

Facilitator Preparation: Facilitators should thoroughly review this module. They should also review their own state's law(s) 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 as handouts. They should also prepare or photocopy handouts to distribute during the course of the case presentation and the “Materials for Learners” packet.

Open the Discussion: Introduce the case title and the objectives of the session. Explain that this will be an interactive case discussion prompted by a series of multiple choice questions and not a lecture. Distribute Part I of the case and ask one or more of the participants to read it aloud.

The Silent Cry

Child Neglect and Parental Substance Use

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Objectives:

By the end of the session the learner should be able to:

- List signs and symptoms of child neglect.
- Discuss how to communicate concerns to parents with concerning alcohol use.
- Describe a management plan for situations where child neglect is suspected.
- List appropriate multidisciplinary services available for families affected by substance abuse.

Part I:

Introduction:

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

Current History:

“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 [*bleep*]in' time. I just can't listen to it anymore. Thank God she's my only one,” Ms. Nickerson states with exasperation.*

Review of Systems

Ms. Nickerson denies any other pertinent symptoms including vomiting, diarrhea, cough, rhinorrhea, or poor oral intake. Ms. Nickerson reports no history of trauma, falls, or

injury.

Past Medical History

On further review of the medical record, you find that Michaela is a former 32 week gestation 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.

Family/Social History

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.”

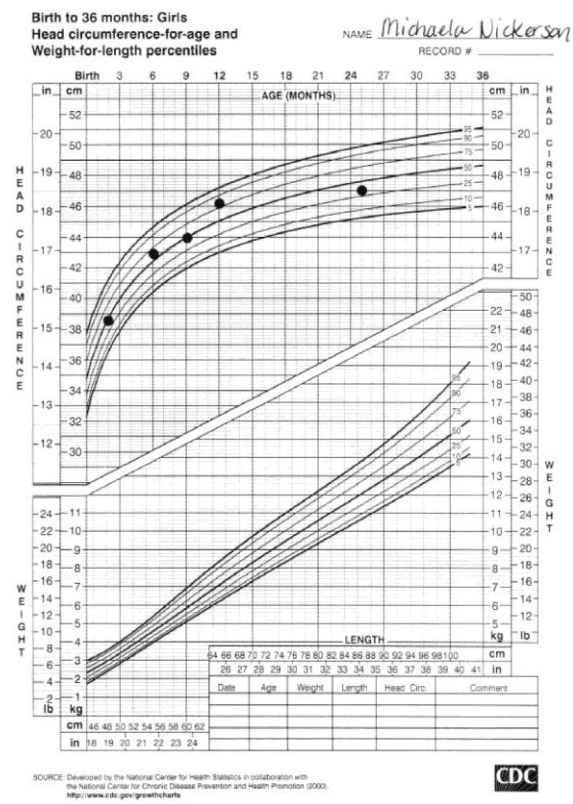
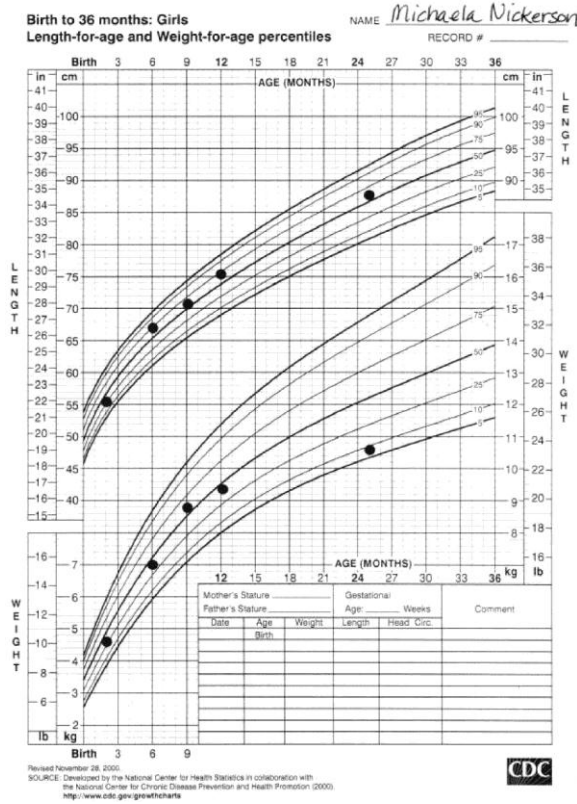
“Who takes care of Michaela when you're working?” you ask.

“Umm, . . . there's a lady across the hall from us. She helps sometimes.”

Physical Exam

You proceed with the physical examination. Michaela has an axillary temperature of 38° C. Her other vital signs are normal. She is a somewhat thin-appearing toddler (refer to growth charts) with a tear in her slightly soiled dress. 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 several colorful stickers, but she doesn't reach for them 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 2cm superficial laceration with circumferential swelling, induration, and tenderness on her left lower leg.



Following this reading, ask all participants, “So what do you think about this case? What would you like to focus on during our discussion today?” List agenda items on a whiteboard or flipchart. Then use the questions below to start the discussion. Remember that the key to successfully leading a small group is facilitation of the discussion rather than lecture. Draw as many participants as possible into the discussion. Allow silences while group members think about questions.

Potential Discussion Questions:

What is your initial impression of Michaela and her mother?

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 typical playful behavior, Michaela's poor hygiene suggests her affect may not be limited to her illness. She also has a number of physical findings that support this concern. Her pattern of dental decay is consistent with early childhood caries 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 statements about her distress with Michaela's crying, as well as saying “I just can't listen to it anymore. Thank God she's my only one” are revealing of her frustration,

which raises concerns about her ability to cope with a young child and evokes the idea that she is being driven to a level of desperation in which she might act irrationally or impulsively. She seems to be overwhelmed and alone. In addition, her erroneous assumption that most two year olds do not talk very much further highlights her lack of knowledge regarding normal child development. 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.

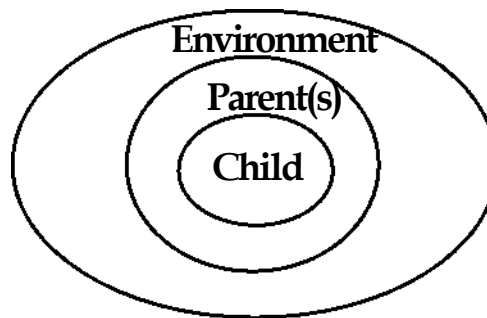
What is your preliminary problem list?

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 which may be causing her pain. 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.

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. Although this may not be very unusual in the context of a single pediatric visit, these could be signs of a difficult temperament and/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, or medical/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 #1.

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 (about 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.

Have Learners refer to Handout #1: Classification of Child Neglect, and give participants a few moments to review the contents

The reasons contributing to the neglect of 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 consistently recognize and provide their child's needs. Thus, it is no surprise that risk factors for child neglect include parental substance abuse and other psychopathology.

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.

Consider distributing copies of the paper by Wilson and colleagues and give participants a few minutes to review the abstract.

Key Teaching Point: Research has found that more than 10% of caregivers bringing their children for routine pediatric care screen positive for alcohol problems. The majority of these caregivers, who were mostly women, were accepting of the pediatrician's role in asking them about their drinking problem.

The parental response to the “trigger questions” that are suggested in the Bright Futures 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?

While these questions may seem fairly routine, many healthcare providers find that they are uncomfortable probing into this area of a family's life, at least initially. Therefore, it is crucial that they be practiced and role-played until they are able to be delivered in a relaxed conversational manner. Physicians should make every effort to establish a safe, nonjudgmental atmosphere for parents to be able to disclose what for them may be incredibly shaming.

****Optional Learning Exercise A:** Facilitators may wish to have participants role play this portion of the dialogue with Ms. Nickerson. The facilitator should appropriately debrief both actors in the role play, the one playing the provider, as well as the one playing Ms. Nickerson. The instructor should normalize the discomfort felt by both actors and highlight those moments when Ms. Nickerson felt safe to disclose vs. not. Evoke the idea of developing a working alliance or rapport.

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

Ask learners to refer to Handout #2: Brief Alcoholism Screening Tests

The CAGE questions are one of several brief screening tests for alcohol disorders (see Handout #3). A “yes” response to two or more CAGE questions is suggestive of a diagnosis of alcohol abuse or dependency. When a parent has a positive CAGE screen, 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. In addition, you might consider using a self-report measure. The AUDIT (Alcohol Use Disorders Identification Test) is a 10-item scale that can be embedded into a paper-pencil or computer-based delivery instrument. The AUDIT yields a score from 0 to 40 and contains 3 subscales related to amount and frequency of drinking, alcohol dependence, and problems caused by alcohol use.

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 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 2 indicates risky drinking.

****Optional Learning Exercise B: 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.

More advanced learners may consider using the technique of motivational interviewing (see references 10 and 11), an empirically supported method for discussing these difficult issues with an ambivalent patient/client. Motivational interviewing essentially has the provider play devil's advocate (e.g., "With things as bad as they sound, what has kept you from drinking more?") so that the patient him/herself articulates reasons for changing rather than the more prototypical response of resisting the provider's suggestions.

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, hospitalization for "psychosocial" reasons has been supported by the American Academy of Pediatrics.

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. During the hospitalization she could receive antibiotics, a social work consult, a nutrition consult, and further developmental/behavioral observation. A dental referral is also indicated.

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:

Next Steps:

You decide to admit Michaela to the hospital. She receives IV antibiotics and local wound care. Social work and nutrition consults are obtained.

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, tripping over the chair, possible hangover) 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:

- 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.

Ask learners to refer to Handout #3: 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 C: 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 rights 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 or if foster care placement is necessary. The emphasis is on keeping the child safe, which in some situations can be done while having the child remain in the home. Regardless of whether the child is removed from the home or not, a family service plan is designed to target areas within the family unit that need to be improved upon. 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, a parent aide, counseling, psychotherapy, and substance abuse treatment. Intensive plans also include family stabilization services (i.e., family-based and individual treatment at the home) often more than once per week. Failure of the parent(s) to abide by the terms of the service plan may result in the child remaining in foster care or the child being removed from the home and placed in foster care. 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.

Despite having filed a mandated report, clinicians should strive to maintain close communication with the parent/family. Remember that parents with alcohol disorders have an illness, 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 principal role is to ensure that Michaela receives adequate medical care. You should also monitor her 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 parents with alcohol or other substance abuse problems usually love their children very much and really want to be good parents. However, their addiction interferes with their ability to follow through. Because of their life histories, chemical coping has become their tried-and-true means of stress management, which creates a vicious circle when childcare inevitably becomes stressful. When there is co-occurring post-traumatic stress, the problem becomes compounded by the re-emergence of posttraumatic symptoms when the parent becomes sober.

Parents with substance use disorders often act out their internal conflicts so that the healthcare provider is alternately made to feel like a rescuer or depriver--excessively impinged upon for short-notice letters and between-session crisis calls or rejected and denigrated for "not understanding" the parent's situation. The provider can feel exhausted, mistreated, or both and understandably feel relieved if/when the parent drops out of treatment. This is a common pattern but ultimately not in the family's best interest.

Pediatricians should be advised that it will be easier to set clear, caring limits up front about the provider's availability for calls and notice needed for fulfilling special requests than it will be to overextend, feel taken advantage of, and placed in the position of "taking back" the favor later. The parent will often experience this latter scenario as depriving and frustrating, which will strain the working alliance and ability of the provider to help the child.

Fortunately, parents with substance use disorders are often highly motivated to enter treatment programs and, with proper encouragement and support, can be successful.

Distribute the Epilogue. Ask someone to read the Epilogue aloud.

Part III:

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 child protection agency. 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. In addition, an appointment is scheduled for her to be seen by a developmental/behavioral pediatrician, as well as a pediatric dentist in the upcoming weeks. 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 2 days. Her immunizations were updated. A routine lead level was 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, 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.

Outcome Commentary

Although the outcome for Michaela and Ms. Nickerson was quite favorable, it does not reflect the challenging course that is common to many children living with parents with alcohol and other substance abuse problems. Addiction is a chronic health condition with a remitting/relapsing course. The chance for relapse is quite high, especially if nothing is done to address co-existing psychosocial stressors. However, the heartening news for providers is that, as with weight loss or smoking cessation, experienced success of the kind described in the epilogue increases the possibility of sustained sobriety now or in the future. Hence, the provision of supportive resources (e.g., visiting nurse, parent aide) can bolster the family to maximally ensure a positive outcome.

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.

Clinical Pearls:

- Child neglect, the most common form of child maltreatment, is the result of a caretaker's failure to provide the adequate needs for a child. Child neglect is divided into several categories depending on the specific area of omission in the child's care. These categories include: physical neglect, emotional neglect, medical neglect, educational neglect, and safety neglect.
- Communication with parents around issues of their alcohol/substance use can be challenging. However, a professional, nonaccusatory, nonjudgmental demeanor will go a long way in helping parents understand your concern for their child's safety, as well as their overall well-being. A structured approach, as outlined by the FRAMER

mnemonic can assist providers in guiding the content of these discussions.

- National mandated reporting statutes require that the state child protection agency is notified when child abuse and/or neglect is suspected. Providers are encouraged to become familiar with the reporting laws of their state, as there is some state-to-state variability.
- Child neglect and parental substance use are complex psychosocial problems which frequently require a multifaceted, multidisciplinary approach in order to achieve a satisfactory outcome. Therefore, providers should familiarize themselves with the services available in their local community, as well as other invaluable resources that can be accessed as a result of involving the state child protection agency.

Knowledge questions:

Ask learners to complete the knowledge questions in their packet. If time allows, questions and answers can be discussed as a group, or learners can complete and review answers on their own.

1. *Which of the following statements is most correct?*
 - a. Child neglect is the result of intentional injury to a child.
 - b. Child neglect occurs when a child is injured in the daycare setting and the parent is unable to explain what occurred.
 - c. All parents who are unemployed and without financial means neglect their children.
 - d. Child neglect is characterized by the failure of a caregiver to provide for the basic needs of a child.

2. *When is the ideal time to approach a parent about your concerns for his/her drinking behavior and its potential impact on the child?*
 - a. At a time when the child is safe and the parent does not appear to be under the influence.
 - b. When you happen to see the parent at the grocery store.
 - c. Immediately when you notice the parent is alone and drinking at the local bar.
 - d. All of the above are incorrect. A parent is not your patient and their drinking is not your concern.

3. *Which of the following statements is correct?*
 - a. The CAGE is an example of a brief alcohol screening test.
 - b. The T-ACE is an example of a brief alcohol screening test.
 - c. The AUDIT is an example of a brief alcohol screening test.
 - d. All of the above are correct.

4. *Which of the following statements is correct?*
 - a. Child neglect is the least common form of child maltreatment.
 - b. Both parental use of alcohol and child neglect may be “silent” problems.
 - c. Most pediatric clinicians routinely screen parents for alcohol abuse.
 - d. Child neglect is usually easy to detect.

Answers to Knowledge Questions

1. *Which of the following statements is most correct?*

Preferred response: D “Child neglect is characterized by the failure of a caregiver to provide for the basic needs of a child.”

This response essentially defines child neglect. Physical abuse is the intentional injury to a child (Response A). Although risk factors for child neglect include environments whereby there are numerous psychosocial stressors such as unemployment, inadequate finances, or general lack of social support (Response C), they are not diagnostic indicators. Parents may not be adequately informed about injuries that occur when the child is not in their care (Response B) and, therefore, their lack of knowledge about the mechanism of injury would not be considered neglectful by the usual standards.

2. *When is the ideal time to approach a parent about your concerns for his/her drinking behavior and its potential impact on the child?*

Preferred response: A “At a time when the child is safe and the parent does not appear to be under the influence.”

The most ideal time to address a parent’s drinking or substance use is when he/she is mentally/emotionally available to have a discussion about their behavior and its influence on their child. A casual, haphazard conversation while at the grocery store (Response B) or when they are actively engaging in the behavior (Response C) is counter to the professional, structured, and nonjudgmental manner that should be encouraged to facilitate an optimal outcome. Although, the parent is not your patient (Response D), their child is and the parent’s substance use has significant implications for their child’s overall health and well-being, thereby, making it an important area to address. 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 healthy.

3. *Which of the following statements is correct?*

Preferred response: D “All of the above are correct.”

Several brief screening tests are available for alcohol use. The CAGE is a 4-item test that can be easily administered verbally. The T-ACE is a 4-item test that may be somewhat more effective in screening women. The AUDIT (Alcohol Use Disorders Identification Test) is a 10-item scale that can be embedded into a paper-pencil or computer-based delivery instrument. The AUDIT yields a score from 0 to 40 and contains 3 subscales related to amount and frequency of drinking, alcohol dependence, and problems caused by alcohol use.

4. *Which of the following statements is correct?*

Preferred response: B “Both parental use of alcohol and child neglect may be “silent” problems.”

Whereas child abuse can frequently be readily detected from the presence of physical evidence, the identification of child neglect depends on the recognition of relatively more subtle signs. It is the omission of necessary provisions to support a child’s growth and development that constitutes child neglect. Likewise, parental alcohol use can be a

“silent” problem, even when adequately screened for, as parents may not always be forthcoming about their use. Thus, in identifying child neglect and parental alcohol use, the astute pediatrician must hear the “silent cry” as well as the audible one.

References

1. Wilson C, Harris SK, Sherritt L, Lawrence N, Glotzer D, Shaw JS, Knight JR. Parental alcohol screening in pediatric practices. *Pediatrics* 2008;122:e1022-1029.
2. Kahn R, Wise P, Finkelstein J, Bernstein H, Lowe J, Homer C. The scope of unmet maternal health needs in pediatric settings. *Pediatrics* 1999;103:576-581.
3. US Dept. of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children’s Bureau (2011). *Child Maltreatment 2010*. Available from <http://www.acf.hhs.gov/programs/cb/pubs/cm10/cm10.pdf>.
4. US Dept. 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.
5. Anonymous. Children of Alcoholics: Important Facts. National Association for Children of Alcoholics [www.health.org/nacoa/], last accessed April 13, 2011.
6. MacDonald D, Blume S. Children of alcoholics. *American Journal of Diseases of Children* 1986; 140:750-754.
7. Weinstein N, Bobe C, Mandell D. *Opening and closing Pandora's box*. New York, NY: Children of Alcoholics Foundation; 1998.
8. Ewing J. Detecting alcoholism: The CAGE questionnaire. *Journal of the American Medical Association* 1984;252:1906-1907.
9. Bush B, Shaw S, Cleary P, DelBlanco TI, Aronson, MD. Screening for alcohol abuse using the CAGE questionnaire. *American Journal of Medicine* 1987;82:231-5.
10. Rollnick S, Miller WR. What is motivational interviewing? *Behavioural and Cognitive Psychotherapy*. 1995;23:325-334.
11. Miller WR. Motivational interviewing with problem drinkers. *Behavioural Psychotherapy*. 1983;11:142-172.
12. American Academy of Pediatrics, Committees on Hospital Care and Child Abuse and Neglect. Medical necessity for the hospitalization of the abused and neglected child. *Pediatrics* 1998;101:715-716.
13. Dubowitz H, Black, M. Child neglect. In: Reece R, editor. *Child abuse: Medical diagnosis and management*. Philadelphia: Lea & Febiger; 1994. p. 279-297.
14. Flaherty EG, Stirling J, and The Committee on Child Abuse and Neglect. The pediatrician’s role in child maltreatment prevention. *Pediatrics* 2010;126:833-841.
15. Jenny C. Recognizing and responding to medical neglect. *Pediatrics* 2007;120:1385-1389.
16. Adger H, Macdonald DI, Robinson P, Wenger S. Helping children in families hurt by substance abuse. *Contemporary Pediatrics* 2004;21(12):52-58.
17. Dubowitz H. Tackling child neglect: A role for pediatricians. *Pediatric Clinics of North America* 2009;56(2):363-378.
18. Hymel KP and Committee on Child Abuse and Neglect. When is lack of

- supervision neglect. *Pediatrics* 2006;118:1296-1298.
19. American Academy of Pediatric Dentistry, Child Abuse Committee. Definition of dental neglect. *Reference Manual, 2011-2012*;33(6):13.
 20. Block RW, Krebs NF. Failure to thrive as a manifestation of child neglect. *Pediatrics* 2005; 116:1234-1237.

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 available online:

Alcoholics Anonymous

<http://www.aa.org>

Telephone: 212-870-3400 (or check your local directory)

Massachusetts Department of Children and Families

<http://www.mass.gov/eohhs/gov/departments/DCF>

National Association for Children of Alcoholics (NACoA)

<http://www.nacoa.org>

Telephone: 1-888-55-4COAS

Council for Children and Families: Clearinghouse on Child Abuse and Neglect <http://www.ccf.wa.gov>

Prevent Child Abuse (PCAA)

<http://www.preventchildabuse.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/cs/root/facts_for_families/children_of_alcoholics

Materials for Learners:

Packet should include the following:

- Handout #1: Classification of Child Neglect
- Handout #2: Brief Alcohol Screening Tests
- Handout #3: Principles of Effective Interventions with Parents
- Clinical pearls
- Knowledge questions and answers
- References
- Parental Alcohol Screening in Pediatric Practices, Wilson CR, Harris SK, Sherritt L, et al, available at:
<http://pediatrics.aappublications.org/content/122/5/e1022.full.pdf+html>

The Silent Cry

Child Neglect and Parental Substance Use

Part I:

Introduction:

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

Current History:

“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 [*bleep*]in' time. I just can't listen to it anymore. Thank God she's my only one,”* Ms. Nickerson states with exasperation.

Review of Systems

Ms. Nickerson denies any other pertinent symptoms including vomiting, diarrhea, cough, rhinorrhea, or poor oral intake. Ms. Nickerson reports no history of trauma, falls, or injury.

Past Medical History

On further review of the medical record, you find that Michaela is a former 32 week gestation 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.

Family/Social History

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.”

Physical Exam

You proceed with the physical examination. Michaela has an axillary temperature of 38° C. Her other vital signs are normal. She is a somewhat thin-appearing toddler (refer to growth

The Silent Cry

Child Neglect and Parental Substance Use

Part II:

Next Steps:

You decide to admit Michaela to the hospital. She receives IV antibiotics and local wound care. Social work and nutrition consults are obtained.

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.

The Silent Cry

Child Neglect and Parental Substance Use

Part III:

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 child protection agency. 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. In addition, an appointment is scheduled for her to be seen by a developmental/behavioral pediatrician, as well as a pediatric dentist in the upcoming weeks. 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 2 days. Her immunizations were updated. A routine lead level was 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, 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.