The Silent Cry
Facilitator's Guide

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Topic: Neglect

Abstract:
Every child deserves to be raised in a nurturing environment. Such an environment provides the emotional, physical, educational, medical, and safety requirements that a child needs to thrive. Child neglect occurs when a parent is unable to adequately provide for any or all of these needs. Substance abuse is one factor that may seriously impair a parent's ability to properly care for a child. Primary care clinicians are in a special position to intervene and offer assistance when neglect or parental substance abuse is suspected. This case presents the story of a 2-year-old girl who shows signs of being neglected and whose mother appears to have an alcohol problem. Clinicians will discuss ways to protect the child and assist her mother in finding appropriate assessment and treatment.

Goal:
To provide clinicians with a basic understanding of how to manage child neglect and parental alcoholism.

Objectives:
As a result of this session, learners will be able to:
1. List signs and symptoms of child neglect.
2. Discuss how to communicate concerns to parents who are abusing alcohol (or drugs).
3. Describe a management plan for situations where child neglect is suspected.
4. List appropriate multidisciplinary services for families affected by substance abuse.

Prerequisite Case:
"The Father's Hand Print" (Child Physical Abuse)

Related Cases:
"Margaret's Secret" *(*Sexual Abuse)
"The Craffty Pupil" (Substance Abuse)
"Jose's New Family" (Atypical Behaviors)

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Themes:
Child Development and Behavior

Key Words:
Child abuse and neglect, alcohol abuse, alcoholism, substance abuse

Bright Future Core Concepts:
While all of the Core Concepts are included in each case, this particular case can be used to highlight communication, partnership, advocacy, and prevention/health promotion.

Materials Provided:
- Facilitator's Guide
- 3-part Case Narrative: Part I, Part II, Epilogue
- Handout #1a and #1b: Michaela's Growth Chart and Head Circumference Chart
- Handout #2: Classification of Child Neglect
- Handout #3: Brief Alcoholism Screening Tests
- Handout #4: Denver II
- Handout #5: Principles of Effective Interventions with Parents
- Bibliography

Facilitator Preparation:
Facilitators should thoroughly review this guide and the other materials provided. They should also review their own state's law regarding mandated reports for suspected child abuse or neglect. It may be helpful to have copies of state regulations and/or mandated report forms available to learners as handouts. Facilitators should obtain and photocopy the article by Kahn and colleagues[1] (see bibliography).

At the end of the guide we have included a section entitled, "**Independent Learning/Prevention Exercises**," that will further stimulate group and individual education on this topic.

Suggested Format for a One Hour Discussion:
We anticipate that case facilitators will modify implementation of the case session to best fit their educational setting and learners. For detailed recommendations on case facilitation, please see the chapter entitled, "A Brief Guide to Facilitating Case-Discussion," found in *The Case Teaching Method; and Growth in Children and Adolescents* (book 1 of this series). This case may be taught in a single one-hour session (without optional role-play exercises) or as two consecutive one-hour sessions (with optional role-play exercises), which is recommended.

Introduction: Child neglect and parental substance abuse are major national health problems. Both have a direct impact on a child's health, well being, and safety. In 1996, child protective service agencies investigated more than 2 million reports alleging abuse or neglect and more than 1 million of these were substantiated.[2] The reporting rate for children in the US is 44 per 1,000. Cases of child neglect account for about two-thirds of

this total.[2] Neglect is a prominent feature in maltreatment cases in which a parent abuses substances.[3] About 28.6 million Americans are children of alcoholics.[4] Current estimates are that 11 million children and adolescents in the United States have an alcoholic parent, or one out of every eight children.[5] Few of these children come in contact with the child protection system. Substance abusing parents are demographically similar to the general population. However, mothers with drug or alcohol problems are more likely than fathers to be reported to child protective services, and African American women with substance abuse problems are more likely to be involved with child welfare agencies than women of other ethnic or racial groups.[3] Many substance abusing parents, especially mothers, enter treatment because they are concerned that their substance abuse is negatively impacting their children. Early recognition of this problem by a primary care provider may present a "golden opportunity" for directing substance-abusing parents into treatment programs and optimizing chances for keeping the family intact.

Both parental use of alcohol and child neglect may be "silent" problems. For example, few clinicians routinely screen parents for alcohol abuse and problems may, therefore, go undetected. In a similar fashion, child neglect may be easily overlooked, partly because of the complexity of its definition. Whereas child abuse is readily detected from the presence of physical evidence, the identification of child neglect depends on the recognition of relatively more subtle signs. It is this omission of necessary provisions to support a child's growth and development that constitutes child neglect. Thus, in identifying child neglect, the astute pediatrician must hear the child's "silent cry" as well as the audible one.

Open the Discussion: Introduce the case title and the session goal. Explain that this will be an interactive case discussion and not a lecture. Distribute Part I of the case and ask one or more of the participants to read it aloud. Distribute the Growth Chart (Handouts #1a and #1b) as this part of the case is being read.

Part I

Michaela is a 25-month old girl brought to your office for an urgent care visit. Her mother, Ms. Nickerson, reports that her daughter has been cranky for the past few days.

"Has she had a fever?" you ask.
"Fever? No, I don't think so. She hasn't felt warm."
"Has she told you that anything hurts?" you continue.
"No. She doesn't talk very much. She's only two. But something must be hurting her, because she's crying all the time. I just can't listen to it anymore. Thank God she's my only one."

Ms. Nickerson denies any other pertinent symptoms including vomiting, diarrhea, cough, rhinorrhea, and poor oral intake. You proceed with the physical examination.

Michaela has an axillary temperature of 100.4° F. Her other vital signs are normal. She is a somewhat thin-appearing toddler. (see Handout #1) Her face is expressionless and does not appear to have been washed recently. She has been sitting quietly in her mother's lap while the two of you have been talking. You show her a wind-up toy but she doesn't reach for it or say anything.

Michaela has no dysmorphic features. Her pupils are equal and reactive to light, and visual tracking of your penlight seems normal. The tympanic membranes are normal in appearance and move well on pneumo-otoscopy. Oral examination is notable for several upper incisors with brown areas of decay. Skin examination reveals a 2 cm. superficial cut with circumferential swelling, induration, and tenderness on her left lower leg.

Following your physical examination, you ask Ms. Nickerson some additional questions (adapted from *The Bright Futures Guidelines for Health Supervision*):

"How are other things going in your family?" you ask.
"We've been better. Michaela's father moved out three weeks ago."
"Do you have anyone else to help take care of her?" you ask.
"No. Her grandparents live on the other side of town, but I don't have a car and haven't seen them in months. It's just the two of us. Right, Sweetie?"

"Are you working outside the home?" you ask.
"I work once in a while as a waitress or cashier, here and there."
"Who takes care of Michaela when you're working?" you ask.
"Umm, . . . there's a lady across the hall from us. She helps sometimes."

On further review of the medical chart, you find that Michaela is a former 32-week infant born to a 20-year-old mother. She has had no hospitalizations or surgeries. You notice that Michaela has missed several well child visits and has not received her 12-15 month immunizations.

Following this, ask all participants "So what do you think about Michaela?" Ask participants what *they* would like to get out of the discussion and list agenda items on a blackboard or flipchart. If a learner suggests an idea that you know cannot be covered in this case discussion, include it on the board but indicate that it would best be covered on another day or by independent reading. Then use the questions below (in bolded font) to guide the discussion. Remember that the key to successfully leading a small group is *facilitation of the discussion* rather than lecture. Draw in as many participants as possible. Allow silences while group members think about questions. Present material from this discussion guide *only* when needed to complement or redirect the group discussion

Guiding Questions for Discussion:

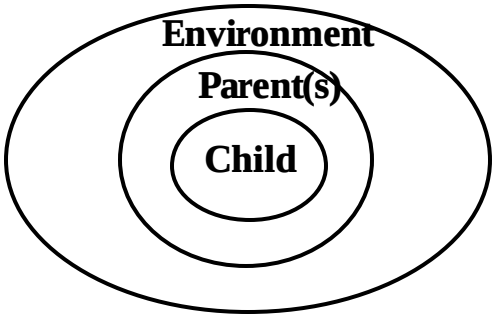
<u>What is your initial impression of Michaela and her mother?</u>
Both Michaela and her mother exhibit some of the common risk factors and findings seen in child neglect cases. Michaela's unkempt appearance, flat affect, and disinterest in play are concerning. While 2-year-olds who are sick may not exhibit usual playful behavior, Michaela's poor hygiene suggests that this may not just be reactive to a concurrent illness. She also has a number of physical findings that support this concern. Her pattern of dental decay is consistent with nursing bottle syndrome often seen in children who are put to bed with a bottle of milk, fruit juice, or any other carbohydrate-rich liquid. In addition, Michaela has an acute infection (cellulitis) on her left lower leg that needs medical attention.

Ms. Nickerson's statement about how distressed she is by Michaela's crying and "*Thank God she's my only one*" are indicative of frustration and very concerning. She seems to be overwhelmed and alone. There are multiple psychosocial stressors that could impact her ability to adequately care for Michaela and should raise concern about the possibility of neglect. Such stressors include irritable child, separation from her significant other, lack of family support, and an unstable employment and financial status.

What is your preliminary problem list?

Michaela has certain obvious problems. She appears to have a cellulitis of the left leg, which may be causing her low-grade fever and contributing to her reported crankiness. She has obvious dental caries. There are other aspects of her presentation, however, that are also concerning.

Child health is a product of the interaction between multiple factors. Clinicians should consider problems inherent in the child, in the parent, and in the environment that may contribute to child neglect.[6]



Child:

- Prematurity
- Developmental disability
- Difficult temperament (e.g., crying, fussiness)

Parent(s):

- Substance abuse
- Depression, other mental disorders
- Domestic violence
- Unrealistic expectations of the child
- Lack of social support system
- History of abuse or neglect as a child

Environmental:

- Family stressors (e.g., unemployment, illness, death, inadequate finances, divorce)
- Lack of community resources

Michaela is reported to cry a lot and appears somewhat disinterested at the present visit. These could be signs of a difficult temperament or developmental delay. Michaela's mother could be experiencing any number of conditions including posttraumatic stress disorder, domestic violence, maternal depression, or substance abuse. She does not have a strong social support network at the present time, and nothing of her own history as a child is known. She has no regular employment.

Is Michaela's presentation consistent with child neglect?

The definition of child neglect varies with professional discipline. However, child neglect should always be considered when there is inadequate nutrition, clothing, shelter, emotional support, education, safety, medical, or dental care. Child neglect may be divided into several categories depending on the specific area of omission in the child's care. Michaela's presentation is concerning for exhibiting some of the forms of child neglect. In general, these categories are listed in Handout #2.

Distribute Handout #2: Classification of Child Neglect, and give participants a few moments to review the contents

A parent's reason to neglect a child may be varied and can range from lack of financial and supportive resources to failure to appreciate the importance of basic provisions for the child. Clearly, the parents' psychological and emotional profile impacts upon their ability to proficiently recognize and supply their child's needs. Thus, it is no surprise that risk factors for child neglect include parental substance abuse and other psychopathology.[6]

Are there other questions you would like to ask?

Review of the medical record has already provided important information regarding Michaela's birth and medical history. Clinicians should elicit further information about her developmental milestones and family and social history. Parents should be specifically asked about their own risk factors. Parents may be more comfortable discussing their stressors with a medical care provider (whom they know) than with a social worker.

Distribute copies of the paper by Kahn and colleagues[1] and give participants a few minutes to review the abstract.

Key Teaching Point: A recent study indicated that two-thirds of mothers bringing their children for pediatric care had significant health problems of their own.[1] More than 17 percent in fact screened positive for alcohol problems and most of these women reported acceptance of the pediatrician's role in asking them about their problems.

The parental response to the "trigger questions" that are suggested in the Bright Future Guidelines for the 2-year visit may provide additional insight into the parent-child relationship:

How are you?
How are things going in your family?
Do you have any questions or concerns about Michaela?
What do you and your partner enjoy most about Michaela? What seems to be most difficult?
Have there been any major changes or stresses in your family since your last visit?
How is child-care going?
How are you dealing with setting limits for Michaela and disciplining her?

Do you ever get so angry with Michaela that you are worried about what you might do next?
Have you ever been in a relationship where you have been hurt, threatened, or treated badly?
Does anyone in the home have a gun? If so, is the gun locked up?

Also, the clinician should explore the maternal and family history—
Do you have any medical problems?
Are there any mental health problems (e.g., depression, anxiety disorders) in the family?
Do you or anyone else in the home smoke, drink alcohol, or use drugs?

When a yes answer is given to this last question, clinicians should follow up with a brief screening test for substance abuse.

Distribute Handout #3: Brief Alcoholism Screening Tests

The CAGE questions[7] are one of several brief-screening tests for alcohol disorders (see Handout #3). A "yes" answer to two or more CAGE questions is suggestive of a diagnosis of alcohol abuse or dependency.[8] When a parent has a positive CAGE, the pediatric clinician should explain the result, share his/her concern, and suggest the parent go for a formal substance abuse evaluation. While the CAGE questions are most well-known, the T-ACE may be a better test for detecting problem drinking in women.

****Optional Learning Exercise A: Facilitators may wish to have participants role-play this conversation, with one person playing the part of Ms. Nickerson and the other a clinician asking her the CAGE or T-ACE questions.**

What would you do next?
Michaela's cellulitis would likely respond to outpatient treatment with antibiotics. However, her presentation should raise serious concerns about child neglect.
Signs and symptoms of child neglect include:

- Missed medical appointments
- Failure or delay in seeking medical care for illness
- Failure or delay in seeking dental care
- Poor growth
- Poor hygiene
- Developmental delay
- Multiple dental caries
- Untreated medical conditions
- Nonspecific behavior patterns (e.g., enuresis, irregular sleep patterns, impaired interpersonal relations, psychopathology, excessive masturbation, academic difficulties, discipline difficulties, role reversal)

One of the most critical decisions in managing situations where child neglect is suspected is to determine whether or not to admit the child to the hospital. This decision rests on

whether there are any immediate threats to the child's safety or medical well-being. If so, it is a medical necessity that the child be hospitalized.[9]

No immediate threat to Michaela's safety has been identified, but the clinician should be concerned about her medical well being given the prior history of non-compliance with medical care and her overall appearance. Therefore serious consideration should be given to admitting Michaela to the hospital. There, she could receive antibiotics, social work consult, nutrition consult, and Denver Developmental Screening. A dental referral would also be needed.

Hospitalization for "psychosocial" reasons may be difficult in this era of managed care. However, clinicians must always put the welfare of the child first. In support of this view, the American Academy of Pediatrics issued a policy statement on the *Medical Necessity for the Hospitalization of the Abused and Neglected Child* that recommends:

1. In communities with no specialized child protection centers, children requiring evaluation and treatment for suspected abuse or neglect should be hospitalized for their initial management until they are determined to be medically stable and safe alternative facilities for their placement are available pending completion of their assessment.
2. Hospitalization of children requiring evaluation and treatment for abuse or neglect should be viewed by third-party payors as medically necessary.[9]

As another option, some clinicians may opt to address Michaela's medical issues by mobilizing outpatient services including social work and a visiting nurse. Close follow-up would be needed to assess the developmental aspects of her profile. A dental appointment should be arranged.

Distribute Part II of the case and have participant(s) read it aloud.

Part II

You decide to admit Michaela to the hospital. She receives IV antibiotics and local wound care. Social work and nutrition consults are obtained. As part of the work-up, the Denver II Developmental Screening Test was performed (see Handout #4).

On your hospital rounds the next day, you are told that Ms. Nickerson left the floor soon after Michaela was admitted. She returned at 5 AM and was observed to have a somewhat unsteady gait. Shortly after going into Michaela's room, the nurse on duty heard a "crash." When she went to check, she found that Ms. Nickerson had tripped over a chair. The nurse reported that she thought she smelled alcohol on Ms. Nickerson's breath.

You go in to see Michaela and her mother is there. When you ask her how she is, she replies, *"I'm OK; I just have this really bad headache."* She appears very fatigued and her conjunctivae are injected. You decide that it would be best to wait until later in the day to talk with her further. You arrange to have a social worker available for this meeting.

What are your next steps given the nurse's report?

While there could be other explanations, Ms. Nickerson's behavior (e.g., early departure and late return to the hospital, smell of alcohol on her breath, unsteady gait, possible hang-over) is concerning for alcohol abuse. Exploration of this concern should be conducted in a sensitive and non-accusatory fashion. The FRAMER mnemonic summarizes important principles of this type of intervention (for similar version, see *The Father's Handprint* teaching case):

Distribute Handout #5: Principles of Effective Interventions with Parents.

Begin by listing the facts that have made you concerned. Clinicians should refrain from drawing any premature conclusions or making a "diagnosis" of alcohol abuse or alcoholism. An example of how one might open the conversation is as follows:

"*How are you feeling today*?" you might begin.

"*Oh, I'm just fine. Thanks,*" Ms. Nickerson responds.

"*Well, Michaela seems to be responding well to her medicine. But I wanted to talk to you today because we are a little worried about you. On the day that Michaela was admitted, the nurse noticed that you had to leave right away and then returned at 5 AM. When you returned, she noted that you were walking unsteadily and that you tripped over a chair when you went in the room. The nurse thought that she could smell alcohol on your breath. So I'd like to ask you a few questions about your drinking*."

****Optional Learning Exercise B: Facilitators may ask participants to role-play this conversation.**

A thorough evaluation of the family's social situation is needed for appropriate management. A child protection specialist/social worker should perform a family assessment whenever possible. The information they collect from speaking with the parents will help determine the safety of the child's environment and the need for additional services. Even if there were no concerns about parental alcohol abuse, Michaela's profile is suspicious for child neglect and warrants a more thorough assessment.

A mandated report filed on behalf of the child is a more formal means of protecting the child's right and securing his/her safety. Once filed, the designated state agency is responsible for conducting a thorough evaluation to determine whether or not the child is safe in his/her current situation and if foster care placement is necessary. The emphasis is on keeping the child safe, which can hopefully be done while keeping the family intact. A family service plan is designed with this goal in mind. Once the plan has been formulated, an assigned family worker closely monitors the family to ensure that recommendations are being followed. The plan may include parenting classes, daycare services, parent aide, counseling, psychotherapy, and/or substance abuse treatment. Intensive plans also include

family-based and individual treatment at the home, often more than once per week. If the parents repeatedly fail to abide by the terms of the service plan, the child may then be placed in foster care and the service plan will be extended. Service plans tend to be about six months in length. If the family is doing well during that time, the state agency often decreases their involvement and monitoring.

Clinicians must resist the temptation to avoid future contact with the parent. Remember that parents with alcohol disorders are sick people, not bad people, and their health can improve dramatically with treatment. When at all possible, this view should be communicated to the child. They should also be told that their parent's disease is not their fault, and its "cure" is not their responsibility. Individual and family counseling is needed, and a referral to child-centered support groups (i.e., Alateen, Alatot) may be helpful.

What will your role be in Michaela's ongoing care?

Working closely with the state agency and caseworker, the physician is an integral part of the team helping to secure the child's well being. In addition, close medical follow up will be needed. As the primary care provider, your primary role is to ensure that Michaela receives adequate medical care. You should monitor development and emotional health.

Primary care providers can also offer support and encouragement to parents, inquire about progress of their own treatment, and stay in touch with treatment providers as appropriate. Clinicians should know that alcoholic and addicted parents love their children very much and really want to be good parents. However, their addiction interferes with their ability to follow through. These parents are often highly motivated to enter treatment programs and, with proper encouragement and support, can be successful.

Distribute the Bibliography page and Epilogue. Ask someone to read the Epilogue aloud.

Epilogue

In your meeting with her, Ms. Nickerson admits that things have been difficult. She has tried to quit drinking on her own but could never seem to stop for long periods of time. She is open to your suggestion about entering a treatment program and receiving counseling. She keeps the same day appointment that is scheduled for her at a local program.

A mandated report is filed on behalf of Michaela with the state Department of Social Services. The assigned family worker formulates an intensive service plan that includes counseling and monitoring for Ms. Nickerson. Early Intervention and daycare services are arranged for Michaela. The Visiting Nurse Services will go to the home daily once Michaela is discharged. The delivery of nutritional supplementation (recommended by the nutritionist) is facilitated by the social worker. A parent aide is assigned to Ms. Nickerson to assist with the routine stressors of daily living.

Michaela remained in the hospital for 3 days. Her immunizations were updated. A routine hematocrit and lead level were normal. PPD screening was negative. Given the intensive service plan, Michaela is discharged into the care of her mother with a follow-up appointment with you in one week.

At the follow-up appointment, a referral to a pediatric dentist is arranged. Ms. Nickerson says that not drinking is tough but she's determined this time. One year later, she has found a new job and reestablished contact with her parents. Michaela has gained weight and seems to enjoy the other children at her language-based preschool.

Refer back to the group's learning agenda and summarize the key teaching points that were made. This will give the group a sense of accomplishment, and emphasize the important messages. Suggest further sources of reading or other information if there are agenda items that were not covered in the discussion.

Independent Learning/Prevention Exercises: Facilitators may wish to assign "Independent Learning/Prevention Exercises" to the group, particularly if time constraints hinder the completion of the case. The following list includes suggestions to explore the available community resources that focus on Neglect and Parental Alcoholism, as well as other avenues of pertinent interest that can be integrated during or after the session. If the exercise is done in the absence of the facilitator, learners should take notes on their experience, then discuss with a faculty member for feedback.

1. Invite a state child protective services worker to speak to the group, discussing issues regarding the role of a primary care provider, how to go about filing an official report when neglect/abuse is suspected (e.g., "51-A" in Massachusetts).
2. Go to an open AA (Alcoholics Anonymous) or ACOA (Adult Children of Alcoholics) meeting. These can be located by calling the central service offices, listed in the telephone directory.

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Part I

Michaela is a 25-month old girl brought to your office for an urgent care visit. Her mother, Ms. Nickerson, reports that her daughter has been cranky for the past few days.

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"Fever? No, I don't think so. She hasn't felt warm."
"Has she told you that anything hurts?" you continue.
"No. She doesn't talk very much. She's only two. But something must be hurting her, because she's crying all the time. I just can't listen to it anymore. Thank God she's my only one."

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Michaela has an axillary temperature of 100.4° F. Her other vital signs are normal. She is a somewhat thin-appearing toddler. (see Handout #1) Her face is expressionless and does not appear to have been washed recently. She has been sitting quietly in her mother's lap while the two of you have been talking. You show her a wind-up toy but she doesn't reach for it or say anything.

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Epilogue

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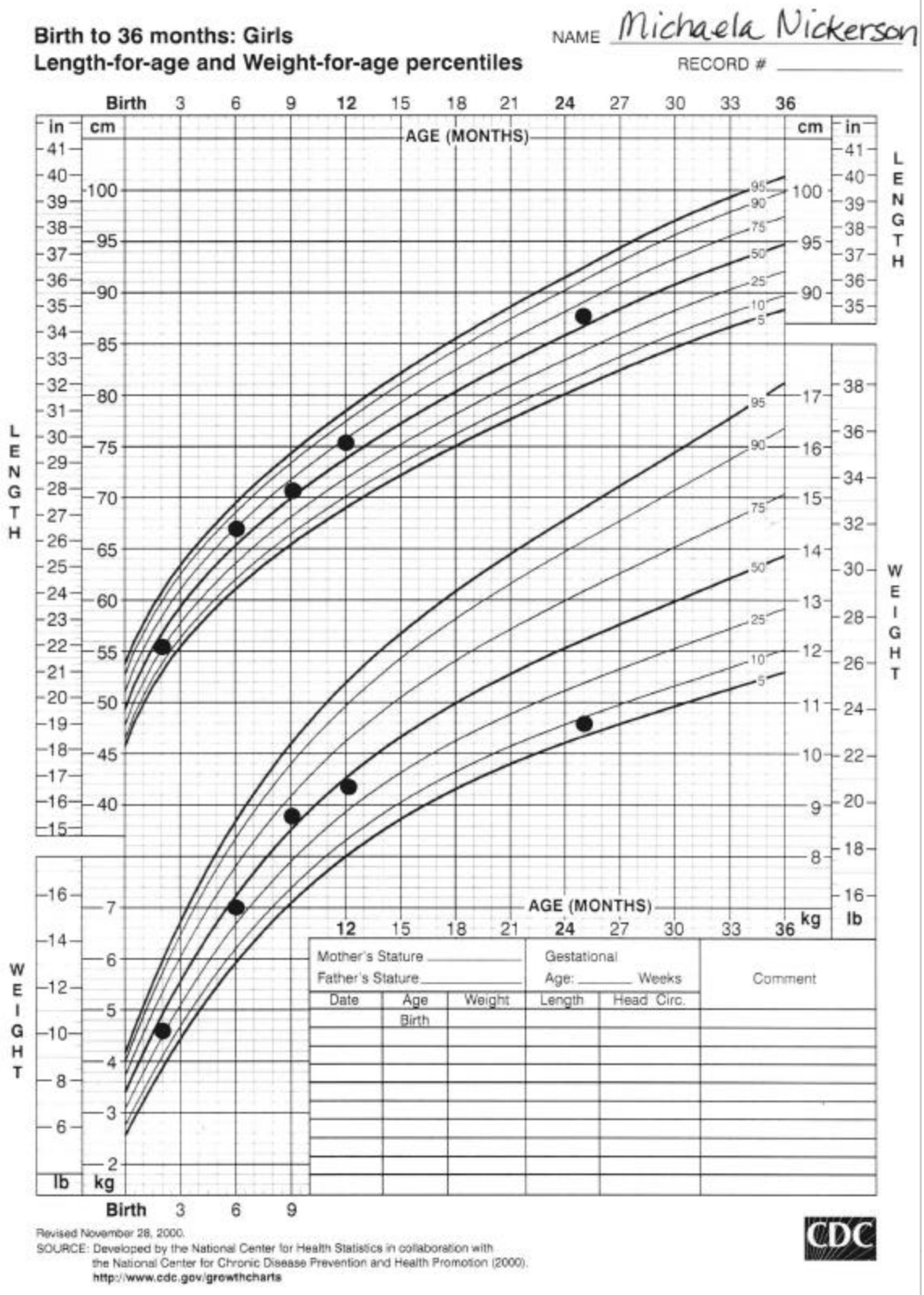
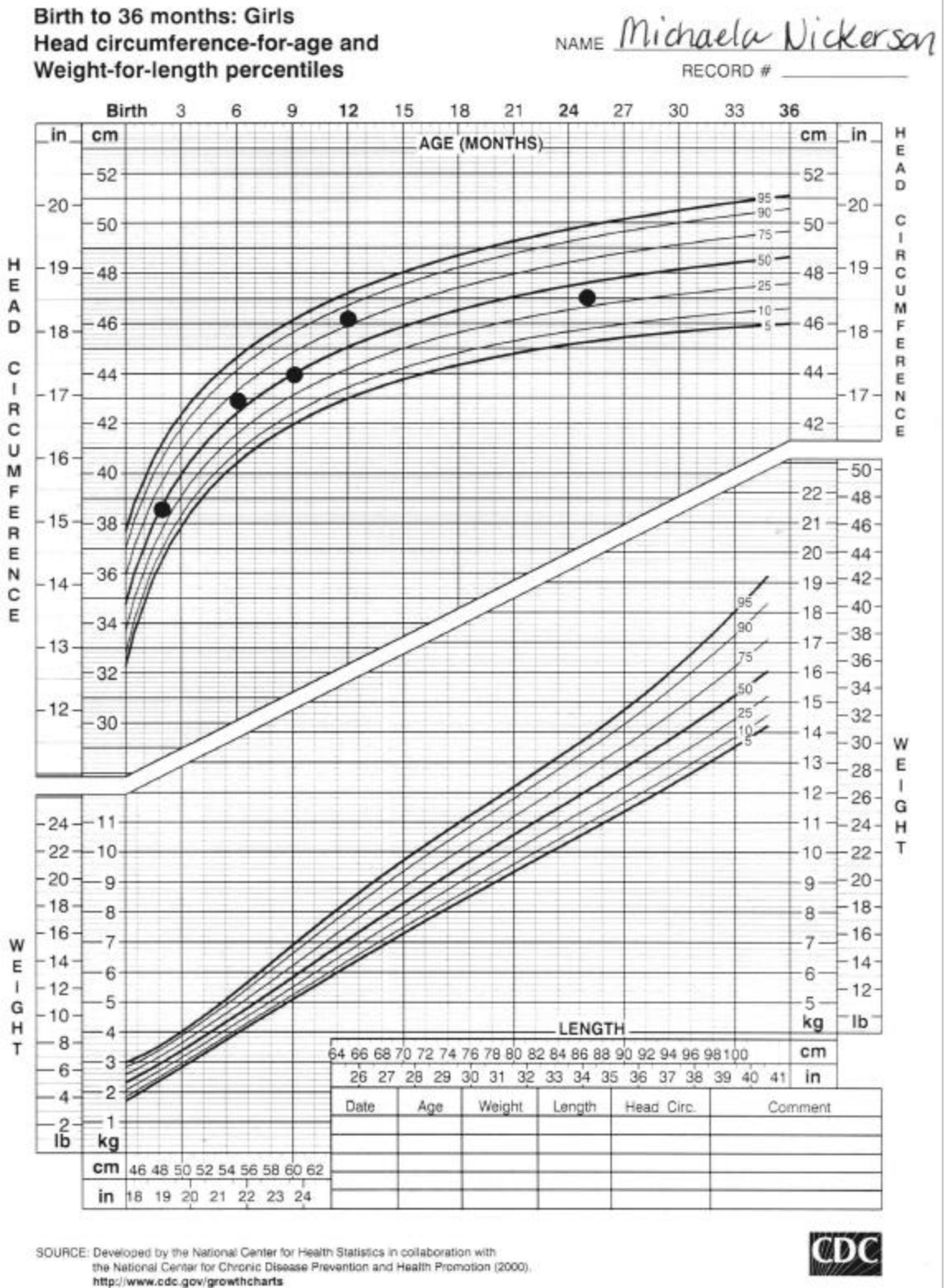
Handout #1a: Michaela's Growth Chart



The Silent Cry
Handout #1b: Head Circumference Chart



The Silent Cry
Handout #2: Classification of Child Neglect

Child neglect may be divided into several categories depending on the specific area of omission in the child's care:[1,2]

Physical neglect—includes failure to provide for adequate food, clothing, and shelter. Child neglect exists on a fairly broad spectrum. Situations such as going to school hungry, poor personal hygiene resulting in alienation by peers, homelessness, or a home failing to meet local sanitation standards would all raise strong suspicion for child neglect. Inability to provide for a child's needs because of poverty does not constitute neglect.[3]

Emotional neglect—includes failure to provide adequate social stimulation to a child in the form of talking, love, and nurturance/affection. Children who suffer from emotional neglect may manifest a variety of behaviors including depression, anxiety, aggression, social withdrawal, and hyperactivity.

Medical neglect—includes failure or delay in seeking medical/dental care or noncompliance with medications or recommended health care. Considerable controversy exists over the degree to which failure to comply with well childcare visits constitutes neglect. Several states require childhood immunizations prior to school entry.

Educational neglect—concerns arise if a child has several school absences (~ one per month). These children may be assigned inappropriate parenting duties (e.g., cleaning the house, baby-sitting) at the expense of their education.

Safety neglect—includes failure to provide adequate supervision, which places a child at significant risk of injury or results in actual injury. To some degree, most accidents are preventable. Thus, primary care providers should place special emphasis on safety related anticipatory guidance recommendations.

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The Silent Cry
Handout #3: Brief Alcohol Screening Tests

CAGE:

Cut Down:	Have you felt you ought to cut down on your drinking?
Annoyed:	Have people annoyed you by criticizing your drinking?
Guilty:	Have you felt bad or guilty about your drinking?
Eye-opener:	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

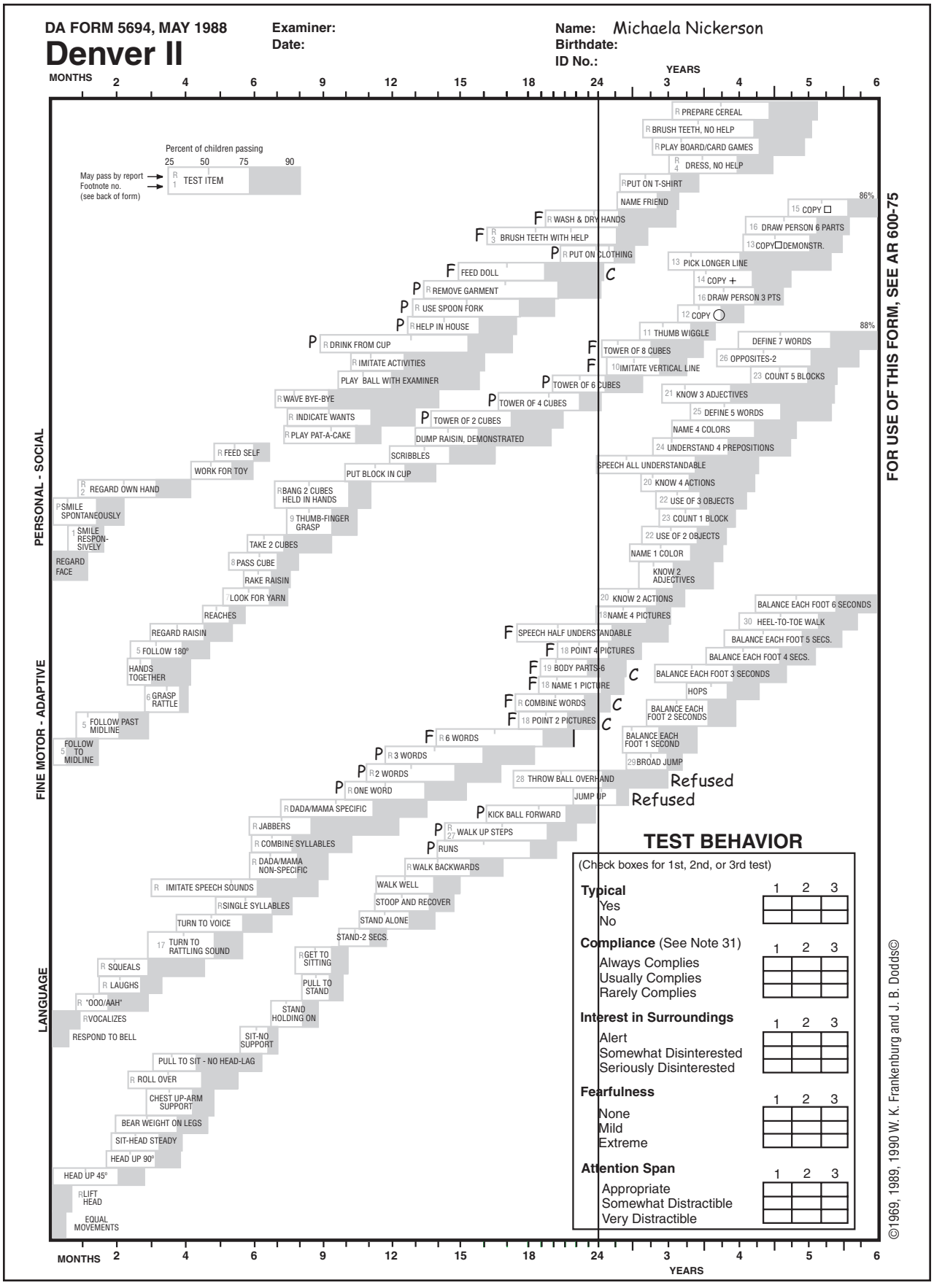
Scoring: 1 point for each "yes" response; sum all points; total, 0-4 point. Total score ³ 2 predictive of alcohol-related disorder.

T-ACE:

Tolerance	How many drinks does it take to make you feel high?
Annoyed	Have people annoyed you by criticizing your drinking?
Cut Down:	Have you felt you ought to cut down on your drinking?
Eye-opener:	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

Scoring: 2 points for Tolerance if positive (i.e., if answer is > 2 drinks); 1 point for each additional yes answer. Total score ³ 2 indicates risky drinking.

The Silent Cry
Handout #4: Denver II



The Silent Cry
Handout 5: Principles of Effective Interventions with Parents

F Give parents a listing of the **FACTS** that have led to your concern.

R Explain that you are legally **REQUIRED TO REPORT** your concern to protective services on behalf of the child.

A Direct that the individual have a formal **ASSESSMENT** to determine the exact nature of the problem and need for treatment.

M Present a **MENU** of alternatives for where and how this assessment can be performed.

E **EMPATHY**. Acknowledge how difficult this process is for everyone involved.

R Insist that you receive a **REPORT BACK** from the assessment and insist on open communication with the child protection worker. This will let you know it has been done, and help you better care for the child.

The Silent Cry

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Annotated Readings:

Dubowitz H, Black, M. Child neglect. In: Reece R, ed. *Child abuse: Medical diagnosis and management*. Philadelphia: Lea & Febiger; 1994. p. 279-297. This chapter highlights the various definitions of child neglect and discusses the epidemiology of the problem. Parent and child characteristics that can contribute to child neglect are listed. Treatment and management options are presented.

Weinstein N, Bobe C, Mandell D. *Opening and closing Pandora's box.* New York, NY: Children of Alcoholics Foundation; 1998. This soft cover manual was written as a guide to child and adolescent health care providers. It includes chapters on family systems theory, interviewing techniques, parental substance abuse and child abuse and neglect.

US Department of Health and Human Services. *Blending perspectives and building common ground: A report to Congress on substance abuse and child protection.* Washington DC: US Government Printing Office; 1999. This is a comprehensive report to the U.S. Congress on substance abuse and child protection. It contains an up-to-date review of pertinent literature and many informative tables and figures that depict the scope of the problem.

Educational Resources on the World Wide Web:

Alcoholics Anonymous
http://www.aa.org
Telephone: 212-870-3400 (or check your local directory)

Massachusetts Department of Social Services
http://www.state.ma.us/dss/

National Association for Children of Alcoholics (NACoA)
http://www.health.org/nacoa
Telephone: 1-888-55-4COAS

National Clearinghouse on Child Abuse and Neglect
http://www.calib.com/nccanch/

Prevent Child Abuse (PCAA)
http://www.childabuse.org

American Academy of Child and Adolescent Psychiatry—Facts for Families. This site provides access to the AACAP's award winning "Facts for Families" pamphlet series on various developmental topics. The information sheet entitled, "Children of Alcoholics" is #17.
http://www.aacap.org/publications/pubcat/facts.htm