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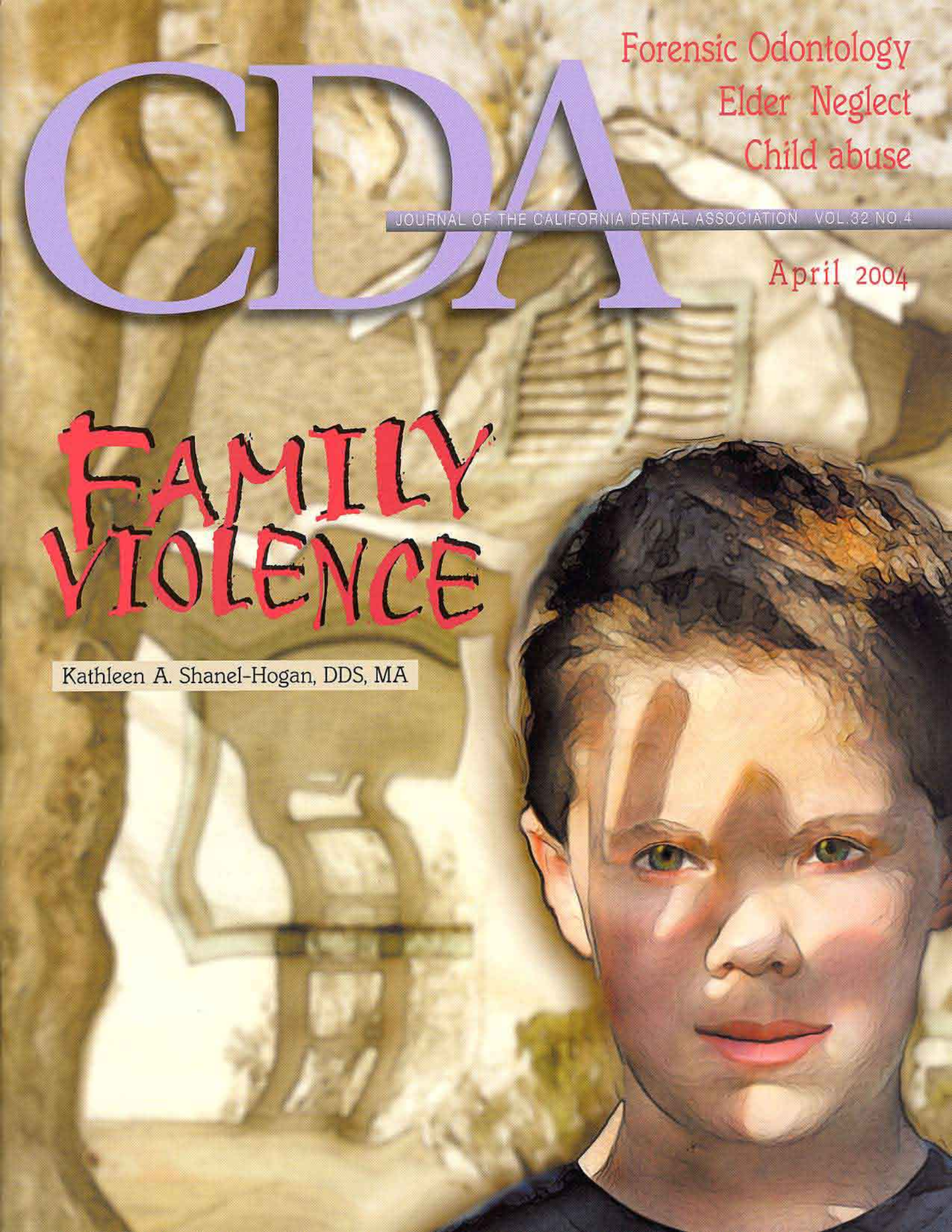
Forensic Odontology
Elder Neglect
Child abuse

FAMILY VIOLENCE

Kathleen A. Shanel-Hogan, DDS, MA



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Leadership Revisited

There is a new momentum at the California Dental Association these days that has not been witnessed for quite some time. At the center of this movement is leadership. Combine the leadership skills of CDA administrative staff and volunteers with the active participation of local staff and leaders in the component dental societies, and you have the ingredients in place to successfully pursue the desired outcomes outlined in the vision and goal statements in the Strategic Plan of the association.

A discussion on leadership is particularly relevant at this time because of two recent events which illustrated the potential for an inspired leadership, and provided some early results illustrating the new energy referred to at the outset of this commentary. The first event was the Annual CDA Leadership Conference attended by CDA and Component Society leaders, and the latter was the Spring 2004 meeting of the CDA Board of Trustees that immediately followed it. Both events demonstrated to this observer some new opportunities and approaches that will assist the profession if it is to successfully negotiate the increasingly more complex social environment which it will face as the future unfolds.

Let's be specific. The conference commenced with a keynote address by noted Leadership and Management Consultant Lance Secretan entitled "Inspire! What Great Leaders Do." His definition of leadership is worth repeating here. "It is a serving relationship with others that inspires their growth and makes the world a better place."

If we replace the reference to "the world" with "the organized profession," we can anticipate that inspired leadership activity will lead to the successful achievement of the goals that the membership expects in return for their membership support. And, according to Secretan, a major step for great leaders is "creating an environment (i.e. the dental profession) that encourages followers to inspire their leader(s)." From long experience, we believe that such an environment is extremely important to motivating leadership to pursue goals with enthusiasm. They must receive support and inspiration from those they serve if they are to remain motivated and inspired to continue their effort.

Secretan ended his presentation with a quotation attributed to noted comedian Lily Tomlin who characterized the "solo" nature of the dental profession as many of us have known it, as well as any non-dentist could. "We are all in this together ... by ourselves!"

It underlined the necessity of individual professionals working together, and inspiring one another if desired outcomes are to be attained.

The conference featured a number of important and well-received breakout sessions, some of which were specific to those in leadership positions. One session that had a more universal application to membership beyond the ranks of leadership was titled "Recruit and Motivate Volunteers." It sought to inform leadership of the differences between genera-

"We are all in this together ... by ourselves!"

"Passion is your calling in life, and where there is passion, excellence is not far behind."

tions of dentists and how these generational groups might be best motivated to serve in leadership roles in the profession. Cynthia Brattasani, DDS, identified many of the characteristics that differentiate the newer generations in our profession from the more established older generation. She provided suggestions on how leadership activities might be modified to best accommodate the interests and needs of current and future new leaders.

Natasha Lee, DDS, a 2000 graduate who has established her practice in San Francisco, currently serves on the American Dental Association Committee on the New Dentist. In this same session, she provided a personal look at the significant financial burden that many, if not most new dentists face as they enter the profession and establish a practice. For established practitioners who have not been familiar with the escalating costs of education and establishing a new practice, her data on new practitioner indebtedness must have been an "eye opener." The information she provided needs to be understood by those who lead at all levels within the profession if dentistry is to properly set its priorities and engage new dentists in the important work of the profession.

A final presentation by Gary Zelesky, a professional speaker and writer, emphasized a characteristic we have found to be present with many outstanding dental colleagues over time. While he intended his comment as a "service" leadership attribute, we have also seen it in successful practitioners who lead in the profession through sharing their expertise on treatment techniques and procedures. His admonition was "Passion is your calling in life, and where there is passion, excellence is not far behind." We have found the latter characteristic a much sought after achievement by many in this profession.

The CDA Board of Trustees commenced shortly after the conclusion of the leadership conference. For those trustees who had attended the conference, perhaps there was more inspiration than there might have been previously. And, maybe the structural reorganization of CDA staffing by Executive Director Peter Dubois had increased the excitement (and perhaps the level of inspiration) of board members as they settled into the agenda ably led by CDA President Dr. Debra Finney. The board proceedings that followed underlined the wisdom of Mr. Dubois' reorganization that had as its objective, increased productivity by staff to make them more responsive to member needs.

Feedback from members during our history with the association has often offered the criticism that CDA has too often been reactive, rather than proactive in dealing with legislation, regulation, or policies of outside agencies that seem to negatively impact the practice of dentistry. There has also been a belief that the working relationships with the ADA on some major issues that either happen first in California or are unique to the profession here, have not been explored to the mutual benefit of the association or their members. Board decisions on some key initiatives emphasized the notion that there is a momentum building that demonstrates what the largest constituent dental association in the ADA is capable of accomplishing in the days ahead.

Examples:

1. The board allocated funds for the purpose of participating in a coalition to defeat any proposed split-roll tax initiative. A proposed initiative for the November 2004 statewide ballot would increase the tax rates imposed on commercial property by 55 percent. Any commercial property tax increase would have adverse effect on dental providers whether they own their building in which they practice or whether the tax is passed to dentists through lease or rental fees. The potential impact was estimated to be several thousand dollars per practice per year. This clearly is a proactive effort that seeks to prevent an additional future burden on practitioners.

2. The board approved start up funding and support for a California Clinical Research Collaborative with the five California dental schools. CDA will facilitate the startup of the collaborative and the CDA Foundation will be the granting agency and fiscal administrator for the collaborative. Pursuit of the federal grant to support this research is certainly in the best interest of discovering enhancements in the future of clinical practice. In a separate action, the board approved the funding of an amalgam-related analysis with the American Dental Association. Again, we see evidence of proactive effort aimed at finding answers and discoveries important to the future of the profession as opposed to waiting for outside interests to dictate our future. Continuation of a closer relationship that has been forged between the ADA and its largest constituent, CDA, will be of significant importance to organized dentistry.

3. As readers of this publication will recall, there has been significant discussion in the recent past about administrative problems with the California Licensure Exam. House of Delegates actions have resulted in the appointment of a Task Force on Licensure that will be deliberating on possible solutions this year. However, the deans of the California dental schools believe that current problems with the examination have resulted in a crisis that requires immediate attention. They requested and received the support of the Board of Trustees for their effort to have the Western Regional Exam Board (WREB) recognized as an examination alternative or option to the Dental Board of California examination for those seeking licensure in California. This is another proactive action because efforts are aimed to produce a short-term remedy for this problem before it escalates and negatively impacts the lives of new dentists seeking to be licensed in California

We believe that the type of recent actions specifically cited illustrate a new momentum that was felt by leadership during the most recent Board of Trustees meeting. There is a new inspiration felt from the top that has motivated the trustee leaders. As was pointed out in the conference presentations by Secretan and Zelesky, if these kinds of decisions successfully benefit the membership and are appreciated by the membership, it should result in the transfer of further inspiration and passion back to the leadership. That should further stimulate progress on other membership issues and needs by staff and association leadership. CDA

There is a new inspiration felt from the top that has motivated the trustee leaders.

Anaheim cda

Spring Scientific Session Held in Anaheim

The CDA Spring Scientific Session has it all. Held Thursday, April 15 through Sunday, April 18 at the Anaheim Convention Center, the 2004 event features a wide range of continuing education programs, networking opportunities and exhibits.

Twenty-five scientific workshops will be held during the four-day Session. Topics range from infection control, gold restorations and forensic dentistry to California law, veneers and periodontics.

The event kicks off 8 a.m. Friday, April 16 at the Anaheim Hotel with Opening Session and breakfast honoring the dental team. Former schoolteacher Erin Gruwell will talk about the power of determination and how it helped many of her students, who had been written off by the education system, succeed.

Her work with students has been pub-

lished in *Freedom Writers' Diary — How a Teacher and 150 Teens Used Writing to Change Themselves and the World Around Them* — and will be made into a major movie with filming starting later this year.

Gruwell, awarded the Teacher of the Year Award by the California Commission on Teacher Credentialing, is founder and president of the Tolerance Education Foundation, a non-profit organization dedicated to teaching tolerance and funding college scholarships to underprivileged students.

Admission is free to members and paid registrants. Seating is limited to first-come, first-served.

On Saturday, April 17, The Bacon Brothers will perform at the House of Blues Anaheim, located in the Downtown Disney District. Actor Kevin Bacon and his brother Michael have emerged as one of the hottest bands in the country. Their music is a mix of soul, rock, folk and country. The show starts at 7:30 p.m. Tickets are $40 and include appetizers, one drink and an all-day pass on the Anaheim Resort Transit.

This year's special events feature a hands-on gourmet cooking course and a painting workshop for adults.

The cooking class is from 10 a.m. to noon Friday, April 16 at Mr. Stox Restaurant. Lunch follows noon to 2 p.m. Cost is $130 and includes recipes, personalized chef hats, menus and transportation.

The "You Can Paint" workshop is held from 9 a.m. to noon for adults and 2 to 4 p.m. for children. The course, taught by husband and wife artists, helps participants discover the joy of oil painting. Cost is $70 for adults and $30 for children. Price includes paint supplies, lesson plan and specially designed box to transport the painting.

(The deadline to register for these events was March 3. If openings are still available, the activities are subject to on-site registration fees.)

Throughout Spring Session, the CDA Foundation will host a silent auction and raffle. Items ranging from sports memorabilia to travel-related gift certificates and wine will be on display in Exhibit Hall D. Members are encouraged to view the items while visiting the exhibits. Proceeds from the auction and raffle help benefit Foundation programs including scholarships, improving access to care and health policy research.

Oral Problems More Prevalent with the Elderly

U.S. Surgeon General Richard Carmona, MD, recently told the Senate Special Committee on Aging that the elderly face far more oral health issues than other age group.

"Seniors by the very nature of their life span are more prone to chronic, disabling diseases and conditions; are more apt to be on regimens of daily medications; and have a greater likelihood to be low-income than other adults," Carmona said. "These factors and others have a profound effect on their oral health."

Among the health problems Carmona said the elderly face: higher rates of oral and pharyngeal cancers, with those over the age of 65 seven times more apt to be diagnosed with oral cancer than their younger counterparts; an estimated 30 percent of seniors over the age of 65 have lost all their teeth; an increased occurrence of periodontal infections; and more frequent incidences of xerostomia and dental decay as a result of medications that have a side effect of reducing salivary flow.

Additionally, more older Americans pay out of pocket since employment-based dental coverage ends when they stop working, and Medicare, except in very few cases, does not include dental care service. And since a majority of seniors live on a limited income, the elderly are more likely to forgo dental visits. Finally, studies have shown potential links between oral infections and systemic diseases such as respiratory infections, diabetes and heart disease.

Organization Seeks Public Comment on Plan for Underserved Communities

The National Institutes of Health is accepting input from the public on its health disparities research agenda.

"Despite tremendous medical advances and improved public health in America in recent decades, African Americans, Hispanics, American Indians, Alaska Natives, Asian and Pacific Islanders, and other medically underserved communities continue to suffer an unequal burden of illness, premature death and disability," said Elias A. Zerhouni, MD, National Institutes of Health director. "In developing and updating the Strategic Plan to eradicate these health disparities, the NIH affirms its ongoing commitment to biomedical research discovery that will ensure improved health for all Americans."

The National Center on Minority and Health Disparities (NCMHD) developed the plan with the NIH Office of the Director, other NIH institutes and centers, and the National Advisory Council on Minority Health and Health Disparities.

"The Strategic Plan defines a broad framework for future efforts of research partners throughout the country to advance scientific knowledge that will improve diagnostic, treatment, and prevention strategies for reducing and eliminating the health disparities afflicting racial and ethnic minority populations and other health disparities populations across the nation," said John Ruffin, PhD, minority and health disparities director.

Ruffin also noted "the genesis of health disparities is multifactorial and requires a coordinated interdisciplinary effort. The Strategic Plan reflects the ongoing commitment of a strong research alliance that is necessary to eliminate health disparities. At the heart of this coalition of NIH Institutes and Centers are our constituencies. Their input is essential to our success in identifying innovative and diverse approaches to eliminate health disparities."

The NCMHD will lead, support, assess and coordinate the effort to decrease and eliminate health disparities. The organization conducts basic social, behavioral and clinical research; supports research training and infrastructure; as well as promotes emerging programs and distributes health information.

The Strategic Plan's three main goals are:

Research — to investigate the development and progression of diseases and disabilities causing disparities in the health of minorities and other populations;

Research Infrastructure — to boost minority health and health disparities career development, research training, and institutional capacity; and

Public Health and Community Outreach — to guarantee the research, healthcare professionals and public communities are educated about the advances in health disparities research.

The "NIH Strategic Research Plan and Budget to Reduce and Ultimately Eliminate Health Disparities, Fiscal Years 2002-2006" currently is on the NCMHD Web site, http://www.ncmhd.nih.gov. Comments also can be sent to the Strategic Plan Review Group, NCMHD, 6707 Democracy Blvd., Suite 800, Bethesda, Md., 20892-5465, or e-mailed to NIHHealthDisparitiesPlan@mail.nih.gov. NCMHD is a component of the National Institutes of Health within the Department of Health and Human Services.

"Despite tremendous medical advances and improved public health in America in recent decades, African Americans, Hispanics, American Indians, Alaska Natives, Asian and Pacific Islanders, and other medically underserved communities continue to suffer an unequal burden of illness, premature death and disability."

ELIAS A. ZERHOUNI, MD

National Institutes of Health director

Evidence-Based Dentistry, Part II

Note: *In 2002, the CDA House of Delegates ratified a resolution establishing an evidence-based dentistry (EBD) action plan that included the formation of a task force to recommend to the Board of Trustees and then implement programs related to evidence-based dentistry. The task force — made up of a membership of James Freed, DDS; Emilio Garcia, Jr., DDS; Raymond Pedersen, DDS; Michael Perry, DDS; and chaired by Richard Kao, DDS, PhD — met last fall to establish a definition of evidence-based dentistry for CDA, establish recommendations to monitor EBD efforts within the Association, and to suggest elements of a communication effort on EBD among CDA's membership. This article, the second in an occasional series, is a conversation with Dr. Kao on the nature and significance of the evidence-based dentistry definition adopted by the task force.*

Q. In some discussions about evidence-based dentistry, there's an impression that it will ultimately provide a "cookbook" approach to the practice of dentistry. Is this necessarily the case?

A. Many research designs and reviews by various groups like the Cochrane Group are looking for a "yes" or "no" approach to a specific question about treatment. Unfortunately, clinical dentistry requires a bit of "fuzzy logic," where clinical experience and patient preferences fine-tune the path that might be suggested by sound evidence. In an evidence-based practice, it is the responsibility of the practitioner to maintain a reasonable appreciation and awareness of the body of scientific literature, and to appreciate the informed patient's preferences. In terms of reasonable appreciation and awareness of the literature, the focus should be on thorough and balanced reviews. In regard to the scientific literature, the EBD task force members recognize, for example, that it is common to find 10 different studies citing 10 different "best practice" approaches in regard to a particular treatment path. Where there is a diversity of conclusions in the literature, the individual dentist must exercise his or her professional experience and judgment to decide which approach would be most appropriate. Given the fact that individual dentists have varying professional experiences, and patients may have varying preferences, it is unlikely a rigid "cookbook" approach can be taken toward treatment and called "evidence-based dentistry." Given the dynamic of how scientific evidence is interpreted and presented, the experience of the clinician, and the individual patient's preference, the evidence-based approach will result in a treatment answer that is not absolute, but has "shades of gray." In this case and it is the clinician's job to choose the best treatment approach.

Q. There's a fear that "evidence-based" treatment options will be used by third-party payers to ration treatment or to restrict payments on traditional and common dental treatments — to use EBD as a means of cutting costs. Is this a legitimate fear, and how does the CDA task force's definition of EBD address this fear?

A. As previously mentioned, one concern is the misuse of EBD. It is possible for selective filtering of the scientific evidence by third-party payers as a mean of defining benefit policies. This abuse is also possible in the marketing of dental products, as I've mentioned. But this approach to, or use of, evidence is contradictory to the concept of EBD. In terms of scientific evidence, there is often a variety of evidence justifying a variety of approaches. Complicating our appreciation of the body of evidence is the fact that we have very little information in regard to long-term outcomes of a procedure, technique, or materials (e.g., how long will a particular restoration last?), and the extent of patient satisfaction with various treatment approaches. Until we have more studies that fulfill these criteria, and have reviews that are more balanced, scientific evidence should be viewed as important, but that its interpretation may at times be inaccurate. Even more important is the fact that these abuses ignore the definition of EBD in that there is a tendency to discount or ignore the patient's desire and the clinician's expertise. In the definition of EBD put forward by CDA's task force and by the ADA, only the clinician is in a position to design a treatment plan that incorporates years of clinical experience, the findings of credible research, and the preference of the patient. Third-party payers may structure benefit designs around "research," but only the dentist can practice "evidence-based dentistry."

Q. In practice, how should a dentist proceed if the treatment direction indicated by one element conflicts with the other two, or if all three elements conflict?

A. A dentist should never design a treatment plan that contradicts the consensus findings of "good science" and research. Again, however, in the real world, there will often not be one obvious treatment course. There may be a number of different treatment approaches, different techniques, or different materials that will achieve the objective of proper care for the patient's condition, and the body of credible research may

support a variety of approaches, techniques, and/or materials. It is then the dentist's role to decide what the best approach is, as long as the patient agrees with the dentist's recommendation. Of course, if the clinical experience of the dentist and the consensus of research agree on a particular treatment path, and the patient disagrees, then it falls upon the dentist to educate the patient about the advisability or wisdom of their preference. If a patient will not yield to sound evidence and the judgment of their dentist, the issue then becomes one of ethics: Should a dentist proceed with a treatment plan that has not been agreed to by the patient? The dentist may have to release the patient from his or her care. Or it may simply mean that the dentist refer the patient to a specialist who may take a different approach to whatever condition needs treatment. But according to our definition of "evidence-based dentistry," where there is no consensus when factoring together treatment experience, the body of research literature, and the wishes of the patient, the professional judgment of the dentist must then weigh more significantly in the equation — within the bounds of what is ethical in terms of the patient's desires.

Q. What will CDA do to promote the concept of EBD?

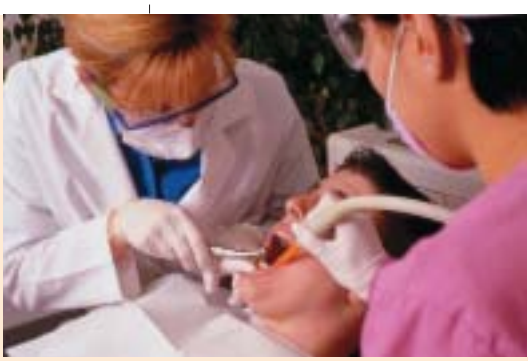
A. CDA's EBD Task Force has with this article, initiated a series to educate members about the nature, uses, benefits, and potential abuses of evidence-based dentistry. The objective of this series will be to promote CDA's definition of evidence-based dentistry within the profession, the payer industry, academia, and among the public; and to educate members to create a sense of comfort about the positive aspects and application of EBD to their practices.

The EBD Task Force will also be considering future recommendations of educational programs on evidence-based dentistry provided by CDA, or in cooperation with California's dental schools.

Dr. Richard Kao is a practicing periodontist in Cupertino, Calif., and is chair of the Council on Dental Research and Developments. *Dr. Kao acknowledges Drs. James Freed, Emilio Garcia, and Raymond Pedersen, and CDA staff Teresa Pichay and Greg Alterton for their assistance.*

In the definition of EBD put forward by CDA's task force and by the ADA, only the clinician is in a position to design a treatment plan that incorporates years of clinical experience, the findings of credible research, and the preference of the patient.

No Link in Dental Amalgam-Disease Claim



A recent review confirmed there is "no connection" between neurodegenerative diseases and mercury in dental amalgam.

In the New England Journal of Medicine, world-renowned mercury toxicology experts wrote in their October 2003 review article that there is "no clear evidence supporting the removal of amalgams."

According to authors, there are three main causes of mercury exposure to the general population: dental amalgam fillings, fish consumption, and thimerosal-containing vaccines. Thimerosal is a mercury-based preservative.

Urinary mercury concentrations in patients with amalgams are estimated at two to four micrograms per liter "well below" the 20- to 50-microgram level found in individuals with occupational exposure. But even at elevated levels associated with occupational exposure, symptoms are mild and cases may be reversible.

While claims have fueled public speculation and concern that long-term exposure to low concentrations of mercury vapor from amalgams can cause or worsen neurodegenerative illnesses such as Parkinson's and Alzheimer's, and amyotrophic lateral sclerosis, epidemiological investigations have not provided proof that amalgam has a role in these diseases.

However, "Cyanide and carbon monoxide are continuously synthesized in the body, proving that even the most toxic compounds have a limit below which they are not toxic," said Lazlo Magos, MD, review co-author.

Toxicity is more of a dose-dependent question, Magos said. "Even essential elements can be toxic when intake (or body burden) exceeds a certain level," he says. "You can kill a person by oversaturating the ambient air with oxygen or forcing large volumes of water in the stomach."

Magos' fellow authors also concluded that "patients who have questions about the potential relation between mercury (dental fillings) and degenerative diseases can be assured that the available evidence shows no connection."

Blood Test May Correlate to Oral Health

Researchers recently discovered that a blood test often given during a routine medical checkup can point to the status of one's oral health.

"In this study we found that generally if the blood was 'healthy,' the oral health was also healthy. Conversely, if the blood test detected certain 'red flags,' the person also had serious symptoms of periodontal diseases," said Dr. Yuko Takami, Department of Preventative Dentistry and Dental Public Health, School of Dentistry, AichiGakuin University, Japan.

The study was published in the *Journal of Periodontology*.

"We also found that males were reported to have more serious symptoms of periodontal diseases than females of the same age group," Takami said.

Researches examined and measured the oral health of nearly 7,500 women and men, and tested their blood for 37 items used in general blood tests such as diabetes and C-reactive protein (CRP) and cholesterol, which typically is linked to heart disease. The blood test results then were compared to the participants' oral health scores.

"These findings mean that in the future when patients visit their medical doctors for a routine check-up and annual blood work, they may also be referred to a periodontist for a periodontal screening if the blood indicates systemic abnormalities," said Michael P. Rethman, DDS, MS, and president of the American Academy of Periodontology.

It remains unknown as to why men reported to have more serious symptoms of periodontal disease than women. Additionally, the only item from the test that showed a significant relationship with periodontal diseases in women was CRP. It is speculated than women and men have differing endocrine situations. Endocrine conditions can influence periodontal diseases.

"With each study that looks at the association between systemic and periodontal diseases, we learn more about the CRP correlation," Rethman said. "Another study in this *JOP* issue reinforces previous studies indicating a relationship between CRP elevation and periodontitis.

Researchers compared the values before and after treatment. What they found was that CRP values dropped considerably following periodontal treatment.

"Since the treatment of periodontitis in this study appears to be effective in reducing levels of CRP, patients at risk for coronary heart disease may want to visit a periodontist to control their periodontitis," Rethman said.

Upcoming Meetings

2004

April 15-18	CDA Spring Scientific Session, Anaheim, (866) CDA-MEMBER (232-6362).
April 27-May 2	American Academy of Cosmetic Dentistry's 20th annual Scientific Session, Vancouver, British Columbia, www.aacd.com.
June 24-26	ADA 18th annual New Dentist Conference, San Diego, (312) 440-2779, www.ada.org/goto/newdentconf
Sept. 8-11	International Federation of Endodontic Association's sixth Endodontic World Congress, Brisbane, Queensland, Australia, www.ifea2004.im.com.au.
Sept. 10-12	CDA Fall Scientific Session, San Francisco, (866) CDA-MEMBER (232-6362).
Sept. 30-Oct. 3	ADA Annual Session, Orlando, Fla., (312) 440-2500.

To have an event included on this list of nonprofit association meetings, please send the information to Upcoming Meetings, *CDA Journal,* P.O. Box 13749, Sacramento, CA 95853 or fax the information to (916) 554-5962.

Anaheim cda

Kathleen A. Shanel-Hogan, DDS, MA, will present "Dental Professionals Against Violence" during CDA's Spring Scientific Session in Anaheim, Calif. The presentation will be held from 10:30 a.m. to 1 p.m. Friday, April 16 in Huntington Rooms A/B/C at the Hilton. A repeat presentation is from 2:30 to 5 p.m.

A Health Issue That Affects Us All

Kathleen A. Shanel-Hogan, DDS, MA; Jon R. Roth, MROD, CAE; Marianne Balin, MPH

Family violence exists in every city, every neighborhood, and every community. It is often a silent cycle of physical, emotional, verbal, and financial abuse that leaves its victims feeling trapped and helpless. Because 65 percent of all physical child abuse and 75 percent of all physical domestic violence results in injuries to the head, neck, and/or mouth, the dental professional is often the first person to render treatment to abuse victims as well as being their first line of defense. Even when victims of violence avoid seeking medical attention, they will keep routine and emergency treatment dental appointments. Dentists, registered dental hygienists, and registered dental assistants are designated by law as mandated reporters in the State of California to report suspicions of abuse and neglect in patients. Dental professionals and allied personnel must report domestic violence physical assault cases in addition to suspected child abuse/neglect and elder abuse/neglect cases.

The April and May issues of the *Journal of the California Dental Association* are dedicated to family violence prevention. The April issue is focused on child abuse/neglect and elder and dependent adult abuse/neglect. The May issue will focus on domestic and intimate partner violence. Articles address frequent questions the dental community asks such as:

"Why should dental professionals get involved?"

Author / Kathleen A. Shanel-Hogan, DDS, MA, is a consultant, educator, facilitator and family violence prevention advocate. She works with the California Dental Association Foundation as a consultant and a mandated reporter trainer in all forms of family violence (child abuse/neglect, domestic violence, elder abuse/neglect). She is author of the Dental Professionals Against Violence Program, and testified on behalf of dentistry at the California Assembly Select Committee On Domestic Violence Hearing "Domestic Violence As A Public Health Issue." She participates on many California statewide committees on family violence prevention. Dr. Shanel-Hogan has experience in private practice and hospital dentistry with medically compromised patients.

Jon R. Roth, MROD, CAE, is executive director of the California Dental Association Foundation.

Marianne Balin, MPH, directs programming and philanthropy focused on the prevention of domestic violence for the Blue Shield of California Foundation.

The victims of abuse often speak to us in non-verbal language through signs and symptoms.

"What can we see in our dental examinations?"

"What is it like to make a mandated report?"

"How can I get reimbursed for care of victims of violence?"

"What happens once a mandated report is made?"

"What is the impact of domestic violence on children?"

In 2001, the California Dental Association Foundation (CDA Foundation) was established to promote the total health of Californians through oral health disease prevention, risk assessment and treatment initiatives. As the charitable arm of the CDA, the Foundation desires to expand healthcare and other California mandated reporter groups' knowledge of abuse and neglect that involves clinical implications for the oral and maxillofacial structure. Through a strategic partnership with, and generous funding from Blue Shield of California Foundation and Dental benefit pro-viders the Dental Professionals Against Violence (DPAV) program was created. This program is the next generation of the PANDA and CDA Abuse Detection and Education Program present in California since 1994.

DPAV consists of both Train-the-Trainer and direct provider training programs designed to assist dental professionals and their teams in recognizing and responding to child abuse/ neglect, intimate partner violence, and elder abuse/neglect. The goals are to raise the dental community's awareness of family violence using the most current information regarding patient risk assessment, clinical signs and symptoms, and dental professional's legal obligation to identify and report elder, child and intimate partner abuse. The program includes definitive action steps for dental professionals to use in their practices and communities. Two DPAV programs kick off this year (10:30 a.m. to 1 p.m., with a repeat program 2:30 to 5 p.m.) at CDA's Spring Scientific Session in Anaheim on Friday, April 16.

DPAV also created an educational poster for the dental office to place in the back office to assist the team in recognizing and responding to abuse and neglect in their practices. This poster is included in this issue of the *Journal*. To obtain additional free copies and/or to learn more about what your organization can do to respond to family violence, call the CDA Foundation Dental Professionals Against Violence Coordinator at (916) 554-4921, ext. 8900.

Involvement of dental professionals in the community effort to foster change in family violence can make an important difference by increasing the awareness of how to detect abuse, especially oral abuse, and to join the community effort. Community capacity to prevent abuse and neglect depends on the communication and collaboration of the entire community. Dentistry is prepared and willing to be collaborative partners with other healthcare providers, agencies, institutions, and policy makers in addressing domestic violence and family violence as a healthcare issue. The effect will be to positively impact children and their families. The victims of abuse often speak to us in non-verbal language through signs and symptoms. We have the opportunity to become their voice. We can make a difference. Now is the time. Family violence is not just a social issue; it is a health issue that affects us all.

CDA

Forms to report abuse/neglect

Copies of forms to report suspected child abuse/neglect and elder/dependent adult abuse/neglect are included in this issue. These can be used as a "working draft" of the report form to assist the mandated reporter in collecting the information in an organized manner. It becomes much simpler to transfer information from the "working draft" to the formal report.

The actual child abuse/neglect and elder/dependent adult abuse/neglect forms are in NCR format. Please contact the California Department of Justice Bureau of Criminal Identification and Information, P.O. Box 90317, Sacramento, Calif., 94203-4170 to obtain actual forms.

Elder Abuse Form
http://www.dss.cahwnet.gov/pdf/SOC341.PDF

Child Abuse Form
http://www.caag.state.ca.us/childabuse/forms.htm

Domestic Violence Form
http://www.ucdmc.ucdavis.edu/medtrng/domain/Suspect_Violent_Injury.pdf

Child Abuse: Dentists' Recognition and Involvement

Duane E. Spencer, DDS

Duane E. Spencer, DDS, will present "Forensic Dentistry: A California Perspective" with James Wood, DDS, at CDA's Spring Scientific Session in Anaheim, Calif. The presentation will be held from 2 to 4:30 p.m. Thursday, April 15 in Rooms A/B at the Anaheim Convention Center.

ABSTRACT

Children in our society are too often maltreated by adults in their lives. These adults may be their parents, caretakers, youth leaders, coaches or perhaps even a health care provider. Children become missing daily in the United States, perhaps running away or being abducted. Occasionally, abductions lead to tragic conclusions. This paper will cover the dental staff's involvement with a physically abused child including documenting suspected injuries, the dentist's responsibility in maintaining good records in case a young patient should go missing, and the role of the forensic dentist with patterned injuries of abusive origin.

PURPOSE OF PAPER

The purpose of the paper is to again remind dentists and their staffs as to the importance of recognizing possible child abuse with their young patients. Reasons for and methods of documenting physical injuries such as bruising are important for the dentist to understand. The paper also relates the role of the dentist in the forensic field with abusive patterned injuries, reasons for a dentist to refer a young patient to a pediatric dentist rather than subjecting the child to uncomfortable treatment, and the importance of the dentist having good dental records on file for the potential forensic identification of a child.

Child abuse is common in American society. Maltreatment of infants and children has been traced far back in history and, tragically, it is still too prevalent in our "modern" world. Good efforts have been made in the U.S. in recent decades in the areas of child abuse recognition and prevention (**Figure 1**). Many dedicated people today work diligently and tirelessly to educate not only mandated reporters of child abuse but the general public as well. This article will discuss some areas of dental involvement in recognizing child abuse, which should be of interest to those dental staff members who provide dental services to children and teens.

A Serious Concern

In 2001, three million referrals were made in the U.S. to Child Protective Service (CPS) agencies. Of these, approximately 903,000 children were listed as victims of maltreatment. Nineteen percent were physically abused. This was a victimization rate of 12.4 per 1,000 children in the population. This rate remained fairly constant over the previous five years. About 84 percent of these children were abused by a parent or parents.

Author / Duane E. Spencer, DDS, is a pediatric dentist in Walnut Creek, Calif., and a forensic dental consultant to law enforcement agencies and the California Department of Justice.

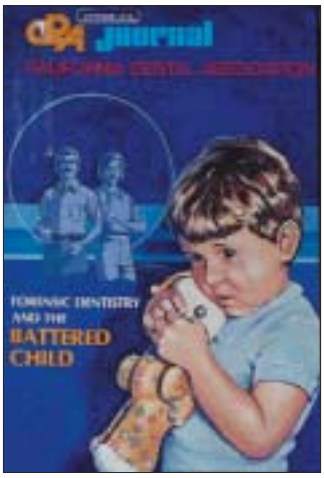


Figure 1. CDA Journal, 1976.

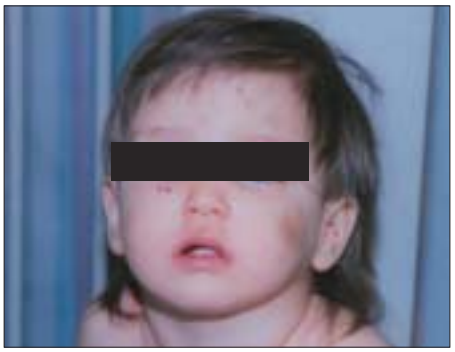


Figure 2. Multiple bruises, abrasions on abused child's face.

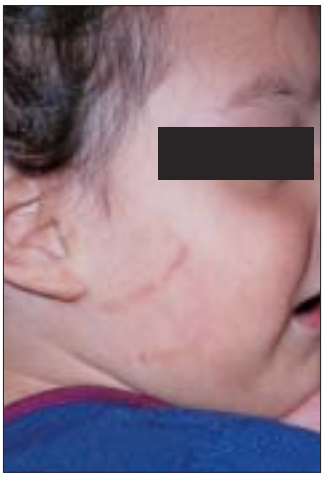


Figure 3. Fingernail marks on child's cheek.

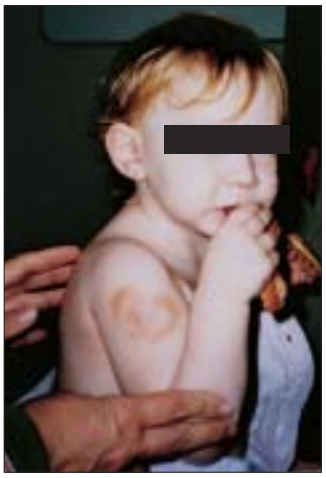


Figure 4. Human bite mark on child's arm.

Approximately 1,300 children died as a result of abuse or neglect in 2001, which is a rate of 1.81 per 100,000 children. Many researchers believe that this number is underreported.[1] Children's Hospital in Oakland, Calif., sees about 1,000 abused children each year. Of these, approximately one-half have been physically abused.[2] One must understand for every suspected abuse referral, there may be scores of unrecognized and unseen cases of abuse and neglect in the area. Child abuse and neglect continue to be a significant concern in America.

Dental Staff's Involvement

How common is it for a pediatric dental patient (child or teen) to be the victim of abuse or neglect? Should the staff member be recognizing these abused patients? One must remember that child abuse is much more than the physical abuse that we may recognize with our dental patients. (Emotional abuse, verbal abuse, sexual abuse, abuse of children over the Internet.) When the entire scope of abuse is taken into account, it is quite possible that the busy pediatric dental practice will encounter several patients per week who may have been victims of abuse. The child's abuse certainly may affect his or her behavior in the dental office. This may range from being quiet and withdrawn to acting out and being uncooperative. The dentist is not expected to recognize the child's behavior as being a manifestation of a specific type of abuse nor is the dentist expected to recognize the child victim of sexual or Internet abuse.

The dental staff should be aware that with physical child abuse it has been reported that approximately two-thirds of visible injuries to a child will be located in the region of the head and neck.[3] The dentist must be cognizant of injuries in questionable locations, multiple injuries (**Figure 2**), injuries that appear to be in different stages of healing and injuries which are not age-appropriate, i.e. facial injuries on the pre-ambulatory child. Be observant for possible patterned injuries such as finger (**Figure 3**), ligature, burn, or bite marks (**Figure 4**), or marks possibly caused by a belt, strap or cord. Multiple bruising, loss of hair (hair pulling) or injuries to the ears should raise suspicion. As we were all taught, treating a dental patient involves more than looking inside the mouth. Observe the child's actions, behavior, physical movements and verbal communication and assess if they are appropriately age-related to the patient. Perform a quick visual assessment of the child's face, head, neck, hands and any other *exposed* area of the body. It is not the dentist's responsibility to either lift or remove the patient's clothing to search for physical injuries.

If the dentist suspects physical abuse with a young patient, then he or she should have another dental staff member also witness the injuries and assist in their documentation. A written descrip-

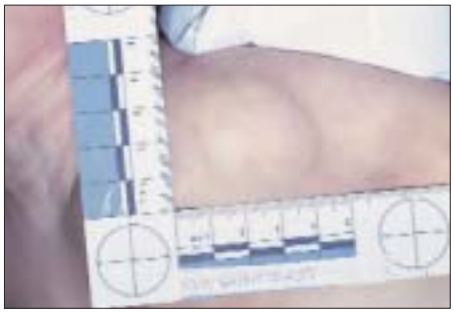


Figure 5. Bite mark on shoulder of seven-week-old child abuse-homicide victim.

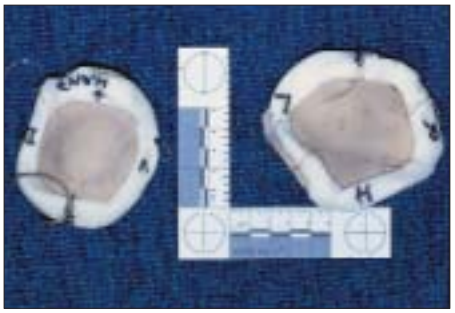


Figure 6. Resected tissue containing bite marks. Shoulder bite mark on right.

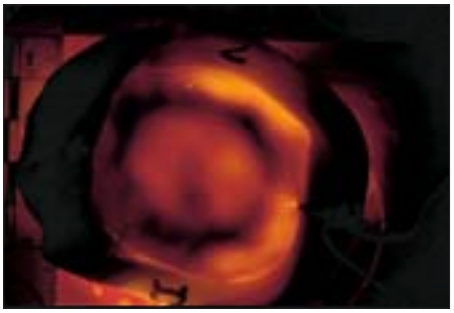


Figure 7. Transillumination of resected bite mark on shoulder.

tion with diagrams can document the locations, shapes, sizes, etc., of injuries. Intra-oral injuries might necessitate the need for dental X-rays. Section 11171(a) of the California Penal Code allows the dentist, or his or her agent, to obtain X-rays of a child without the consent of the parent when the dentist is diagnosing the case as one of possible child abuse and determining the extent of such child abuse.[4] If there are injuries present, such as on the face, on the child that lead the dentist to suspect child abuse, it is recommended that photographs be taken of the injuries. Most dentists have available a clinical camera, either 35mm or digital. A photograph should be taken of the entire face as well as close ups of the individual injuries. The close-up photographs should include some type of scale (ruler) placed near the injury but not covering any part of the injury. X-rays, photographs, etc., should be documented. When reporting the suspected abuse, it is recommended the dentist advise CPS, sheriff, etc., what documentation of injuries the dentist obtained. X-rays or photographs taken in the dental office may be the only evidence available to authorities. It cannot be assured that subsequent photographs will be taken, and if they are, what quality they will be and of what stage of healing the injuries may have reached.

Some dentists may be concerned about becoming involved in a case of suspected child abuse with one of their patients. It must be emphasized the law mandates that the dentist, as well as an RDH or RDA, report the suspected abuse. The dental staff should be concerned more about the health and well being of the child than of any personal concerns. The dentist need only document the injuries and report the suspected abuse. He or she is not required to investigate the possible abuse nor to try to be a detective. The proper authorities will handle the investigation. Certainly there could be potential for the dentist to be required to testify in future court proceedings (although the author never has had to testify as a pediatric dentist in 38 years of treating children). The dentist must not let a concern of getting involved or testifying prevent him or her from making a report.

Forensic Odontologist and Child Abuse

Those active in the field of forensic odontology may be called upon to evaluate patterned injuries in child abuse. Usually these injuries will be bite marks inflicted upon the child. The odontologist may have the opportunity to examine the child, living or deceased. More often the odontologist will be supplied with photographs and asked to give an opinion as to the presence of bite marks, the quality of the marks, and whether an adult or child may have inflicted the marks. Too often the supplied photos are of poor quality, taken at too great a distance from the injury, out of focus or without the presence of a scale (ruler). An experienced odontologist will take quality photographs when he or she has the opportunity to see the child whether in the hospital ER, morgue, etc.

Bite marks on a child's body, unless observed soon after the bite was inflicted, often present as a diffuse bruising of ovoid or elliptical shape with little or no definition of individual teeth.[5] Often, the odontologist can only determine if it is a human bite mark and perhaps if it was inflicted by an adult or young child. It has been the author's forensic experience that just this amount of information can lead the abuser to admit their involvement with the child or can rule out certain individuals who may have had access to the child. Proper photography of patterned injuries (bite marks) in the physician's or dentist's office, the hospital emergency room, or at the police station can greatly aid in the subsequent analysis and potential comparison of the mark(s).

In cases of child abuse-homicide, the forensic odontologist will take photographs of the suspected patterned injuries. If there is any third dimension to an injury, the odontologist will take an impression with a dental impression material in order to have a model of the injury to use for potential comparison to dental models of any suspected biters. It also is recommended that the odontologist resect the tissue involving the bite mark and properly preserve it for later transillumination (**Figures 5 and 6**). Transillumination may yield more detail of the bite pattern and arch sizes (**Figure 7**). This often can tell the odontologist an adult or teenager inflicted the bite on the child, not the young sibling the suspect may try to blame for the abuse.

Good forensic evidence collection with patterned injuries in child abuse can be of great assistance to the law enforcement investigator and the prosecutor. In some cases, the defendant has pleaded guilty just prior to trial or there was a stipulation as to the bite mark evidence rather than having the odontologist testify.

Referrals: Recognizing One's Limitations

The management and treatment of the dental needs of a child can be extremely challenging. Not all dentists have the personality, patience, experience or training to work with young patients. Most such dentists realize this and refer them to pediatric dentists. Some dentists restrict their pediatric treatment to older, more cooperative children. This is as it should be. Children deserve healthy and happy experiences when receiving dental treatment. Too many adults comment on how their own poor childhood dental experiences led to their current apprehensions with dental treatment. Over-treatment of children may not only be wrong but might be considered by some an assault on the young patient. Restoring teeth with no caries or which are soon to exfoliate with the goal of increasing office revenue could be considered abusive. The dental health professional should be above rendering such "treatment" and fortunately most are. If the dentist does not have the patience to treat children he or she, should not do so. It is difficult to review cases such as one where a young child received a stainless steel crown but was taken back to the parent in the reception room perspiring, with a flushed face, tears in the eyes and marks on their face and the neck. The dentist should recognize before beginning treatment that the young child might need some type of sedation or general anesthesia. In such cases, referral might be the correct option. Children do not deserve to grow up with bad memories of their pediatric dental experiences.

Good forensic evidence collection with patterned injuries in child abuse can be of great assistance to the law enforcement investigator and the prosecutor.

The Dentist's Role in Aiding in the Identifications of Missing Children

The media keeps us well informed of cases of children in our communities who go missing or who are abducted. Most parents and grandparents keep close, protective watch on their children in today's society. We all remember too well the tragic cases of young girls such as Polly Klaas, Christina Williams, Xiana Fairchild, and Danielle van Dam. Dental identifications were used with each of these homicide victims. Lately, advertisements in some dental journals tout bite registration wafers to record the bites of young patients in case they should ever go missing. Experience in identifying the burned, decomposed or skeletal remains of children, has been that bite records are not of value. Additionally, a dentist advertising the use of such bite records to attract new patients to his or her practice may border on the unethical. Good written dental records and dental radiographs are vital to an identification effort. These records remain the legal standard for identification by dental means. When they do not exist, for example if a child is too young for X-rays, then DNA analysis can be used successfully for identification. It must be noted however, that DNA analysis is very time consuming and costly, while dental identification can produce a positive identification in a very short time, at a low cost to the investigating agency.

The Dentist and Child Abuse Prevention

Dentists who treat children or are interested in aiding in the prevention of child abuse and neglect certainly

have several options. The staff can be trained to recognize and report suspected abuse. Attending a presentation on child abuse recognition may be helpful. Another suggestion is to provide literature, posters, handouts, etc. in the reception room to assist in educating parents. Information also is available for spousal and elder abuse. The local child abuse prevention council has a number of resources and training courses for those who want to become a volunteer community educator. Those volunteers speak to local groups such as childcare providers, and pre-school teachers.

Summary

This article has discussed the prevalence of child abuse; the importance of the dentist recognizing physical abuse and methods of documenting suspected abusive injuries. The forensic odontologist may be called upon to document and analyze patterned abusive injuries. It is important that dentists realize their comfort level and competence in treating children and refer the young patient to a specialist when indicated. The dental office should maintain complete and legible records on their pediatric patients for potential forensic utilization. CDA

To request a printed copy of this article, please contact / Duane E. Spencer, DDS, 1855 San Miguel Drive, Suite 9, Walnut Creek, Calif., 94596-5214.

References / 1. Child Maltreatment 2001 report. The National Child Abuse and Neglect Data System (NCANDS) U.S. Dept. of Human Services.

2. Crawford James, MD, Children's Hospital Oakland Calif.; Personal communication.

3. Cameron JM, Johnson HR, Camps FE, The Battered child syndrome. *Med Sci Law* 6:2-21, 1966.

4. California Department of Justice, *Child Abuse Prevention Handbook* pg. 93, 1993.

5. Spencer DE, Bite marks in Child Abuse. *Manual of Forensic Odontology* third ed. Printing Specialists, Montpelier, Vt., pg. 178, 1995.

What is This Red Mark?

Kathleen A. Shanel-Hogan, DDS, MA

Kathleen A. Shanel-Hogan, DDS, MA, will present "Dental Professionals Against Violence" during CDA's Spring Scientific Session in Anaheim, Calif. The presentation will be held from 10:30 a.m. to 1 p.m. Friday, April 16 in Huntington Rooms A/B/C at the Hilton. A repeat presentation is from 2:30 to 5 p.m.

The three-year-old child waits for you in your operatory. As you begin the dental examination, you observe a reddening of the soft palate.

Do you note it, look past it, and continue with the exam? Most caring and unaware dentists unconsciously do. I was one of those dentists until 1994 when I first saw this photograph of a child of sexual abuse from forced oral sex (**Figure 1**). So, what is your next step?

You review some differential diagnosis possibilities.

- Normal variations in oral mucosa?
- Sore throat?
- Oral cancer lesions?
- Trauma?

You review the child's health history. Is discussing it with the parent accompanying the child a good idea? Perhaps you might begin with an open-ended question to the parent, i.e. "I am noticing a red mark on the roof of the child's mouth. Can you help me understand more about this?" Listen closely to the history the parent provides. Does it correlate with the mark present? Is the explanation correlate to the child's age and development?

- Is there notation in the chart of this type of observation of the child on previous visits?
- Has the child experienced a cold or sore throat lately?
- Has the child complained of a sore throat, had difficulty swallowing, or refused to eat?
- Has there been any trauma or accident in the child's mouth lately, i.e. falling with a candy pop or toy in the mouth?

Maybe this is normal mucosa. Maybe there is another possible diagnosis. It may be an indication of sexual abuse with forced oral sex.

Child sexual abuse is often a silent crime with the victim being told the relationship is special or secret. Maybe the perpetrator threatens to harm others, i.e. parents, the child, pets. Unless the child shares their experience with another, evidence of the crime may only be observed physically in the genito-anal area or the oral cavity of the child. The child's head and neck are the areas of examination of the dental professional. The average age of a physically abused child is 3 years old. With the initial dental examination now being advocated at age 1, imagine how many potentially abused children can be recognized and assisted through the efforts of dentists and physicians before the child can voice their situation and pain.

Sharing your concerns for the child with the parent may be exactly what the parent or guardian needs. They also may have concerns and/or appreciate your completeness. You have the option of telling the parent that it is your legal obligation to contact a child protective services agency and file a mandated report. If you have concern for the child's immediate safety, call 911 and report it to law enforcement. If sharing with the adult concerns you for your own safety or your staff's safety, you can call Child Protective Services or 911 without telling the parent or accompanying adult.

Dentists, registered dental hygienists, and registered dental assistants are mandated reporters in California. We are not investigators or accusers. We are the legally bound observers that assist agencies that are qualified to investigate and obtain assistance for the child and family. We can make a positive difference for our patients and their families.

I never did find out what happened to the 3-year-old child in this scenario,

Author / Kathleen A. Shanel-Hogan, DDS, MA, is a consultant, educator, facilitator and family violence prevention advocate. She works with the California Dental Association Foundation as a consultant and a mandated reporter trainer in all forms of family violence (child abuse/neglect, domestic violence, elder abuse/neglect). She is author of the Dental Professionals Against Violence Program, and testified on behalf of dentistry at the California Assembly Select Committee On Domestic Violence Hearing "Domestic Violence As A Public Health Issue." She participates on many California statewide committees on family violence prevention. Dr. Shanel-Hogan has experience in private practice and hospital dentistry with medically compromised patients.

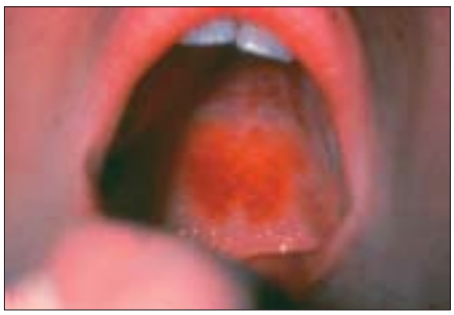


Figure 1. Bruised soft palate from forced oral sex. *Photo courtesy of Lynn Mouden, DDS, MPH.*

but the impact in my life since seeing the photograph has been profound. My observation skills are expanded and enhanced. I am actively working toward informing our dental community regarding family violence prevention. Please join with me and the Dental Professionals Against Violence at the California Dental Association Foundation at (800) 736-8702, ext. 8900. For more information mandated reporting and the law refer to California Department of Justice Crime and Violence Prevention Center's Web site, www.safestate.ca.gov. CDA

Reprinted with permission from the Sacramento District Dental Society's October 2001 newsletter, *The Nugget*.

To request a printed copy of this article, please contact / Kathleen A. Shanel-Hogan, DDS, MA, P.O.Box 660758, Sacramento, Calif., 95866.

Mandated Reporting of Child Abuse: Answers for Dentists

Patty Lough, LCSW, PhD

ABSTRACT

As mandated reporters, dentists play an important role in recognizing child abuse. This article covers many of the key issues involved in making a suspected child abuse report and what happens after a report is made.

The prevention of dental pain and suffering is the ultimate goal of dentists and dentistry. Related, yet perhaps not immediately thought of in relation to dentists, is their role in preventing child abuse. As mandated reporters, dentists are in a key position to notice signs of child abuse in their clients and report it.

This article is a comprehensive review of issues and answers in relation to mandated reporting and suspected child abuse. This will aid dentists in making informed decisions on behalf of themselves and their clients. The topics covered include liability, the limits of confidentiality, reasonable suspicion, who takes the report, the investigation process, "What happens if the child is removed?" "Are children taken away forever?" the court's role, where information about the suspected abuser is kept, and prevention efforts.

Since Congress enacted the Child Abuse Prevention & Treatment Act in 1974, there has been a significant increase in awareness regarding child abuse and neglect.[1] One outcome is that mandated reporting has been implemented throughout the nation. In California alone, the child welfare services case management system (CWS/CMS) received more than 257,560 calls in 2001 reporting suspected child abuse. Of that, 74,217 became substantiated cases.[2] While approximately 54 percent of all reports of abuse and neglect are either unfounded or not substantiated, it is known that most abused children never come to the attention of authorities.[3]

Dentists have important skills in detecting child abuse. Their role cannot be understated. The American Academy of Pediatrics and the American Academy of Pediatric Dentistry stated that "craniofacial, head, face, and neck injuries occur in more than half of the cases of child abuse." The academies also cited the need for collaboration: "Physicians receive minimal training in oral health and dental injury and disease and thus may not detect dental aspects of abuse or neglect as readily as they do child abuse and neglect involving other areas of the body. Therefore, physicians and dentists should collaborate to increase the prevention, detection, and treatment of these conditions."[4,5]

Still, in their own practices, some dentists may feel reluctance about reporting suspected abuse. Reasons may stem from uncertainty that abuse has occurred or professional concerns about maintaining a good relationship with the patient. Or there may be concerns about anonymity and consequences to the patient or oneself.[6] Most of these concerns relate to what happens after a child abuse report is made. This article explores key issues involved in making a report of suspected child abuse.

Liability

The law protects anyone who reports known or suspected child abuse from civil or criminal liability, unless it can be proven the report was false and the person who made the report knew it was false. However, immunity does not apply to liability arising from willful misconduct or gross negligence for either making a false report or failing to report.[7]

One should also keep in mind that there are criminal penalties for failure to report suspected child abuse. In California, a dentist (or any mandated reporter) who fails to report a known or reasonably suspected instance of child

Author / Patty Lough, LCSW, PhD, is a social services consultant for the Office of Child Abuse Prevention, California Department of Social Services. Her area of expertise is in mandated reporting.

abuse can be found guilty of a misdemeanor punishable by up to six months in jail or by a fine of $1,000 or both. (Penal Code 11166(b).) Additionally, under PC11166.01, "any supervisor or administrator who impedes or inhibits a report of child abuse and neglect is guilty of an infraction punishable by a fine not to exceed $5,000." Because failure to report can be a crime, "subsequent injuries resulting from failure to report" might open a dental professional to exposure to uninsured professional liability.[8]

The Limits of Confidentiality

The confidentiality of the doctor-patient relationship is given high regard by health care professionals, as it should be. However in relation to child abuse, privileged communication provisions do not apply and there is a statutory duty to report.

Prior to starting any dental work, dentists may wish to have clients sign confidentiality statements. Mental health professionals prior to beginning treatment routinely use confidentiality statements that relate to child abuse and neglect. An example of a statement used in this context is: "I will need, and am compelled by law; to report to an appropriate other person(s) if I believe there is reasonable suspicion that a child has been abused or neglected."

This makes it clear to the patient that "reasonable suspicion" of child abuse or neglect is to be reported, as required by law. Having a signed confidentiality statement, as well as restating the information verbally to a patient may help alleviate feelings of betrayal or guilt in the event it is necessary to make a report.

What is Reasonable Suspicion?

As defined in the law, reasonable suspicion means that "it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect child abuse or neglect"(California Penal Code 11166). Therefore, if a dentist has a reasonable suspicion that child abuse has occurred, a suspected child abuse report is to be completed.

Anonymity

Many people wish to remain anonymous when making a suspected child abuse report. However, as mandated reporters, dentists are required by law to give identifying information[9] including name, business address, and telephone number, and the capacity of what makes that person a mandated reporter, i.e. dentist. In addition, any known information about the child, what has led the dentist to reasonably suspect child abuse, and relevant information about the suspected abusers will be asked for in both the verbal and written reports. Even if only some of the information is known, the dentist should still make a report.

Except under certain conditions specified in the law, such as waiver of confidentiality or court-ordered disclosure, the identity of the dentist, or others making the report, is kept confidential and disclosed only among agencies receiving or investigating the report (California Penal Code 11167).

Who Takes The Report?

In California, a report of suspected child abuse is made to local law enforcement (police or sheriff's departments) or child protective services (CPS, or county welfare department). In some counties, the probation department can receive mandated reports. A school district's police or security department is not included in those who take reports.

When Do You Report?

You must make a report immediately (or as soon as practically possible) by phone. A written report must be forwarded within 36 hours of receiving the information regarding the incident (California Penal Code 11166(a)). Written reports must be submitted on a Department of Justice form (Suspected Child Abuse Report SS 8572, revised December 2002. *See Page 312.*) They can be requested from the local law enforcement or child protective services agency.[10]

The Investigation Process

Once a report is filed, the investigation process begins. No two reports are handled in exactly the same way. Decisions are based on each child's situation. Even reports on two children in the same family may be handled differently. The agency receiving the report will determine how to proceed, based on the information available. What the response will be and how quickly it will be made depends on the seriousness of the events reported, and the situation facing the child. Where it appears the child is in danger, the response will be immediate. Where there is less risk involved, it may be three to 10 days before action is taken.

The investigations by a child welfare services agency and law enforcement are conducted separately. The child welfare agency will concern itself with the welfare of the child and family. Law enforcement efforts will focus on obtaining evidence to determine whether a crime has been committed and by whom. The safety of the child is given the greatest weight in the investigation process.

Not all reports are serious enough to require the assistance of the law enforcement agency. In these cases, only the local social service department

may contact the family. An in-person response may not be made when the county social services department, based upon an assessment, determines that one is not appropriate.[11]

When the welfare department is investigating a report of suspected abuse, it will interview the child. The law allows the interview to take place during school hours and at the school. The child is interviewed in private and can have an adult from the school staff present if they choose.

Investigations in the home include assessing the allegations and the level of risk to the child. The environment is considered in relation to safety and whether or not basic needs are being provided, i.e. food, shelter. Other factors that can affect the investigation include the extreme anger or cooperation by the suspected abuser(s).[11]

What Happens if the Child is Removed?

Most reports of child abuse do not result in children being removed from their families. The first goal is to enable the child to remain safely in his or her own home. If this is not possible, the social worker must protect the child's safety by placing him or her in foster care. Sometimes the child welfare services agency is able to place the child with a relative.

Are Children Taken Away Forever?

California has strict rules about removal of children from their families. However, because children are vulnerable, the law also affords them significant protection. Peace officers are authorized to take an endangered child into protective custody and place the child in the care of the social service department. This initial emergency removal is allowed by law, without a warrant, for up to 48 hours. Should the child protection agency decide the child cannot safely return home, the agency must formally request the juvenile court hold a hearing to determine if continued removal is necessary. This is accomplished by submitting a dependency petition outlining the allegations that brought the child to the attention of the child protection agency.[11]

The Court's Role

More than one type of court may be involved as a result of a child abuse report: juvenile court, criminal court, or an administrative hearing.

The juvenile court determines whether the child should be removed from the home and whether services should be ordered in the interest of the child and family. This court becomes involved when it is a parent or guardian or other person in the child's home who appears to bear the responsibility for the abuse or neglect.

Criminal prosecutions are initiated in municipal court. Misdemeanor cases will remain in this court, but felony cases will go to superior court. The primary issue is whether it can be proved beyond a reasonable doubt that a particular person abused or neglected the child.

If a child is abused or neglected in a child day-care facility, or a foster home or other residential placement, a proceeding may be brought to revoke the facility's license, and/or to exclude a perpetrator from employment in the facility. If the case goes to hearing, an administrative law judge presides.

Is Information About the Suspected Abuser Kept Somewhere?

Reports of suspected child abuse contain information about the known or suspected abuser. Once investigated, reports of suspected child abuse are categorized as substantiated, unfounded or inconclusive (insufficient evidence). The substantiated or inconclusive reports are then filed in the California Department of Justice Child Abuse Central Index (CACI) database. The submitting agencies are responsible for the accuracy of the reports. The public cannot access the CACI. Only agencies specified in the law can receive information indicating that a person has been reported as a child abuser on the CACI. Applicants or employees in a facility providing 24-hour care for children, or employment in positions having disciplinary power over a child, are examples of where verifying information may be released to the specified agency. A person may determine if he or she is listed in CACI by submitting a written request for information to the Department of Justice (Penal Code 11170(e)). Additionally, the agency making the report to the CACI also is responsible for notifying the "suspected abuser" that they have been reported to the index. Unfounded reports are never sent to the CACI, however, if substantiated or inconclusive reports are later determined to be unfounded, they then are purged from the index. Inconclusive reports are deleted from CACI after 10 years if no subsequent report concerning the same suspected child abuser is received (Penal Code 11170).

Prevention Efforts — What Can Be Done?

Factors that affect abuse vary.[12,13] Child abuse affects all socioeconomic levels. While each individual is different, some risk factors, such as social isolation, poverty, past abuse and increased stress are known contributors to the potential for abuse.[14] However, there are no perfect answers to always knowing who will and who won't abuse their children. What is known is that

early intervention programs can have a positive impact (home visiting[15] or family resource centers).

Most California communities have resources available locally to parents or caregivers in need of help. This includes local Child Abuse Prevention Councils or Family Resource Centers (www.http://capcsac.org/crisisnumbers/councils.html). California's Parent Outreach (www.parentoutreach.org) is available statewide to overburdened parents as well. It includes a 24-hour toll-free hotline, (800) 901-4565. For professionals who would like to get involved in the effort, or post resource materials, contact can be made with the local resources previously cited or through the State of California Department of Social Services, Office of Child Abuse Prevention (www.dss.cahwnet.gov/cdssweb/default.htm). For more information on child abuse and neglect, go to the state attorney general's Web site, www.safestate.org.

Summary

Dentists can make a difference for a child who is abused or neglected. Individually and collectively, dentists play a key role in prevention because of their specialized knowledge in dentistry and their ability to recognize signs and symptoms of abuse that others might dismiss.

Preventing child abuse is also a legal responsibility of dentists in relation to mandated reporting. It is wise for anyone with a dental practice to be informed about the limits of liability insurance because of a failure to report, which can be a crime, can open a dentist to uninsured professional liability.

Knowing what "reasonable suspicion" is should be a basic part of every dentist's knowledge base in relation to child abuse. As stated earlier, reasonable suspicion means that "it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect child abuse or neglect" (California Penal Code 11166).

Knowledge of other factors that relate to the child protective system such as the investigation process and possible outcomes will help the dental professional to make informed choices. Resources, such as one's local child protective services or law enforcement office, can be called upon to clarify if a suspected child abuse report should be made or answer questions in relation to child abuse.

Lastly, every dentist can potentially make a difference by having preventative pamphlets and material geared to offer community resources available to clients. Often times there are local resources as well as hotline numbers that a "stressed out" family member can call upon for help. CDA

To request a printed copy of this article, please contact / Patty Lough, LCSW, PhD, Department of Social Services, Office of Child Abuse Prevention, 744 P St., MS 11-82, Sacramento, Calif., 95814, or e-mail, patty.lough@dss.ca.gov.

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SUSPECTED CHILD ABUSE REPORT

To Be Completed by **Mandated Child Abuse Reporters**
Pursuant to Penal Code Section 11166

PLEASE PRINT OR TYPE

CASE NAME: _____

CASE NUMBER: _____

A. REPORTING PARTY

NAME OF MANDATED REPORTER | TITLE | MANDATED REPORTER CATEGORY

REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS | Street | City | Zip | DID MANDATED REPORTER WITNESS THE INCIDENT? ☐ YES ☐ NO

REPORTER'S TELEPHONE (DAYTIME) ( ) | SIGNATURE | TODAY'S DATE

B. REPORT NOTIFICATION

☐ LAW ENFORCEMENT ☐ COUNTY PROBATION ☐ COUNTY WELFARE / CPS (Child Protective Services) | AGENCY

ADDRESS | Street | City | Zip | DATE/TIME OF PHONE CALL

OFFICIAL CONTACTED - TITLE | TELEPHONE ( )

C. VICTIM
One report per victim

NAME (LAST, FIRST, MIDDLE) | BIRTHDATE OR APPROX. AGE | SEX | ETHNICITY

ADDRESS | Street | City | Zip | TELEPHONE ( )

PRESENT LOCATION OF VICTIM | SCHOOL | CLASS | GRADE

PHYSICALLY DISABLED? ☐ YES ☐ NO | DEVELOPMENTALLY DISABLED? ☐ YES ☐ NO | OTHER DISABILITY (SPECIFY) | PRIMARY LANGUAGE SPOKEN IN HOME

IN FOSTER CARE? ☐ YES ☐ NO | IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: ☐ DAY CARE ☐ CHILD CARE CENTER ☐ FOSTER FAMILY HOME ☐ FAMILY FRIEND ☐ GROUP HOME OR INSTITUTION ☐ RELATIVE'S HOME | TYPE OF ABUSE *(CHECK ONE OR MORE)* ☐ PHYSICAL ☐ MENTAL ☐ SEXUAL ☐ NEGLECT ☐ OTHER (SPECIFY)

RELATIONSHIP TO SUSPECT | PHOTOS TAKEN? ☐ YES ☐ NO | DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? ☐ YES ☐ NO ☐ UNK

D. INVOLVED PARTIES

VICTIM'S SIBLINGS

NAME	BIRTHDATE	SEX	ETHNICITY	NAME	BIRTHDATE	SEX	ETHNICITY
1.				3.			
2.				4.			

VICTIM'S PARENTS/GUARDIANS

NAME (LAST, FIRST, MIDDLE) | BIRTHDATE OR APPROX. AGE | SEX | ETHNICITY

ADDRESS | Street | City | Zip | HOME PHONE ( ) | BUSINESS PHONE ( )

NAME (LAST, FIRST, MIDDLE) | BIRTHDATE OR APPROX. AGE | SEX | ETHNICITY

ADDRESS | Street | City | Zip | HOME PHONE ( ) | BUSINESS PHONE ( )

SUSPECT

SUSPECT'S NAME (LAST, FIRST, MIDDLE) | BIRTHDATE OR APPROX. AGE | SEX | ETHNICITY

ADDRESS | Street | City | Zip | TELEPHONE ( )

OTHER RELEVANT INFORMATION

E. INCIDENT INFORMATION

IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX ☐ *IF MULTIPLE VICTIMS, INDICATE NUMBER:* _____

DATE / TIME OF INCIDENT | PLACE OF INCIDENT

NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incidents involving the victim(s) or suspect)

SS 8572 (Rev. 12/02)

DEFINITIONS AND INSTRUCTIONS ON REVERSE

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS 8583 if (1) an active investigation was conducted and (2) the incident was determined not to be unfounded.

WHITE- COPY-Police or Sheriff's Department; BLUE COPY-County Welfare or Probation Department; GREEN COPY- District Attorney's Office; YELLOW COPY-Reporting Party

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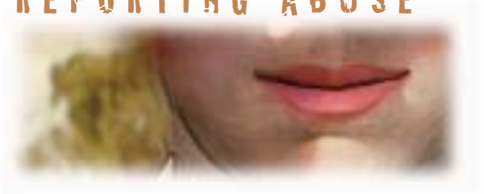

Do I Make the Call? A First-Person Account

Kathleen A. Shanel-Hogan, DDS, MA

Kathleen A. Shanel-Hogan, DDS, MA, will present "Dental Professionals Against Violence" during CDA's Spring Scientific Session in Anaheim, Calif. The presentation will be held from 10:30 a.m. to 1 p.m. Friday, April 16 in Huntington Rooms A/B/C at the Hilton. A repeat presentation is from 2:30 to 5 p.m.

It was 1 p.m. and a new patient was scheduled for an emergency appointment. A "fractured tooth and pain in the upper right quadrant." My mind was beginning the process of planning the next step — history of complaint, health history, exam, X-rays, differential diagnosis, etc.

I was standing by the operatory as I observed the 11-year-old boy walking from the waiting area to the operatory. He walked tentatively as if on eggshells and guarded his buttocks. He moved uneasily and winced as he sat in the dental chair. I briefly asked him his complaints. He indicated his tooth was hurting and pointed to the upper right quadrant.

On examination, tooth No. 3 had a fractured cusp with 1+ mobility. There was bruising on the buccal mucosa. I asked the registered dental assistant to take the appropriate X-rays and went to the waiting room to speak to the adult accompanying the patient.

I inquired about the history of the emergency and was told by the father that the child had fallen. No other health concerns. The man appeared nervous and had a sharp edge to his voice. This was his first visit to our office and I imagined at the time that he was anxious for the child. I assured him that I was there to assist the child.

While I was speaking to the parent, the RDA was working with the patient. It was an extremely warm summer day of 98 degrees with 98 percent humidity. The child was wearing a long-sleeved cotton shirt with jeans and army boots. She skillfully helped the boy to relax and mentioned the heat of the room. She asked if he would be more comfortable moving the sleeves of his shirt toward his elbows because of the warmth. At first he refused, but as he relaxed he rolled up his sleeves. Around each wrist were linear marks and bruises.

As I returned to the operatory, the RDA caught my eye and silently indicated that we needed to talk. She excused herself and we huddled in the lab. We shared observations and conversations. Both of us strongly had a suspicion of possible child abuse. We decided to document carefully what we were observing.

We returned to the operatory. I struck up a conversation with the child as I continued my examination. The rest of the teeth were within normal limits and there was tenderness in the upper right molar area with bruising on the buccal mucosa. "When did this occur? How did it occur?" The boy said, "I fell today." Bruising on the face was just beginning to show in the right cheek area over the zygomatic arch.

As I was treating the fractured tooth, I was rolling my observations over in my mind. *Is this child abuse? Do I have enough information for reasonable suspicion?* I reviewed our observations.

- The child's way of walking and sitting in the dental chair.
- The fractured tooth, tooth mobility.
- The buccal mucosa bruising and facial bruise.
- The way the child was dressed for the season.
- The linear marks and bruises on both wrists.
- The nervousness of the parent.
- The emergency history of trauma.

Author / Kathleen A. Shanel-Hogan, DDS, MA, is a consultant, educator, facilitator and family violence prevention advocate. She works with the California Dental Association Foundation as a consultant and a mandated reporter trainer in all forms of family violence (child abuse/neglect, domestic violence, elder abuse/neglect). She is author of the Dental Professionals Against Violence Program, and testified on behalf of dentistry at the California Assembly Select Committee On Domestic Violence Hearing "Domestic Violence As A Public Health Issue." She participates on many California statewide committees on family violence prevention. Dr. Shanel-Hogan has experience in private practice and hospital dentistry with medically compromised patients.

Each of the red flags alone may not have been suspicious, but in combination, my gut feeling said "yes" to a suspicion of possible child abuse.

What do I do now? What do I do with the parent? The procedure to make a report had been very sketchily described when I was in dental school but it had been a few years. I decided to call Child Protective Services. Because of the demeanor of the parent, I chose not to tell the parent. I updated the parent that we were waiting for some dental materials to set up, so it would be a bit more of a wait. This provided me with some more time.

I went to my personal office and stared at the telephone. I am a mandated reporter and am legally bound to report reasonable suspicion of child abuse and neglect. *How do I make this call? What do I say? What if I am wrong? What if the parent or family gets angry or even hostile?* I felt anxiety grip my chest and caught my breath. Then I remembered the look in the little boy's eyes as I was treating his tooth. It was a combination of trust, fear, and helplessness. This child deserved to be safe. So I made the call.

The Child Protective Services caseworker was very patient and walked me through the procedures and asked questions such as, "What did you observe? What was said? What is the history? Where is the child now?" I later realized that the questions followed the items on the mandated report form. After the short discussion, she thanked me, reminded me that I still need to follow-up with a written report within 36 hours and indicated that CPS would follow up with the child. I could let the child go from my office.

As the patient and parent left, I was fearful for the boy. I struggled with the fear of wondering if I had done the right thing by making the call. Maybe I had exaggerated my suspicions. But no, both the RDA and I were concerned. I was very appreciative of the RDA's astute observations and our collaborative teamwork.

For the next few days I was careful when I arrived and left the office. We were an all-woman office and I was concerned for our safety. I called a friend on the police force for advice. He reminded me that patients could be angry, hostile and potentially violent for many reasons. Taking appropriate precautions and being observant is important in any situation. If I felt or experienced the threat of violence, I could call law enforcement. Nothing happened at the office.

This event occurred 24 years ago. The eyes of the little boy still speak to me.

I followed up with CPS later to request information on my report. The little boy in my dental chair that day was a child of bondage and the marks on his wrists were from physical restraints. The child and family received assistance. I never saw the family again. Our entire dental team knows in our hearts that we acted with the best intentions for the child. This event occurred 24 years ago. The eyes of the little boy still speak to me.

Looking back at that summer day, I now have more information that might have put some of my fears to rest and about what I might have do differently now. I could ask the father and son separately more specifics about the fall that injured the tooth to corroborate the stories and be watchful of inconsistencies. I could photograph the tooth, buccal mucosa and face to provide documentation. In California, parental permission for photos and X-rays in the cases of suspicion of abuse is not required (California Penal Code 11171 [a] and 11172 [a]). I could prepare a draft of the reporting form to use as a format to make the call to CPS and record information provided on the call. This would greatly assist me make the written report in 36 hours. I know I have immunity, anonymity in reporting and legal support as a mandated reporter. I have the peace of mind that the report I made is a report of observations NOT an accusation. I am not an investigator. I also know better how I am a part of the mandated reporter network of the community. I am not alone.

So when this happens to you, are you and your team ready? Just like CPR and poison emergencies, office protocol and preparation is critical. Is it scary? Is it important? Can you and the team make a difference that might be to save a life? The answer to these questions is "yes." As mandated reporters of child abuse/neglect, domestic/ intimate partner violence (in the case of physical assault), and elder and dependant adult abuse/neglect, we can be the child's, adult's and family's voice to assist in seeking freedom from abuse and neglect.

We can assist in breaking the cycle of family violence. CDA

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To request a printed copy of this article, please contact / Kathleen A. Shanel-Hogan, DDS, MA, P.O.Box 660758, Sacramento, Calif., 95866.

How Are Children Impacted by Adult Partner Violence?

Connie Mitchell, MD

Michael is a 10-year-old male previously noted to have had mild developmental delay, poor social skills, and difficulties in school. He presented with fractured incisors after falling off his bike. After being asked what led to the fall, he said he had been standing astride his bike at the bottom of the porch stairs preparing to flee because his mom and dad were fighting. His mother wanted to leave, and as his parents were struggling over the keys on the front porch, his father pushed his mother. She fell down the steps onto Michael, causing him to fall and injure his teeth on the handlebars. Subsequent interviews revealed a long history of physical violence between the parents, but no history of child physical or sexual abuse.

Epidemiology/Statistics

There are two types of data documenting the adverse effects of intimate partner violence upon children. The first group comprises children who witness family violence and who are also physically abused, neglected, or endangered. The second group comprises children who witness domestic violence, but are not physically abused.

Exposure to adult partner violence runs a gamut of scenarios. Children have been described being hit or threatened in their mother's arms, children taken hostage or threatened in an effort to coerce the mother's behavior, children being forced to watch physical assault, children used as a physical weapon, and children being used as spies or being interrogated as to the mother's activities and whereabouts.[1] Children can also be involved in the aftermath of a violent episode by trying to help or having to attend to injuries or being involved with law enforcement.

A study of all child protection cases in Massachusetts over a seven-month period found that 32 percent of the records documented adult domestic violence.[2] A study of 403 battered women in Colorado found that 53 percent of the women reported that their abuser also abused their children, and that 28 percent of the women also disclosed that they abused their children.[3] An examination of medical records of the mothers of 116 children referred to a hospital for suspected abuse found that 45 percent of the mothers' records showed evidence of a battering history.[4] Of the 258 questioned women who had sought refuge in battered women's shelters, 40 percent reported their spouse also physically abused their children.[5] A national random telephone survey of 6,000 American adults found that 50 percent of fathers who frequently beat their wives also frequently abused their children.[6] The data appears to establish a clear link between woman battering and child abuse, in many cases. Various studies using different samples and types of data show that 30 percent to 60 percent of battered mothers' children are maltreated.[7]

Children may not be directly abused but can be endangered or injured in the course of a violent episode in the home. Reviewed emergency department records of children identified as having been hurt during family violence.[8] The reviewed charts of 139 children, mean age of 5, found 29 percent were injured while held in the mother's arms and 24 percent were injured while intervening. Seventy-eight of the adolescents were injured while attempting to intervene and stop violence.

Author / Connie Mitchell, MD, is a board-certified specialist in emergency medicine with expertise in the field of family violence. She is the director of Domestic Violence Education at the California Medical Training Center, a state-legislated project funded by the California Office of Criminal Justice and Planning to improve the health care response to victims of violence. She has authored comprehensive curricula for clinicians, book chapters on intimate partner violence (IPV) and other publications in this field. The Training Center has been recognized by the National Institute of Medicine, the Family Violence Prevention Fund, and the National Association of Attorneys General.

Dr. Mitchell is a recognized forensic medical expert in IPV and teaches criminal justice professionals for the California District Attorney's Association. She is a member of the faculty at the University of California, Davis, chair of the University Bioethics Committee and a practicing clinician in the emergency department at UCD Medical Center.

Psychological Impact of Witnessing Family Violence

In 1999, there was a review of 84 studies that specifically addressed children in homes with partner physical violence and of these, 31 examined children who were witnesses to violence had not been physically abused themselves.[9] Studies using the Child Behavior Checklist (CBCL) and similar measures have found that child witnesses of domestic violence exhibit more aggressive and antisocial behaviors (often called externalized behaviors) as well as fearful and inhibited behaviors (internalized behaviors), and show lower social competence than other children. Children who witnessed violence were also found to show more anxiety, lack self-esteem, depression, anger, and temperament problems than children who did not witness violence at home. Children from homes where their mothers were being abused have shown less skill in understanding how others feel and examining situations from other's perspectives than children from non-violent households. Peer relationships, autonomy, self-control, and overall competence were also reported significantly lower among boys who have experienced serious physical violence and been exposed to the use of weapons between adults living in their homes.

One study also found long-term developmental problems in children witnesses to violence such as depression and low self-esteem, and other researchers have found greater distress and lower social adjustment in adults who witnessed violence in their childhood.[10] There is some support for the link between exposure to violence and subsequent violent behavior in the child. A study of 2,245 children found exposure to violence in the home to be a significant predictor of a child's violent behavior.[11]

Impact of Abuse and Witnessing Family Violence

Child abuse victims who witness family violence experience a "double whammy."[12] They found that children who were both abused and witnessed family violence exhibited the most problem behaviors in a control study of abused children, children who witnessed violence only, and children without abuse or family violence in their household. This same pattern has appeared in other studies. A summary list by age is provided below.

Children from homes where their mothers were being abused have shown less skill in understanding how others feel and examining situations from other's perspectives.

Prenatal

- Increased miscarriages due to increased beatings
- Poor health due to maternal stress and lack of proper nutrition

Infants

- Crying and irritability
- Sleep disturbances
- Digestive problems

Toddlers/Preschool

- More aggressive than other children
- More withdrawn than other children
- Impaired cognitive abilities
- Delays in verbal development
- Poor motor abilities
- General fearfulness, anxiety
- Stomach aches
- Nightmares
- Lack of bowel and bladder control over 3 years of age
- Lack of confidence to begin new tasks

School Age

- Poor grades, or in special classes
- Failure of one or more grades
- Poor social skills
- Low self-esteem
- General aggressiveness
- Violent outbursts of anger
- Bullying
- Withdrawn, dependent
- Bedwetting
- Nightmares
- Digestive problems, ulcers
- Headaches (not related to eyestrain or sinus)

Teenagers

- Poor grades, failure in school, quits school
- Low self-esteem
- Refuses to bring friends home
- Stays away from home
- Feels responsible to take care of the home and mother
- Runs away
- Violent outbursts of anger, destroys property
- Poor judgment, irresponsible decision making
- Unable to communicate feelings
- Immaturity
- Withdrawn, few friends
- Nightmares

- Ulcers, digestive problems
- Bedwetting
- Severe acne
- Headaches
- Males hitting their girlfriends
- Females being hit by their boyfriends
- Joining in on beatings of mother

Some studies indicate that boys show more externalized behavior problems (hostility, aggression) and girls show more internalized problems (depression, somatization). Few studies have found any differences based on race and ethnicity. Modulating factors include time since the violent event (fewer problems the longer the time since exposure), and the child's coping mechanisms (emotion-focused or problem-focused coping strategies).

Implications for Screening, Assessment and Reporting

All children should be screened for their experiences with abuse and violence including witnessing of violence. The American Academy of Pediatrics Committee on Child Abuse and Neglect recognizes that intervention on behalf of battered women is an active form of child abuse prevention.[13]

- Abused and neglected children should be screened for the possibility that a parent is being battered.
- Battered patients should be screened for the possibility that the children are being abused or neglected.
- Pregnant women should be screened for the possibility of being in a battering relationship.
- Healthcare providers should consider whether medical problems may have a stress-related origin due to family violence.
- Healthcare providers should consider whether school problems might have a stress-related origin due to family violence.

Many states, including California, have mandatory training and reporting laws requiring health care providers to report domestic violence if a victim presents with injuries caused by spousal or partner assault. The mandatory reporting of child abuse and neglect also encompasses dental neglect, i.e. poor diet, failure to follow through with necessary treatment, etc. The State of California also has a domestic violence screening requirements for licensed clinics and hospitals. CDA

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Resources

California Medical Training Center,
Domestic Violence Education Division
(916) 734-4143

Family Violence Prevention Fund
San Francisco, California
(415) 252-8900
http://www.fvpf.org

California Alliance Against Domestic Violence
926 J St., Suite 1000
Sacramento, California 95814
(916) 444-7163
http://www.caadv.org

SUSPECTED VIOLENT INJURY/SUSPECTED DOMESTIC VIOLENCE INJURY REPORT

- Note to Law Enforcement: Patient's whereabouts and place of contact must be deleted from any report required to be disclosed to suspect or suspect's attorney.
- To Be Completed by Reporting Party Pursuant to Penal Code Section 11160-11163
- **Type or print legibly**

Case Identification or Addressograph

Victim Name: _____

Medical Record # or PCR: _____

Reported to

Police/Sheriff (Circle one) Department Name: | Crime Report #

Mailing Address

Name of Official Contacted | ID# | Phone ( ) | Date/Time Verbal Contact | Date/Time Written Copy Sent

Reporting Party

Name of Facility | Name of Reporting Party (print)

Facility Address | Title of Reporting Party

Phone ( ) | Date/Time of Observation | Signature of Reporting Party

Involved Parties

Victim

Name (Last, First, Middle) | DOB | Sex | Race | SS# or DL# | Marital Status

Address | Ages of Children Living With Victim

Location of victim after evaluation | Home phone ( ) Message phone ( )

Suspect

Name (Last, First, Middle) | DOB | Sex | Race | Relationship to victim

Address

Location of suspect | Home phone ( ) Message Phone ( )

Incident Information

If Necessary, Attach Extra Sheet or Other Form and Check This Box ☐

Date/Time of Incident | Place of Incident

Narrative description of Incident using victim's own words when possible

Type of Injuries: (Check one or more)
☐ Bruises ☐ Fractures ☐ Internal Injuries ☐ Gunshot Wound ☐ Other _____
☐ Lacerations ☐ Strangulation ☐ Stab Wound ☐ Sexual Assault

Location of Injuries: (Check one or more)
☐ Face ☐ Mouth ☐ Eye ☐ Ribs ☐ Abdomen ☐ Pelvis
☐ Neck ☐ Head ☐ Chest ☐ Upper Back ☐ Lower Back ☐ Extremities
☐ Other _____

Narrative description of injuries ☐ photos taken ☐ x-rays ☐ dental models available

Is victim willing to talk to law enforcement: ☐ Yes ☐ No *Primary language of the victim:* _____
Describe a safe way to contact the victim: (contact person and contact phone number, time of day to call)

INSTRUCTIONS
1. This is not a substitute for complete documentation in the medical record.
2. The police crime report is not a substitute for this report
3. Report by phone to the jurisdiction where the injury occurred
4. Prepare this report and send to the contacted law enforcement agency within two days of receiving information about the injury
5. Retain a copy of this report
6. Sexual Assault, Child Abuse and Elder Abuse are reported on separate forms

Original – Law Enforcement **Copy – Medical Records**

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Abuse and Neglect of Elderly Individuals: Guidelines for Oral Health Professionals

Paul D. Glassman, DDS, MA, MBA;
Elisa M. Chávez, DDS; and
Doris Hawks RDH, MA, JD

ABSTRACT

The number of elderly individuals in our society is growing rapidly. This demographic change presents a number of challenges to our society and our health care systems. One of these is elder abuse and neglect, a serious and growing problem. In California, there are a number of state agencies responsible for oversight of care provided to elderly individuals and several systems for reporting suspected abuse and neglect depending on where the suspected abuse or neglect is occurring. Dental professionals are mandated reporters and therefore must understand how to recognize and — where possible prevent — abuse and neglect in their older patients and know how to report these suspicions.

PURPOSE OF PAPER

Dental professionals are "mandated reporters" of suspected elder abuse. As such, it is critical that they are aware of this issue and their legal responsibility and know how to recognize potential instances of elder abuse. It is also critical that dental professionals understand what steps to take when they suspect elder abuse. This article will review these issues and includes recommendations for dental professionals in this area.

The elderly are the fastest growing segment of our population. Between 1990 and 2000 there was a 12 percent increase in the population of people over 65 and a 38 percent increase in the population 85 years and older. In 2000, there were 35 million people 65 years and older representing almost 13 percent of the total population and those 85 years and older represented 1.5 percent of the total population. Those 85 years and older will represent almost 5 percent of the population by 2050.[1] In 2011, the "baby boom" generation will begin to turn 65, and by 2030, it is projected that one in five people will be age 65 or older. The size of this older population is projected to double over the next 30 years, growing to 70 million by 2030.[1] The elderly population in the United States is not evenly distributed with more elderly people living in California (3.6 million) than in any other state.[2] The aging of the population has

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important consequences for the health care system. As the elderly fraction of the population increases, more services will be required for the treatment and management of chronic and acute health conditions. Providing health care services needed by Americans of all ages will be a major challenge in the 21st century.[3]

The 2000 Surgeon General's Report on Oral Health in America,[4] the 2003 follow-up *National Call to Action to Promote Oral Health*[5] and other publications[2,7] document the lack of access to oral health services and poor oral health conditions among our nation's elderly population. The elderly are described in these reports as one group who suffers from the "silent epidemic of oral diseases."[4]

The *National Call to Action* summarized these findings about older adults from the *Surgeon General's Report*:

- Twenty-three percent of 65- to 74-year-olds have severe periodontal disease.
- About 30 percent of adults 65 years and older are edentulous; figures are higher for those living in poverty.
- Oral and pharyngeal cancers are diagnosed primarily in the elderly.
- Most older Americans take both prescription and over-the-counter drugs. Individuals in long-term care facilities are prescribed an average of eight drugs and at least one of the medications used will have an oral side effect — usually dry mouth — increasing the risk for some oral diseases.
- At any given time, 5 percent of Americans aged 65 and older (currently some 1.65 million people) are living in a long-term care facility where dental care is problematic.
- Many elderly individuals lose their dental insurance when they retire; older women generally have lower incomes and may never have had dental insurance. Medicaid funds dental care for the low-income and disabled elderly in some states, but reimbursements are low. Medicare is not designed to reimburse for routine dental care.

These issues with oral health and elderly populations are becoming more prevalent. One hundred years ago, the life expectancy of most Americans was only 47.3 years. Most people could expect to lose their teeth by middle age. Now in the 21st century Americans have a life expectancy of more than 76 years and are maintaining many of their natural teeth due to great strides in understanding and preventing dental diseases. Baby boomers were the first generation to receive the benefits of water fluoridation and will reach age 65 more dentate than previous generations.[6,7,8] They are also more demanding and financially able than their predecessors to undergo more extensive restorative dental treatments that may require more diligent oral hygiene and increased regularity of dental visits to maintain those restorations.[8] Ironically, there is an increased caries rate as people age due to numerous exogenous and endogenous factors: limited education, limited financial resources for a variety of food choices and preventive measures, lack of fluoride exposure, exposure of soft root surfaces due to the presence of periodontal disease, use of medications that impair salivary flow, or diseases that impede oral hygiene due to motor or cognitive deficits or have concomitant adverse oral effects.[9,10] These factors combined with histories of complex restorative dental care are likely to result in many challenges to maintaining good oral health as our population ages. Even for edentulous patients, some systemic diseases and/or their management can leave them particularly vulnerable to fragile oral tissues and impaired denture use or microbial infections.[9,10]

Thirty- four percent of people over age 65 have some limitation due to chronic health conditions.

The new elderly are better educated, are more politically aware, and have greater expectation for health, including dental health.[7] However, one in 10 Americans has a severe, activity-limiting disability.[11] In 2000, 19.3 percent of the population reported some type of long lasting condition or disability. However, among seniors over the age of 65 this number was dramatically higher with 41.9 percent of people in this age group reporting some disability and 20.4 percent reporting a disability severe enough that they had difficulty going outside their home.[12] Additionally there may be limited financial resources and access to providers who might provide assessment and treatment.[8] Fewer than 20 percent of individuals over 75 years old have private dental insurance and Medicaid is not required to provide dental coverage for this population.[13,14] These factors can make it difficult for seniors who have kept their teeth to maintain their oral health.

When we think of individuals at risk of declining oral health and of abuse or neglect, perhaps it is more appropriate to consider their functional status along with other risk factors rather than chronological age.[7] Forty-three percent of Californians over age 65 in 2002 reported having a disability.[15] In addition to considering their functional status we must also consider their access to resources, and their economic or social dependence upon those who might abuse or neglect them.[16] Thirty-four percent of people over age 65 have some limitation due to chronic health conditions. Approximately 4.5 percent of the population over 65 years of age (down from 5 percent in 1990-2000) lives in a long-term care setting, and about 10 percent are housebound.[8,15]

In California, issues facing elderly individuals have recently been highlighted in response to SB 910 which requires, among other things, that the California Health and Human Services Agency (HHSA) prepare a long-range strategic

plan on aging.[17] The California Commission on Aging (CCoA), the principal advisory body to the governor, Legislature, and state, federal and local departments and agencies on issues that ensure a quality of life for older Californians, held a series of hearings and meetings to provide input to this plan. As a part of the process the CCoA produced a statement of findings on senior-related oral health issues in April 2003.[18]

The Oral Health Section of This Statement Reported That:

- Seniors still have the poorest oral health of any age group and it is the most widespread disease in the population. In fact, seniors have a 300 percent higher rate of cavities than children.
- About 14 percent of community-dwelling elderly are considered "frail" with chronic conditions that create major limitation in mobility. Often homebound, these seniors often face insurmountable dental access barriers.
- In nursing homes, up to 70 percent of the residents have unmet oral needs, including high rates of edentulism, poor oral hygiene, periodontal disease, and soft tissue lesions.
- There is a lack of dental providers available to treat seniors who have low incomes.
- There is a lack of adequate training of oral health providers to treat this population.
- There is a lack of effective self-care or caregiver assistance with oral care.

Some of the difficulties with a senior's ability to maintain oral health reported above are related to the fact that many older individuals become dependent on others to provide oral health and other caregiving services for them. It has been estimated that as many as 30 percent of elders are unable to visit dental offices independently either because of medical, physical, financial, or social reasons.[19,20] As older individuals become more dependent on others for caregiving, they become more vulnerable to abuse and neglect.

Table 1

Categories of Elder Abuse

Physical Abuse includes:

- Physical assault
- Sexual assault
- Unreasonable physical constraint
- Prolonged deprivation of food or water
- Inappropriate use of a physical or chemical restraint or psychotropic medication

Neglect includes:

- Failure to assist in personal hygiene
- Failure to provide clothing and shelter
- Failure to provide medical care
- Failure to protect from health and safety hazards
- Failure to prevent malnutrition or dehydration
- Self-neglect

Emotional Abuse includes:

- Verbal assaults, threats or intimidation
- Subjecting an individual to fear, isolation or serious emotional distress
- Withholding of emotional support
- Confinement

Isolation includes:

- Restricting the elder's contact with others
- Not giving the elder the opportunity to speak freely or have contact with others without the caregiver being present

Financial Abuse includes:

- Theft or embezzlement of money or any other property from an elder

Adopted from The California Department of Justice. A citizen's guide to preventing and reporting elder abuse.[25]

Abuse and Neglect in Elderly Individuals

The California Institutions Code contains several definitions related to elder abuse. It defines "elders" as any person residing in this state, 65 years of age or older.[21] Elder abuse is mistreatment or neglect of an elder, most often by a relative or caregiver, and includes physical sexual, verbal, or emotional abuse, financial exploitation, abandonment, neglect, self-neglect and isolation. **Table 1** lists some of the activities included in these categories. Full text of this law may be found at http://www.leginfo.ca.gov/calaw.html by searching the Welfare and Institutions Code for the keywords "elder abuse."

The law in California defines dependent adult abuse as either physical, neglect or financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering or the deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering.[22] Neglect is defined as "the negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise or the negligent failure of an elder or dependent adult to exercise that degree of self care that a reasonable person in a like position would exercise." Neglect is considered to

include, but not be limited to failure to assist in personal hygiene, or in the provision of food, clothing, or shelter; failure to provide medical care for physical and mental health needs; failure to protect from health and safety hazards; failure to prevent malnutrition or dehydration; and failure of an elder or dependent adult to satisfy the needs described above for himself or herself as a result of poor cognitive functioning, mental limitation, substance abuse, or chronic poor health.[23]

The Institute of Medicine reports a "paucity of research" on elder abuse and neglect, with most prior studies lacking empirical evidence. In fact, they report there are no reliable, national estimates of elder abuse, nor are the risk factors clearly understood. However, in spite of imprecise national data, the states attorney general estimates that nearly 200,000 Californians are victims of elder abuse each year.[25] The 1998 National Elder Abuse Incidence Survey concluded that at least half a million older persons in domestic settings were newly abused, neglected, and/or exploited, or experienced self-neglect in 1996. The study also found that for every reported incident of elder abuse, neglect, exploitation, or self-neglect, approximately five were unreported.[26] A special report on abuse indicated that 5,283 — almost one out of every three U.S. nursing homes — was cited for an abuse violation from Jan. 1, 1999 through Jan. 1, 2001. All of these violations had at least the potential to harm nursing home residents. In more than 1,600 of these nursing homes, the abuse violations were serious enough to cause actual harm to residents or to place the residents in immediate jeopardy of death or serious injury.[27]

There are federal and state laws that specifically address definition and prohibition of abuse and neglect of elders and dependent adults. A listing of these laws can be found on the Web site of the Department of Aging, Long Term Care Ombudsman Program.[28] Among these is Section 368 of the California Penal Code which defines "elder" as "any person who is 65 years of age or older" and "caregiver" as "any person who has the care, custody, or control of, or who stands in a position of trust with, an elder or a dependent adult."[29]

Elder abuse is not only a problem in California and the U.S., but it is recognized as an issue around the world.[30] According to California's attorney general, elder abuse is found among individuals from various socio-economic groups, gender, race, ethnicity, educational background and geographic locations. Abuse victims often remain silent because of embarrassment, fear or intimidation.[25] The 2000 survey of State Adult Protective Services conducted by The National Center on Elder Abuse found that the most frequently occurring substantiated allegation of maltreatment involved self-neglect, 41.9 percent; followed by physical abuse, 20.1 percent; and caregiver neglect/abandonment, 13.2 percent.[31]

Sometimes there are clear signs that abuse is occurring or has occurred. Most often the signs are not so clear. Dental professionals should look for signs that abuse *might* be occurring. **Table 2** lists some things that can be observed that might be signs of elder abuse or neglect. The presence of these indicators should initiate further investigation.

Many state, federal, and local agencies provide information and resources for professionals and the public about elder abuse and neglect.[32,33,34] The Federal Administration on Aging funds the National Center on Elder Abuse

Table 2

Signs that abuse or neglect might be occurring

Physical Signs of Abuse or Neglect:

- Uncombed or matted hair
- Poor skin condition or hygiene
- Unkempt or dirty
- Patches of hair missing or bleeding scalp
- Any untreated medical condition
- Malnourished or dehydrated
- Foul smelling
- Torn or bloody clothing or undergarments
- Scratches, blisters, lacerations or pinch marks
- Unexplained bruises or welts
- Burns caused by scalding water, cigarettes or ropes
- Injuries that reflect an outline of an object, for example, a belt, cord or hand

Behavioral Signs of Abuse or Neglect:

The individual is:

- Withdrawn
- Confused or extremely forgetful
- Depressed
- Helpless or angry
- Hesitant to talk freely
- Frightened
- Secretive

Signs of Isolation of the Elder by Others:

- Contact with visitors or professionals is unnecessarily restricted
- Elder is not given the opportunity to speak freely or have contact with others without the caregiver being present

Adopted from The California Department of Justice. A citizen's guide to preventing and reporting elder abuse.[25]

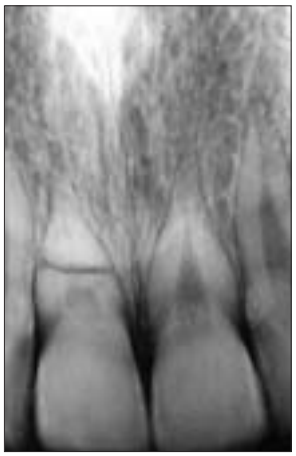


Figure 1. Evidence of dental trauma may be a sign of abuse.

Table 3

Oral/Dental Status

- Oral debris present
- Has dentures or removable bridge
- Has some or all natural teeth — does not have/use partial or denture
- Has broken, loose or carious teeth
- Has inflamed gums (gingivitis; swollen or bleeding gums; oral abscesses, ulcers or rashes)
- Daily cleaning of teeth/dentures by resident or staff is performed
- None of the above

From Minimum Data Set (MDS) version 2.0, section L. Oral/Denture Status.[37]

(NCEA) to serve as a resource for the public and for professionals. NCEA consists of a consortium of six partners: the National Association of State Units on Aging, the lead agency; the Commission on Law and Aging of the American Bar Association; the Clearinghouse on Abuse and Neglect of the Elderly of the University of Delaware, which has an online searchable database; the San Francisco Consortium for Elder Abuse Prevention of the Institute on Aging; the National Association of Adult Protective Services Administrators; and the National Committee for the Prevention of Elder Abuse.[32,35,36]

The Role of Oral Health Care Professionals in Investigating Suspected Abuse or Neglect

In long-term care facilities federal law mandates certain assessment and treatment procedures. The Center for Medicare and Medicaid Services (CMS) guidelines mandate that each nursing facility resident be "assessed" by a nurse within 14 days of admission and annually for seven oral health triggers identified in a "Minimum Data Set" (MDS).[37] **Table 3** lists the components of the oral health section of the MDS. When detected, the problems must be identified and a care plan created to address each problem or an interdisciplinary review conducted. Unless a dental professional (DDS or RDHAP) is involved with this process, many problems go undetected and untreated often until a resident has lost more than 10 pounds. Such weight loss then triggers another evaluation. Oral pain has been identified as the most frequent cause of weight loss in long-term care facility residents. Although sometime thought of as "mere neglect," this failure to identify oral pain and disease, which ultimately leads to the need for chemical restraint or results in malnutrition, dehydration and failure to provide appropriate care reaches the definition of elder abuse.

A nursing facility must arrange for all residents to receive necessary dental care. This requirement makes the facility directly responsible for the dental care needs of its residents. The facility must ensure that a dentist is available for residents, i.e., employ a staff dentist or have a contract arrangement with a dentist to provide services.[38]

Dental professionals must be careful not to automatically attribute bruises, poor hygiene or trauma from reported falls as a normal part of aging.[16] It is true that these may be consequences of a disease or disorder that result in an increased risk of falling, a limited ability to provide self-care or a medication such as an anticoagulant, but oral health professionals must ask about the history of the injury or other findings to determine if it may in fact be a result of abuse or neglect — especially if it appears to be recurrent.

From a dental perspective, signs of abuse or neglect are often ambiguous. There are many patients whose oral condition is less than optimal, and this may or may not constitute a sign of abuse or neglect. It is also possible that appropriate interventions by dental professionals can prevent instances of abuse or neglect through identification of active diseases or other oral conditions such as trauma or poor oral hygiene and education about treatment options and prevention. Social isolation is often a risk factor for abuse or neglect.[16] Good oral function and health is important in maintaining quality of life, adequate nutrition and the ability to speak and interact in social situations[9,10,39,40] (**Figure 1**).

It is important to realize that both dentate and edentulous individuals can achieve good oral health whether they are a well elder or a frail elder, functionally independent or dependent. Most oral diseases and conditions associated with aging, for example: caries, periodontal disease leading to tooth loss, edentulism, oral cancer, candidiasis, and pulpal necrosis are in fact due to a disease process or trauma and not due to the aging process itself.[9,10] Neglect may be avoided by continuing to educate patients, guardians and caregivers about effective and safe treatment options for preventing, resolving or controlling these conditions for even the frailest individuals and not allow the assumption that they are a natural consequence of aging.[6,8,41,42] Dental practitioners must also guard against the justification that

because a particular disease or condition is not painful, i.e. cavities, periodontal disease or oral lesions, it does not require treatment.[16,43] This becomes especially important for those individuals who cannot effectively communicate that they are in pain or discomfort. Assessment of pain in elderly patients can be a complex process.[42,43] At the same time, we must be careful not to impose unrealistic expectations on or withhold information from patients, families and guardians who are doing their best to make responsible choices based upon the information given them or, in some cases, upon wishes previously made known to them by the individual.[16,44]

Guidelines for Reporting Elder Abuse for Oral Health Professionals

Oral health professionals can play a role in detecting and reporting signs of possible abuse or neglect in their older patients. In fact, as mandated reporters, oral health professionals are required to do so. Mandated reporters are those groups specifically identified in California law as required to report suspected abuse or neglect. Licensed dental professionals (all license categories for dentists, hygienists, dental assistants) are among this group and can be found guilty of a crime for not reporting.[45] This law is specific about the reporting requirements. It says that "any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse, or neglect, or is told by an elder or dependent adult that he or she has experienced behavior, including an act or omission, constituting physical abuse, abandonment, abduction, isolation, financial abuse, or neglect, or reasonably suspects that abuse, shall report the known or suspected instance of abuse by telephone immediately or as soon as practicably possible, and by written report sent within two working days." The California Department of Social Services form for filing a written report can be downloaded from the Internet.[46]

There are several systems in California for providing oversight of care for elders and therefore several ways that suspected abuse and neglect can be reported. These are summarized in **Table 4**. In April 2003, the state's attorney general's office launched a "SafeState" Campaign.[47] The campaign features a statewide hotline, (888) 436-3600, for reporting suspected cases of elder or dependent adult abuse. The hotline will directly connect callers wishing to report suspected abuse to the responsible agency including their local Adult Protective Services Agency or the Long-Term Care Ombudsman Crisis Line (**Figure 2**).

In California, there is an extensive system for regulation and inspection of long-term care facilities including nursing homes and skilled nursing facilities in the Department of Health Services, Licensing and Certification Division. This system, which regulates 30 different types of health care facilities and more than 6,000 providers, is described on the California Department of Health Services' Web site.[48] There are a number of documents available on the Department of Health Services, Licensing and Certification Web site that describe the rights of residents of nursing and other long-term care facilities.[49] Among these are publications on "Nursing Home Residents' Rights: Abuse — What to Do" and "Nursing Home Residents' Rights — Your Rights as a Resident in a Nursing Home."

There is also a system for oversight of long-term care facilities under the California Department of Aging called the Long-Term Care Ombudsman Program. Information on this program can be found on the Department of Aging Web site.[50] The Office of the State Long-Term Care Ombudsman (OSLTCO) develops policy and provides oversight to the 35 local county ombudsman programs. These programs recruit, train, and supervise local volunteer ombudsmen who are responsible and available to answer questions or concerns about quality of care or concerns about suspected physical, mental, emotional abuse or financial abuse of residents. Ombudsman can also provide witnessing services for advanced directives, attend resident care plan meetings and attend a resident or family council meeting. The state maintains a 24-hour, seven-days-a-week crisis line at (800) 231-4024 to receive complaints from residents. There is also a listing of each county's Long-Term Care Ombudsman Program available on the Department of Aging Web site.[51] In an

Table 4

Attorney General's Elder and Dependent Abuse Hot line

- Referral to Ombudsman or Adult Protective Services: (888) 436-3600

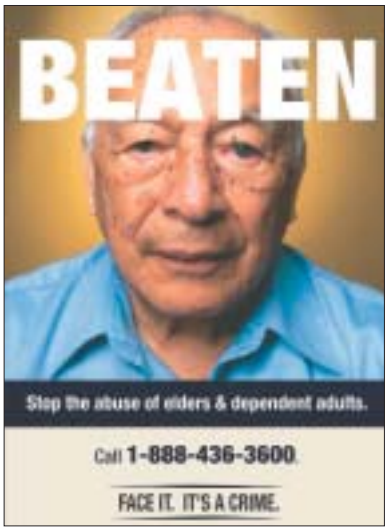
Reporting Suspected Elder Abuse in Long-Term Care Facilities

- Status Ombudsman 24/7 crisis line: (800) 231-4024
- List of Local County Ombudsman Programs: http://www.aging.state.ca.us/html/programs/ombudsman_contacts.html
- California Attorney General's Bureau of Medi-cal Fraud and Elder Abuse Hot Line — (800) 722-0432
- Local Law Enforcement

Reporting Suspected Elder Abuse Outside of Long-Term Care Facilities

- Adult Protective Services County Contact List with 24/7 hotline numbers: http://www.dss.cahwnet.gov/pdf/apscolist.pdf
- Local Law Enforcement

From the California Attorney General, Department of Aging and Department of Social Services Web sites.[50,52,53]



Figures 2 and 3. Posters from the California Attorney General's SafeState Campaign.[4]
Used with permission by the California Attorney General's Office.

emergency, suspected abuse or neglect can be reported to local law enforcement agencies using the 911 system.

Another state agency concerned with elder abuse is the Bureau of Medi-Cal Fraud and Elder Abuse in the attorney general's office. This agency is concerned with attempts to defraud California's Medi-Cal program, including health care providers and persons involved in the program's administration. They are also concerned with abuse and neglect of patients in Medi-Cal-funded facilities, such as nursing homes, developmental treatment facilities, and hospitals. They can be contacted at the attorney general's bureau of Medi-Cal Fraud and Elder Abuse toll-free hotline, (800) 722-0432.[52]

Suspected or known abuse that occurs anywhere other than in a long-term care facility should be reported to the local Adult Protective Services (APS) agency or local law enforcement. A county's adult protective services program is within the California Department of Social Services. These agencies provide assistance to elderly and dependent adults who are functionally impaired, unable to meet their own needs, and who are victims of abuse, neglect, or exploitation. They investigate reports of abuse of elderly and dependent adults in private homes, hotels, acute care hospitals and health clinics, as well as in adult and social day-care centers. They provide or coordinate support services, such as counseling, money management, conservatorship, and advocacy. They also provide information and education to other agencies and the public about reporting requirements and other responsibilities under the elder and dependent adult abuse reporting laws.[53] There is an Adult Protective Services county contact list available on the APS Web site.[54] This contact list includes a 24-hour, seven-days-a-week hot line maintained by each county agency. A description of elder abuse regulations and guidelines and list of county APS agencies is also available on the California Dental Association Web site.[55]

Conclusion

The number of elderly individuals in our society is growing rapidly. This demographic change provides a number of challenges for our society and our health care systems. One of these is elder abuse and neglect, a serious and growing problem. In California, there are a number of state agencies responsible for oversight of care provided to elderly individuals and several systems

for reporting suspected abuse and neglect depending on where the suspected abuse or neglect is occurring. Dental professionals may be in a position to prevent elder abuse and neglect. Dental professionals are mandated reporters and therefore must understand how to recognize possible abuse and neglect in their older patient and know how to report these suspicions. **CDA**

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STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY

CONFIDENTIAL REPORT - NOT SUBJECT TO PUBLIC DISCLOSURE

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE

TO BE COMPLETED BY REPORTING PARTY. PLEASE PRINT OR TYPE. SEE GENERAL INSTRUCTIONS.

COUNTY APS/OMBUDSMAN CASE NUMBER

LAW ENFORCEMENT CASE/FILE NUMBER

RECEIVING AGENCY USE ONLY

A. VICTIM [As applicable under Welfare and Institutions Code (WIC) 15630 (a)] ☐ *CHECK THIS BOX IF VICTIM CONSENTS TO DISCLOSURE OF INFORMATION (Ombudsman use only)*

*NAME (LAST NAME FIRST) | *AGE | DATE OF BIRTH | SSN | SEX ☐ M ☐ F | ETHNICITY | LANGUAGE (✔ CHECK ONE) ☐ NON-VERBAL ☐ ENGLISH ☐ OTHER (SPECIFY)

*ADDRESS (IF FACILITY, INCLUDE NAME) | *CITY | *ZIP CODE | *TELEPHONE ( )

*PRESENT LOCATION (IF DIFFERENT FROM ABOVE) | *CITY | *ZIP CODE | *TELEPHONE ( )

☐ ELDERLY (65+) ☐ DEVELOPMENTALLY DISABLED ☐ MENTALLY ILL/DISABLED ☐ PHYSICALLY DISABLED ☐ UNKNOWN/OTHER | ☐ LIVES ALONE ☐ LIVES WITH OTHERS

***B. REPORTING PARTY:** *Check Appropriate Box If Reporting Party Waives Confidentiality:* ☐ ✔ ALL ☐ ✔ All but victim ☐ ✔ All but Perpetrator

*NAME (PRINT) | SIGNATURE | OCCUPATION | AGENCY

RELATION TO VICTIM/HOW KNOWS OF ABUSE | WHERE TO CONTACT | (STREET) | (CITY) | (ZIP CODE) | TELEPHONE ( )

C. INCIDENT INFORMATION - Address where Incident Occurred:

*DATE/TIME OF INCIDENT(S)

PLACE OF INCIDENT (✔ CHECK ONE)
☐ OWN HOME ☐ COMMUNITY CARE FACILITY ☐ HOSPITAL/ACUTE CARE HOSPITAL
☐ HOME OF ANOTHER ☐ NURSING FACILITY/SWING BED ☐ OTHER (Specify)

***D. REPORTED TYPES OF ABUSE (✔ CHECK ALL THAT APPLY).**

1. PERPETRATED BY OTHERS (WIC 15610.07 & 15610.83)

a. PHYSICAL
- ☐ ASSAULT/BATTERY
- ☐ CONSTRAINT OR DEPRIVATION
- ☐ SEXUAL ASSAULT
- ☐ CHEMICAL RESTRAINT
- ☐ OVER OR UNDER MEDICATION

b. ☐ NEGLECT
c. ☐ FINANCIAL
d. ☐ ABANDONMENT
e. ☐ ISOLATION
f. ☐ ABDUCTION
g. ☐ OTHER (Non-Mandated: e.g., deprivation of goods and services: psychological/mental)

2. SELF-NEGLECT (WIC 15610.57(b)(5))

a. ☐ PHYSICAL CARE (e.g., personal hygiene, food, clothing, shelter)
b. ☐ MEDICAL CARE (e.g., physical and mental health needs)
c. ☐ HEALTH and SAFETY HAZARDS
d. ☐ MALNUTRITION/DEHYDRATION
e. ☐ OTHER (Non-Mandated e.g., financial)

ABUSE RESULTED IN (✔ CHECK ALL THAT APPLY) ☐ NO PHYSICAL INJURY ☐ MINOR MEDICAL CARE ☐ HOSPITALIZATION ☐ CARE PROVIDER REQUIRED ☐ DEATH ☐ MENTAL SUFFERING ☐ OTHER (SPECIFY) ☐ UNKNOWN

E. REPORTER'S OBSERVATIONS, BELIEFS, AND STATEMENTS BY VICTIM IF AVAILABLE. *LIST ANY POTENTIAL DANGER FOR INVESTIGATOR (E.G., ANIMALS, WEAPONS, COMMUNICABLE DISEASES, ETC.). ☐ ✔CHECK IF MEDICAL, FINANCIAL, PHOTOGRAPHS OR OTHER SUPPLEMENTAL INFORMATION IS ATTACHED).

F. FAMILY MEMBER OR OTHER PERSON RESPONSIBLE FOR VICTIM'S CARE. *(If unknown, list contact person).*

*NAME | IF CONTACT PERSON ONLY ✔ CHECK [ ] | *RELATIONSHIP

*ADDRESS | *CITY | *ZIP CODE | *TELEPHONE ( )

G. OTHER PERSON BELIEVED TO HAVE KNOWLEDGE OF ABUSE. *(e.g., family significant others, neighbors, medical providers and agencies involved, etc.)*

NAME | ADDRESS | TELEPHONE NO. ( ) | RELATIONSHIP

H. SUSPECTED ABUSER ✔ *Check if* ☐ *Self-Neglect*

NAME OF SUSPECTED ABUSER ☐ CARE CUSTODIAN (type)__ ☐ HEALTH PRACTITIONER (type)__ ☐ PARENT ☐ SON/DAUGHTER ☐ OTHER__ ☐ SPOUSE ☐ OTHER RELATION

ADDRESS | *ZIP CODE | TELEPHONE ( ) | SEX ☐ M ☐ F | ETHNICITY | AGE | D.O.B. | HEIGHT | WEIGHT | EYES | HAIR

I. TELEPHONE REPORT MADE TO: ☐ APS ☐ Law Enforcement ☐ Ombudsman ☐ Calif. Dept. of Mental Health ☐ Calif. Dept. of Developmental Services

NAME OF OFFICIAL CONTACTED BY PHONE | *TELEPHONE ( ) | DATE/TIME

J. WRITTEN REPORT ☐ Mailed or ☐ Faxed **(DO NOT FAX REPORT TO CDSS) FAX to agency to which telephone report was made.**

AGENCY NAME | ADDRESS OR FAX # | DATE MAILED OR FAXED

K. RECEIVING AGENCY USE ONLY ☐ Telephone Report ☐ Written Report

1. Report Received by: Date/Time:
2. Assigned ☐ Immediate Response ☐ Ten-day response ☐ No initial face-to-face required ☐ Not APS
   Approved by: Assigned to (optional):
3. Cross-Reported to: ☐ CDHS, Licensing & Cert.; ☐ CDSS-CCL; ☐ CDA Ombudsman; ☐ Bureau of Medi-Cal Fraud & Elder Abuse; ☐ Mental Health; ☐ Law Enforcement; ☐ Professional Board; ☐ Developmental Services; ☐ APS; ☐ Other (Specify) Date of Cross-Report:

SOC 341 (8/03)

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REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE
GENERAL INSTRUCTIONS

PURPOSE OF FORM

This form, as adopted by the California Department of Social Services, is required under Welfare and Institutions Code (WIC) Sections 15630 and 15658(a)(1). This form documents the information given by the reporting party on the suspected incident of abuse of an elder or dependent adult. **"Elder,"** as defined in WIC Section 15610.27 means any person residing in this state who is 65 years of age or older. **"Dependent Adult,"** as defined in WIC 15610.23 means any person residing in this state, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age. Dependent adult includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code (H & S).

REPORTING RESPONSIBILITIES

Mandated reporters* (see definition on p. 2 under "Reporting Party Definitions") shall complete this form for each report of a known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect (including self-neglect), isolation, and abandonment (see definitions in WIC 15610) involving an elder or a dependent adult. **The original of this report shall be submitted within two (2) working days of making the telephone report to the responsible agency as identified below:**

- The county Adult Protective Services (APS) agency or the local law enforcement agency (if abuse occurred in a private residence, apartment, hotel or motel, or homeless shelter).
- Long-term care ombudsman (LTCO) program or the local law enforcement agency (if abuse occurred in a nursing home, adult residential facilities, adult day programs, residential care facility for the elderly, or adult day health care center).
- The California Department of Mental Health or the local law enforcement agency (if abuse occurred in Metropolitan State Hospital, Atascadero State Hospital, Napa State Hospital, or Patton State Hospital).
- The California Department of Developmental Services or the local law enforcement agency (if abuse occurred in Sonoma State Hospital, Lanterman State Hospital, Porterville State Hospital, Fairview State Hospital, or Agnews State Hospital).

WHAT TO REPORT

Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment has observed, suspects, or has knowledge of an incident that reasonably appears to be physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect), or is told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, isolation, financial abuse, abduction, or neglect, shall report the known or suspected instance of abuse by telephone immediately or as soon as practicably possible, and by written report (SOC 341) sent within two working days to the appropriate agency.

MULTIPLE REPORTERS

When two or more persons who are required to report are present and jointly have knowledge of a suspected instance of abuse of an elder or a dependent adult and when there is agreement among them, the telephone report may be made by a member of the team selected by mutual agreement and a single written report may be made and signed by the selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so, shall thereafter make the report.

FAILURE TO REPORT

Failure to report physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect) of an elder or a dependent adult is a misdemeanor, punishable by not more than six months in the county jail, or by a fine of not more than $1,000, or by both imprisonment and fine. Any mandated reporter* who willfully fails to report abuse of an elder or a dependent adult, where the abuse results in death or great bodily injury, may be punished by up to one year in the county jail, or by a fine of up to $5,000, or by both imprisonment and fine.

WRITTEN REPORT/TELEPHONE REPORT

1. This form may be used by the receiving agency to record information through a telephone report of suspected dependent adult/elder abuse. Complete asterisk (*) sections on the form when a telephone report of suspected abuse is received as required by statute and the California Department of Social Services (CDSS).
2. If any item of information is unknown, write "unknown" beside the item.
3. Part B. REPORTING PARTY - Please check if reporting party waives confidentiality.
4. Part B. REPORTING PARTY - Mandated reporters* are required to give their names and non-mandated reporters may report anonymously.
5. Part C. INCIDENT INFORMATION - Please provide best known time frame (e.g., 2 days, 1 week, or ongoing).
6. Part D. Please check all types of suspected abuse that apply.
7. Part E. Reporter may attach medical diagrams, photographs of injuries or environment, etc.
8. Part I. TELEPHONE REPORT MADE TO - The mandated reporter* completes this section after making the telephone report.
9. Part K. AGENCY USE ONLY - This section may be used by the agency receiving the written report.

DISTRIBUTION OF SOC 341 FORMS/COPIES

Mandated reporter- After making the telephone report send the original and 1 copy to the receiving agency, keep 1 copy for your file.
DO NOT SEND A COPY TO THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES.
Receiving Agency - Place the original in the case file. The copy may be sent to a cross-reporting agency or it may be discarded.

GENERAL INSTRUCTIONS (continued)

IDENTITY OF THE REPORTER

The identity of all persons who report under WIC Chapter 11 shall be confidential and disclosed only between APS agencies, local law enforcement agencies, LTCO coordinators, Bureau of Medi-Cal Fraud and Elder Abuse of the Office of the Attorney-General, licensing agencies or their counsel, Investigators of the Department of Consumer Affairs who investigate elder and dependent adult abuse, the office of the District Attorney, the Probate Court, the Public Guardian, or upon waiver of confidentiality by the reporter, or by court order.

REPORTING PARTY DEFINITIONS

*Mandated Reporters (WIC) "15630 (a) Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter."

Care Custodian (WIC) "15610.17 'Care custodian' means an administrator or an employee of any of the following public or private facilities or agencies, or persons providing care or services for elders or dependent adults, including members of the support staff and maintenance staff: (a) Twenty-four-hour health facilities, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code. (b) Clinics. (c) Home health agencies. (d) Agencies providing publicly funded in-home supportive services, nutrition services, or other home and community-based support services. (e) Adult day health care centers and adult day care. (f) Secondary schools that serve 18- to 22-year-old dependent adults and postsecondary educational institutions that serve dependent adults or elders. (g) Independent living centers. (h) Camps. (i) Alzheimer's Disease day care resource centers. (j) Community care facilities, as defined in Section 1502 of the Health and Safety Code, and residential care facilities for the elderly, as defined in Section 1569.2 of the Health and Safety Code. (k) Respite care facilities. (l) Foster homes. (m) Vocational rehabilitation facilities and work activity centers. (n) Designated area agencies on aging. (o) Regional centers for persons with developmental disabilities. (p) State Department of Social Services and State Department of Health Services licensing divisions. (q) County welfare departments. (r) Offices of patients' rights advocates and clients' rights advocates, including attorneys. (s) The office of the long-term care ombudsman. (t) Offices of public conservators, public guardians, and court investigators. (u) Any protection or advocacy agency or entity that is designated by the Governor to fulfill the requirements and assurances of the following: (1) The federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, contained in Chapter 144 (commencing with Section 15001) of Title 42 of the United States Code, for protection and advocacy of the rights of persons with developmental disabilities. (2) The Protection and Advocacy for the Mentally Ill Individuals Act of 1986, as amended, contained in Chapter 114 (commencing with Section 10801) of Title 42 of the United States Code, for the protection and advocacy of the rights of persons with mental illness. (v) Humane societies and animal control agencies. (w) Fire departments. (x) Offices of environmental health and building code enforcement. (y) Any other protective, public, sectarian, mental health, or private assistance or advocacy agency or person providing health services or social services to elders or dependent adults."

Health Practitioner (WIC) "15610.37 'Health practitioner' means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, licensed clinical social worker or associate clinical social worker, marriage, family, and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any emergency medical technician I or II, paramedic, or person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code, a marriage, family, and child counselor trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, or an unlicensed marriage, family, and child counselor intern registered under Section 4980.44 of the Business and Professions Code, state or county public health or social service employee who treats an elder or a dependent adult for any condition, or a coroner."

EXCEPTIONS TO REPORTING (WIC 15630 (b) (3) (A))

A mandated reporter who is a physician and surgeon, a registered nurse, or a psychotherapist, as defined in Section 1010 of the Evidence Code, shall not be required to report a suspected incident of abuse where all of the following conditions exist:

- (I) The mandated reporter* has been told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect).
- (ii) The mandated reporter* is not aware of any independent evidence that corroborates the statement that the abuse has occurred.
- (iii) The elder or the dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia.
- (iv) In the exercise of clinical judgment, the physician and surgeon, the registered nurse, or the psychotherapist, as defined in Section 1010 of the Evidence Code, reasonably believes that the abuse did not occur.

In a long-term care facility, a mandated reporter* who the California Department of Health Services determines, upon approval by the Bureau of MediCal Fraud and the state office of the Long-term Care Ombudsman (LTCO), has access to plans of care and has the training and experience to determine whether all the conditions specified below have been met, shall not be required to report the suspected incident of abuse (WIC 15630 (b) (4) (A)):

- (I) The mandated reporter* is aware that there is a proper plan of care.
- (ii) The mandated reporter* is aware that the plan of care was properly provided and executed.
- (iii) A physical, mental, or medical injury occurred as a result of care pursuant to clause (I) or (ii).
- (iv) The mandated reporter* reasonably believes that the injury was not the result of abuse.

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

STATEMENT ACKNOWLEDGING REQUIREMENT TO REPORT SUSPECTED ABUSE OF DEPENDENT ADULTS AND ELDERS

NOTE: RETAIN IN EMPLOYEE/ VOLUNTEER FILE

NAME

POSITION

FACILITY

California law REQUIRES certain persons to report known or suspected abuse of dependent adults or elders. As an employee or volunteer at a licensed facility, you are one of those persons - a "mandated reporter."

PERSONS WHO ARE REQUIRED TO REPORT ABUSE

Mandated reporters include care custodians and any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not paid for that responsibility. [Welfare & Institutions Code ("W&I") section 15630(a)] **Care custodians** include administrators or employees of any CDSS licensed facility, including support and maintenance staff, or persons providing care or services for elders or dependent adults. [W&I §§ 15610.17(e)&(j)]

PERSONS WHO ARE THE SUBJECT OF THE REPORT

Elder means any California resident, 65 years or older. [W&I § 15610.27]
Dependent adult means any California resident, aged 18 through 64, who has physical or mental limitations that restrict his/her ability to carry out normal activities or to protect his/her rights including, but not limited, to persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age. [W&I § 15610.23]

WHEN REPORTING ABUSE IS REQUIRED

Any mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be abuse or neglect, or is told by an elder or dependent adult that he or she has experienced behavior constituting abuse or neglect, or reasonably suspects that abuse, shall report the known or suspected instance of abuse. This must be done BY TELEPHONE IMMEDIATELY or as soon as practically possible, and BY WRITTEN REPORT WITHIN TWO (2) WORKING DAYS. [W&I § 15630(b)]

PENALTY FOR FAILURE TO REPORT ABUSE

Failure to report abuse of an elder or dependent adult is a MISDEMEANOR CRIME, punishable by jail time, fine or both. [W&I § 15630(h)]

CONFIDENTIALITY OF REPORTER AND OF ABUSE REPORTS

The duties of mandated reporters are individual and no supervisor or administrator shall impede or inhibit the reporting duties, and no person making the report shall be subject to any sanction for making the report. However, internal procedures to facilitate reporting, ensure confidentiality, and apprise supervisors and administrators of reports may be established, provided they are not inconsistent with the reporting law. [W&I § 15630(f)]

The reporting person, the report, and the information on the report, shall be kept confidential and may be disclosed ONLY as provided by law. Any violation of confidentiality is a MISDEMEANOR CRIME. [W&I § 15633(a)]

ABUSE THAT MUST BE REPORTED

Abuse of an elder or dependent adult that must be reported includes: 1) physical abuse; 2) neglect; 3) financial abuse; 4) abandonment; 5) isolation; and 6) abduction. [W&I § 15630(b)]

DEFINITIONS OF ABUSE

Physical abuse means any of the following: (1) **assault** (an unlawful attempt, coupled with a present ability, to commit a violent injury on another person); or assault with a deadly weapon; (2) **battery** (willful and unlawful use of force or violence upon another person); (3) **unreasonable physical constraint, or prolonged or continual deprivation of food or water;** (4) **sexual assault** (as defined in the Penal Code); or (5) **use of a physical or chemical restraint or psychotropic medication** for (a) punishment, or (b) a period beyond that for which the medication was ordered, or (c) any purpose not authorized by the physician and surgeon. [W&I § 15610.63]

Neglect means the negligent failure of any person having the care or custody of an elder or dependent adult to exercise that degree of care that a reasonable person in a like position would exercise. [W&I § 15610.57(a)] Neglect Includes, but is not limited to, the following: (a) failure to assist in personal hygiene, or in the provision of food, clothing, or shelter; (b) failure to provide medical care for physical and mental health needs (unless the sole reason is voluntarily relying on treatment by spiritual means through prayer alone in lieu of medical treatment); (c) failure to protect from health and safety hazards; or (d) failure to prevent malnutrition or dehydration. [W&I § 15610.57(b)]

SOC 341A (3/03)

Financial abuse occurs when a person or entity does any of the following: (1) takes, secretes, appropriates, or retains real or personal property of an elder or dependent adult to a wrongful use or with intent to defraud, or both; or (2) assists in any of these acts. [W&I § 15610.30(a)]

Abandonment means the desertion or willful forsaking of an elder or dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody. [W&I § 15610.65]

Isolation means any of the following: (1) acts intentionally committed for the purpose of preventing, and that do serve to prevent, an elder or dependent adult from receiving his or her mail or telephone calls; (2) telling a caller or prospective visitor that an elder or dependent adult is not present or does not wish to talk with the caller, or does not wish to meet with the visitor where the statement is false, is contrary to the express wishes of the elder or dependent adult, whether he or she is competent or not, and is made for the purpose of preventing the elder or dependent adult from having contact with family, friends, or concerned persons (3) false imprisonment (the unlawful violation of the personal liberty of another); or (4) physical restraint for the purpose of preventing the elder or dependent adult from meeting with visitors. [W&I § 15610.43(a)] These acts shall not constitute isolation if they are performed in response to a reasonably perceived threat of danger to property or physical safety. [W&I § 15610.43(c)]

Abduction means the removal from California and the restraint from returning, or the restraint from returning, of any elder or dependent adult who does not have the capacity to consent to the removal or restraint. [W&I § 15610.06]

WHERE TO CALL IN AND SEND THE WRITTEN ABUSE REPORT

If the abuse is alleged to have occurred in a long-term care facility, including a licensed or unlicensed residential facility serving adults or elders or an adult day program, you must report to either local law enforcement or the local long-term care ombudsman. [W&I § 15630(b)(1)(A)] If the abuse is alleged to have occurred anywhere other than a long-term care facility, you must report to either local law enforcement or county adult protective services. [W&I § 15630(b)(1)(C)]

AS AN EMPLOYEE OR VOLUNTEER OF THIS FACILITY, YOU MUST COMPLY WITH THE DEPENDENT ADULT AND ELDER ABUSE REQUIREMENTS, AS STATED ABOVE. IF YOU DO NOT COMPLY, YOU MAY BE SUBJECT TO CRIMINAL PENALTY.

I, _____, have read and understand my responsibility to report known or suspected abuse of dependent adults or elders. I will comply with the reporting requirements.

SIGNATURE	DATE

CASE STUDY

Forensic Odontology and Elder Abuse — A Case Study

Gregory S. Golden, DDS

Teeth can be the best and sometimes the only remaining source of information that provide the clues to an unknown person's identity. Teeth may also serve either as weapons of aggression or self-defense. Bite marks found on victims of homicide, rape, assault, or abuse can occasionally be the only evidence linking the suspect to the crime. Dentists with specialized training in forensic investigation, collection, and handling of dental evidence, play a pivotal role in bringing answers to these difficult legal questions. However, when it comes to abuse, all health-care personnel including dentists should be capable of recognizing it and knowing what to do about it whenever encountered. Once abuse is determined to exist, it is the responsibility of the forensic odontologist to provide the bridge that links the dental evidence to the legal world. This article discusses the aforementioned topics, the frequency, signs, and indicators of elder abuse, and demonstrates how the data and information collected by the dentist can be put to use in situations that require thorough dental investigation.

Background

Statistics gathered by the U.S. Department of Justice indicate that violent crimes against people ages 65 or older are approximately 4 in 1,000.[1] Numbers on non-violent abuse indicate that neglect of the elderly is the most frequent type of mistreatment, 48.7 percent; and that emotional/psychological abuse is next at 35.5 percent. Third highest is physical abuse, 25.6 percent; financial and material exploitation ranks fourth, 30.2 percent; and abandonment was found to be the least common form of elder abuse, 3.6 percent.

From other accumulated data, it is estimated that the majority of cases go unreported (1 in 14), although from 1986 to 1996 the number of reported cases steadily increased by 150.4 percent.[2] This trend may continue to grow with more and more education and training becoming available for law enforcement, social workers, and medical caregivers with each successive year.

Indicators of Abuse

Neglect

Neglect presents itself in several forms. Self-neglect can stem from an elderly person's inability to manage day-to-day tasks such as personal hygiene, housework, and preparing a meal for themselves. An elder may mismanage their personal finances by failing to pay bills, hoard money, or give money away. Other signs of self-neglect can range from failing to keep medical appointments, refusing medications, or suicidal acts. Neglect from a caregiver is also an area wherein the elder may be abused by not receiving adequate attention to hygiene, clothing, nourishment, or medical care.

Emotional/Psychological

Signals that an elderly person may be experiencing psychological or emotional abuse can range from hesitation to talk openly, feelings of helplessness, fear, withdrawal, depression, disorientation, and even anger. One possible indicator that a caregiver is contributing to emotional abuse is that the elder may not be given an opportunity to speak for himself/herself. Inappropriate reactions by the caregiver, particularly unwarranted defensiveness or a reluctance to comply with service providers when planning for activities or supervision can be a warning flag. Engaging the elder and the caregiver in conversation to determine whether or not they are open and responsive to dialogue or if they are hesitant to talk could mean there is something going on that may need closer scrutiny.

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Physical

The signs and symptoms listed here are not intended to be a confirmation of abuse; only indications of a condition that may be ongoing and otherwise unnoticed. Some of the clues dentists may encounter that may give the impression that physical abuse of an elderly person is occurring are bruises, lacerations or puncture wounds, injuries with incompatible histories, loss of hair or hemorrhaging under the scalp, weight loss, malnutrition, and soiled clothing. Burns of questionable sources should be discussed in depth, such as from caustic chemicals, cigarettes, and friction injuries from objects that could be ligatures.

Even though there may be great reluctance or even fear for the elder to report abuse, it is the responsibility of the dentist to report cases of suspected abuse when encountered.[3] If abuse is suspected, dentists should ask a few questions to check it out and contact the area's appropriate agency that handles reported elderly abuse. Professionals should handle it and make the determination of whether or not a complaint is valid.

Role of the Odontologist

Whatever the numbers say about the frequency and type of abuse, the forensic odontologist is regularly consulted when either law enforcement or health care personnel recognize that there is dental evidence connected to an incident. One area where the skills of an odontologist are needed for the elderly is in identification, both in the deceased and the living.

For instance, a person with Alzheimer's disease or dementia, but who is still ambulatory, unwittingly drives to a remote location where they become totally disoriented and lost, (i.e. mountains or desert). They then proceed to wander aimlessly until they become physically exhausted and collapse or worse — die, only to be found several days or weeks later. Having left their original location without personal identification, sometimes the only means of proving their true identity is through dental records. This scenario can present a difficult problem for the odontologist when the decedent is edentulous or has no recent dental history. Should that person survive the ordeal but suffer from complete memory loss, answers to their identity may again have to be confirmed through a dental examination.

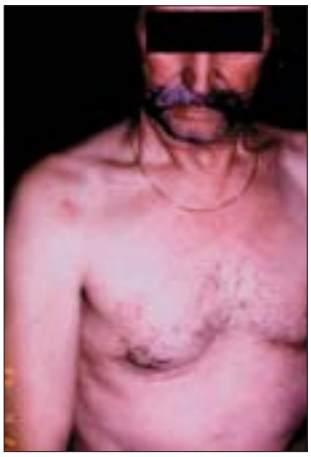

Figure 1. Bite marks on right shoulder and breast.

Figure 2. Multiple bites on upper back.

Similarly, if several elderly people are sharing the same facility (convalescent hospital or assisted living community), the opportunity can exist where dentures may get misplaced or mismatched with their rightful owners, either by accident or through malicious intent. This presents a situation where placing a person's name or other identifying feature in both dentures is highly advisable. Dentists who make full or partial dentures for their patients, no matter what their patient's age, should recommend that the laboratory that processes them make sure to include an identification tag in the resin bases. Several states, including California, have created laws requiring mandatory labeling of dentures; although many labs and dentists are not aware these statutes exist.

Bites are another form of dental evidence and usually occur during domestic arguments, homicides, battery, sexual assaults, and human abuse. Initially one might think that the older segment of the population is less likely to have these types of violent crimes committed against it rather than younger or middle-aged people. Unfortunately, perpetrators look upon the elderly person as an easy target, simply because of a possible diminished mental capacity or inability to resist physical attack. Once identified as a bite mark, a comprehensive investigation and collection of evidence must occur from several agencies. In emergency situations, the primary concern is the survival of the victim. If alive, once the patient is stabilized there should be collection of DNA evidence from the bite mark before the patient is washed or has the wound attended. The importance of DNA collection cannot be overemphasized. Crime scene analysts or other law enforcement personnel usually accomplish this by swabbing the bitten area for trace salivary residue.

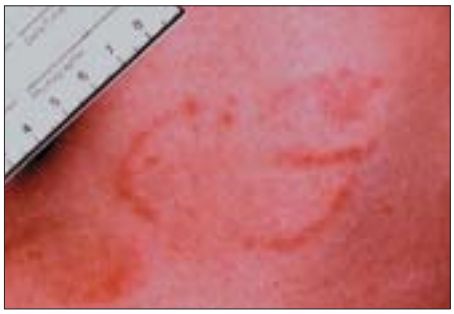

Figure 3. Close up of multiple bites on lower back.

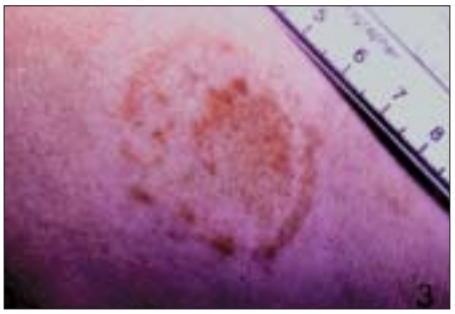

Figure 4. Closeup of bite mark on right shoulder.

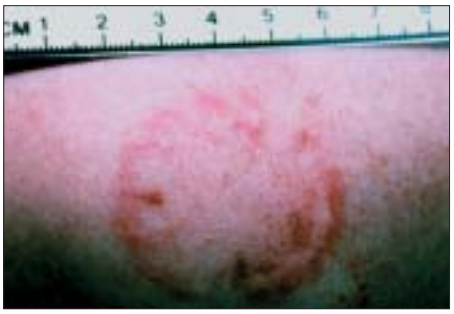

Figure 5. Close up of bite mark on upper back.

DNA evidence is a crucial element in bite mark investigation. The odontologist is then responsible for accurately documenting the bite mark injury with photographs, analyzing and comparing it to suspects, and ultimately presenting his/her findings and conclusions in a judicial setting.

In living bitten victims, the initial contact usually comes from emergency care providers, social workers, nurses, doctors, or law enforcement agents. In the deceased, notification usually comes from a forensic pathologist, homicide investigator, or an official from the medical examiner's or coroner's department.

In regard to photographic documentation, timing is crucial in bitten living victims due to the process of inflammation response, healing, and other wound reactions and tissue changes that occur immediately after injury. With elderly victims, the skin is generally less elastic and bruises more easily than in children or young adults. This fact can render the appearance of the bite to become useless as evidence if not documented quickly. No matter what the age of the living victim, it is essential to accurately record the injury as soon as possible with adequate photography.

The role of the dental practitioner is to be aware of the signs and symptoms of human abuse, and to know when and where to report it whenever encountered. The forensic odontologist then assists law enforcement by providing a link between dental evidence and the judicial system. Whether it is an identification or investigation of a bite mark, the odontologist acts as a neutral party whose function is to demonstrate to the court the facts of the dental evidence. A typical example of how forensic odontology integrates with abuse of the elderly follows.

Case History

Original contact in this case came from the principal homicide investigator at the police department in Ontario, Calif. Circumstances as explained were that the younger of two male co-tenants living in a detached rental house owned by an 84-year-old landlady, committed assault and battery on the older co-tenant, sexually assaulted the landlady and fatally stabbed her in the neck with a pair of scissors. Several suspected bite marks were observed on both victims. The author's first encounter was with the surviving 64-year-old co-tenant who was examined at Ontario Community Hospital. He presented 13 separate bite marks distributed over his head, torso, and back (**Figures 1-5**).

These bites were all 2-dimensional (no depth of penetration) and were photographically documented for subsequent comparison to any suspect(s) dentition.

Immediately after examining the male co-tenant, attention was turned to the deceased 84-year-old female. Two bites marks were recognized and photographically documented: One bite was centrally located on the abdomen, the other on the right breast (**Figures 6-8**).

Several days after the examination of the two victims, dental impressions were made of the suspect's dentition. From the stone casts, clear acetate tracings were prepared that indicated the incisal edge outlines and positions of the anterior maxillary and mandibular teeth. These overlays were compared to life-size photographic prints of the injuries to both victims. A few samples of these comparisons are presented in **Figures 9-11**.

Numerous consistencies were present in both arches, including the arch size, shape, and distribution of teeth to the bruise pattern. Additionally, under close examination of the incisal edges of the suspect's mandibular teeth, an unusual intra-dental feature was observed in the tissue of the bite. The distal-incisal corners of the mandibular lateral incisors, (Nos. 23 and 26) were fractured, leaving sharp edges of enamel (**Figure 12**).

Figure 6. Orientation photo of homicide victim.

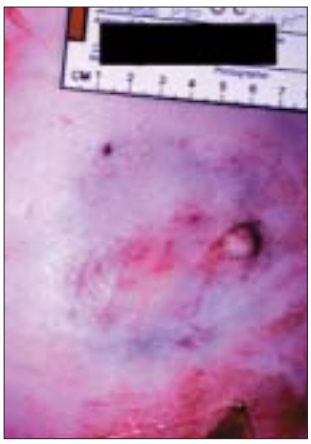

Figure 7. Close up of bite mark on right breast. Note diffuse deep bruise pattern and surface scratches.

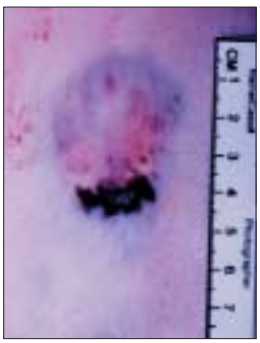

Figure 8. Close up of abdominal bite mark. Lower arch is darker area at six o'clock position.

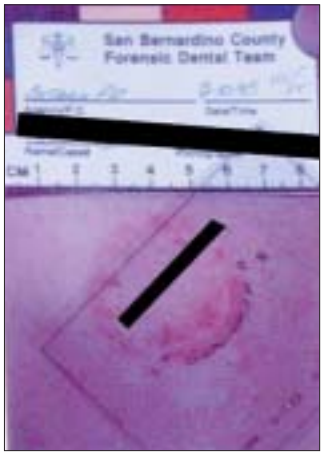

Figure 9. Comparison of suspect's lower dentition to bite on male victim. Overlay is just below bruise to facilitate seeing the concordant points of injury.

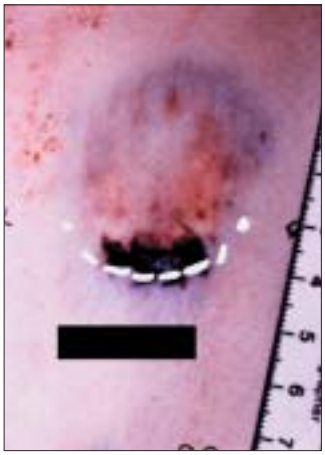

Figure 10. Overlay of suspect's lower teeth compared to bite on abdomen of homicide victim.

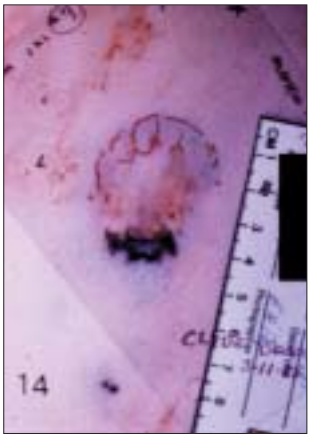

Figure 11. Overlay of suspect's maxillary dentition compared to bite on abdomen.

Macroscopic examination revealed tissue disruption and surface scratches evident in corresponding areas of the abdominal bite. These two areas of surface abrasion were created during the motion of biting by the sharp, fractured edges of these teeth (**Figures13-15**).

A microscopic examination of these linear abrasions to the skin was performed using a ballistics comparison scope. Measurements of the actual widths of the parallel surface scratches proved to be identical to the distances between the distal corners of the laterals. Additionally, the sharp fractured edges of both teeth could be attributed to parallel linear abrasions within their respective areas of the mandibular arch component of the bruise.

Once faced with this and other incriminating evidence, the suspect pled guilty to multiple charges of battery and one count of homicide. After a preliminary hearing, he received a maximum allowable sentence of incarceration in a state correctional facility.

Summary

This case presented an opportunity wherein a crossover of forensic disciplines occurred. By utilizing equipment normally employed in ballistics examination for a dental comparison, the

Figure 12. Fractured distal-incisal edges of Nos. 23 and 26 — lingual view.

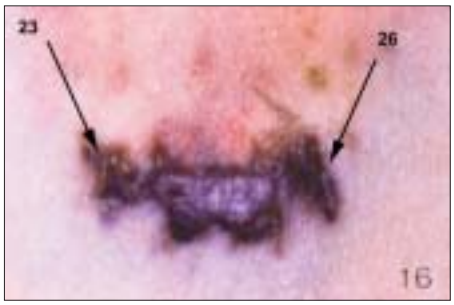

Figure 13. Arrows indicate two areas of tissue abrasion from the indicated mandibular teeth.

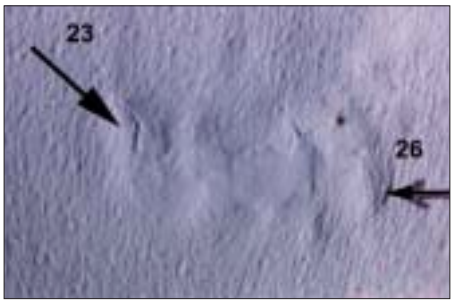

Figure 14. Silicone model of same area of bite in **Figure 13**. Note improved surface detail.

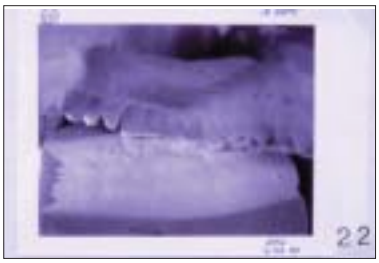

Figure 15. Comparison of model to silicone duplicate of bite mark indicating corresponding teeth to the injury and locations of tissue abrasion to fractured incisal corners of laterals.

author was able to indicate to a reasonable dental certainty that the perpetrator of multiple bites on two individuals was the same person and had a unique dental feature that was represented in the abdominal bite on the homicide victim. In any investigation that offers a multidisciplinary approach as an option (such as DNA testing), the forensic odontologist/investigator should utilize all the available techniques at hand. With a comprehensive approach, both in the clinical environment and in the forensic arena, the dentist becomes a central component for prevention as well as investigation of elder abuse. CDA

To request a printed copy of this article, please contact / Gregory S. Golden, DDS, 8577 Haven Ave., Suite 105, Rancho Cucamonga, Calif., 91730.

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2. Tatara R, "Reporting Requirements and Characteristics of Victims," Domestic Elder Abuse Information Series No. 3, Washington D.C., National Center on Elder Abuse, November 1997.

3. California Penal Code (PC) Section 11166, and California Welfare and Institutions (W&I) Code, Section 15630.

Robert E. Horseman, DDS

Statisticians Have It All Figured Out

Statistics are more pliable than facts and are, in fact, like witnesses; you can always get them to testify for either side.

ta-tis-tic\ *sta-'tis-tik*\ *n* 2 a : *a quantity that is computed from a sample*

Stat-is-ti-cian \ *stat-a-stish-an* \ *n : one who carefully assembles facts and figures for others who carefully misinterpret them*

Not once in recent memory have any of my colleagues asked for my opinion on anything. In my immediate family, my input is required only occasionally when there is some question as to who takes out the trash or is responsible for replenishing the gas tank. I am surprised, therefore, to recently receive a lengthy survey requesting my opinions on dozens of topics.

Q. During an average week how many full dentures do you seat?

0 – 1
2 –5
6 – 50
Over 500

This is a tricky question. My worst nightmare is seating more than one denture every six months, but I don't want this to be interpreted somehow that my supply of denture adhesive samples is to be terminated, so I fudge a little and check box No. 3. Six to 50 sounds as if I am reasonably busy, but not a denture fanatic.

Q. Which of the following mouthwashes do you recommend?

Listerine
Scope
Rembrandt
Liquid Plumber
Whichever I have the most free samples of

When I give away the free samples, it is not necessarily a recommendation, it's more of a house cleaning. The patient thinks it has my blessing and as long as I believe the product will not actually poison him, it works out well for everybody.

Q. How many patients do you see in an average month?

Continued on Page 353

Continued from Page 354

First of all, there is no such thing as an average month, or an average day, for that matter. I have feast or famine days and months. Statisticians hate this kind of an answer. If all statisticians were placed end-to-end, they would come to endless conclusions, so I make it easy for them by supplying a figure they can live with. I have chosen 123 as a number that sounds possible without any hint of grandiose production braggadocio. Statistics are more pliable than facts and are, in fact, like witnesses; you can always get them to testify for either side.

Q. How many dentists are in your practice?

1
2
3 – 9½
163

It is so embarrassing to admit that I operate in an HMO-less Mom-and-Pop practice like some shoe cobbler out of the Middle Ages that I always put down 8. I figure this is my one and only chance to appear in somebody's eyes as a Big Shot, even if it is a statistician who can always use facts and figures to support anything, especially himself.

Q. How many amalgams, implants, full mouth reconstructions, third molar surgical extractions and full banded cases do you do in an average year?

Now, I could go back into my last year's appointment book and laboriously count the number of these operations page by page, but it would seriously interfere with my post-lunch nap, so I enter 1947. That was the year I was married and it has always occupied a special place in my heart.

Q. What was your before-tax gross earnings from your practice last year?

$100,000 – $150,000
$150,000 – $400,000
$400,000 – $1,000,000
$1,000,000 – $975,612,733

> The last thing I want to admit is a figure, however accurate, that puts me in the bottom 5 percent of widely published professional incomes.

Another tricky question. The last thing I want to admit is a figure, however accurate, that puts me in the bottom 5 percent of widely published professional incomes. To statisticians, fractions speak louder than words, so carefully threading my way somewhere between accepted poverty levels and the chance of attracting the attention of the Internal Revenue Service, I have chosen $361,493.16 as a respectable income for a average dentist in an average town in an average part of the country working average hours during an average week with the average number of disabling afflictions, one of which is the dislike of filling out surveys.

A representative sample of 100,000 dentists is thought to be in the neighborhood of 150 with an average of seven replies considered statistically significant. When you read the results of any survey in which I have had the honor of participating, keep in mind that statistics can prove anything by statistics. If he weren't already deceased, you could confirm this with Tom Dewey, or even Al Gore if he is still with us. CDA