Identifying and responding to the drug-endangered child

By Sharlee Burch, RDH, MPH, EdS

As drug use and abuse has risen throughout the United States, dental professionals find themselves faced with increasing requests to assist in the prevention of drug-related issues in their communities. It is vital that dental professionals learn simple ways to identify and assist the most vulnerable of those affected by addiction, the drug-endangered child (DEC). In the end, this will allow the dental community to better serve their patients and the public.

The drug-endangered child (DEC)
A drug-endangered child is any child who is physically, emotionally, and/or psychologically harmed by an adult who is using, selling or manufacturing drugs.

Some drug production (specifically the production of methamphetamine) will change the physical environments in which children reside. They are likely to inhale toxic fumes of colorless, odorless gases. Drug-endangered children often ingest chemicals through contaminated food and handling other objects.

Drug-endangered children typically experience a chaotic home life with poor supervision. They are at increased risk of future substance abuse, and having been born prematurely or with low birth weight, often suffer from developmental delays and disabilities. Finally, they are at increased risk of child abuse, sexual abuse and injury.¹

Seventy-six percent of all substantiated child abuse cases for children aged 0 to 18 years involve adult drug use. More than 3 million cases of child maltreatment are reported each year, and approximately 3 million adults and an additional 3 million seniors are also abused or neglected annually. Although at least 75 percent of physical abuse of children, adults

Third ‘Pros in the Profession’ winner selected

Crest Oral-B has honored RDH Mary Lynne Murray-Ryder of Hermon, Maine, with the brands’ third Pros in the Profession award. A champion for dental hygiene, Mary Lynne has improved the lives of others both inside and outside the office. In addition to her 31 years of experience as a registered dental hygienist, Murray-Ryder has served as an American Dental Hygienists’ Association (ADHA) delegate, Maine Dental Hygienists Association (MDHA) president and on several MDHA councils, while currently serving as immediate past president and continuing education council liaison.

“I applaud Crest Oral-B for the message of commitment and support the Pros in the Profession award sends to the dental hygiene profession,” said Murray-Ryder. “Further, I salute this recognition of the role that dental hygienists play in patient wellness.”

Having spent the last 10 years of her career at a private holistic practice, Murray-Ryder has a passion for providing individualized solutions to each of her patients. She expands this devotion to comprehensive care by helping put her state on the map through initiatives with Maine’s Independent Practice Dental Hygienists, which allows dental hygienists to practice in community service projects that focus on helping the homeless. A constant learner, she also attends and organizes continuing education classes for her fellow registered dental hygienists.

“As a recipient of the Pros in the Profession award, I hope to inspire Maine dental hygienists and students of dental hygiene to share their talents wherever their paths may lead,” said Murray-Ryder.

With this honor, Murray-Ryder will join previous Pros in the Profession winners Ann Benson and Trudy Meinburg on a VIP all-expense-paid trip to the ADHA’s 88th Annual Session in Montreal, Canada. 

Fig. 1: Oral injury resulting from an openhanded slap (Photo/Provided by PANDA, www.healthyarkansas.com/Oral_Health/panda/panda_index.htm)
and the elderly involve injuries to the head, neck and mouth, less than one percent of all reports of child maltreatment are made by dental professionals.1

Identifying the DEC

It is important for the dental professional to understand the legal responsibilities to identify and report suspected child abuse and neglect cases. Part of that understanding is learning the legal definitions associated with child abuse and neglect.

Federal legislation provides a foundation for states by identifying a minimum set of acts or behaviors that define child abuse and neglect. The Federal Child Abuse Prevention and Treatment Act (CAPTA), as amended by the Keeping Children and Families Safe Act of 2003, defines child abuse and neglect as, at minimum, any recent act or failure to act on the part of a parent or caretaker that results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act that presents an imminent risk of serious harm. This definition of child abuse and neglect refers specifically to parents and other caregivers. A “child” under this definition generally means a person who is younger than 18 or who is not an emancipated minor.

While CAPTA provides definitions for sexual abuse and the special cases related to withholding or failing to provide medically indicated treatment, it does not provide specific definitions for other types of maltreatment such as physical abuse, neglect or emotional abuse. While federal legislation sets minimum standards, each state is responsible for providing its own definition of maltreatment within civil and criminal contexts.

Within the minimum standards set by CAPTA, each state is responsible for providing its own definitions of child abuse and neglect. Generally, most states recognize four major types of maltreatment: neglect, physical abuse, sexual abuse and emotional abuse.3

According to the Child Welfare Information Gateway, the following definitions of major maltreatment are the generally recognized standard used by most states.

“Neglect” is failure to provide for a child’s basic needs. Neglect may be: physical (e.g., failure to provide necessary food or shelter, or lack of appropriate supervision); medical (e.g., failure to provide necessary medical or mental health treatment); educational (e.g., failure to educate a child or attend to special education needs); emotional (e.g., inattention to a child’s emotional needs, failure to provide psychological care or permitting the child to use alcohol or other drugs).

These situations do not always mean a child is neglected. Sometimes cultural values, standards of care in the community or poverty may be contributing factors, indicating the family is in need of information or assistance. When a family fails to use information and resources and the child’s health or safety is at risk, then child welfare intervention may be required.

“Physical abuse” is physical injury (ranging from minor bruises to severe fractures or death) as a result of punching, beating, kicking, biting, shaking, throwing, stabbing, choking, hitting (with a hand, stick, strap or other object), burning or otherwise harming a child. Such injury is considered abuse regardless of whether the caretaker intended to hurt the child. Generally recognized standard used by most states.

“Sexual abuse” includes activities by a parent or caretaker such as fondling a child’s genitals, penetration, rape, sodomy, incest, rape, sodomy, indecent exposure and exploitation through prostitution or the production of pornographic materials.

“Emotional abuse” is a pattern of behavior that impairs a child’s emotional development or sense of self-worth. This may include constant criticism, threats or rejection, as well as withholding love, support or guidance. Emotional abuse is often difficult to prove, and therefore child protective services may not be able to intervene without evidence of harm to the child. Emotional abuse is almost always present when other forms are identified.

Individual states also have different reporting laws when it comes to child abuse and neglect. Currently, every state has immunity (individuals cannot be sued or held liable following a report) for mandated reporters, which are most health-care professionals, including dental professionals. Those states that do not have mandated reporting and penalties for health care professionals who fail to report are: Mississippi, North Carolina and Wyoming.4

One key to reporting child abuse and neglect is being able to recognize common indicators. A dental professional may easily identify some of these physical and behavioral indicators during routine dental care. Dental professionals should establish an office protocol for identifying drug endangered children. According to the Arkansas Office of Oral Health, there are four recommended steps in identifying a suspected case of child abuse or neglect. Those four steps include:

- General physical assessment of the child. Although general physical examinations may not be appropriate in all settings, be aware of obvious physical traits that may indicate abuse or neglect (e.g., difficulty in walking or sitting, physical signs that may be consistent with the use of force).
- Behavior assessment. Judge the child’s behavior against the demeanor
of children of similar maturity in similar situations.

- **Health histories.** If you suspect child maltreatment, it can be useful to obtain more than one history, one from the child and one from the adult.

- **Orofacial examination.** Look for signs of violence, such as multiple injuries or bruises, injuries in different stages of healing or oral signs of sexually transmitted diseases.

Along with the four steps to identifying a drug-endangered child, there are four steps in the child abuse or neglect reporting process that dental professionals should follow. These steps include:

- **Documentation.** Carefully document any findings of suspected abuse or neglect in the patient's record. Don't forget to take intraoral and extra-oral pictures.

- **Witness.** Have another individual witness the examination, note and co-sign the records concerning suspected child abuse or neglect.

- **Report.** Call the appropriate child protective services (CPS) or law enforcement agency in your area, consistent with state law. Make the report as soon as possible without compromising the child's dental care.

- **Necessary information.** Have the following information available when you make the report: name and address of the child and parents or other persons that have care and custody of the child; child's age; name(s) of any siblings; nature of the child's condition, including any evidence of previous injuries or disabilities; any other information that you believe might be helpful in establishing the cause of such abuse or neglect and the identity of the person believed to have caused such abuse or neglect.

Dental professionals should realize that many drug-endangered children may not be seen in the dental office. Other areas where children can be identified include school screening days, Head Start required oral exam days and other oral and public health events.

It is well-documented that the systemic health of drug-endangered children is greatly affected long term; therefore, we can confidently assume that their oral health will be seriously harmed as well.

**Responding to the DEC**

Dental professionals can become involved in the fight for drug-endangered children in their community in several ways.

First, they have the opportunity to form or become part of an established drug-endangered child team in their community.

Secondly, by working to identify children within their dental practice who may be drug-endangered or volunteering their time to examine pre-identified DEC who are currently a part of the social services system.

Finally, they can receive more training on child abuse and neglect, eventually educating other health professionals on the need to recognize and respond to drug-endangered children.

A complete list of references is available from the publisher.

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**Fig. 2:** Baby with cigarette burns (Photo/Provided by PANDA)

**Fig. 3:** Young child with tooth abscess. Could this be attributed to neglect? (Photo/Courtesy of Dr. Jim Cecil)

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**About the author**

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