20th in a state-wide comparison for teen pregnancy rates (National Campaign to Prevent Teen Pregnancy and Unplanned Pregnancy, 2016b).

Adolescent pregnancy rates for girls 12 and younger is miniscule and pregnancies among those 11 and younger are exceeding rare (Finer & Philbin, 2013).

In 2013, the percent of sexually active high school students in Michigan reporting using any method of contraception the last time they had sexual intercourse was 91.1%. The percent of all high school students in Michigan that have ever had sex was 38.1% (Michigan Department of Education [MDE], 2016a).

In 2013, 62.2% of Michigan students in participating in the Youth Risk Behavior Survey indicated their parents or other adults in their family talked with them about what they expect them to do or not to do when it comes to sex (MDE, 2016a).

Legal Framework for Sex Education in Schools

Federal Law

<table>
<thead>
<tr>
<th>Title IX of the Education Amendment Act of 1972</th>
<th>Ends sex discrimination in education and prohibits discrimination against pregnant and/or parenting students seeking an education. Schools are required to provide the same level of services to pregnant and parenting teens. Therefore, if a school provides special services, such as at-home tutoring, for students who miss school because they have a temporary disability, it must do the same for students who miss school because of pregnancy or childbirth.</th>
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<tbody>
<tr>
<td><a href="http://www2.ed.gov/about/offices/list/ocr/docs/tix_dis.html">http://www2.ed.gov/about/offices/list/ocr/docs/tix_dis.html</a></td>
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<tr>
<th>Title X of the Public Health Service Act</th>
<th>Funds agencies to provide services to promote the reproductive and general health care of the family planning client population.</th>
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</table>
### Michigan Law

<table>
<thead>
<tr>
<th>Consent of minor to provision of health care; notice; permission to contact parents for additional medical information; giving or withholding information without consent of minor; “health care” defined.</th>
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<tr>
<td><strong>Pregnancy</strong> - if a minor gives consent to the provision of prenatal and pregnancy related health care by a health facility or agency or health professional, the consent is valid and binding. For medical reasons the treating physician or another health professional (on the advice of the treating physician) may withhold or provide information regarding the minor to the parent, guardian, or person in loco parentis even if the minor refused to have the information released.</td>
</tr>
<tr>
<td><strong>§ 333.9132</strong></td>
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<tr>
<th>Child Protection Law-Act 238 of 1975. MCL 722.623</th>
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<tr>
<td>Delineates persons required to report child abuse or neglect; written report; transmitting report and results of investigation to prosecuting attorney or county family independence agency; pregnancy of or venereal disease in child less than 12 years of age.</td>
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<th>Safe delivery law of newborns</th>
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<tr>
<td>Safe Delivery allows parents to safely surrender their newborn child no more than 72 hours old to an employee who is inside and on duty at any hospital, fire department, police station, or by calling 911. This program is a safe, legal and anonymous alternative to abandonment or infanticide and releases the newborn for placement with an adoptive family.</td>
</tr>
<tr>
<td><a href="http://www.michigan.gov/mdhhs/0,5885,7-339-71548_7200--.00.html">http://www.michigan.gov/mdhhs/0,5885,7-339-71548_7200--.00.html</a></td>
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<tr>
<th>THE STATE SCHOOL AID ACT OF 1979 (EXCERPT) Act 94 of 1979 Providing appropriate instructional services to pupil requiring hospitalization or confinement at home. 388.1709 Sec. 109.</th>
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<tbody>
<tr>
<td>Under Michigan state law, all school districts are required to provide homebound or hospitalized instructional services to students who are absent for five or more consecutive school days because of a medical condition, including pregnancy, childbirth, and recovery.</td>
</tr>
</tbody>
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School Nurse’s Role

The National Association of School Nurses (NASN) (2015) believes school nurses have a crucial leadership role on the school team to support the health, well-being and educational success of pregnant and/or parenting students. Interventions include assistance in pregnancy identification, referral or provision of quality prenatal care, childcare referrals, parenting education, prevention education regarding future pregnancy, referral to clinical services and healthcare, and leadership on interdisciplinary teams. School nurses can utilize the principal of Care Coordination in the NASN Framework for 21st Century School Nursing Practice as a guide to deliver care to the pregnant and/or parenting teen (Maughan, Bobo, Butler, Schantz, & Schoessler, 2015; NASN, 2016).

Recommendations for Practice

Student-Centered Care

1. Collaborate with school staff to help identify students who may be pregnant. Teachers can provide information about observed weight gain, appetite, fatigue, school absence, and changes in academic performance (Platt, 2014).

2. Collaborate with colleagues and advocate for comprehensive education and services to prevent the incidence of pregnancy in adolescence (NASN, 2015).

3. Advocate for youth development programs that have proven, evidence-based strategies to prevent unwanted teen pregnancies (AAP Committee on Adolescents and Committee on Early Childhood, 2012).

4. Provide parents resources to help them talk to their child about their expectations for sexual behavior. The CDC (2014) provides resources for parents at http://www.cdc.gov/teenpregnancy/parent-guardian-resources/index.htm

5. Maintain current information about community programs that support adolescents and their infants (AAP Committee on Adolescents and Committee on Early Childhood, 2012).

6. Collaborate with school staff and administrators to help establish systems that will accommodate the student so he/she can maintain school attendance ultimately leading to graduation (NASN, 2015; AAP Committee on Adolescence and Committee on Early Childhood, 2012; Griswald et al., 2013; MDE, 2016b; Schaffer, Goodhue, Stennes, and Lanigan, 2012).

Collaborative Communication

1. Offer emotional support by fostering communication between parent and pregnant and/or parenting students (NASN, 2015).

2. Facilitate communication and coordination with teachers, other health care providers and parents of the pregnant or parenting teen.
Transition Planning

1. Plan for re-entry into school after the pregnancy with the multi-disciplinary team (Taliaferro & Resha, 2016).

2. Provide referrals for childcare (NASN, 2015).

Motivational Interviewing and Counseling


2. Assess student or refer student for domestic violence and mental health issues (AAP Committee on Adolescence and Committee on Early Childhood, 2012; Hodgkinson, et al., 2014).

Student Care Plans

1. Develop an individualized health plan for pregnant teens (NASN, 2015).

Care Coordination in Action

1. Encourage student to seek pregnancy testing and counseling services if the youth has been sexually active and experiences symptoms of pregnancy such as, missed period, nausea and/or vomiting, fatigue. (Taliaferro & Resha, 2016).

2. Plan a meeting with the teen’s parents (Pratt, 2014).

3. Refer for prenatal care and a medical home (NASN, 2015; AAP Committee on Adolescence and Committee on Early Childhood, 2012).

4. Notify Children’s Protective Services when abuse is suspected or if the student is less than 12 years of age (Platt, 2014; MDHHS, 2013).

5. Referral to school counselor and other school staff to provide the necessary accommodations to support the pregnant student in the school setting (Platt, 2014; Taliaferro & Resha, 2016).

6. Use a multidisciplinary and comprehensive approach to care for parenting adolescents by helping the student access community resources, social services, nurse visitation programs, supplemental Nutrition Program for Women, Infants, and Children (AAP Committee on Adolescents and Committee on Early Childhood Development, 2012; Hodgkinson et al., 2014; CDC, 2013; Platt, 2014).

7. When appropriate, promote contact with the infant’s father or grandmother to foster the quality of these important relationships. A positive and supportive relationship between the teen mom and her mother and the infant’s father has repeatedly been found to be a protective factor for teen mothers and their children (Hodgkinson et al, 2014; NASN, 2015).

Student Self-Empowerment

1. Provide information and resources to pregnant teens about self-care during pregnancy and parenting education and/or refer to community resources. Assist students and their families in making health choices (NASN, 2015).

2. Encourage healthy lifestyles. Provide information on the effect of maternal substance use and cigarette smoking. Understand that pregnant adolescents have been shown to decrease or limit their use of alcohol, cigarettes, marijuana and other substances during gestation but have also shown to
increase steadily during the first 6 months postpartum (AAP Committee on Adolescence and Committee on Early Childhood, 2012).

3. Refer to reproductive health services and home visiting services regarding prevention of a future pregnancy (NASN, 2015; CDC, 2013).

**Social Determinants of Health and Health Equity**

1. All school-based interventions should be age appropriate, culturally sensitive, and student-centered (NASN, 2015).

2. Assist and support students to achieve health equity by building a network of support around the pregnant and parenting teen and utilizing evidence-based strategies (NASN, 2015).

3. Understand and intervene to assist pregnant teens with barriers to access services, such as, lack of insurance, time availability and transportation (Hodgkinson, et al, 2014).

**Red Flags for Supporting Pregnant and Parenting Teens in the School Setting**

1. School nurses need to understand the legal statues that protect minor consent and confidentiality and follow state and federal laws regarding adolescent reproductive health issues (Taliaferro & Resha, 2016).

2. Michigan’s Safe Delivery law allows parents to safely surrender their newborn child no more than 72 hours old to an employee who is inside and on duty at any hospital, fire department, police station, or by calling 911 (MDHHS, 2016b).

3. Pregnant students are the population group most likely to commit neonaticide (murder of an infant less than 24 hours old), in school, at home, or in any other place where a teen delivers a baby (Platt, 2014).

4. Neonatodial mothers are often poor, young, single and lack prenatal care (Platt, 2014).

5. Infant mortality rates are highest among mothers younger than age 15. The baby’s death often results from failure to seek health care rather than violence (Platt, 2014).

6. The pregnant teen in denial may gain weight, have nausea, or experience fetal movements or uterine contractions without awareness of the cause (Platt, 2014).

7. Title IX protects against discrimination against students on the basis of a student’s pregnancy, childbirth, false pregnancy, termination, or recovery therefrom (National Women’s Law Center [NWLC], 2012a; NWLC, 2012b; NWLC, 2012c). The law requires the following:

   - If schools choose to offer separate programs or schools for pregnant and parenting students, participation in those programs must be voluntary.
• Any alternative program for pregnant and parenting students must offer those students access to the same range of educational opportunities, including extracurricular and enrichment activities as those offered to students who are not pregnant or parenting.
• A pregnant student should be allowed to continue her studies for as long as she would like to continue at school.
• Schools must excuse absences for students who are pregnant or who give birth for as long as that student’s doctor determines is necessary.
• Schools must provide pregnant students with any special services they provide to students with temporary disabilities.

References


U.S. Department of Education (2013). *Supporting the academic success of pregnant and parenting students.* Retrieved from [http://www2.ed.gov/about/offices/list/ocr/docs/pregnancy.pdf](http://www2.ed.gov/about/offices/list/ocr/docs/pregnancy.pdf)

U.S. Department of Education (2015). *Title IX and Sex Discrimination.* Retrieved from [http://www2.ed.gov/about/offices/list/ocr/docs/tix_dis.html](http://www2.ed.gov/about/offices/list/ocr/docs/tix_dis.html)
