Shaken Baby Syndrome

What is shaken baby syndrome?

Shaken baby syndrome is one form of abusive head trauma. Head trauma, as a form of child abuse, can be caused by direct blows to the head, dropping or throwing the child, or shaking the child. Head trauma is the leading cause of death in child abuse cases in the United States.

Unlike other forms of abusive head trauma, shaken baby syndrome results from injuries caused by someone vigorously shaking an infant. An infant's brain is relatively small in relation to its head and an infant's head is one-fourth to one-third of his/her body weight. In addition, an infant's neck muscles are not yet strong enough to fully support the neck. So, if a baby is shaken violently, the neck is jerked, the head snaps back and forth similar in fashion to a whiplash. Shaking a baby may cause injuries that lead to any of the following conditions:

- blindness
- deafness
- learning disabilities or delay in normal development
- paralysis
- seizures
- death

What are some of the signs and symptoms of shaken baby syndrome?

Subdural hematomas (internal brain bleeding) and edema (brain swelling) that can be seen on a computed tomography (CT) scan of the head—the infant might have:

- swelling soft spot
- larger than normal head size
- bleeding in the eyes
- irritability
- excessive drowsiness
- sluggish behavior
- seizures
- projectile vomiting
- unresponsiveness, limpness, abnormal breathing or apnea (stops breathing)

If you suspect that a baby is suffering from shaken baby syndrome, consult with a health care provider or a social worker immediately. Proper diagnosis is critical in starting appropriate treatment. If the diagnosis is positive, local law enforcement officials and the department of human services should be notified.

How is shaken baby syndrome diagnosed?

Shaken baby syndrome is difficult to diagnose, unless someone accurately describes what happens. Physicians often report that a child with possible shaken baby syndrome is brought for medical attention due to falls, difficulty breathing, seizures, vomiting, altered consciousness or choking. The caregiver may report that the child was shaken to try to resuscitate it. Babies with severe or lethal shaken baby syndrome are typically brought to the hospital unconscious with a closed head injury.

To diagnose shaken baby syndrome, physicians look for retinal hemorrhages (bleeding in the retina of the eyes), subdural hematoma (blood in the brain) and increased head size indicating excessive accumulation of fluid in the tissues of the brain. Damage to the spinal cord and broken ribs from grasping the baby too hard are other signs of shaken baby syndrome. Computed tomography (CT) and magnetic resonance imaging (MRI) scans can assist in showing injuries in the brain, but are not regularly used because of their expense.

A milder form of this syndrome also can be observed and may be missed or misdiagnosed. Subtle symptoms that may be the result of shaken baby syndrome, are often attributed to mild viral illnesses, feeding dysfunction or infant colic. These include a history of poor feeding, vomiting or flu-like symptoms with no accompanying

fever or diarrhea, lethargy and irritability over a period of time. Often the visit to the medical facility does not occur immediately after the initial injury. Without early medical intervention, the child may be at risk for further damage or even death, depending on the continued occurrences of shaking.

How many children are affected by shaken baby syndrome?

An estimated 1,200 to 1,400 cases occur each year in the United States. One shaken baby in four dies as a result of this abuse (Poissaint & Linn, 1997). Head trauma is the most frequent cause of permanent damage or death among abused infants and children, and shaking accounts for a significant number of those cases (Showers, 1992). Some studies estimate that 15 percent of children's deaths are due to battering or shaking and an additional 15 percent are possible cases of shaking. The victims of shaken baby syndrome range in age from a few days to five years, with an average age of six to eight months (Showers, 1997).

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Who is responsible for shaking babies?

While shaken baby abuse is not limited to any special group of people, males tend to predominate as perpetrators in 65 to 90 percent of cases. In the United States, adult males in their early 20s who are the baby's father or the mother's boyfriend are typically the shaker. Females who injure babies by shaking them are more likely to be baby-sitters or child care providers than mothers (Showers, 1997). Frustration from a baby's incessant crying and toileting problems have been described as events leading to severe shaking. The adult shaker also may be jealous of the attention that the child receives from his or her partner.

How is Shaken Baby Syndrome prevented?

Parents should receive information about shaken baby syndrome prevention in the hospital and/or from their child's health care provider. Health care providers and other professionals who interact with infants and their families should talk to them about their level of stress and how they respond to a crying infant who cannot be readily calmed. Finding ways to alleviate the parent or caregiver's stress at the critical moments when a baby is crying can significantly reduce the risk to the child. Some methods that may help are described in author Dr. Harvey Karp's "five S's":

- shushing (using "white noise," or rhythmic sounds that mimic the constant whir of noise in the womb, with things such as vacuum cleaners, hair dryers, clothes dryers, a running tub or a white noise CD)
- side/stomach positioning (placing the baby on the left side – to help digestion – or on the belly while holding him or her then putting the sleeping baby in the crib or bassinet on his or her back)
- sucking (letting the baby breastfeed or bottle feed, or giving the baby a pacifier or finger to suck on)
- swaddling (wrapping the baby up snugly in a blanket or help him or her feel more secure)
- swinging gently (rocking in a chair, using an infant swing or taking a car ride to help duplicate the constant motion the baby felt in the womb)

Remember that babies do cry for a variety of reasons: they need to be changed or fed or they are just adjusting to life. It can be very frustrating, so try some of the following suggestions

- feed slowly and burp often;

- offer a pacifier;
- place the baby in a crib; leave the room for a few minutes;
- hold the baby against your chest and walk or rock;
- put on soft music or sing;
- take the baby for a ride in the stroller or car;
- put the baby in a baby swing;
- avoid eating onion or drinking coffee, tea and colas if you are breastfeeding;
- check for the discomforts of diaper rash, teething or fever;
- ask a friend to "take over" for a while;
- don't pick up the baby until you feel calm.

References

This information was adapted from the National Center on Shaken Baby Syndrome, Ogden, UT 84401, (801) 399-8016 www.dontshake.com and The Arc's Q & A Web page, revised October 1998: www.thearc.org/publications and Kids Health at http://www.kidshealth.org.

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Cultural Considerations Related to Child Maltreatment

Although ideas about child rearing vary from culture to culture, it is understood that regardless of the cultural context, there is no excuse for hurting a child. Community members in every culture understand that they have a responsibility to intervene if a child is being hurt. Problems tend to arise, however, when there is disagreement among cultures about certain behaviors. Traditions Westerners may label as abusive or neglectful may appear just the opposite to someone from Asia or Africa. When working with a family from another culture, it is important to be mindful of differences and become knowledgeable about various cultural practices.

General Considerations When Working with Families from Various Cultures

Do not assume

- that because your client is of certain ethnicity, you will know about cultural norms and practices of that client;
- that you know the ethnicity of your client—ASK;
- that the client is an immigrant.

There is great opportunity to build on the strengths of your client's ethnic culture. Each culture is rich in spiritual, communal and emotional qualities that can support an abuse victim/survivor's journey. A culturally sensitive assessment takes into account level of acculturation, language preferences, immigration history, family structure, economic status and the patient's age.

Consider building trust through conversation, using an opening dialogue, such as,

- *"How long have you been in the U.S.?"*
- *"How are the children doing?"*
- *"Do you need help with the children?"*

Then, listen to your client.

Other tips include

- share information about yourself;
- engage clients in telling their stories;
- focus on supporting self-esteem, the right to do things for themselves and their children, positive reinforcement, self-care, and the value of connecting with advocacy services;
- remember that some clients may have had negative experiences with social services or the health care environment.

References

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Identifying Cultural Healing Marks

There are cultures in which certain things that are done to children out of caring may create the appearance of child abuse to members of other cultures. In some cultures, rituals are performed that may be unacceptable in the United States. In general, the laws of the country in which you live are the laws that must be obeyed. Colorado statutes recognize and "take into account accepted child-rearing practices of the culture in which the child participates" (CRS 19-3-303). Physical punishment should be restricted to those parts of the body that will not put a child's health in danger (Besharov, 1990). Even then, the punishment must not exceed certain limits. Examples of excessive punishment would be bruising or leaving marks. When in doubt about whether or not to report child abuse and neglect, consult with your local child protective services office.

Some examples of cultural healing practices

Coining: The Vietnamese name for this folk practice is Cao Gio (pronounced "Cow Zow"). This practice is used to reduce fever, chills and headaches. The skin on the chest and back is massaged with oil and stroked with the edge of a coin until bruising occurs.

Burns: Some Mexican-Americans use a practice called "cupping" for respiratory ailments, in which ignited alcohol is placed in a cup and held directly on the skin. When the heated skin area cools, the skin is sucked into the cup, causing redness and burns. Some Southeast Asians practice a healing method in which burning strings are lowered onto a child's abdominal area to cure stomach pain or fever. These types of burns often resemble cigarette burns.

Head Injuries: A Mexican-American folk remedy for "fallen fontanel" can cause a subdural hematoma. This practice is used when the baby's soft spot on the head has "collapsed" or is concave, often when a baby is dehydrated from an illness. To bring it back, the area is sucked vigorously, often causing a hematoma.

Moxibustion: The Asian healing practice of placing burning pieces of yarn or balls of moxa herb on the skin, which leaves deep, circular burns.

Resources

Asian Pacific Center for Human Development
(303) 393.0304
1825 York Street
Denver, CO 80206
Services offered: Individual and family counseling, victim advocacy, and translation services.

Denver Indian Family Resource Center
(303) 871.8035
393 S. Harlan Street, Suite 100
Lakewood, CO 80226
www.difrc.org
Mission: To strengthen vulnerable American Indian children and families through collaborative and culturally responsive services. Based in the spirit of the Indian Child Welfare Act, we strive to keep children safely with their families.
Services offered: family reunification, family preservation, family support and resource and referral.

Servicios De La Raza, Inc.
(303) 458.5851
4055 Tejon Street
Denver, CO 80211
www.serviciosdelaraza.org
Services offered: support for adult victims of domestic violence; mental health services for adults, adolescents and children; HIV/AIDS case management; youth services; emergency services, such as food and clothing; and bilingual mediation services related to family issues.

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The Link Between Child Abuse and Domestic Violence

What is domestic violence?

Domestic violence is a pattern of assaultive and coercive behaviors, including physical, sexual and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners. The U.S. Department of Justice estimates that 95 percent of reported assaults on spouses or ex-spouses are committed by men against women (Douglas, 1991).

What is child abuse?

Prevent Child Abuse America defines child abuse as a non-accidental injury or pattern of injuries to a child for which there is not "reasonable" explanation.

Is there a link between domestic violence and child abuse?

A growing body of research points to a definite link between adult domestic violence and child abuse. These connections are pervasive. Forty-five to 70 percent of battered women in shelters report that their batterers also have committed some form of child abuse, with some shelters reporting that the first reason many battered women give for fleeing the home is that the perpetrator also was attacking the children. Even using the more conservative 45 percent figure, child abuse is 15 times more likely to occur in households where adult domestic violence is also present (Hilton, 1992). Women who have been beaten by their spouses are, in turn, reportedly twice as likely as other women to abuse a child. It also is estimated that 3.3 million to 10 million children witness domestic violence each year. Many child witnesses of domestic violence experience increased problems themselves.

A variety of family dynamics are at work in homes in which spousal abuse leads to child abuse or neglect. Sometimes a child is the unintended victim when he or she attempts to intervene in an attack on a parent. In

other instances, a child is accidentally struck by a blow directed at the mother. Since domestic violence is a pattern of behavior, not a single event, episodes may become more severe and more frequent over time, resulting in an increased likelihood that the children will eventually become victims. However, many children are deliberate targets in violent households. The severity of wife beating also is predictive of the severity of child abuse, and the manner in which children are abused strongly resembles the type of maltreatment experienced by their mothers.

More difficult for many to understand is the battered woman who abuses or neglects her children. According to those who work with battered women, several explanations are possible. In an effort to forestall further violence, some battered women devote all their attention to their abusers or they withdraw from the family, even the children, in an effort to protect themselves. Both responses may result in child neglect. The tremendous stress associated with living in a violent situation also may prompt physical abuse of children by those women at risk for such behaviors. Some physical or emotional abuse of children also results from battered women who are so fearful of their spouse's reaction to childhood behavior that they overdiscipline in an attempt to protect the children from what they perceive to be the greater danger from the batterer.

Even in households in which children are not themselves physically abused or neglected, they can be victimized by witnessing spousal abuse.

Even in households in which children are not themselves physically abused or neglected, they can be victimized by witnessing spousal abuse. Because children do not fully understand the dynamics of domestic violence, they may come to view power and control, aggression and violence, as the only means of getting one's needs met. Children also may imitate the violent adult behavior they observe by victimizing younger siblings, peers and animals. Other children may adopt the victim role, becoming passive and withdrawn in their interactions with other people. Child witnesses of domestic violence also may display an inability to control and express emotion or to delay gratification.

Are there similarities between families involved in domestic violence and families involved in child abuse?

The two populations share several similarities, as well as some important differences. Both forms of abuse cross all boundaries of economic level, race, ethnic heritage and religious faith. Neither child abuse nor domestic violence is a phenomenon of recent history. Children have been physically traumatized, deprived of the necessities of life and molested sexually by adults since the dawn of human history (National Committee to Prevent Child Abuse and Neglect, 1993). Traditionally, parents claimed ownership of their children and society hesitated to interfere with the family unit. Similarly, society in the past has sanctioned the belief that men have the right to use whatever force is necessary to control the behavior of women. Those in intimate relationships, as well as those who abuse children, often are repeating learned behaviors transmitted intergenerationally. Both forms of abuse are marked by patterns. Neither domestic violence nor child abuse is an isolated event. Adults who were abused as children have an increased risk of abusing their children, and adults who grew up in a violent home are more likely to become perpetrators or victims of domestic violence. For a number of reasons, including shame, secrecy and isolation, both types of abuse are underreported.

Domestic violence and child abuse also differ in some significant ways. Parental stress is an important factor

in instances of child abuse, but this link has not been established in cases of domestic violence. Reported perpetrators of child maltreatment are equally men and women, but the majority of perpetrators of domestic violence are men.

How can we prevent these problems?

Domestic violence and child abuse proliferate in an environment that accepts the lesser status of women and children. Shrouding the violence in secrecy allows this behavior to continue. Educating the public about the extent of the problem has established a foundation that has permitted victims to come forward. Prevention efforts that reach parents before or soon after the birth of a baby, and that provide intensive services on a moderately long-term basis, can greatly reduce the incidence of child abuse, as well as identify other problems such as domestic violence. Home visitors using a comprehensive approach can tailor their services to match a family's needs. After establishing a trusting relationship with the family, the home visitor will be able to identify problems. While the home visitor may not be able to offer intervention services, he or she can provide resources and ensure the safety of the children.

The connections between child abuse and neglect make it important for those working in the field of child abuse and neglect to understand the connection between spousal abuse and child abuse and to respond with treatment and protective resources that recognize the link. Cooperation between professionals working with battered women and with abused or neglected children is essential. In practice, formal connections between the two fields often are not in place. They are sorely needed, however, beginning with the initial intake contact with the abused child or battered woman and continuing through assessment of the precipitating incident and family interaction, treatment, planning, intervention strategies and evaluation of client progress.

Other prevention efforts include the following:

- Educate health and child welfare agencies about the prevalence of domestic violence and its effects on children.
- Involve the community in a multidisciplinary approach to provide intervention and prevention services to those families in need.
- Educate the public about domestic violence and child abuse and the long-term costs to society.
- Provide access to self-help groups and other supportive services for all perpetrators, victims and survivors of abuse.
- Educate all who work with children and families – including teachers, service providers and health care professionals – about the interplay between domestic violence and child abuse.

Intervention strategies

Intervention strategies must recognize the need for safety for victims of both spousal abuse and child abuse through services such as legal advocacy and shelter resources. When both women and children are victims, treatment modalities must not reinforce the idea that the battered spouse is somehow to blame for the violence within the family, for example, by labeling her a poor parent and mandating attendance at parenting classes. Individual or unisex group counseling may be the more effective treatment modality and may involve less risk than joint family counseling when the spouse also is a victim. Most importantly, professionals working in both fields must not lose sight of their ultimate goal: ending violence within families.

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The Greenbook Initiative

When addressing the interface between domestic violence and child abuse and neglect, it is important to be familiar with the Greenbook Initiative.

What is the Greenbook?

Effective Intervention in Domestic Violence & Child Maltreatment Cases: Guidelines for Policy and Practice, also known as the "Greenbook," is a set of recommendations designed to help dependency courts and child welfare and domestic violence agencies better serve families experiencing violence. The Family Violence Department of the National Council of Juvenile and Family Court Judges brought together a diverse, expert committee to develop the Greenbook over many months. Its recommendations are being used, formally and informally, by hundreds of communities across the nation and around the world.

Why is the Greenbook necessary?

Some studies show that as many as half of men who abuse their spouses also abuse their children. When domestic violence coincides with child maltreatment, courts and child welfare and domestic violence agencies may all be called upon to help. These groups have different protocols and different goals, and often fail to coordinate effectively. The result can be ineffective interventions and additional trauma to families that already are under great stress. In worst-case scenarios, the systems work at cross-purposes and children can be taken from their battered mother, who is blamed for allowing them to be exposed to violence. The Greenbook offers recommendations that can help communities respond more effectively and do much more to protect and support families experiencing violence.

How does the Greenbook project aim to change the status quo?

Too often, women and children in violent situations are victimized twice: first by the abuser and, second, by

the very systems that are designed to help them. The Greenbook recommendations are designed to promote safety by teaching judicial, child welfare and domestic violence workers to coordinate more effectively. The goal is to keep women and children safe, allow women in violent relationships to access services without fear of losing custody of their children, and in most cases, to prevent the removal of a child from a nonabusive parent. When social service and court workers coordinate, all family members are more likely to receive the counseling and support that they need.

How is the Greenbook Initiative being piloted in local communities?

In December of 2000 and January of 2001, the U.S. Departments of Justice and Health and Human Services funded six communities under an inter-Departmental demonstration initiative: Six counties are receiving $1.05 million each in federal grants over three years to implement new collaborations. These counties – Grafton County, New Hampshire; El Paso County, Colorado; Lane County, Oregon; Santa Clara County, California; San Francisco County, California; and St. Louis County, Missouri – also are receiving ongoing technical assistance and support. The six counties were selected from more than 100 applicants in a rigorous selection process run by the U.S. Department of Health and Human Services and the U.S. Department of Justice. Many other sites that did not receive federal funding are using the "Greenbook" to improve collaboration across agencies and to alter their policies and practices.

Have the jurisdictions that are part of the Greenbook test program had positive results?

The six federally funded counties that are part of the Greenbook project are discovering new ways for juvenile courts and child welfare and domestic violence agencies to work together to aid and support families. They are succeeding in breaking down barriers and overcoming long-standing mistrust between departments. But the work still is in progress, and no evaluations or results are available yet.

Are other jurisdictions implementing all or part of the Greenbook strategies?

The National Council of Juvenile and Family Court Judges has distributed more than 22,000 copies of the Greenbook to judges, domestic violence advocates, child welfare workers and others around the country in response to numerous requests. The council will continue to make the Greenbook available and share the results of its work in order to help other communities better address the intersection of child maltreatment and domestic violence.

Reference

Extracted from The Greenbook Initiative website FAQ: http://www.thegreenbook.info/faq.htm

Resource

For more information about the Greenbook Initiative and to download a copy (in Adobe Acrobat format) of the Greenbook, go to http://www.thegreenbook.info/

Child Maltreatment in Drug-Endangered Homes

There are several aspects of child abuse and neglect in drug-endangered homes. The environments themselves are frequently so dangerous that simply allowing a child to live there constitutes child endangerment. Substance abuse also affects the caregiver's ability to parent, placing the child at additional risk for abuse and neglect.

It has been shown that a large portion (80-90 percent) of caretakers involved in the child welfare system for child abuse face substance abuse as one of their major personal issues. Substance abuse is believed to cause or exacerbate 7 out of 10 cases of child abuse and neglect. In fact, children whose parents abuse drugs and alcohol are three times more likely to be abused and four times more likely to be neglected (*No Safe Haven: Children of Substance-Abusing Parents*, The National Center on Addiction and Substance Abuse at Columbia University, January 1999).

Clandestine methamphetamine labs ("meth labs") create an environment that is so dangerous that some states have determined that allowing children to live in such residences even part of the time constitutes child endangerment/abuse/neglect. About 30-35 percent of meth labs seized are in residences where children live. Children are at an increased risk in a meth lab environment because of their physiologic status (higher rates of growth, metabolism, respiration and development) and their behaviors (hand-to-mouth behaviors and increased contact with their physical environment). At least two reports have demonstrated that 35-70 percent of children removed from labs have a urine drug screen that is positive for methamphetamine at the time of removal from the home.

The specific hazards to children living in these labs are numerous. The children are exposed to toxic chemicals and are at risk of inhaling toxic fumes. Clothing and skin contact with improperly stored chemicals, chemical waste dumped in play areas, and potential explosions and fires (the specific risks of the different chemicals are outlined in the Clandestine Lab section) also are possible. Children in these residences are frequently exposed to a hazardous environment, which often includes accessible drugs; exposure to drug users, cooks and dealers; hypodermic needles within reach of children; accessible glass smoking pipes, razor blades and other drug paraphernalia; weapons left accessible; and booby traps placed to "protect" the clandestine laboratory and its contents from intruders.

The use of illegal drugs or excessive amounts of alcohol affects the caregiver's judgment, rendering them unable to provide the consistent supervision and guidance that children need for appropriate development. Therefore, substance abuse in adults is a critical factor in the child welfare system. With specific reference to methamphetamine, children are frequently neglected during their caregiver's long periods of sleep while "crashing" from a drug binge. The caregivers also frequently display inconsistent and paranoid behavior, especially if they are using methamphetamine. They often are irritable and have a "short fuse," which may ultimately lead to physical abuse. Children in these homes often are exposed to violence and unsavory individuals. Unfortunately, these caregivers often were not parented well themselves and, therefore, did not learn effective parenting skills. Finally, the caregiver's ability to provide a nurturing home for a child is complicated by the caregiver's own mental health issues, which may have contributed to, or resulted from, substance abuse.

Children whose caregivers are substance abusers are frequently neglected. They often do not have enough food, are not adequately groomed, do not have appropriate sleeping conditions, and usually have not had adequate medical or dental care. These children are frequently not well-supervised, placing them at additional risk of injury. Children raised by substance-abusing caregivers

often are exposed to pornographic material, emotionally abused and have a heightened risk for sexual abuse. Additionally, they frequently do not get the appropriate amount of support, encouragement, discipline and guidance they need to thrive.

It is clear for many reasons that caregivers who are using illegal substances or excessive amounts of alcohol are not able to provide safe and nurturing homes for their children. It is for this reason that multiple agencies (law enforcement, fire departments, EMS, social services, the medical community, public health departments, the judicial system, legislators, substance abuse and mental health treatment providers, and our entire communities) need to work together to, first and foremost, assure that these children are safe and then work to break the cycle to improve the futures for our children, our families and our communities.

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Retrieved from http://www.colodec.org/decpapers/childabuseandneglect.htm, July 7, 2006.

The definition of child abuse includes any case in which, in the presence of a child, or on the premises where a child is found, or where a child resides, a controlled substance, as defined in Section 18-18-102(5), C.R.S., is manufactured or attempted to be manufactured.

National Protocol for Medical Evaluation/Child Protective Services

Personnel Decontamination:
Decontamination of the children should occur prior to transport to the medical facility, as medically appropriate. Removal of clothing, cleansing of the skin and hair, and replacement clothes are the minimum requirements of decontamination.

Emergency Activation:
Transport immediately to the emergency department by emergency personnel if there is an explosion, active chemicals at the scene, or the child appears ill, i.e., fast breathing, obvious burns, lethargy or somnolence.

Emergency Department

1. Complete medical evaluation to assess **acute medical needs.**
2. Devote specific attention to the pulmonary exam, as the chemicals can cause acute respiratory problems. Respirations at rest, oxygen saturation and a chest x-ray in the symptomatic child are the minimum required.
3. Blood tests as needed in addition to a complete blood count, chemistry panel to include blood urea nitrogen/creatinine and liver function tests.
4. Collect urine for toxicology. This should happen as soon as possible but **must** occur within 12 hours for optimal results. This should be submitted to a lab that screens and reports for the level of detection, **not** just at National Institute of Drug Abuse standards. Chain of evidence forms may be utilized or usual medical protocols for urine toxicology screens may be followed.

Law Enforcement

Immediate

1. Document the quantity and, types of chemicals present and document how found (e.g., uncapped, in tin cans) so that the exposure of the child can be determined. Document the condition of the home. Document odors and state of lab (actively cooking, decanting stage, drying stage, etc.) Document the people at the scene and those who also reside in the home.
2. Personnel on scene should be both clandestine lab—and Drug Endangered Children—certified in order to be able to accurately collect, document and photograph the scene to aid in the child endangerment prosecution (e.g., height of chemical, location of drugs, general state of children, guns and pornography).
3. Collect and submit all the required data for EPIC and/or other database collection.
4. Transport child as per local Drug Endangered Children protocol in conjunction with child protective services.

Within 72 hours

1. Children must be interviewed by personnel trained in the forensically correct method for children. Coordinate this process with child protective services.

Follow-up

1.Update databases as needed.

National Protocol for Medical Evaluation/Child Protective Services

MEDICAL PERSONNEL

Immediate

1. Medical personnel should conduct a head-to-toe exam of the children within 2 to 4 hours to ensure medical stability and document any acute findings that might need treatment or change over time. This may occur in an emergency department, physician's office or by emergency medical technicians on scene. This should include but not be limited to a good pulmonary exam, skin exam, neurologic exam and affect (scared, happy, detached). The exam may include observations by emergency medical technicians, RN on scene or other personnel to document the affect of the children.
2. Blood tests should include a complete blood count (anemia, cancers, thrombocytopenias), Chemistry Panel to include blood urea nitrogen/creatinine and liver function tests (kidney and liver damage, electrolyte imbalances). The blood test can be done acutely or within 72 hours.
3. Collect urine for toxicology. This should happen as soon as possible but must occur within 12 hours for optimal results. Submit urine to a lab that screens and reports for the level of detection, not just at the National Institute of Drug Abuse standards. Chain of evidence forms may be utilized or usual medical protocols for urine toxicology screens may be followed.

Within 72 hours

1. Do a complete medical evaluation as needed, based on the exam done at the first evaluation.
2. Order a blood test, if not done on the earlier exam.
3. Order Hepatitis B and C panels as indicated if Liver Function Tests are elevated.
4. Conduct a developmental evaluation using an age-appropriate standardized tool.
4. Conduct a mental health evaluation.
5. Conduct a dental evaluation.

Follow-Up

1. Repeat medical evaluation in 30 days, 6 months and 1 year.
2. Conduct follow-up developmental evaluations as needed, based on the initial evaluations.
3. Conduct follow-up mental health interventions and assessments as needed.

CHILD PROTECTIVE SERVICES

Immediate

1. Assist law enforcement in the collection and documentation of the scene from the child's perspective. Decide who will photograph scene.
2. Transport child as needed to facility as designated in your local Drug Endangered Children protocols.
3. Place children in a safe environment, as per local protocol.

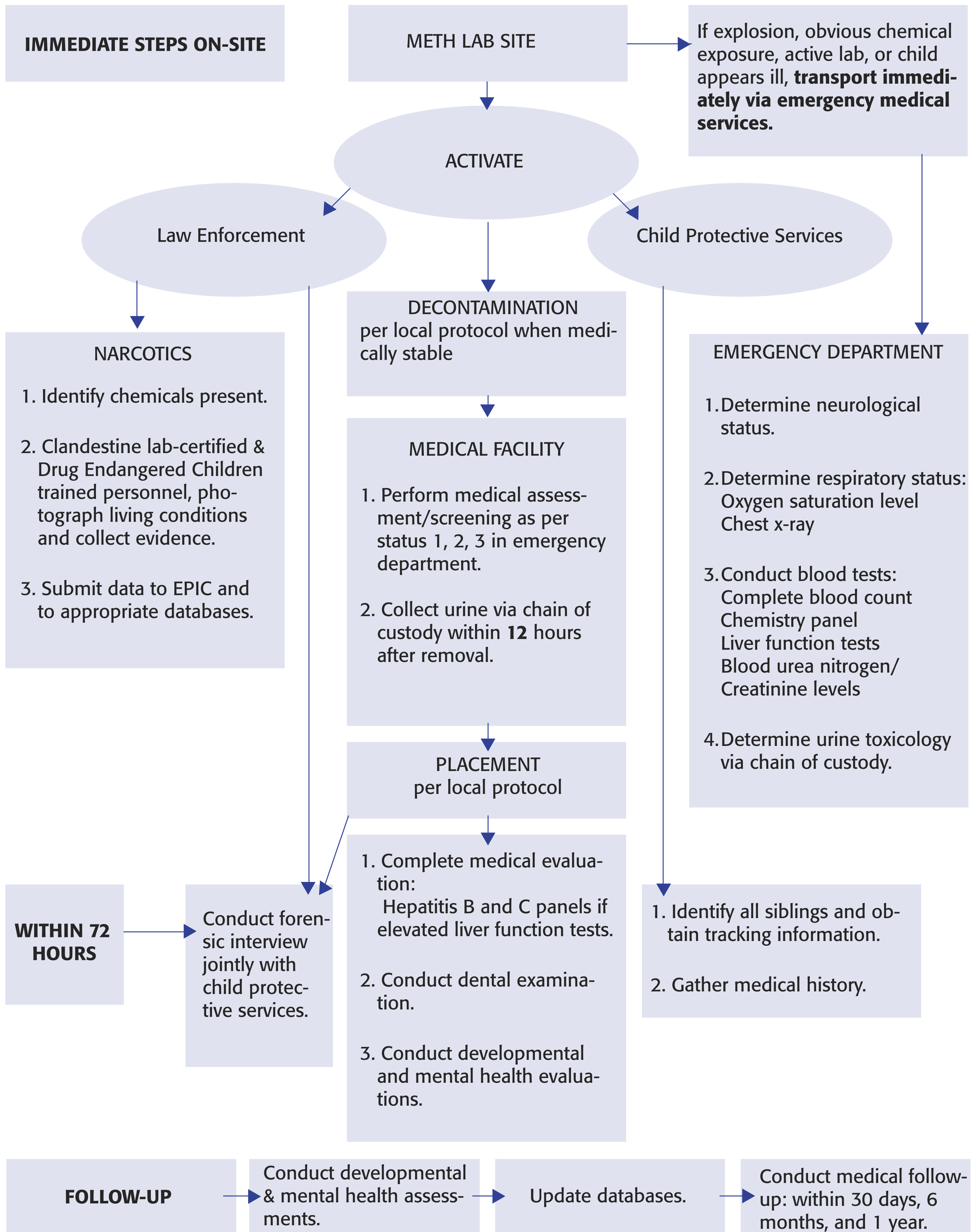
Within 72 hours

1. There may have been other children in the family or home who were not present at the time of the seizure. All children who have lived in the home must be examined and their information collected for tracking.
2. The medical histories of the children must be investigated and documented.

Follow-up

1. Input all the gathered information into a database as determined by the local, state and national protocols.

National Protocol for Medical Evaluation for Children



-Adapted from National Alliance for Drug Endangered Children, 2005

Detection Periods for Drugs of Abuse in Blood and Urine

Drug	Detection Period
Alcohol/Ethyl	3-10 hours
Amphetamines	2-4 days (depending on use)
Barbituates	Seconbarbital: 24 hours; Phenobarbital: 2-6 weeks
Benzodiazepines	3-5 days (heavy use: 3-6 weeks)
Cocaine	5 hours; Benzoylecgonine (cocaine metabolite): 2-4 days
Codeine	1-2 days
Heroin	1-2 days
Hydromorphone (Dilaudid)	1-2 days
LSD	8 hours
Methaqualone (Quaaludes)	2 weeks
Methadone (Dolophine)	2-3 days
Morphine	1-2 days
PCP	2-8 days
Propoxyphene (Darvon)	6 hours; Propoxyphene metabolites: 6-48 hours
THC Metabolite (Marijuana)	1 joint, urine: 2 days 3 times weekly, urine: 2 weeks daily, urine: 3-6 weeks; blood: 8 hours

Note: A urine test is the standard test for drugs; a blood test is standard for alcohol.

Retrieved from Medtox Scientific, Inc., St. Paul, MN: www.medtox.com

Colorado law determines that a child may be considered neglected or dependent if “the child tests positive at birth for either a schedule-I controlled substance, as defined in section 18-18-203, C.R.S., or a schedule-II controlled substance, as defined in section 18-18-204, C.R.S...” (CRS. 19-3-102(1)(g)). While alcohol is not considered a schedule-I or II controlled substance, ingestion of alcoholic beverages pose a significant risk to the developing fetus, especially during early in-utero development.

A report entitled, *Identifying, Reporting, and Responding to Substance Exposed Newborns: An exploratory study of Policies and Practices*, drafted by the National Abandoned Infants Assistance Center, describes a study that explored policies and practices related to the treatment of substance-exposed newborns at the time of delivery. Specifically, it presents the methodology, results from the study, and a discussion of policy and practice implications with regard to testing for illicit drugs and alcohol, informed consent, referrals to and response from Child Protective Services, prenatal intervention and substance abuse treatment. This report can be found at http://aia.berkeley.edu/media/pdf/rwj_report.pdf.

Fetal Alcohol Spectrum Disorders (FASD)

Background

Fetal alcohol spectrum disorders is an umbrella term describing a range of effects that may occur in an individual whose mother drank alcohol during pregnancy. Effects may include physical, mental, behavioral and/or learning disabilities with possible lifelong problems. This term is not intended for use as a clinical diagnosis. An individual would not receive the diagnosis of FASD, since diagnoses such as fetal alcohol syndrome (FAS), partial FAS and alcohol-related neurodevelopmental disorder (ARND) fall under the larger term FASD.

Statistics

- More than 60 percent of prisoners in U.S. prisons are likely affected by alcohol in utero.
- It costs $120,000 year to incarcerate a young offender and $82,000 to incarcerate an adult offender. Neurological damage is not cured in prison.
- Each year, 40,000 babies are born with fetal alcohols spectrum disorders, costing the nation about $4 billion.
- At least 5,000 infants are born each year with fetal alcohol syndrome; another 50,000 children show symptoms of alcohol-related neurodevelopmental disorder.
- Fetal alcohol syndrome, alcohol-related brain damage and alcohol-related neurodevelopmental disorder are widely underdiagnosed. Some experts believe that between one-third and two-thirds of all special education children have been irreversibly affected by alcohol in some way.

Fetal Alcohol Syndrome

This is the name given to a combination of mental and physical defects that are present at a baby’s birth and continue throughout the rest of the child’s life. The defects are a direct result of a woman drinking alcohol while she is pregnant. Even when a woman is in the earliest weeks of conception, a fetus is still susceptible to the effects of alcohol. Therefore, no amount of alcohol consumption is considered safe. Fetal alcohol syndrome is the leading known cause of preventable mental retardation.

Symptoms include

- prenatal alcohol exposure;
- growth deficiency less than 10th percentile (shorter size, underweight, small head, deformed fingers and toes);
- unique cluster of minor facial anomalies

(small eyes, smooth philtrum, thin upper lip) and physical malformations in the face and cranial areas;

- central nervous system damage (neurological, structural and/or functional impairment) that may result in learning disabilities and lower IQ;
- birth defects of the heart, brain, eyes, kidneys, ears and joints;
- behavioral and mental problems, which may progress into adulthood;
- permanent brain damage.

Other facts about fetal alcohol syndrome

- Fetal alcohol syndrome is a problem found in all races and socio-economic groups.
- Fetal alcohol syndrome produces irreversible physical and mental damage.
- The total lifetime cost per typical case of FAS for a child born in 1980 was estimated to be $596,000 (Stratton, K, et al., 1996).*Fetal Alcohol Syndrome: Diagnosis, Epidemiology, Prevention, and Treatment*, p.19 Institute of Medicine, National Academy Press, 1996.)
- Forty percent of children will not experience the full syndrome of fetal alcohol syndrome and will display only portions of the disorder.
- A significant percentage of those described as having learning disabilities and behavioral difficulties are believed to have alcohol-related neurodevelopment disorder (ARND).
- Behavioral and mental health problems of alcohol-exposed children can be just as severe as those of fetal alcohol syndrome children.
- Many children with fetal alcohol syndrome are not able to understand cause-and-effect relationships and long-term consequences.
- Many children with fetal alcohol syndrome are poorly coordinated, have short attention spans, are hyperactive and exhibit behavioral problems.
- Children with fetal alcohol syndrome and alcohol-related neurodevelopment disorder have been described as having similar behavioral characteristics. Many of the above-described difficulties of a fetal alcohol syndrome child also can be true for a child with alcohol exposure.
- Even one drink may risk an unborn baby's health.
- Fetal alcohol spectrum disorders can be completely prevented by a woman not drinking alcohol while she is pregnant.

Partial Fetal Alcohol Syndrome

This is a diagnostic classification for patients who present characteristics of fetal alcohol syndrome, but not all of the characteristics. Characteristics may include

- most, but not all, of the growth deficiency and/or facial features of fetal alcohol syndrome;
- central nervous system damage (structural, neurological and/or functional impairment);
- prenatal alcohol exposure.

Alcohol-Related Neurodevelopmental Disorder (ARND):

Alcohol-related neurodevelopment disorder is a lesser set of the same symptoms that make up fetal alcohol syndrome. This is a diagnostic classification coined by the Institute of Medicine in 1996 for patients who present with

- central nervous system damage (structural, neurological and/or functional impairment);
- prenatal alcohol exposure.

Fetal Alcohol Effects (FAE)

This is a term introduced in 1978 to describe abnormalities that were compatible with those caused by prenatal alcohol exposure, but a pattern was not complete to render a diagnosis of fetal alcohol syndrome. (This term

is not used by the Fetal Alcohol Spectrum Disorder Diagnostic Code).

Terms used in lieu of ARND or FAE

Static Encephalopathy (alcohol exposed): The term, "encephalopathy" means "any significant condition of the function or structure of the brain tissues" (Anderson, 2002). "Static" means abnormalities in the brain are unchanging; neither progressing nor regressing. Symptoms present include

- central nervous system damage (structural, neurological and/or significant functional abnormalities);
- prenatal alcohol exposure.

Neurobehavioral Disorder (alcohol exposed): A diagnostic outcome for patients with

- central nervous system dysfunction (mild functional impairment with no evidence of structural or neurological abnormalities);
- prenatal alcohol exposure.

Outcomes such as alcohol-related neuro-development disorder, static encephalopathy and neurobehavioral disorder are far more prevalent than fetal alcohol syndrome or partial fetal alcohol syndrome.

In general, the central nervous system damage/dysfunction observed in individuals with alcohol-related neuro-development disorder or static encephalopathy (alcohol exposed) are frequently as severe as those observed in individuals with fetal alcohol syndrome.

Retrieved from FAS Diagnostic and Prevention Network, University of Washington, Seattle: http://depts.washington.edu/fasdpn/

References

Stratton, K, et al., (1996). *Fetal Alcohol Syndrome: Diagnosis, Epidemiology, Prevention, and Treatment*, p.19 Institute of Medicine, National Academy Press, 1996.)

Drescher-Burke, K. and Price, A. (2005) *Responding to Substance Exposed Newborns: An Exploratory Study of Policies and Practices*. Berkeley, CA: The National Abandoned Infants Assistance Resource Center.

Section Notes: