Proceedings:

Dentists C.A.R.E. (Child Abuse Recognition and Education) Conference

July 31 – August 1, 1998

Conference Sponsored by:
American Dental Association
Council on Access, Prevention
and Interprofessional Relations

Additional Support from:
American Dental Association Health Foundation
U.S. Health Resources and Services Administration,
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Disclaimer

The Dentists C.A.R.E. Conference was designed to provide continuing education for dental professionals regarding detecting and reporting suspected child abuse. The information presented is not offered as professional advise or to set standards of care, or to suggest that dentists should undertake activity beyond their scope of practice. Remarks made by speakers do not necessarily reflect policies and positions of the American Dental Association. Dental professionals should become familiar, and comply, with applicable laws regarding reporting suspected child abuse and other forms of family violence.

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Chapter 1 Introduction

Background

Three children each day die from abuse

Prevent Child Abuse America (formerly the National Committee to Prevent Child Abuse) reports that in 1997, over three million children in this country were reported to child protective service (CPS) agencies as being abused or neglected. Of these, over one million cases were substantiated. This represents a fifty percent increase compared to eight years ago. Three children each day die from abuse. In approximately 65% of all cases of physical abuse, injuries occur in the head, neck and face areas. Knowing that dentists are in a good position to detect such injuries, the profession has stepped up professional education efforts to improve the public's health.

The American Dental Association's *Principles of Ethics and Code of Professional Conduct* includes a statement about a dentist's ethical duty to become familiar with the perioral signs of child abuse and to report all suspected cases to the proper authority. Also, the American Dental Association's House of Delegates has adopted policies that seek to promote education of members in the signs of child abuse and appropriate consulting and reporting approaches. The hope is that more dentists will become aware of the signs of child abuse and report suspected cases to appropriate state agencies.

Conference Agenda

The Dentists C.A.R.E. (Child Abuse Recognition and Education) Conference was held on July 31 and August 1, 1998, at the ADA Headquarters Building in Chicago. Participants represented a range of health care and human services disciplines, as well as experts in the area of family violence and dentistry. The meeting began with brief welcoming remarks from American Dental Association Executive Director, Dr. John S. Zapp and Conference Moderator and Chairman of the ADA Council on Access, Prevention and Interprofessional Relations, Dr. Paul Stubbs. Presentations from experts in various aspects of child abuse followed; they covered the clinical signs of child abuse and neglect specific to dentistry, forensic dentistry and case management, legal and liability issues related to reporting suspected abuse, ethical issues related to child abuse and family violence, psychological and patient management considerations in treating pediatric patients, dentistry's interventions and perspectives in preventing child abuse and neglect, the American Medical Association's perspective and family violence as a public health issue.

Chapter 2 Opening Session

Opening Remarks

John S. Zapp, DDS
Executive Director, American Dental Association

Dr. John S. Zapp welcomed participants to the 1998 Dentists C.A.R.E. Conference on behalf of the officers and staff of the American Dental Association (ADA). He thanked the ADA Health Foundation and the U.S. Health Resources and Services Administration, Maternal and Child Health Bureau for their generous financial support for the conference. He noted that this conference was the first national conference on child abuse since 1980, and the first ever in the ADA building. Further, Dr. Zapp stressed the ADA's pride in this particular conference because of the unique opportunity it presents for those with a shared concern for preventing child abuse. The conference, he noted, was in keeping with the dental profession's longstanding commitment to children's health and oral health.

The conference, he noted, was in keeping with the dental profession's longstanding commitment to children's health and oral health.

Dr. Zapp closed by noting a 1993 amendment to the ADA's *Principles of Ethics and Code of Professional Conduct* which makes it an ethical obligation for all ADA members to become familiar with the perioral signs of child abuse and report suspected cases to the proper authorities consistent with state law. Since that amendment, two additional Houses of Delegates have adopted policies urging the ADA and its state societies to expand training in detecting abuse and resources for its members. Also, a large survey has indicated that ADA members want continuing education activities on recognizing and reporting child abuse. Finally, Dr. Zapp thanked the participants for attending the conference and assured the group of the ADA's commitment to this issue.

Paul Stubbs, DDS
Conference Moderator and Chairman, Council on Access, Prevention and Interprofessional Relations

Dr. Paul Stubbs welcomed conference participants and expressed his pleasure to represent the ADA's Council on Access, Prevention and Interprofessional Relations (CAPIR). He noted the conference was the culmination of much hard work and is a highlight of the Council's activities. CAPIR's role, he said, involves advocacy, prevention of disease and injury, and collaboration with other health professionals, and is the "inner voice and conscience" of the Association. Dr. Stubbs echoed Dr. Zapp's thanks to the conference supporters, specifically recognizing Mr. Dwight Edwards and Mr. Robert Czarnecki of the ADA Health Foundation and Drs. Mark Nehring and John Rossetti of the U.S. Maternal and Child Health Bureau. Further, he gave special recognition to Dr. Lynn Mouden for his work in planning the conference, as well as ADA staff members.

…the overreaching goals of the conference were to increase awareness of abuse and neglect, to act appropriately and to share what we have learned with others.

Dr. Stubbs acknowledged that participants were at this conference because they cared about children and victims of abuse and neglect. He noted that the information presented in the conference was not offered as

professional advice or to set standards of care, and remarks made by speakers did not necessarily reflect policies and positions of the American Dental Association. Overall, Dr. Stubbs said, dental professionals should become familiar, and comply, with applicable laws regarding reporting suspected child abuse and other forms of family violence. In closing, Dr. Stubbs stated that the overreaching goals of the conference were to increase awareness of abuse and neglect, to act appropriately and to share what we have learned with others.

Keynote Address

A. Sidney Johnson III, MSW

President, Prevent Child Abuse America (formerly National Committee to Prevent Child Abuse)

Mr. A. Sidney (Sid) Johnson III began by expressing his thanks to and admiration for the Council, noting it was right on target in its concern with child abuse and neglect. The conference, he said, was exactly what is needed in order to make progress in protecting children.

Mr. Johnson then briefly described the Prevent Child Abuse America organization. The organization's mission, he said, was to prevent child abuse in all its forms. Headquartered in Chicago, Prevent Child Abuse America has a budget of $4.5 million and a staff of 50. The organization was founded 25 years ago and has chapters in 42 states. (Refer to Appendix F for a list of the chapters.) In addition, Prevent Child Abuse America supports 270 Healthy Families America sites, a program that provides home visiting to first time parents. Mr. Johnson was pleased to note the program's encouraging results in decreasing or preventing child abuse and supporting healthy families. For example, immunization rates have increased and more children are receiving well baby care. In Vermont the Healthy Families America program reaches 83 percent of all new parents and in six years abuse rates for children are down 42 percent. He further noted Arizona and Florida have seen abuse rates cut in half, decreased welfare dependency and improved child-parent relationships.

The scope of the problem, Mr. Johnson said, is widespread. Once a child has been abused, the scar will never be removed. For this reason, Prevent Child Abuse America's main focus is on prevention. Last year, three million reports of child abuse were filed and, of these, over one million were substantiated. This represents a fifty percent increase compared to eight years ago. Three children each day die from abuse, making this a major public health problem.

$10-12 billion is spent each year for health care for abused children…

Mr. Johnson noted that two billion dollars are spent each year responding to abuse, including investigation and treatment. Unfortunately, he said, not much is spent on prevention. An additional $10-12 billion is spent each year for health care for abused children, which does not even take into account the predictable costs that child abuse produces in children who go on to drop out of school, become pregnant as teens, become substance abusers or commit crimes. Studies have shown that a very large percentage of criminals were abused as children.

Mr. Johnson then turned to the challenges of dental neglect among children. He noted that dental neglect might be one of the first visible signs of neglect. Neglect is often very difficult to determine, yet makes up 55 percent of child abuse. Mr. Johnson said dental neglect has been defined as the willful failure by a parent or guardian to seek and obtain appropriate treatment for caries and infections or any other condition of teeth or supporting structure that make routine eating difficult or impossible, cause chronic pain, delay or retard a child's growth or development, or make it difficult or impossible for a child to perform daily activities like playing or going to school. He emphasized national data showing that 25 percent of children, generally from economically or socially disadvantaged families, have 75 percent of the dental disease. Reasons for this may include the following: these children do not receive as much care, children may be eligible to receive Medicaid benefits but parents/guardians do not access services, Medicaid families give dental care a lower priority than other illnesses or diseases, and the youngest children are often the most difficult to serve. Remedies, he stated, might include increasing Medicaid reimbursements, streamlining claims processing, outreach, education and voluntary efforts by dentists.

Dental professionals are in a unique position to detect and report suspected abuse because about 65 percent of abuse cases involve injuries to the head, neck and mouth. Sadly, Mr. Johnson noted, some studies show that less than one percent of these injuries are reported. He stressed the need for more education and training in identifying and reporting suspected cases of abuse and neglect. He urged conference participants to become leaders in the field among their colleagues. The critical difference, he said, is to make a difference.

To be more proactive and assertive, Mr. Johnson stressed the need to get involved effectively – in a nonpartisan way – in political policy decisions. Political constituencies must be built to support public leaders who advocate for children and youth. While the word policy connotes a high order of decision making and power that is unmoved by sentiment and unchangeable, Mr. Johnson stressed that we know better…policies are changed and exceptions are made every day. To achieve these changes, Mr. Johnson listed ten suggestions to increase nonpartisan political effectiveness:

- Provide accurate information, including cost-benefit figures if possible, for a legislator's district. If a recommendation is not going to have a positive impact on that legislator's district, tell the legislator. You may not get that legislator's vote, but he or she will know you are honest.

- Recognize the delicacy and sensitivity of issues involving government and families. Some may see policy actions as strengthening families while others may see actions as intrusive.

- Present cases in personal and human terms, not just statistics, charts and written testimony, in order to show the impact on people's real lives. Do not exploit emotion, but recognize it. Present problems and solutions in real and personal terms.

- Reach out to those who do not already believe as strongly as you do. Reach out to the Chamber of Commerce, Rotary, Kiwanis and other business leaders.
- Use nontraditional messages and unexpected messengers.
- Bi-partisanship is crucial.
- Compliment policy leaders who take the lead on issues that are important to you. Leaders get many more letters in disagreement with their actions than agreement. Let leaders know you are trying to thank them. Send a letter to the editor of your local paper recognizing good actions. Give awards to leaders for excellence.
- Visit legislators in their home districts, where they tend to listen better.
- Get involved in the political electoral process. Elections are the lifeblood of politicians and we must be there when they need us if we want them to be there when we need them.
- Have staying power and be relentless, persistent and passionate. Politicians respect those who win, but also those who lose but keep coming back until they get it right.

Mr. Johnson then quoted Woody Allen, who said "90 percent of success is just showing up." By personally committing ourselves, he stated, we can get greater strength and effectiveness and prevent abuse as a result.

To end his presentation, Mr. Johnson quoted from "A Prayer for Children" by Ina J. Hughes which provided a painful and powerful reminder why we work to prevent child abuse. Finally, Mr. Johnson again commended the audience on their focus and stressed his desire to work with them and be part of an increasingly successful effort to prevent child abuse.

Chapter 3 Presentations

Clinical Signs of Child Abuse and Neglect Specific to Dentistry

Howard Needleman, DMD
Associate Dentist-in-Chief, Children's Hospital, Boston and Clinical Professor of Pediatric Dentistry, Harvard School of Dental Medicine

Dr. Needleman began his presentation by relating two personal incidents which have made it clear to him where we were, where we are and where we are going related to child abuse. His goal, he said, was to provide data and lend evidence to support what we all are trying to do to prevent child abuse. He started by defining child abuse as any act (non-accidental or trauma) that endangers or impairs a child's physical or emotional health or development. He noted that in Massachusetts the definition was more specific: any child suffering physical or emotional injury which causes harm or substantive risk of harm to the child's health or welfare including sexual abuse or from neglect or who is determined to be physically dependent upon an addictive drug at birth.

Types of child abuse, he noted, include physical abuse, emotional abuse and neglect, health care neglect (medical and dental), physical neglect, sexual abuse, failure to thrive, safety neglect, intentional poisoning, and Munchausen Syndrome by proxy (fabricated or induced illness by parent). Factors contributing to abuse include stress (e.g. life crises such as unemployment or homelessness), lack of a support network, substance/alcohol abuse, learned behavior (many abusers were previously victims) and other forms of family violence in the home such as spousal or elderly abuse.

Dr. Needleman defined child neglect as the failure to provide adequate support, supervision, nutrition, medical or surgical care. The American Academy of Pediatric Dentistry defined dental neglect as the willful failure of a parent or guardian to seek and follow through with treatment necessary to ensure a level of oral health essential for adequate function and freedom from pain and infection. The problem of dental neglect, he said, was recently described in a 1998 article by Ramos-Gomez et al. published in the Journal of the American Dental Association. In this particular study 15,000 dentists were surveyed in California. Of the only 13 percent responding to the California survey, two-thirds knew to report suspected cases of child abuse. In addition, only one-third knew to report cases of dental neglect, though neglect is much more prevalent than physical abuse and is noticeable during the course of dental treatment.

The dental professional's role in child abuse and neglect, Dr. Needleman stated, is to know the current state law regarding reporting child abuse and to follow the law. Dr. Needleman outlined his suggestions for awareness, identification, documentation and notification. Each point was specifically discussed.

The dental professional's role in child abuse and neglect, Dr. Needleman stated, is to know the current state law regarding reporting child abuse and to follow the law.

Awareness

If you do not know about it, you do not look for it. Dr. Needleman assured participants that if they are aware of abuse and start looking for it, they will find it. It is important to not always assume that a child's injuries are as reported.

To detect abuse, he said, there must be a clinical protocol including behavioral assessment of the child and parent/guardian, patient history, general physical assessment, oral examination, injury documentation, and consultation with state social service department to discuss suspicions. It is critical to look at all possible indicators in order to discriminate accidental from non-accidental trauma. Dr. Needleman said types of indicators include:

- Behavioral indicators of abuse: Child does not make eye contact, is wary of parents, demonstrates fear of touch, dramatic mood changes, withdrawal or aggressiveness, has a history of suicide attempts and running away.

- Patient history indicators of abuse: unexplained injuries or injuries that are inconsistent with the explanation, delays in seeking care, an adult who was present at the time of the injury but absent at the examination, or a specific accusation. If a child accuses someone, take that as the truth.

- Specific caregiver indicators strongly suggestive of abuse: explanation of the injury not believable, explanations that are inconsistent or changing, paramour in the home, child has been previously abused, caregiver understates the seriousness of condition, projects blame to a third party, delays seeking attention, cannot be located, functions poorly, or has a history of substance abuse. Medical questionnaires should include a question about previous abuse.

- Non-specific caregiver indicators of abuse: hostile and aggressive attitude, compulsive, inflexible, unreasonable and cold, passive and dependent, "hospital shopper" (parent or caregiver avoids hospitals because they know signs of abuse are noticed), unrealistic expectations of the child, or overreaction to the child's misbehavior.

- Children with special needs are especially vulnerable to abuse.

Identification

Identification, he said, should start with a general physical assessment of the child including overall visual impression, general cleanliness and dress, stature based on age, gait, complexion and examination of accessible body surfaces (extremities, chest, back). Dr. Needleman noted that results of three large studies looking at the location of injuries in abuse cases showed that the head and face make up about 60 percent of all injuries. These areas, he emphasized, are observable by dentists during examination and treatment.

Physical indicators of abuse include bruises, welts, bite marks, tattoos, abrasions, lacerations, bite marks, slap marks, belt marks, burns, fractures, injuries to the head and dental/medical neglect. Dr. Needleman again cited three large studies, specifically looking at the types of injuries recorded. Contusions and bruises totaled 37 percent of all injuries; bony fractures were the next highest with 15 percent; abrasions and lacerations made up another significant amount of types of injuries. Burns, subdermal hematomas, dental injuries and bites were a less significant percentage of injuries reported. He mentioned that physicians, not dentists, conducted the examinations in the studies, so the percentage of dental injuries recorded may be lower than what was actually present. Dr. Needleman also briefly mentioned coin rubbing, which may appear to be abuse, but is rather an Asian tradition used to treat children for various medical problems by "warding off evil spirits."

A 1996 study looked at the location of injuries as a function of age. It was shown that injuries to the head or skull are more significant in younger children, but as the child grows and the head becomes smaller in proportion to the body, injuries to the face become more prominent. Dr. Needleman stressed the importance of keeping the location of injuries in mind. He also noted that the types of injuries change with age as well. Fractures are more prominent in younger children, but become less as age increases. In contrast, bruises become much more common as the age of the child increases.

The location of bruises should also be taken into consideration. Common areas for bruises to occur are over the bony prominences (knees, shins and elbows). The face, back, groin, buttocks, and soft tissues of the legs are rare areas to have bruises and should raise suspicion if noted in the course of an examination. Equally important, he said, is the healing stages of bruises. An individual who exhibits bruises in various stages of healing may indicate the child is being repeatedly traumatized.

Inflicted burns are rare, he noted, but very serious in nature. The hand is often a target of abuse and cigarette burns to the hand are common. Dr. Needleman cited a 1990 study which looked at 944 cases of child abuse. Of these cases, 10 percent had hand injuries, 42 percent of the hand injuries were burns, 37 percent had evidence of previous injuries and 20 percent of hand injuries were serious enough to require hospitalization. Cigarette burns are very obvious as are radiator burns and the "glove or stocking" burn where the child is placed or held in scalding water, leaving a well-demarcated burn. Also sometimes seen is lye burn, caused by ingestion of household cleaning products which have not been locked up.

Intraoral injuries include trauma to the oral mucosa, frenal lacerations, tooth fractures, palatal lesions, ecchymoses, lacerations, and jaw fractures. Dr. Needleman again noted that intraoral injuries make up a very small percent of all reported injuries, and most are injuries to the soft tissue. Frenal lacerations are an uncommon sign of abuse, except in pre-ambulatory children. Extraoral injuries include bites, slaps, gagging, burns and lacerated lips. He continued by saying that often injuries to the mouth are not immediately diagnosed as abuse. This is why it is so

important to look beyond the oral cavity for additional signs which may support suspicions of abuse.

Dental injuries include discolored teeth (sign of previous trauma), avulsed incisors, displacement injuries and fractures. Dr. Needleman again stressed that it is the context in which these injuries occur that is very important.

Finally, physical indicators of sexual abuse include oral lesions indicative of sexually transmitted diseases, bruising of the hard palate, pregnancy in teens, difficulty walking or sitting and fear of oral exam.

Documentation

If abuse is suspected in a child patient, Dr. Needleman stressed the need to document these suspicions. If taking photographs is allowed, do so. Make good clinical notes, because good records are critical when and if there is prosecution in an abuse case.

Treatment and Notification

Even after abuse is suspected, Dr. Needleman stressed the importance of rendering appropriate care, being as definitive as possible, because the child may not return for follow-up care. When the child leaves, he recommended discussing any suspicions with a physician and the state department of social services. His final statement stressed that it is important to remember that it is not the dental professional's job to determine whether abuse has occurred; this is the social services department's job. The dental professional's only duty is to report his/her suspicions if there is reasonable cause to suspect abuse or neglect.

Forensic Dentistry and Case Management

John P. Kenney, DDS, MS
Director, Identification Services, Du Page County (IL) Coroner's Office and Chief Odontologist (1984-1997), Cook County (IL) Medical Examiners Office

Dr. Jack Kenney opened by citing his charge – to discuss forensic dentistry and case management. Forensic resources, he said, include 100 board certified forensic odontologists in the United States, Canada and Europe, and 400 members in the section of the American Academy of Forensic Scientists.

Identification of bite marks comprises a large segment of forensic dentistry. Dr. Kenney encouraged participants to seek assistance from an experienced forensic odontologist when applicable. The four R's of bite marks, he said, are recognition, recording, reporting and referral. There are several techniques for recognition. When documenting bite marks, it is most important to use a ruler for scale. Coins can also be useful in documenting injuries if no ruler is available. Bites can be subtle, he noted. Even an ovoid or circular bruise can be used to eliminate or include possible suspects in cases. Dr. Kenney explained that in a child abuse case, there is a closed population of people who are exposed to the

child. With bite marks, impressions can be taken of suspects and matched to the bite mark. He also stated that even if the bite mark only includes one or two or three teeth markings, it is important to recognize and record it with a photograph and scale. Even partial bite marks can be used to identify perpetrators.

When recognizing bite marks, dog or animal bites must be differentiated from human bites. Canine teeth on animals are larger and tipped outward and will appear so on a bite mark. With human bites, he noted, a mark that is 3 centimeters or greater at the widest point (canine to canine) is an adult bite mark, 2.5 to 3 centimeters is a small adult or child, and under 2.5 centimeters is a child's bite mark.

Dr. Kenney next discussed photography of the bite mark. He stressed that good 35 mm photography is crucial, using color print film, ASA 100 or slower (ASA 25) because of its good reproducibility and enlargement. Additionally, a macro lens is recommended and the film plane should be 90 degrees to the area photographed. An architectural grid used in the camera is a time saving technique when lining up photographs. An identification photo of the victim with an identification tag in the frame of the photograph is helpful, as is a long shot with the face and bite in same picture if possible. Mid-range and close-up shots should be taken as well.

He then listed various photography techniques which could be used in bitemark recording: black and white analog, color analog, digital (B&W, color) and reflective and absorptive ultraviolet photography. A significant problem with digital photography, he noted, is that it can be manipulated. This can pose questions in court as to the authenticity of the photograph. He also mentioned that ultraviolet photography can record bite marks as long as six months post injury.

Three-dimensional impressions of the injury can be taken using dental impression materials and provide an additional tool to include or rule out suspects. When taking impressions, he stressed the importance of knowing the materials and techniques. Impressions are best taken when the child is sedated, and cartridge systems make the process easier. Additionally, Scotch Cast® (an orthopedic casting material) with Permadyne® (Espee Corporation) polyether impression material adheres very well when used as a layer over the impression material. A model is then made from the impression. He noted that the impression and model should be marked with the date and time, and the child's body should be marked for orientation.

Other techniques for examining bite marks include scanning electron microscopy, trans-illumination and digitization and scanning for use with computer software programs such as Adobe Photoshop.

Charting of all injuries should be done in conjunction with photography and radiography, if allowed based on state law.

Dr. Kenney next discussed documentation and reporting. Charting of all injuries should be done in conjunction with photography and radiography, if allowed based on state law. If abuse is suspected, the practitioner must follow state law and file a report. Failure to report may result in a civil suit or even a more serious crime if abuse did occur. He stressed that chances are good you will <u>not</u> have to appear in court after making a report, unless the child has a specific dental injury that you

may be called on to testify about. If you must testify, it will be as either a fact witness (answer questions put to you by the prosecution) or an expert witness (act as a teacher to the court).

He concluded by asking "What will you do if confronted by abuse?" Bite marks are typically a pattern injury. Record with photographs and then seek assistance from someone experienced in interpreting the bite marks.

Legal and Liability Issues Related to Reporting Suspected Abuse

Donald C. Bross, JD, PhD
Professor in Pediatrics (Family Law), University of Colorado School of Medicine and Director of Education and Legal Counsel, Kempe Children's Center

After briefly discussing his involvement with the Kempe Children's Center and its projects and affiliated activities, Dr. Bross moved on to the subject matter of his presentation and identified several actions which could be the basis for potential liability in the identification and reporting of child maltreatment.

- ***Failure to diagnose child abuse or neglect***, including orofacial trauma, untreated caries and dental fractures, milk bottle caries, and sexually transmitted diseases or other signs of sexual abuse. Dr. Bross discussed what a "difficult" child means in terms of behavior management as well as in terms of etiology. If we do not understand someone's behavior, he said, we do not understand their history. Often, patients have something in their lives which makes them act difficult. We need to think about what has happened in these children's lives to make them not want us to be involved.

- ***Failure to obtain a second opinion***. Dr. Bross listed many specialists who may be consulted in suspected child abuse cases, including forensic dentists for bite marks and pediatric child abuse specialists for orofacial trauma. Specialists see a large volume of abuse cases each year and may offer good ideas about what to do. He also mentioned the importance of using colleagues in other fields such as psychology, toxicology, infectious disease, radiology and mental health.

- ***Failure to report***. Dr. Bross reiterated what other speakers have said – there is a statutory obligation to report suspected child abuse. The language of state laws differs from state to state. Reporters are immune from criminal liability if they report in good faith in accordance with their state law. He stressed that if you are uncertain about what to do in a given situation, contact a lawyer.

- ***Malicious reporting versus reporting in error***. Dr. Bross posed the question, "How can you jeopardize the good faith

protection?" He cited an example: Parents brought in a child with a bombed out mouth, the dentist recommended treatment, but the parents left and failed to pay the bill. The dentist then called and said because they did not pay their bill, he was going to report the parents for dental neglect because the child still had untreated caries. This, he said, would be malicious reporting. Making a report for a purpose other than protecting the child raises doubt about the reporter's "good faith." Reporting because someone did not pay their bill could be considered malicious reporting. On the other hand, he stressed, even if you are wrong about a report, as long as you make the report in "good faith" you should be immune from liability.

- ***Other risk management considerations related to child maltreatment and dentistry***. Dr. Bross noted that there are health and mental health problems associated with maltreatment which may affect behavior management of the pediatric patient population. Also, as adults, many victims of childhood abuse report problems with their physical and psychological health. There is a vulnerability created by childhood abuse that carries over into adulthood.

Dr. Bross noted that there is an analogy between child abuse or neglect reporting rationale to infectious disease reporting in that a dangerous condition exists which threatens a population which cannot protect itself from the vector of harm. Child abuse identification, he said, permits an understanding of the possible source of the harm and the steps needed to prevent reoccurrence or worsening of the injury.
In closing, Dr. Bross stated that while possible sources of liability exist, there are very few cases known in which dentists have been sued either for reporting or not reporting.

Ethical Issues Related to Child Abuse and Family Violence

Kathleen Todd, JD
ADA Associate General Counsel and Director, ADA Council on Ethics, Bylaws and Judicial Affairs

On behalf of the ADA Council on Ethics, Bylaws and Judicial Affairs, Ms. Kathleen Todd greeted participants and briefly discussed the history of ADA ethics policy on child abuse. She noted that since the policy was added to the ADA *Principles of Ethics and Code of Professional Conduct* (*ADA Code*) in 1993, there has not been much evidence of increased reporting by dentists, but it has still done some good.

…there is no uniformity in state laws regarding immunity for reporting in good faith in partner and elder abuse.

Ms. Todd provided participants with the *ADA Code* definition of child abuse: "Dentists shall be obliged to become familiar with the perioral signs of child abuse and to report suspected cases to the proper authorities consistent with state law." She noted that this definition reflects choices made by the Council in dealing with child, not partner or elder, abuse. The main reason, she said, is because there is no uniformity in state laws regarding immunity for reporting in good faith in partner and elder abuse. Further, the definition deals with child abuse and not neglect. Child neglect is very difficult to define, thus it would be inappropriate at this time to impose an enforceable obligation on dentists.

The *ADA Code* is meant to be enforced, she explained. It is a document by which the profession exercises self regulation. ADA *Bylaws* state that members may be disciplined for violations of the *ADA Code*. Violations can result in censure, suspension or expulsion of members from the ADA. She further explained that the disciplinary process is quasi-judicial. A complaint can be filed at the local or state level. The complainant can be represented by counsel and can appeal. She said that the Council hears approximately two appeals from member dentists per year.

The best definition of neglect, she believed, is from the American Academy of Pediatric Dentistry: The willful failure of a parent or guardian to seek and follow through with treatment necessary to ensure a level of oral health essential for adequate function and freedom from pain and infection. The Council, however, thought this definition left too many questions about the meaning of dental neglect. Subsequently, the Council opted for the current *ADA Code* which states "to become familiar with perioral signs of child abuse…" because this is consistent with dental education, and "to report suspected cases…" because this is consistent with state laws placing responsibility for investigating child abuse on child welfare agencies or law enforcement officials rather than on the health professional.

Ms. Todd then answered the question, "Why has the Council not recognized an ethical responsibility to report spousal or elder abuse?" As she stated earlier, the Council was concerned about legal liability because state laws do not uniformly protect a reporter if sued by a suspected victim. Further, a suspected victim, if a competent adult, may turn on the reporter and say his/her confidentiality was breached and a report filed which was against the patient's will. She noted that when reporting spouse and elder abuse, the legal risk could be substantial and the benefits to the patient are not always agreed on. Until these issues are resolved, she said, the Council is wary of creating an ethical obligation.

Since the 1993 *ADA Code* adoption, no ethics charges are known to have been brought against a dentist for failure to report a suspected case of child abuse. However, that section of the *ADA Code* has provided moral support to educators, legislators and others by saying that what they are doing is important. She stressed that if the *ADA Code* helps raise member awareness of the problem, if it helps convince state legislators that coursework in recognizing signs of child abuse should be part of a state's mandatory continuing education requirement for dentists and dental hygienists, if it helps to convince and educate colleagues about the problem and if it helps give professionals confidence when they make reports of suspected abuse, then the Council has achieved at least part of what it set out to do.

She closed by asking participants how the ethical issues look from their perspective and how the ADA, through the Council, can better support them. The Council, she said, would reevaluate the scope of legal and ethical responsibility to include spousal and elder abuse if legal immunity for this reporting became more widespread.

Psychological and Patient Management Considerations in Treating Pediatric Patients – Panel Presentation

Stephen M. Blain, DDS, MS
Clinical Professor of Pediatric Dentistry, UCLA School of Dentistry and Director, UCLA Children's Dental Center

Dr. Blain started by thanking the ADA for giving the panel the opportunity to share their combined experience in the area of child abuse as it relates to dentistry. His goal was to raise consciousness by presenting the current thinking, philosophy and research concerning pediatric dental patient management as it relates to institutional abuse and neglect.

To begin, Dr. Blain defined institutional abuse as an act in which an owner or employee in facilities or offices inflicts or allows to be inflicted any physical injury upon a child, creates or allows to be created a risk of physical injury upon a child, commits or allows to be committed an act of sexual or emotional abuse against a child, fails to provide or allows a child to go without food, clothing, shelter, education or medical/dental care, or fails to provide proper supervision. Institutional abuse and neglect, he noted, has been around forever although little has been written in the medical literature. Although the issue is sensitive and controversial, discussion needs to be opened. Addressing institutional abuse and neglect presents the same difficulties as addressing abuse or neglect by a parent or caregiver. He noted that reporting responsibilities are the same, but lack of knowledge by the professional or staff regarding criteria for identifying abuse, lack of administrative or collegial support, fear of consequences for patient and practitioner, fear of practice reputation and fear of lawsuit lead to the lack of reporting.

Dr. Blain then discussed the growing recognition that children today are raised differently than in previous generations. Parents teach children the values and standards of behavior that are expected in their culture, but cultures are extremely diverse. At the same time, he noted, there has been an increase in child advocacy over the last ten years. Children are no longer considered the sole responsibility of their parents and it is better understood why children develop and behave as they do. He cited a 1990 editorial which discussed an increased permissiveness in child rearing which creates a generation of "brats." Dr. Blain noted that patient management practices have changed in that premedication is not often used and parents are allowed into the operatory.

In response to public outcry about institutional abuse, Dr. Blain said dentists are applying more positive-only behavior management techniques. This trend, he said, may create problems because children who have extreme behavioral difficulties may not be able to control their behavior enough to receive needed treatment.

Dr. Blain closed by saying that training and professionalism will increase the odds of not losing patience or panicking when a child is uncooperative or a procedure is not going well. To address the problem of potential institutional abuse, increased research and training in child development and communication as they relate to pediatric dentistry is needed. Dr. Blain noted that the best predictor of patient compliance is

the practitioner's ability to communicate. Clearly, basic communication with the patient and the parent/caregiver is crucial in successful treatment.

Robert J. Musselman, DDS, MDS
Head, Department of Pediatric Dentistry, LSU School of Dentistry

Bringing over 30 years experience as Head of the Department of Pediatric Dentistry at LSU School of Dentistry in New Orleans, Dr. Musselman outlined pediatric behavior management techniques that are advocated by many dental schools and dentists. He discussed the Hand Over Mouth (HOM) technique, which is a behavior management method that has been documented in the dental literature for more than 30 years. The technique is an extension of other communication methods and is not applied until much interaction with the child has taken place. Parental or guardian informed consent must be obtained and should be documented when HOM use is anticipated. When indicated, a hand is placed over the child's mouth and behavioral expectations are calmly explained. The child is told that the hand will be removed as soon as appropriate behavior begins. Dr. Musselman noted that although HOM is accepted in theory, the technique is not commonly practiced and the prevalence of providers utilizing it is not known. HOM has only been used when other behavioral methods have failed and the dental procedure cannot be postponed.

Dr. Musselman echoed what others have said concerning the increasing number of poorly behaved children seen in dental practices. He noted that we deal with children reared in a more permissive society and that parents either try to overcontrol their children or undercontrol them by not setting limits when they should be set. He noted the change in pediatric behavior management techniques from 30 years ago, which stressed "to make and keep submissive," and today, which states "to direct with a degree of skill."

Paul E. Kittle, Jr., DDS
Private Practice in Pediatric Dentistry

After briefly detailing his 24 year career in the military and in private practice pediatric dentistry, part of which included being the chief of a child abuse team, Dr. Kittle centered his discussion on behavior management for the pediatric patient and how behavior paradigms taught in dental school have changed over the years. He noted that years ago, the philosophy of behavior guidance was taught due to the void in knowledge of the psychological approaches to treating children. If a child did not cooperate, then restraint was justified after permission was provided by the parent or guardian. Dentists at that time preferred to see the child without the parent. Later in the 1980's, he said, psychological management of children's behavior was emphasized, with behavior modification second. The pediatric triangle was introduced in the literature in which the dentist, child and parent all communicate together. Parental presence in the operatory was still not supported.

In the 1990's, he went on, behavior management continues to be one of the foundations of pediatric dentistry, but children today differ from

those 30 years ago. More parents insist on accompanying their child into the operatory. He noted that this keeps parents involved and lets them see what the practitioner is doing, while at the same time parents can see how well their child is accepting treatment. Communication, he said, is crucial. The dentist must communicate with his/her staff, the child and the parent. Parents must be involved in behavior management decisions and options and agree to them. In closing, he stressed the importance of education in child behavior for predoctoral and doctoral students, as well as stress management and communication skills.

Steps in Child Protection: Reporting, Social Services and the Judicial System – Panel Presentation

John D. McDowell, DDS, MS
Assistant Professor, Department of Diagnostic and Biological Sciences, University of Colorado School of Dentistry

Dr. McDowell expressed his pleasure at participating in the conference and reiterated what other speakers have said about "preaching to the choir." He began his presentation by looking at child abuse from a historical perspective. Forty years ago in America, he said, physicians started to recognize a syndrome involving signs and symptoms such as subdermal hematomas and certain types of long bone fractures. Researchers looked into the syndrome and brought it to the attention of medical groups. Also from a historical perspective, Dr. McDowell discussed domestic violence by defining the term "rule of thumb." The definition, he said, comes from a judicial ruling that said a man could discipline his wife with a stick no greater than the diameter of his thumb.

Dr. McDowell noted that it is important to recognize that child abuse is part of a big picture. Battered women cannot be separated from abused children or abused elderly, handicapped or disabled persons. There is a common theme – abuse of the unempowered. Many times, battered women present to shelters not because of their injuries, but because of what is happening to their children.

Diagnosing child abuse, Dr. McDowell said, is based on three things: history, physical exam and laboratory tests. He stressed that information can be elicited from histories, especially when questions about domestic violence are included on the history form. Also, believe the children – they do not have the ability to make up histories supporting abusive relationships. Further, he noted, if you have concerns about injuries, ask questions. If you do not ask, you will not ever know what really happened. Histories should be taken in a quiet, supportive nonaccusatory environment, with only the patient and dentist present if possible.

As other speakers had mentioned, Dr. McDowell listed characteristics often seen in battered children: injuries at various stages of healing, injuries inconsistent with history given, interpersonal difficulties, inappropriate language, or inappropriate clothing for the time of year. In battered women, he noted, maxillofacial injuries are very common because the weapon used most often by the abuser is a fist.

Most of the American population, he continued, is very concerned about violence. We know that violence frequently begins in the home.

Further, he encouraged participants to go out and help dental professionals get educated about preventing abuse and violence in their various locales.

Despite widespread concern, he noted that he sees the same faces again over and over at conferences such as this. He suggested that when we go back to our various states, we go to the department of public health and volunteer to work on the state's child abuse review committee. Further, he encouraged participants to go out and help dental professionals get educated about preventing abuse and violence in their various locales. Many courses are offered at various locations to recognize the abused child and many support systems are available. He cited the Kempe Center in Denver as a model.

Dr. McDowell closed by reminding the audience that the best thing they will leave here with are business cards. None of us is as smart as all of us, he said. Call attorneys, pediatricians and others who can make suggestions when you have questions or suspicions. The people here today are the foot soldiers who are dedicated to stopping abuse in our society.

Edward E. Cotton

Deputy Director of Child Protection, Illinois Department of Children and Family Services

Bringing many years experience with the Department of Children and Family Services (DCFS) in Illinois, Mr. Edward Cotton addressed the audience about that state's social services system and its governing of child abuse and neglect investigations from beginning to end. He distributed a copy of the Illinois law (Abused and Neglected Child Reporting Act, 325 ILCS 5) and noted that all states have different child protection laws. He compared the reporting and investigation processes as a narrowing net. First, mandated reporters report suspected cases. This is the broadest part of the net. Second, is the state hotline. He noted that in Illinois, 375,000 calls are received by the hotline each year. Hotline staff are not clerical staff, but rather are social workers who have a social work degree, a minimum two years experience in the field, and 40 hours of legal training on jurisdictional boundaries, the right to intervene and parental boundaries to raise children. Hotline staff do not determine the credibility of reports, but whether the case is in the judicial boundaries to require an investigation. Legal criteria must be met. One such criteria is the category of eligible perpetrators. He said that not every child injured in a non-accidental injury is investigated. The perpetrator must be a parent or responsible party to the child. For example, if a child is beaten by an adult in the park, child welfare has no jurisdiction because it is a police matter. He stressed that jurisdictional issues are very important in determining what cases are pursued.

Further, Illinois hotline staff must be sure the report constitutes abuse or neglect as defined by the state's rules that outline 45 different allegations. He noted that Illinois rules carry the force of law. The allegations in the rules range from serious injuries to mid-level injuries to relatively minor injuries (inadequate supervision, clothing, shelter). High risk injuries are identified in the rules. Staff note the age of the child, whether an instrument was used and the chronicity of injuries. Hotline staff compare the reports with applicable rules to determine what to investigate. Some investigations, he noted, are not indicated based on the report.

The third step in the process is an investigation. When a report is accepted, it is transmitted to a local office. There are legal requirements that must be met right away. Investigators must see every identified child within 24 hours, but hotline staff can set the parameter lower if immediate danger is suspected. Each report is evaluated separately. The investigator must interview the reporter personally to gather specific information, and must also make collateral contacts when doing the investigation (usually the child's teacher and physician). He noted that dentists could be used as collateral contacts. The investigator must also complete a safety assessment, called the Child Endangerment Risk Assessment Protocol, which determines the child's immediate safety. Workers focus on safety issues that are identified in the protocol. He was pleased to note that since this protocol was instituted in Illinois, the number of reabused children has dropped.

Finally, investigations must be completed within 60 days, although 30-day extensions are given in a limited number of cases.

Mr. Cotton noted that less than eight percent of reported cases end up taking a child into protective custody. In Illinois, police officers, physicians and DCFS workers are the only people who can take a child into protective custody and then must get a court order within 48 hours. Also, it is rare for a reporter to appear in court. Efforts are always made to work out protective plans or an agreement with the parents.

If a report is determined to be unfounded, Mr. Cotton said, mandated reporters have the right to appeal if they strongly believe that abuse took place. The DCFS will reexamine the case and set up a hearing if needed.

Mr. Cotton closed on a somber note. In the last three months of last fiscal year (April-June 1998), 20,000 investigations occurred. Of these, 2,940 were made by teachers, 2,223 by physicians, 1,905 by police officers and only 12 by dentists. Increasing awareness of child abuse continues to be a need for dentistry.

Honorable Nancy Sidote Salyers, MA, JD

Presiding Judge, Child Protection Division, Cook County (IL) Circuit Court

Judge Salyers began by expressing her surprise that the question is being asked, "What do dentists have to do with child abuse?" Any child coming under our care is our responsibility, she said, because we are the educated professionals. This responsibility includes how we handle ourselves in response to children and others who are vulnerable and how we communicate this to others. Many times what is in a child's best interest gets lost in what is going to happen to the individual because of the media focus and personal comfort levels. She warned that this was a real mistake and a danger zone for every judge, attorney, social worker, professional and adult dealing with children. If we only think of what happens to ourselves, we lose sight of what happens to the child. Our responsibility is not to determine whether abuse or neglect occurred, but rather to be on the alert and have the right mindset.

One hundred years ago, she noted, there was no juvenile court anywhere in the world. In 1898, after calls for attention, there was a movement in

Illinois which resulted in the introduction into legislature of the first juvenile court act in the world. She was pleased to say that this historic event will celebrate its 100-year anniversary this year and there will be a national movement to send out informational packets to each state.

Within the Illinois judicial system, she said, there is a current movement to help lawyers, social workers and health care professionals understand each other and work together. Risk assessment is being implemented in the field, and now there are trainings in the court system so those in the legal system will know what to look for and what questions to ask so the right decisions can be made in the best interest of children. Judge Salyers stressed that a juvenile court judge must take an active leadership role and advocate on behalf of children who come before them. If an attorney does not ask the right questions, the judge is obligated to ask them. This differs from the rest of the judicial system.

Her job, she said, was frustrating. Only in the most seriously unsafe situations can a child be removed from the home, and often the child does not want to leave the situation. Serious emotional damage can take place when a child is removed from his/her family, therefore a balancing test must be done when investigating reports in order to make a decision in the best interest of the child.

Serious emotional damage can take place when a child is removed from his/her family, therefore a balancing test must be done when investigating reports in order to make a decision in the best interest of the child.

In Illinois there is a mandate to find a permanent home or set a permanent goal for each child in the juvenile court system within 12 months. She tells parents when they appear in court that they need to understand that in one year a permanent plan will be set in place for their child. It is her hope that remaining with the parents will be that permanent plan, but they must understand that a decision may be made to terminate their rights as parents in order to find the child a safe home. Parents are given those admonishments on the first day they appear in court, when they return to court and at any intervening court dates leading to the permanency hearing occurring on the twelfth month. Through this concerted effort to develop permanent plans, there are now only 32,000 children who are the responsibility of the court in Cook County, compared to 58,000 in 1995.

The juvenile court is not about blame, Judge Salyers said, but about protection. Children who are involved in domestic violence situations cannot learn or develop patterns that allow learning. Children are our future. If we are giving rise to a generation of children who cannot learn, who disrupt classrooms and who leave the school system before being properly educated, imagine what we are unleashing into the future. Also, she noted, children who grow up in these environments frequently abuse others.

The juvenile court is not about blame, Judge Salyers said, but about protection.

When dealing with the court system, she encouraged participants to not be intimidated if they are ever asked to appear in court. She stressed getting as much information about the system as possible.

Finally, she said she was thrilled to be asked to come to the conference. She stressed that once we all start speaking the same language, it will be easier for children to speak up for themselves. We are the big people, she concluded, the ones they should be able to trust.

Dentistry's Interventions and Perspectives in Preventing Child Abuse and Neglect

Lynn Douglas Mouden, DDS, MPH
Deputy State Dental Director, Missouri Department of Health, Assistant Clinical Professor, UMKC and Vice Chairman, ADA Council on Access, Prevention and Interprofessional Relations

Dr. Mouden started his discussion by talking about attitudes. He compared the way people deal with child abuse and family violence to the five stages of dying identified by Elizabeth Kubler Ross. The first stage is denial, followed by anger, then bargaining, whereby people may attend a family violence program but not do anything about it once they leave. The next stage is depression or burnout, and finally acceptance, which is where most of us are. We accept what the problems are, that there are solutions and that we can be part of the solution.
Dr. Mouden stressed that once there is acceptance, much can be done to tackle the problem.

The ADA first publicized the challenges of child abuse in 1967 with an editorial printed in its journal dealing with dentists' infrequent reporting. He noted that the ADA has come a long way since then, reflected in its *Principles of Ethics and Code of Professional Conduct* and official policy regarding child abuse.

Statistically, he said, we know that abuse happens in every neighborhood, in all ethnicities and socioeconomic classes.

When talking about attitudes, he continued, there are two things to worry about: recognition and reporting. One without the other will not do a thing for protecting children. Although dentists are mandated reporters in all 50 states, we have not lived up to our jobs. He noted that providers are most likely to see suspected cases in situations unrelated to the abusive injuries and that we must keep reminding people to look for symptoms of abuse.

Attitudes are also noticeable when looking at the demographics of victims. People like to think that family violence does not happen in their part of town. Statistically, he said, we know that abuse happens in every neighborhood, in all ethnicities and socioeconomic classes. The only two statistics that really matter when talking about family violence victims are the ones who survived and the ones who did not.

Dr. Mouden then briefly discussed the recognition of child abuse. As other speakers have said, he noted that many times child abuse cases are obvious, but often are not. We must look for warning signs: repeated injuries (multiple bruises), unusual sites for accidental bumps and bruises, inappropriate behavior, neglected appearance, strict, overly critical parents and extremely isolated families. Behavioral indicators of abuse are not easy to judge, he said. Everyone wants a cookbook or checklist, but there is no such thing. Every child is different and so you must judge a child's behavior on children of similar maturity given a similar set of circumstances.

Dr. Mouden then addressed domestic violence. He noted that most audiences he addresses are dominantly male and said that the average middle class male is not as inclined to deal with domestic violence issues as he is to deal with child abuse issues. However, domestic violence in

the United States is as common as birth…four million times each year. The health care professional's role for adult victims can be that of a facilitator, providing information, support and encouragement. He stressed this does not necessarily mean encouraging them to leave an abusive environment, but rather supporting them in any way they can.

"Why might dentists not report suspected child abuse?" he asked. He listed various answers given to him over the years including, "I'll lose my patients," "It's not my problem," "These children aren't in my practice," "I'm JAD (just a dentist)," "I might make it worse," "I'll get sued," "These people are my friends and neighbors," and finally, "I can't make any real difference."

Dr. Mouden then discussed the P.A.N.D.A. program (Prevent Abuse and Neglect through Dental Awareness), with which he has been very involved since its inception in 1992. P.A.N.D.A. has been one of the most active programs in getting dental professionals involved in child abuse awareness. Coalition members generally include the state dental director, Delta Dental plan, the state dental association, the state social services agency, the state dental hygiene association, the state pediatric dental association and dental schools. Benefits to coalition members, he said, include networking and sharing resources.

In closing, Dr. Mouden encouraged participants to leave the conference, go home and either form a coalition or give their existing P.A.N.D.A. coalition "a kick." He compared conference participants to a tack. We can sit upon a mountain, he said, but we cannot sit on a tack. Similarly, we can sit on the huge problem of child abuse and do nothing, but instead we must be the tack in order to get people involved.

American Medical Association Perspective

John C. Nelson, MD, MPH
Board Certified Obstetrician-Gynecologist in Private Practice

Dr. Nelson noted he was honored to be at the conference and thanked the American Academy of Pediatrics for being pioneers in the area of violence against children. He then stated that his goal was to expand the topic of domestic violence a little bit, to share how the American Medical Association is attempting to speak with physicians and to suggest ways we can work together.

The problem, he said, is yours and mine. Abuse of women occurs everywhere and has been around for centuries: female Egyptian mummies from 2,000 to 3,000 years ago have shown evidence of abuse. He cited grim statistics which said that in the United States, a woman is beaten every 5 to 15 seconds of every day. Also, 50,000 deaths occur yearly which are attributable to violence in the form of homicide or suicide. He also said that the most common reason for females between the ages of 15 and 44 to access an emergency room is because of injuries inflicted on her by violence of some sort. Estimates range from 20 to 35 percent of all emergency room visits by women are for this reason. Further, there are approximately 1,200 domestic violence shelters in the U.S., and approximately 3,800 shelters for animal protection.

Health providers must find ways to work with existing groups and be at the table in the discussion of family violence.

Dr. Nelson quoted Drs. C. Everett Koop and George D. Lundberg as stating that domestic violence is a public health problem. Health providers must find ways to work with existing groups and be at the table in the discussion of family violence. He noted that often coalitions are formed without any input from health providers, which is a sad thing because often we are the ones who can provide help. We do not need to take over the coalitions, he said, but we do have something to add.

Many victims and abusers do not understand what abuse is. The definition of abuse is controlling behavior – not necessarily the injury, but the idea of being in control and making a person do something against her will. The definition of a woman as abused is that she has had intentional, usually repeated, physical or psychological harm done to her by a man with whom she is or has been in an intimate relationship. Abuse has a cycle, he noted, starting with a honeymoon period, after which tension mounts, and finally violence erupts. Battering usually increases over time in frequency and severity. Therefore, he stressed, early identification and intervention is crucial.

Abuse comes in many forms and many victims do not even realize abuse is occurring – they believe "these things always happen." Types of abuse include:

- ***Battery and physical assault***: throwing objects at the victim, pushing, hitting, slapping, choking, beating up, kicking, attacking with a weapon.

- ***Sexual assault***: the abuser forces sexual intimacy.

- ***Psychological abuse***: forcing a victim to perform degrading and or humiliating acts, threatening to harm a female partner or her children, attacking/destroying valued possessions and pets. This form of abuse is more difficult to ascertain, but its effects may be just as long lasting, or perhaps worse.

According to the medical model, a diagnosis is made by the history (85%), physical exam (10%) and laboratory data (5%). Therefore, if you do not ask questions about abuse and listen to the history, you will be 85% down the wrong road to a diagnosis. Dr. Nelson cited a study published in the Journal of Family Physicians which said that only four percent of physicians actually asked their patients about abuse, yet 68 percent of victims want to be asked about abuse and 84 percent of females are comfortable discussing anything with their physicians.

He stressed the need to make sure we are trained to ask the tough questions and to look for the subtleties. Equally important, he said, is to avoid revictimization. Do not express shock or disdain and do not push, simply allow the patient to share what she wants to share. On average (in heterosexual relationships), it takes three years from the time a victim confides in her caregiver that she is a victim until she is able to leave. Sadly, the most likely time for homicide or suicide is at the time of separation. Women stay for a variety of reasons including: lack of self esteem, fear for themselves or their children, economic dependency, lack of a place to go, love for abuser or the feeling that somehow it will get better.

An abused woman who is planning to leave should have an exit plan, he said. She should know exactly where she will go and how she will get there at any hour of the day or night. Her friend or confidant needs to be able to receive her immediately at any time, often without warning. She should pack a suitcase to store with a friend or neighbor and include a change of clothing for her and her children, toiletries and keys to the house and car.

Dr. Nelson then described what the AMA has done to deal with victims of violence:

- asserted that domestic violence is a public health issue;
- collaborated with government agency heads on the issues of violence;
- established the National Coalition of Physicians Against Violence;
- published a series of booklets on various forms of abuse;
- worked to balance concerns of gun control;
- collaborated with the American Bar Association;
- established a Report Card on violence;
- formed the SAVE (Stop American Violence Everywhere) program of the AMA alliance;
- created lapel pins reading "It's ok to talk to me about family violence";
- published a compendium of articles on family violence;
- published an inventory of state laws regarding mandatory reporting; and
- helped develop the television programs rating system to publicize violent content of television programs.

We need to get involved and work together because many of the things the AMA and dentists are doing are complementary.

"Are we doing enough?" he asked. No, he answered, but we are doing something. We need to get involved and work together because many of the things the AMA and dentists are doing are complementary. The biggest problem of today, he said, is not Ebola virus, AIDS or even family violence…it is apathy.

In closing, Dr. Nelson told the story of the star thrower. Thousands of starfish washed up on shore. A man came upon a woman throwing the starfish back into the ocean. He told her she could never throw them all back. She agreed, but said it sure makes a difference to each individual one she throws.

Family Violence as a Public Health Issue – Panel Discussion

Robert J. (Skip) Collins, DMD, MPH
Deputy Executive Director, International and American Associations for Dental Research

Dr. Collins briefly discussed his history in family violence prevention, including treating victims while stationed in New Mexico, personal

experience with an abused co-worker and initiatives during his tenure as Chief Dental Officer of the United States Public Health Service.

His charge, he noted, was to talk about family violence from a public health point of view. He first defined a public health problem as a disease or condition that has broad impact on the population in terms of morbidity and/or mortality and is perceived by citizens, the government or public health officials to be a public health problem. He then defined a public health action as a public health problem to which resources have been allocated. Family violence, including child abuse and neglect, elder abuse and domestic violence, is a public health problem. The costs of family violence are large and include costs for care (medical, dental, psychiatric, hospital/emergency room), costs for the community and costs for the individual.

Dr. Collins next discussed the United States Department of Health and Human Services' Healthy People 2000 project, which lists national health promotion and disease prevention objectives for the year 2000. The section on violent and abusive behavior contains 19 objectives and details five major background points to prevent violence and address its consequences in the United States: cooperation and collaboration; the need for better data; the need to know about effective services; the prevention of alcohol and drug abuse; and the need for professional education in recognizing and treating victims. He also went through many of the objectives specifically, noting that progress has been made in some areas, but others have seen no change or are worsening.

He said that public awareness programs can be an effective way to dispel myths, publicize and coordinate the availability of services, expand court ordered treatment programs for abusers, expand emergency shelters and provide training programs for professionals.
In closing, Dr. Collins commended organized dentistry for working with research and public health communities, beginning back in the 1940's when caries was identified as a major public health problem. He encouraged the ADA to be involved in the upcoming Surgeon General's Report on Oral Health and Healthy People 2010 so that not only are oral health concerns expressed, but family violence concerns as well.

He finished with a quote by former Surgeon General Antonia Novello:

We need to change the way we view and treat each other. We must offer a strong sense of community and not a feeling of alienation. We must encourage the recognition of the importance of each individual and teach the politics of inclusion, not exclusion. We must offer hope and take the necessary steps to make that hope a reality. As health professionals, the prevention of violence by using public health methods in our communities is as much our responsibility as the treatment of its victims.

Mark Nehring, DDS, MPH
Senior Program Management Consultant, Emergency Medical Services for Children Program, U.S. Maternal and Child Bureau, Health Resources and Services Administration

As he began, Dr. Nehring said that he was there to "share one Fed's perspective on child abuse." He noted that his job involves advocacy through collaboration to bring parties together for problem solving.

Child abuse and neglect programs within the federal government, he said, were housed in the Administration for Children and Families (ACF) within the Department of Health and Human Services. The agency was authorized by the Child Abuse Prevention and Treatment Act. The child abuse and neglect program, he said, provides grants to states to improve and increase prevention and treatment activities.

The ACF is also responsible for several domestic violence programs. He noted that children are affected by abused women, even if not directly abused themselves. Further, the Children's Bureau of the ACF supports a national clearinghouse on child abuse and neglect information which is a national resource on information for professionals. The clearinghouse provides statistics, status reports and technical assistance to help professionals recognize child abuse and welfare issues.

Dr. Nehring then detailed another federal activity related to child abuse, the Emergency Medical Services for Children Program. The program strives to ensure that the entire spectrum of emergency services is provided for children and adolescents, including prevention of illness and injury, acute care and rehabilitation. The program's five-year plan was initiated due to concerns that emergency departments did not have adequate equipment for treating children. Currently, there are no national protocols for treating victims of violent assault. He said that such national protocols for treating children are important because they will help ensure that appropriate treatment is provided for victims. The program also aims to improve coordination with the judicial system.

Dr. Nehring noted that the government has entered into a contract with the American College of Emergency Physicians (ACEP) to develop these national protocols. A multidisciplinary team has been gathered within this activity representing medical, legal, judicial, legislative and community organizations. When finalized, ACEP, the American Academy of Pediatrics and the American College of Obstetrics and Gynecology will collaborate to disseminate the protocols through submissions to their journals and publications, inclusion in the professional organizations' World Wide Web sites, targeted meetings and educational conferences.

Dr. Nehring also described another project within the Emergency Medical Services for Children Program, which has a three-pronged approach to creating training resources on domestic violence by providing on-site training, implementing train-the-trainer workshops and operating a lending library of educational and training resources. He stated that this is a partnering activity that creates a network of support for isolated service providers who may deal with domestic violence on a daily basis.

Dentistry can bring its special expertise to a local or state team managing the tough reality of child abuse.

Dr. Nehring closed by emphasizing that dentistry need not reinvent wheels in dealing with child abuse, but rather be a spoke in the wheel that is already in place. Dentistry can bring its special expertise to a local or state team managing the tough reality of child abuse. The

federal government, he said, is not the answer to solving the problem of child abuse, but can be part of the solution. He noted that smaller federal government programs have learned the importance of gaining consensus among groups with which they work. Relationships with other professionals create effective referral systems and group participation facilitates professional growth along with the potential to truly provide for the treatment of the individual when the patient's health needs extend beyond the oral cavity.

Ideas for Increasing Awareness and Building State Coalitions: Successes, Challenges and Opportunities – Audience Participation

Lynn Douglas Mouden, DDS, MPH
Deputy State Dental Director, Missouri Department of Health, Assistant Clinical Professor, UMKC and Vice Chairman, ADA Council on Access, Prevention and Interprofessional Relations

Individual states must take charge to develop programs and activities for their communities.

Dr. Mouden served as moderator of the final session of the C.A.R.E. Conference and led the audience in an open discussion of child abuse and neglect activities taking place in the participants' communities. The audience shared their successes, concerns and complaints. The overriding message was that child abuse and neglect prevention and reporting activities cannot be done on the national level. Individual states must take charge to develop programs and activities for their communities. Participants were urged to use the resources, information and professional contacts they gained at the conference and become active in child abuse and neglect prevention programs in their communities.

Chapter 4 Closing Remarks

Closing Remarks

Paul Stubbs, DDS

Conference Moderator and Chairman, ADA Council on Access, Prevention and Interprofessional Relations

Dr. Stubbs closed the conference by expressing his sincere gratitude to the speakers and participants. He stressed that the goal of the conference had been education and now the real work begins when we leave and go home. His charge for participants: "Don't lose hope or become discouraged about the epidemic of child abuse and family violence. Take one thing at a time, one small attainable goal, to spread the message." Only then, he said, can we say we've made a difference.

APPENDICES

Appendix A Conference Agenda

Dentists C.A.R.E. (Child Abuse Recognition and Education) Conference

Sponsored by the American Dental Association's
Council on Access, Prevention and Interprofessional Relations
ADA Headquarters, Second Floor Hillenbrand Auditorium, Chicago

Friday July 31, 1998

8:00-8:30 **Registration and Continental Breakfast**

8:30-8:45 **Opening Remarks**
John S. Zapp, DDS, Executive Director, ADA, Chicago, IL
Paul E. Stubbs, DDS, Conference Moderator and Chairman, ADA Council on Access, Prevention and Interprofessional Relations, Austin, TX

8:45-9:15 **Keynote Address**

A. Sidney Johnson III, President, Prevent Child Abuse America, Chicago, IL

9:15-10:15 **Clinical Signs of Child Abuse and Neglect Specific to Dentistry**
Howard Needleman, DMD, Needham, MA

10:15-10:45 **Discussion and Break**

10:45-11:45 **Forensic Dentistry and Case Management**
John (Jack) Kenney, DDS, MS, Park Ridge, IL

11:45-12:00 **Discussion**

12:00-1:15 **Lunch**

1:15-2:15 **Legal and Liability Issues Related to Reporting Suspected Abuse**
Donald C. Bross, JD, PhD, Denver, CO

2:15-3:00 **Ethical Issues Related to Child Abuse and Family Violence**
Kathleen Todd, JD, Chicago, IL

3:00-3:30 **Discussion and Break**

3:30-5:00 **Psychological and Patient Management Considerations in Treating Pediatric Patients – Panel Presentation**
Stephen Blain, DDS, MS, Santa Monica, CA
Robert Musselman, DDS, MDS, New Orleans, LA
Paul Kittle, Jr., DDS, Leavenworth, KS

5:00-6:00 **Reception**
Beverages (Juice, Soda and Wine) and Appetizers

Saturday August 1, 1998

7:30-8:00 **Continental Breakfast**

8:00-9:30 **Steps in Child Protection: Reporting, Social Services and the Judicial System – Panel Presentation**
Lynn Douglas Mouden, DDS, MPH, Moderator, Jefferson City, MO
John McDowell, DDS, MS, Denver, CO
Edward Cotton, Deputy Director of Child Protection, Illinois Department of Children and Family Services, Springfield, IL
Hon. Nancy Sidote Salyers, MA, JD, Chicago, IL

9:30-10:15 **Dentistry's Interventions and Perspectives in Preventing Child Abuse and Neglect**
Lynn Douglas Mouden, DDS, MPH, Jefferson City, MO

10:15-10:45 **Discussion and Break – Light Brunch**

10:45-11:15 **American Medical Association Perspective**
John C. Nelson, MD, Salt Lake City, UT

11:15-12:00 **Family Violence as a Public Health Issue – Panel Discussion**

Mark Nehring, DDS, MPH, Damascus, MD
Robert (Skip) Collins, DMD, MPH, North Ease, MD

12:00-12:30 **Ideas for Increasing Awareness and Building State Coalitions: Successes, Challenges and Opportunities – Audience Participation**
Lynn Douglas Mouden, DDS, MPH, Moderator

12:30-12:45 **Closing Remarks**
Paul E. Stubbs, DDS, Chairman, ADA Council on Access, Prevention and Interprofessional Relations

12:45 **Conference Ends**

Appendix B Participants

Dr. Ernest S. Adler
Alaska Society of Dentistry for Children
Alaska P.A.N.D.A. Coalition
500 North Main Street, Suite B
Wasilla, AK 99654
Phone: 907-376-2760
Fax: 907-376-2761
Email: esalder@ptialaska.net

Mr. Raul Alverez, Jr.
Communications Specialist
Corporate Communications
Delta Dental Plan of Michigan
P.O. Box 30416
Lansing, MI 48909-7916
Phone: 517-347-5241
Fax: 517-347-5499
Email: alverezr@ddpmi.com

Dr. Gary M. Berman
9840 Haggerty Road
Belleville, MI 48331
Phone: 734-697-4400
Fax: 734-697-0519
Email: gberman@mich.com

Dr. Stephen M. Blain
Clinical Professor of Pediatric Dentistry
UCLA School of Dentistry
1243 7th Street
Santa Monica, CA 90401
Phone: 310-451-5748
Fax: 310-393-9528

Dr. John A. Bogert
Executive Director
American Academy of Pediatric Dentistry
211 East Chicago Avenue, #700
Chicago, IL 60611
Phone: 312-337-2169
Fax: 312-337-6329
Email: jabogert@aapd.org

Dr. Donald C. Bross
Kempe Children's Center
1825 Marion
Denver, CO 80218
Phone: 303-864-5241
Fax: 303-864-5179
Email: bross.donald@tchden.org

Dr. Cynthia Brzozowski
179 Dayton Street
Sea Cliff, NY 11579

Dr. Donald Collins
1539 West Sherwin Avenue
Chicago, IL 60626

Dr. Robert J. Collins
Deputy Executive Director
International Association for Dental Research
1619 Duke Street
Alexandria, VA 22314-3405
Phone: 703-548-0066
Fax: 703-548-1883
Email: robert@IADR.com

Mr. Edward E. Cotton
Deputy Director
Division of Child Protection
Department of Children and Family Services
406 East Monroe, Station 40
Springfield, IL 62701
Phone: 217-785-0629
Fax: 217-785-0395

Ms. Stephanie Courcy
Consultant, Dental Public Health
55 Bluff Court
South Burlington, VT 05403
Phone: 802-658-0970
Email: stephaniecourcy@msn.com

Dr. Charles Czerepak
Attending Pediatric Dentist
The Children's Memorial Hospital
2536 North Lincoln Avenue
Chicago, IL 60614
Phone: 773-880-5455
Fax: 773-880-5809
Email: pinedent@aol.com

Ms. Linda Dautenhahn
Violence Prevention Planner
Illinois Department of Public Health
535 West Jefferson Street
Springfield, IL 62761
Phone: 217-785-2060
Fax: 217-782-1235
Email: ldautenh@idph.state.il.us

Dr. Lawrence A. Dobrin
Forensic Consultant
Union County Commission on Child Abuse and Missing Children
471 East Westfield Avenue
Roselle Park, NJ 07204
Phone: 908-298-1300
Fax: 732-918-8732
Email: the.dobie@worldnet.att.net

Ms. Barbara Dubbs
Administrative Secretary
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
Phone: 312-440-2897

Ms. Junetta Everett
Vice President, Professional Relations
Delta Dental Plan of Kansas
P.O. Box 49198
Wichita, KS 67201
Phone: 316-264-1099
Fax: 316-264-5912
Email: jeverett@southwind.net

Dr. Tundi M. Frank
4200 West Peterson Avenue Suite 100
Chicago, IL 60646
Phone: 773-481-1940
Fax: 773-283-7787
Email: saugdent@aol.com

Dr. B. Kalman Friedman
Consultant, Suffolk County Medical Examiner
42 Greene Avenue
Amityville, NY 11701
Phone: 516-264-1010

Ms. Judith Friedman
Professor and Department Chair
Dental Hygiene
SUNY-Farmingdale
Route 110
Farmingdale, NY 11735
Phone: 576-420-2060
Fax: 576-420-2582
Email: friedjm@farmingdale.edu

Mr. Anthony E. Gardner
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
Phone: 312-440-2500

Dr. R. Terry Grubb
222 North Mission Street
Wenatchee, WA 98801
Phone: 509-662-8156

Ms. Marylou Gutmann
Associate Professor
Baylor College of Dentistry
Department of Dental Hygiene
P.O. Box 660677
Dallas, TX 75266-0677
Phone: 214-828-8406
Fax: 214-828-8196
Email: mgutmann@tambcd.edu

Dr. Peter F. Hampl
Forensic Odontologist
5114 Point Fosdick Drive, NW
E-236
Gig Harbor, WA 98335
Phone: 253-383-5722
Fax: 253-383-0696
Email: phampl@narrows.com

Ms. Julie Jarrett
Coordinator
Council on Community Health
California Dental Association
1201 K Street Mall
Sacramento, CA 95814
Phone: 916-443-3382 x4350
Fax: 916-443-2943
Email: jarrett@breeze.net

Ms. Jane Forsberg Jasek
Manager, Fluoridation and Preventive Health Activities
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
Phone: 312-440-2862
Fax: 312-440-4640
Email: jasekj@ada.org

Dr. Stephen A. Jessee
Assistant Professor
University of Texas Dental Branch
6516 John Freeman Avenue
Suite 28A
Houston, TX 77030
Phone: 713-500-4277
Fax: 713-500-4108
Email: sjessee@mail.db.uth.tmc.edu

Mr. A. Sidney Johnson III
President
Prevent Child Abuse America
200 South Michigan Avenue
17th Floor
Chicago, IL 60611
Phone: 312-663-3520
Fax: 312-939-8962

Dr. Charles F. Johnson
Professor of Pediatrics and Director, Child Abuse Program
Ohio State University
Children's Hospital
Columbus, OH 43205
Phone: 614-722-3279
Fax: 614-722-4966
Email: Cjohnson@chi.osu.edu

Dr. John P. Kenney
Pediatric Dentist/Forensic Odontologist
DuPage County Coroners Office
101 South Washington Avenue
Suite 114
Park Ridge, IL 60068
Phone: 847-698-2088
Fax: 847-698-2091
Email: frnscdds@aol.com

Dr. Paul E. Kittle
309 South 2nd Street
Leavenworth, KS 66048
Phone: 913-651-9800
Fax: 913-651-8559
Email: pedident@aol.com

Mr. John S. Klyop
Director
Council on Access, Prevention and Interprofessional Relations
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
Phone: 312-440-2751
Fax: 312-440-4640
Email: klyopj@ada.org

Mrs. Debby Kurtz-Weidinger
Arizona Department of Health Services
Office of Oral Health
1740 West Adams, Room 10
Phoenix, AZ 85007
Phone: 602-542-1866
Fax: 602-542-2936
Email: dkurtzw@hs.state.az.us

Dr. Andrea Lacayo
Silva Dental Center
5919 West Cermak Road
Cicero, IL 60804

Dr. Lewis N. Lampiris
Chief, Division of Oral Health
Illinois Department of Public Health
535 West Jefferson Street
Springfield, IL 62761
Phone: 217-785-4899
Fax: 217-815-1503
Email: llampiri@idph.state.il.us

Mr. John Lenke
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
Phone: 312-440-2500

Dr. Phil Levine
6202 North 9th Avenue, #1-B
Pensacola, FL 32505
Phone: 850-474-0001
Fax: 850-474-1122
Email: pjlevine@pen.net

Ms. Anita Mark
Department of Communications
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
Phone: 312-440-2500

Ms. Tara McAndrews
3061 Cascade Drive
Springfield, IL 62704

Dr. John D. McDowell
Chair, Division of Oral Diagnosis, Medicine and Radiology
University of Colorado School of Dentistry
Campus Box C-284
4200 East 9th Avenue
Denver, CO 80262
Phone: 303-312-6365
Fax: 303-315-6954
Email: john.mcdowell@uchsc.edu

Ms. Jane S. McGinley
Coordinator
Council on Access, Prevention and Interprofessional Relations
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
Phone: 312-440-2858
Fax: 312-440-4640
Email: mcginleyj@ada.org

Dr. Carole McKnight-Hanes
Professor and Predoctoral Director
Medical College of Georgia
School of Dentistry
1459 Laney Waler Boulevard
Augusta, GA 30912
Phone: 706-721-2116
Fax: 706-721-6276
Email: chanes@mail.mcg.edu

Ms. Catherine McNish
Program Analyst
National Institute of Dental Research
NIDR/NIH
Building 45, Room 3AN44
45 Center Drive
Bethesda, MD 20892
Phone: 301-594-5489
Fax: 301-435-8669
Email: mcnishc@de45.nidr.nih.gov

Dr. Lynn D. Mouden
Deputy State Dental Director
Missouri Department of Health
Bureau of Dental Health
P.O. Box 570
Jefferson City, MO 65102-0570
Phone: 573-751-6247
Fax: 573-526-2753
Email:
moudeL@mail.health.state.mo.us

Ms. Sharon G. Muraoka
Manager
Council on Access, Prevention and Interprofessional Relations
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
Phone: 312-440-2861
Fax: 312-440-4640
Email: muraokas@ada.org

Dr. Robert J. Musselman
Professor of Pediatric Dentistry
Louisiana State University
School of Dentistry
1100 Florida Avenue, Box 139
New Orleans, LA 70119
Phone: 504-619-8666
Fax: 504-619-8749
Email: Rmusse@lsusd.lsumc.edu

Dr. Lillian A. Nawrocki
Forensic Dental Consultant
Suffolk County Medical Examiner
5225-8 Nesconset Highway
Port Jefferson Station, NY 11776
Phone: 516-331-8676
Fax: 516-331-8677 (T,W, Th)

Dr. Howard Needleman
Associate Dentist-in-Chief
Department of Dentistry
Children's Hospital
300 Longwood Avenue
Boston, MA 02115
Phone: 617-355-4425
Fax: 781-444-3607
Email: needleman@A1.tch.harvard.edu

Dr. Mark E. Nehring
Senior Program Management Consultant
Health Resources and Services Administration
5600 Fishers Lane
Parklawn Building, Rm 18A-39
Rockville, MD 20857
Phone: 301-443-3449
Fax: 301-443-1296
Email: mnehring@hrsa.dhhs.gov

Dr. John C. Nelson
Trustee, American Medical Association
515 North State Street
Chicago, IL 60610
Phone: 312-464-5000
Fax: 312-464-4184

Dr. Nora Avril Odingo
Dental Public Health Resident
Montefiore Medical Center
3450 Wayne Avenue #13P
Bronx, NY 10467
Phone: 718-405-9541
Fax: 718-405-9541
Email: toothist@hotmail.com

Dr. Debra Oro
Dentists Against Child Abuse
991 West Wheatgrass Place
Oro Valley, AZ 85737
Phone: 520-297-7676
Fax: 520-297-7975
Email: oro-dont@primenet.com

Dr. Robert J. Oro
Dentists Against Child Abuse
991 West Wheatgrass Place
Oro Valley, AZ 85737
Phone: 520-297-7676
Fax: 520-297-7975
Email: oro-dont@primenet.com

Ms. Janis Oshensky
Administrator, Plan and Provider Relations
Delta Dental Plans Association
1515 West 22nd Street
Oak Brook, IL 60523
Phone: 630-574-7052
Fax: 630-574-6999

Dr. Marian W. Patton
Program Director – Dental Hygiene
Tennessee State University
Meharry Medical College
3500 John Merritt Boulevard
Nashville, TN 37209-1561
Phone: 615-963-5801
Fax: 615-963-5836
Email: mpatton@picard.tnstate.edu

Judge Haskell M. Pitluck
State of Illinois, 19th Judicial Circuit
McHenry County Government Center
2200 North Seminary Avenue
Woodstock, IL 60098
Phone: 815-334-4369
Fax: 815-338-0948

Ms. Debra A. Pontecorvo
Associate Faculty
Indiana University Dental Education
PO Box 508
Angola, IN 46703
Phone: 219-833-6263

Dr. Dennis N. Ranalli
Professor and Chairman
Department of Pediatric Dentistry
University of Pittsburgh
School of Dental Medicine
3501 Terrace Street
Pittsburgh, PA 15261
Phone: 412-648-3181
Fax: 412-648-8219
Email: dnr4+@pitt.edu

Ms. Lisa Roberts
25 East Washington #1115
Chicago, IL 60602
Phone: 312-263-5090
Fax: 312-263-5131

Dr. Daniel E. Rose
Director, Extramural Programs
University of Minnesota
School of Dentistry
15-137 Moos Health Towers
515 Delaware Street, S.E.
Minneapolis, MN 55455-0348
Phone: 612-626-6935
Fax: 612-626-6095
Email: rosex035@gold.tc.umn.edu

Honorable Nancy Sidote Salyers
Presiding Judge
Division of Protective Services
Department of Children and Family Services
2245 West Ogden, Suite 804
Chicago, IL 60612
Phone: 312-433-4756
Fax: 312-433-6591

Ms. Linda Samek
Director, Professional Affairs
Ontario Dental Association
4 New Street
Toronto, ONT M5R 1P6
Canada
Phone: 416-922-3900 x343
Fax: 416-922-9005
Email: lindas@oda.on.ca

Dr. Tara E. Schafer
Assistant Professor, Pediatric Dentistry
Medical College of Georgia
Department of Pediatric Dentistry
1459 Laney Walker Boulevard
Augusta, GA 30912
Phone: 706-721-2116
Fax: 706-721-6272
Email: tschafer@mail.mcg.edu

Ms. Sylvia Seaver
Associate Professor and Allied Health Coordinator
Tunxis Community Technical College
271 Scott Swamp Road
Farmington, CT 06032
Phone: 860-679-9636
Email: TX_SEAVER@commnet.edu

Dr. Patricia A. Simon
5323 Harry Hines Boulevard
CS3.102
Dallas, TX 75236
Phone: 214-648-3034

Ms. Bonnie Simpson
Director, Ethics and Dental Benefit Services
Texas Dental Association
1946 South IH35 #400
Austin, TX 78704
Phone: 512-443-3675
Fax: 512-443-3031
Email: bonnie@tda.org

Dr. Duane E. Spencer
Pediatric/Forensic Dentist
1855 San Miguel Drive, Suite 9
Walnut Creek, CA 94596
Phone: 925-937-7000
Fax: 925-937-7574
Email: snoopydds@aol.com

Dr. Frank M. Stechey
151 York Boulevard, Suite 202
Hamilton, ONT L8R 3M2
Canada
Phone: 905-577-0770
Fax: 905-577-0721

Dr. Angela M. Stout
Pediatric Dentist
Chesheim Dental Association
716 Bethlehem Pike
Erdenheim, PA 19038
Phone: 215-233-0206
Fax: 215-233-4752

Ms. Sharon Struminger
Professor of Dental Hygiene
SUNY-Farmingdale
Route 110
Farmingdale, NY 11735
Phone: 516-420-2060
Fax: 516-420-2532
Email: toothprof@aol.com

Dr. Paul E. Stubbs
Chairman
Council on Access, Prevention and Interprofessional Relations
3737 Williams Drive
Georgetown, TX 78628
Phone: 512-863-8559

Dr. Deborah Studen-Pavlovich
Director, Predoctoral Pediatric Dentistry
University of Pittsburgh
366B Salk Hall
3501 Terrace Street
Pittsburgh, PA 15261-1955
Phone: 412-648-8183
Fax: 412-383-8662
Email: das12+@pitt.edu

Ms. Kathleen Todd
Associate General Counsel
Division of Legal Affairs
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
Phone: 312-440-2500

Ms. Delanor Tucker
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
Phone: 312-440-2747

Dr. Allan J. Warnick
Chairperson – CHIPIDS Committee
Michigan Dental Association
31632 Schoolcraft Road
Livonia, MI 48150
Phone: 734-425-6920
Fax: 734-425-1541
Email: alforden@aol.com

Dr. John M. Williams
Forensic Odontology
M.E.O. Hennepin County
Minneapolis Childrens' Hospital
1011 West Broadway Avenue
Minneapolis, MN 55411
Phone: 612-521-7611
Fax: 612-521-9350
Email: burgerbare@aol.com

Dr. Franklin D. Wright
Chairman, Forensic Dental Team
Ohio Dental Association
1055 Nimitzview Drive
Cincinnati, OH 45230
Phone: 513-231-5353
Fax: 513-474-0552
Email: frankwright@msn.com

Ms. Jeanette Young
P.O. Box 49198
Wichita, KS 67201

Dr. Beverly B. Zinser
3737 Williams Drive
Georgetown, TX 78628

Appendix C Resources

World Wide Web Sites

- American College of Emergency Physicians: http://www.acep.org
- American Dental Association: http://www.ada.org
- USDHHS Agency of Children and Families: http://www.acf.dhhs.gov
- University of Medicine and Dentistry – New Jersey: http://www.umdnj.edu/~baum/famvio.htm
- American Academy of Pediatrics: http://www.aap.org
- National Clearinghouse on Child Abuse and Neglect Information: http://www.calib.com/nccanch
- Prevent Child Abuse America (formerly National Committee to Prevent Child Abuse): http://www.childabuse.org
- National Data Archive on Child Abuse and Neglect: http://www.ndacan.cornell.edu

Toll-Free Hotlines

Child Abuse Hotline (24-hour) 800-4-ACHILD

National Family Violence Helpline 800-222-2000

Covenant House Nineline 800-999-9999

Bureau of Indian Affairs Federal Hotline 800-633-5155

Books and Journal Articles *(available at a local library or through interlibrary loan)*

LaCerva V. Pathways to peace: forty steps to a less violent America. Tesuque, NM:Heartsongs Publications;1996.

Domestic violence: A directory of protocols for health care providers. Children's Safety Network, 1992. Newton, MA: Education Development Center, Inc.

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Journal of the American Medical Association. Theme issue on Violence/Human Rights. JAMA 1998 Aug.

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Rupp RP. Conditions to be considered in the differential diagnosis of child abuse and neglect. Gen Dent 1998 Jan-Feb:96-9.

The future of children: protecting children from abuse and neglect. Center for the Future of Children, The David and Lucille Packard Foundation. Vol.8(1):1998. (An electronic edition of this issue can be found at http://www.futureofchildren.org

Other

P.A.N.D.A. (Prevent Abuse and Neglect through Dental Awareness) Programs. For information, contact: Lynn Douglas Mouden, DDS, MPH, 573-751-6247.

Updated bibliography on dentistry and family violence, including child abuse and neglect. To obtain: Lynn Douglas Mouden, DDS, MPH, PO Box 570, Jefferson City, MO 65102. Email: moudeL@mail.health.state.mo.us.
CD-ROM, "The Many Faces of Violence." To be used as a reference or as continuing education with available CE accreditation. To obtain: Medical Protective, 800-981-3213.

American Academy of Pediatrics resources. Reporting forms, clinical pathways, teaching slides, mini-residencies, curriculum, testing knowledge in child abuse. For more information, contact: Dr. Charles F. Johnson, 700 Childrens Drive, Columbus, OH 43205, 614-722-3279.

Training videotape on family violence for the health professional. "One by One – Making a Difference." To obtain: Massachusetts Dental Society, Committee Against Abuse and Neglect, 83 Speer Street, Natick, MA 01760-4144. Email: madental@massdental.org.

Crimes Against Children Conference. For information contact: Ms. Jessie Shelburne, Dallas Children's Advocacy Center, PO Box 720338, Dallas, TX 75372-0338. Phone: 214-823-4243.

Pamphlet, "Reporting Child Abuse: Your Responsibility Under the Child and Family Services Act." To obtain: Pamphlet #7710-95037P01. Ministry of Community and Social Services, Communications and Marketing Branch, 80 Grosvenor Street, 7th Floor, Ontario, Canada, M7A 1E9.

Handbook, "Family Violence Handbook for the Dental Community." To obtain: National Clearing House of Family Violence, Family Violence Prevention Division, Health Programs and Services Branch, Health Canada, Postal Locator: 0201A2, Ottawa, Canada K1A 1B4. Fax: 613-941-8930

Child abuse information for professionals and the public. To obtain: Community Child Abuse Council of Hamilton-Wentworth, Attn: Suzanne Mulligan, Executive Director, 75 MacNab Street South, Hamilton, Ontario, Canada L8P 3C1.

Child abuse pamphlets (various). To obtain: Ms. Judy VanVranken, NYS Division of Criminal Justice Services, Missing & Exploited Children Clearinghouse, 4 Tower Place, Albany, NY 12203-3704. Phone: 800-FIND-KID

Pamphlet. Recognizing and Reporting Elder Abuse. To obtain: Ms. Julie Jarrett, California Dental Association, 1201 "K" Street Mall, Sacramento, CA 95814. Phone: 916-443-3382 ext.4350. Email: jarrett@breeze.net
Lecture format, "Abuse Detection and Education." To obtain: Ms. Julie Jarrett, California Dental Association, 1201 "K" Street Mall, Sacramento, CA 95814. Phone: 916-443-3382 ext.4350. Email: jarrett@breeze.net

Lectures on child abuse and neglect. To obtain: American Society of Dentistry for Children (ASDC), 875 North Michigan Avenue, Suite 4040, Chicago, IL 60611-1901. Phone: 312-943-1244.

Abuse reporting and referral resources for Dallas County residents. To obtain: Ms. Marylou Gutmann, Associate Professor, Baylor College of Dentistry, Department of Dental Hygiene, PO Box 660677, Dallas, TX 75266-0677. Phone: 214-828-8406. Fax: 214-828-8196. Email: mgutmann@tambed.edu

Simple printed guidelines for photo documentation of bite marks. To obtain: Dr. Franklin D. Wright, 1055 Nimitzview Drive, Cincinnati, OH 45230. Phone: 513-231-5353. Email: frankwright@msn.com

How to start a "Blue Ribbon Campaign" for dentists in your state. (A program to show support of child abuse prevention by distributing and wearing a pin and blue ribbon during April, National Child Abuse Prevention Month.) To obtain: Ms. Junetta Everett, Delta Dental Plan KS, PO Box 49198, Wichita, KS 67201. Phone: 316-264-1099 ext.128. Email: deltadentalks@southwind.net

Full-color brochure on oral manifestations of child abuse. (Depicts lesions, protocol and assessment procedures.) To obtain: Ms. Debby Kurtz-Weidinger, Arizona Department of Health Services, Office of Oral Health, 1740 W. Adams, Room 10, Phoenix, AZ 85007. Phone: 602-542-1866. WWW: http://www.hs.state.az.us/cfhs/ooh (click on "Publications")

Brochure on Idiopathic Thrombocytopenic Purpura (ITP). To obtain: Drs. Debra or Robert Oro, 991 W. Wheatgrass Place, Oro Valley, AZ 85737. Phone: 520-297-7676. Email: oro-dont@primenet.com

Appendix D State Reporting Laws

This appendix is informational only and not intended to set a standard of care. Dentists should always exercise their own professional judgment in any given situation. This information is not intended as legal advice; dentists must consult with their own attorneys for such advice, and know the current requirements of their particular state law.

To report a suspected case of child abuse, notify the mandated agency in the state where the child lives. State child protective services agencies are listed in Appendix E.

State laws related to child abuse are available either by contacting individual states or through the State Statutes Database, which is maintained by the National Center on Child Abuse and Neglect's Clearinghouse and contains information on states' civil and criminal child maltreatment laws, including reporting laws, central registries, investigations, child witnesses and crimes. For further information, contact NCCAN Clearinghouse, PO Box 1182, Washington, DC 20013, 800-FYI-3366, 703-385-7565, http://www.calib.com/nccanch, Email: statutes@calib.com.

Appendix E State Child Protection Agencies

This appendix is informational only and not intended to set a standard of care. Dentists should always exercise their own professional judgment in any given

situation. This information is not intended as legal advice; dentists must consult with their own attorneys for such advice, and know the current requirements of their particular state law.

REPORTING PROCEDURES—CURRENT AS OF 1997

Because the responsibility for investigating reports of suspected child abuse and neglect rests at the state level, each state has established a Child Protective Services (CPS) reporting system. Listed below are the name and address of the CPS agency in each state, followed by the procedures for reporting suspected child maltreatment. A number of states have toll-free (800) telephone numbers that can be used for reporting. Some states have two numbers, one for individuals calling within the state and the other for those calling outside of the state. Normal business hours vary from agency to agency, but are typically from 8:00 or 9:00 a.m. until 4:30 or 5:00 p.m.

Alabama
Alabama Department of Human Resources
Division of Family and Children's Services
Office of Protective Services
50 Ripley Street
Montgomery, AL 36130

During business hours, make reports to the County Department of Human Resources, Child Protective Services Unit. After business hours, make reports to local police.

Alaska
Department of Health and Social Services
Division of Family and Youth Services
Box H-05
Juneau, AK 99811

Make reports in-state to 800-478-4444. Out-of-state, use area code 907. This telephone number is toll free.

American Samoa
Director of Human Resources
Department of Human Resources
American Samoa Government
Pago Pago, AS 96799

Arizona
Department of Economic Security
Administration for Children, Youth and Families
P.O. Box 6123, Site COE 940A
Phoenix, AZ 85005

Make reports to Department of Economic Security local offices.

Arkansas
Arkansas Department of Human Services
Division of Children and Family Services
P.O. Box 1437
Little Rock, AR 72203

Make reports in-state to 800-482-5964.

California
Make reports to County Departments of Welfare or law enforcement agency.

Colorado
Department of Social Services and Child Welfare Services
225 East 16th Street
Denver, CO 80203-1702

Make reports to County Departments of Social Services.

Connecticut
Connecticut Department of Children and Youth Services
Division of Children and Protective Services
170 Sigourney Street
Hartford, CT 06106

Make reports in-state to 800-842-2288 or out-of state to 203-344-2599.

Delaware
Delaware Department of Services for Children, Youth and Their Families
Division of Child Protective Services
1825 Faulkland Road
Wilmington, DE 19802

Make reports in-state to 800-292-9582.

District of Columbia
District of Columbia Department of Human Services
Commission on Social Services
Family Services Administration
Child and Family Services Division
609 H. Street, NE
Washington, DC 20002

Make reports to 202-727-0995.

Florida
Florida Protective Service System
Abuse Registry
2729 Fort Knox Blvd.
Tallahassee, FL 32308

Make reports in-state to 800-96-ABUSE or out-of-state to 904-487-2625.

Georgia
Georgia Department of Human Resources
Division of Family and Children Services
878 Peachtree Street, NW
Room 502
Atlanta, GA 30309

Make reports to County Departments of Family and Children Services.

Guam
Department of Public Health and Social Services
Child Welfare Services
Child Protective Services
P.O. Box 2816
Agana, GU 96910

Make reports to the State Child Protective Services Agency.

Hawaii
Department of Human Services
Public Welfare Division
Family and Adult Services
P.O. Box 339
Honolulu, HI 96809

Make reports to each Island's Department of Human Services CPS reporting hotline.

Idaho
Department of Health and Welfare
Field Operations Bureau of Social Services and Child Protection
450 West State Street
Boise, ID 83720

Illinois
Illinois Department of Children and Family Services
Station 75
State Administrative Offices
406 East Monroe Street
Springfield, IL 62701

Make reports in-state to 800-25-ABUSE or out-of-state to 217-785-4010.

Indiana
Indiana Department of Public Welfare
Child Abuse and Neglect
Children and Families Division
402 West Washington Street
Room W-364
Indianapolis, IN 46204

Make reports to County Departments of Public Welfare.

Iowa
Iowa Department of Human Services
Bureau of Adult, Children and Family Services
Central Child Abuse Registry
Hoover State Office Building
Fifth Floor
Des Moines, IA 50319

Make reports in-state to 800-362-2178 or out-of-state (during business hours) to 515-281-5581 and (after business hours) to 515-281-3240.

Kansas
Kansas Department of Social and Rehabilitation Services
Child Protection and Family Services Section
Smith-Wilson Building
300 S.W. Oakley Street
Topeka, KS 66606

Make reports to Department of Social and Rehabilitation Service Area Offices and in-state to 800-922-5330.

Kentucky
Kentucky Cabinet of Human Resources
Division of Family Services
Children and Youth Services Branch
275 East Main Street
Frankfort, KY 40621

Make reports to County Offices in fourteen state districts.

Louisiana
Louisiana Department of Social Services
Office of Community Services
P.O. Box 3318
Baton Rouge, LA 70821

Make reports to parish Protective Service Units.

Maine
Maine Department of Human Services
Child Protective Services
State House, Station 11
Augusta, ME 04333

Make reports to Regional Office of Human Services; in-state to 800-452-1999 or out-of-state to 207-287-2983. Both operate 24 hours a day.

Maryland
Maryland Department of Human Resources
Social Services Administration
Saratoga State Center
311 West Saratoga Street
Baltimore, MD 21201

Make reports to County Departments of Social Services or to local law enforcement agencies.

Massachusetts
Massachusetts Department of Social Services
Protective Services
24 Farnsworth Street
Boston, MA 02210

Make reports to Area Offices of Protective Screening Unit or in-state to 800-792-5200.

Michigan
Michigan Department of Social Services
P.O. Box 30037
235 South Grand Avenue
Suite 412
Lansing, MI 48909

Make reports to County Departments of Social Services.

Minnesota
Minnesota Department of Human Services
Children's Services Division
Human Services Building
St. Paul, MN 55155

Make reports to County Departments of Human Services.

Mississippi
Mississippi Department of Human Services
Office of Social Services Protection Department
P.O. Box 352
Jackson, MS 39205

Make reports in-state to 800-222-8000 or out-of-state (during business hours) to 601-354-6639.

Missouri
Missouri Child Abuse and Neglect Hotline
Department of Social Service
Division of Family Services
DFS, P.O. Box 88
Broadway Building
Jefferson City, MO 65103

Make reports in-state to 800-392-3738 or out-of-state to 314-751-3448. Both operate 24 hours a day.

Montana
Department of Family Services
Child Protective Services
P.O. Box 8005
Helena, MT 59604

Make reports to County Departments of Family Services.

Nebraska
Nebraska Department of Health and Human Services
Protection and Safety Division
301 Centennial Mall South
P.O. Box 95026
Lincoln, NE 68509

Make reports to local law enforcement agencies or to local social services offices or in-state to 800-652-1999.

Nevada
Department of Human Resources
Welfare Division
2527 North Carson Street
Carson City, NV 89710

Make reports to Division of Welfare local offices.

New Hampshire
New Hampshire Division for Children and Youth Services
6 Hazen Drive
Concord, NH 03301-6522

Make reports to Division for Children and Youth Services District Offices or in-state to 800-852-3345 (ext. 4455).

New Jersey
New Jersey Division of Youth and Family Services
Department of Human Services (CN717)
50 East State Street
Sixth Floor
Trenton, NJ 08625

Make reports in-state to 800-792-8610. District offices also provide 24-hour telephone services.

New Mexico
New Mexico Human Services Department
Children's Bureau
Pollon Plaza, P.O. Box 2348
Santa Fe, NM 87503-2348

Make reports to County Social Services offices or in-state to 800-432-6217.

New York
New York State Department of Social Services
Division of Family and Children Services
State Central Register of Child Abuse and Maltreatment
40 North Pearl Street
Albany, NY 12243

Make reports in-state to 800-342-3720 or out-of-state to 518-474-9448.

North Carolina
North Carolina Department of Human Resources
Division of Social Services
Child Protective Services
325 North Salisbury Street
Raleigh, NC 27603

Make reports in-state to 800-662-7030.

North Dakota
North Dakota Department of Human Services
Division of Children and Family Services
Child Abuse and Neglect Program
600 East Boulevard
Bismarck, ND 58505

Make reports to County Social Services Offices.

Ohio
Ohio Department of Human Services
Bureau of Children's Protective Services
30 East Broad Street
Columbus, OH 43266-0423

Make reports to County Departments of Human Services.

Oklahoma
Oklahoma Department of Human Services
Division of Children and Youth Services
Child Abuse/Neglect Section
P.O. Box 25352
Oklahoma City, OK 73125

Make reports in-state to (800) 522-3511.

Oregon
Department of Human Resources
Children's Services Division
Child Protective Services
500 Summer Street, NE
Salem, OR 97310-1017

Make reports to local Children's Services Division Offices and to 503-378-4722.

Pennsylvania
Pennsylvania Department of Public Welfare
Office of Children, Youth and Families
Child Line and Abuse Registry
Lanco Lodge, P.O. Box 2675
Harrisburg, PA 17105

Make reports in-state to CHILDLINE 800-932-0313.

Puerto Rico
Puerto Rico Department of Social Services
Services to Family With Children
P.O. Box 11398
Santurci, PR 00910

Make reports to 809-724-1333.

Rhode Island
Rhode Island Department for Children and Their Families
Division of Child Protective Services
610 Mt. Pleasant Avenue, Bldg. #9
Providence, RI 02908

Make reports in-state to 800-RI-CHILD or 742-4453 or out-of-state to 401-457-4996.

South Carolina
South Carolina Department of Social Services
1535 Confederate Avenue
P.O. Box 1520
Columbia, SC 29202-1520

Make reports to County Departments of Social Services.

South Dakota
Department of Social Services
Child Protection Services
Kneip Building
700 Governors Drive
Pierre, SD 57501

Make reports to local social services offices.

Tennessee
Tennessee Department of Human Services
Child Protective Services
Citizen Bank Plaza
400 Deadrick Street
Nashville, TN 37248

Make reports to County Departments of Human Services.

Texas
Texas Department of Human Services
Protective Services for Families and Children Branch
P.O. Box 149030
MC-E-206
Austin, TX 78714-9030

Make reports in-state to 800-252-5400 or out-of-state to 512-450-3360.

Utah
Department of Social Services
Division of Family Services
120 North 200 West
Salt Lake City, UT 84145-0500

Make reports to Division of Family Services District Offices.

Vermont
Vermont Department of Social and Rehabilitative Services
Division of Social Services
103 South Main Street
Waterbury, VT 05676

Make reports to District Offices or to 802-241-2131.

Virgin Islands
Division of Children, Youth & Families
Department of Human Services
Government of the Virgin Islands
Barbel Plaza South
Charlotte Amalie
St. Thomas, VI 00802-4355

Make reports to Division of Social Services 809-773-2323.

Virginia
Commonwealth of Virginia
Department of Social Services
Bureau of Child Protective Services
Blair Building
8007 Discovery Drive
Richmond, VA 23229-8699

Make reports in-state to 800-552-7096 or out-of-state to 804-662-9084.

Washington
Department of Social and Health Services
Division of Children and Family Services
Child Protective Services
Mail Stop OB 41-D
Olympia, WA 98504

Make reports in-state to 800-562-5624 or local Social and Health Services Offices.

West Virginia
West Virginia Department of Human Services
Office of Social Services
Building 6, Room 850
State Capitol Complex
Charleston, WV 25305

Make reports in-state to 800-352-6513.

Wisconsin
Wisconsin Department of Health and Social Services
Department of Health and Social Services
Bureau for Children, Youth and Families
1 West Wilson Street
P.O. Box 7851
Madison, WI 53707

Make reports to County Social Services Offices.

Wyoming
Department of Family Services
Hathaway Building, #322
Cheyenne, WY 82002

Make reports to County Departments of Public Assistance and Social Services.

Appendix F Prevent Child Abuse America (PCAA) Chapters

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Alaska

South Central Alaska Chapter
Elizabeth Forrer, Executive Director
Anchorage Center for Families
3745 Community Park Loop, Suite 102
Anchorage, AK 99508-3466
Phone: 907-276-4994
Fax: 907-276-6930
Email: acf@aonline.com

Fairbanks Alaska Chapter
David Leone, Executive Director
Resource Center for Parents and Children
1401 Kellum Street
Fairbanks, AK 99701
Phone: 907-456-2866
Fax: 907-451-8125
Email: rcpc@polarnet.com

Arizona
Child Abuse Prevention Arizona
P.O. Box 63921
Phoenix, AZ 85082-3921
Phone: 602-835-1411
Fax: 602-969-9277
Email: jkoenig@idt.net

California
Julie Christine, Executive Director
Prevent Child Abuse California
926 J Street, Suite 717
Sacramento, CA 95814-2707
Phone: 916-498-8481
Fax: 916-498-0825
Email: pcaca@pca-ca.org
Web Site: www.pca-ca.org

Connecticut
Jane Bourns, Director
CT Center for Prevention of Child Abuse
Wheeler Clinic
91 Northwest Drive
Plainville, CT 06062
Phone: 860-793-3844
Fax: 860-793-3520
Email: ccpca@wheelerclinic.com
Web Site: www.wheelerclinic.com

Delaware
Karen DeRasmo, Executive Director
Delawareans United to Prevent Child Abuse
Tower Office Park
240 N. James Street, Suite 103
Newport, DE 19804
Phone: 302-996-5444
Fax: 302-996-5425
Email: dupca@aol.com

District of Columbia
Leila Smith, Executive Director
Prevent Child Abuse Metro Washington
P.O. Box 57194
Washington, DC 20037
Phone: 202-223-0020
Fax: 202-296-4046
Email: pcamw@juno.com

Florida
Stephanie Meincke, Executive Director
The Family Source
345 Office Plaza Drive
Tallahassee, FL 32301
Phone: 850-488-5437
Fax: 850-921-0322
Email: info@familysource.org
Web Site: www.familysource.org

Georgia
Sandra Wood, Executive Director
GA Council on Child Abuse, Inc.
1375 Peachtree Street, NE, Suite 200
Atlanta, GA 30309
Phone: 404-870-6565
Fax: 404-870-6541
Email: spwood@aol.com
Web Site: www.gcca.org

Hawaii
Charles Braden, Executive Director
Prevent Child Abuse Hawaii
1575 W. Beretania Street, Suite 202
Honolulu, HI 96826
Phone: 808-951-0200
Fax: 808-941-7004
Email: pcah@aloha.com

Illinois
Roy Harley, Executive Director
Prevent Child Abuse Illinois
528 South 5th Street, Suite 211
Springfield, IL 62701
Phone: 217-522-1129
Fax: 217-522-0655
Email: pcai@fgi.net

Indiana
Andie Marshall, Executive Director
Prevent Child Abuse Indiana
32 East Washington Street, Suite 1200
Indianapolis, IN 46204
Phone: 317-634-9282
Fax: 317-634-9295
Email: generalinfo@pcain.org
Web Site: www.pcain.org

Iowa
Steve Scott, Executive Director
Prevent Child Abuse Iowa
550 11th Street, Suite 200
Des Moines, IA 50309
Phone: 515-244-2200
Fax: 515-280-7835
Email: iowancpca@earthlink.net
Web Site: www.pcaiowa.org

Kansas
Robert L. Hartman, Executive Director
KS Children's Service League
1365 North Custer Street
P.O. Box 517
Wichita, KS 67201
Phone: 316-942-4261
Fax: 316-943-9995
Email: Bhartma@kcsl.org

Kentucky
Jill Seyfred, Executive Director
Prevent Child Abuse Kentucky
489 East Main Street, 3rd Fl.
Lexington, KY 40507
Phone: 606-225-8879
Fax: 606-225-8969
Email: kycca@uky.campus.net

Louisiana
Marketa Gautreau, Executive Director
Prevent Child Abuse Louisiana
733 East Airport Avenue, Suite 101
Baton Rouge, LA 70806
Phone: 225-925-9520
Fax: 504-926-1319
Email: mgautreau@pcal.org

Maine
Franklin County Chapter
Liz Kuhlman, Executive Director
Franklin County Children's Task Force
69 North Main Street
Farmington, ME 04938
Phone: 207-778-6960
Fax: 207-779-1029
Email: fccts@somtel.com

Greater Maine Chapter
Lucky Hollander, Executive Director
Greater Maine Chapter, Prevent Child Abuse America
400 Congress Street
P.O. Box 912
Portland, ME 04104
Phone: 207-874-1120
Fax: 207-874-1124
Email: llhollander@youthalternatives.org

York County Chapter
Marilyn Staples, Executive Director
York County Child Abuse and Neglect Council, Inc.
0 Dental Avenue
P.O. Box 568
Biddeford, ME 04005
Phone: 207-284-1337
Fax: 207-284-1593
Email: yccanc@gwi.net

Maryland
Gloria Goldfaden, Executive Director
People Against Child Abuse, Inc.
2530 Riva Road, Suite 3
Annapolis, MD 21401
Phone: 410-841-6599
Fax: 410-224-3725
Email: pacancpca1@aol.com

Massachusetts
Jetta Bernier, Executive Director
MA Committee, Children and Youth
14 Beacon Street, Suite 706
Boston, MA 02108
Phone: 617-742-8555
Fax: 617-742-7808
Email: mail@masskids.org
Web Site: www.masskids.org

Michigan
Deborah Strong, Executive Director
Michigan Children's Trust Fund
235 South Grand Avenue, Suite 1411
Lansing, MI 48909
Phone: 517-373-4320
Fax: 517-241-7038
Email: strongd@state.mi.us

Michael Foley, Executive Director
Michigan Children's Charter
324 Pine Street, Suite 1
Lansing, MI 48933
Phone: 517-482-7533
Fax: 517-482-2626
Email: mikfoley@aol.com

Minnesota
Suzann Eisenberg Murray, Executive Director
Prevent Child Abuse Minnesota
c/o The Family Support Network
1821 University Avenue West
Suite 324-S
St. Paul, MN 55104
Phone: 651-523-0099
Fax: 612-523-0380
Email: smurray@familysupport.org
Web Site: www.familysupport.org

North Dakota
Kathy Mayer, Executive Director
Prevent Child Abuse ND
P.O. Box 1213
418 East Rosser, Suite 303
Bismarck, ND 58502-1213
Phone: 701-223-9052
Fax: 701-255-1904
Email: pcand@juno.com

Ohio
Debbie Sendek, Executive Director
Center for Child Abuse Prevention
Timken Hall, Suite 130
700 Children's Drive
Columbus, OH 43205
Phone: 614-722-6800
Fax: 614-722-5510
Email: dsendek@chi.osu.edu

Missouri
Connie Cunningham, Executive Director
Prevent Child Abuse Missouri
621 East McCarty, Suite E
Jefferson City, MO 65101
Phone: 573-634-5223
Fax: 573-635-8499
Email: pcam@plnet.net

Montana
Sara Lipscomb, Executive Director
Montana Council for Families
P.O. Box 7533
127 East Main, Suite 209
Missoula, MT 59807
Phone: 406-728-9449
Fax: 406-728-9459
Email: mcf@montana.com

Nevada
Dr. Paula Ford, Executive Director
We Can, Inc.
5440 West Sahara, Suite 202
Las Vegas, NV 89102
Phone: 702-368-1533
Fax: 702-368-1540
Email: paulaford@aol.com
Web Site: www.wecan-inc.org

New Hampshire
Cheryl Avery Molloy, Executive Director
New Hampshire Task Force to Prevent Child Abuse
P.O. Box 607
2 Industrial Park Drive
Concord, NH 03302
Phone: 603-225-5441
Fax: 603-228-5322

Oklahoma
Debbie Richardson, Executive Director
Prevent Child Abuse Oklahoma
Citizen's Tower
2200 Classen Boulevard, Suite 630
Oklahoma City, OK 73106
Phone: 405-525-0688
Fax: 405-525-0689
Email: ocpca@juno.com
Web Site:
Members.aol.com/ocpca/child

Pennsylvania
Beth McDaid, President
Prevent Child Abuse Pennsylvania
117 South 17th Street, Suite 1000
Philadelphia, PA 19103
Phone: 215-561-5640
Email: nhtf@juno.com
Web Site: www.Gran-net.com/nhtf

New Jersey
Sharon Copeland, Executive Director
Prevent Child Abuse New Jersey, Inc.
103 Church Street, Suite 210
New Brunswick, NJ 08901
Phone: 732-246-8060
Fax: 732-246-1776
Email:
preventchildabuse@worldnet.att.net

New York
James Cameron, Executive Director
Prevent Child Abuse New York
134 South Swan Street
Albany, NY 12210
Phone: 518-445-1273
Fax: 518-436-5889
Email: ncpcanys@aol.com
Web Site: http://child.cornell.edu/ncpca/home.html

North Carolina
Jennifer Tolle, Executive Director
Prevent Child Abuse North Carolina
3344 Hillsborough Street, Suite 100D
Raleigh, NC 27607
Phone: 919-457-6233
Fax: 919-457-8525
Email: jentolle@mindspring.com
Web Site: www.childabusenc.org

Fax: 215-561-3907

Rhode Island
Ted Whiteside, Executive Director
Prevent Child Abuse Rhode Island
500 Prospect Street
Pawtucket, RI 02860
Phone: 401-728-7920
Fax: 401-724-5850
Email: teddiez@earthlink.net

South Carolina
Beebe James, Executive Director
Prevent Child Abuse South Carolina
1800 Main Street, Suite 3A
Columbia, SC 29201
Phone: 803-733-5430
Fax: 803-733-5424
Email: pcasc@mindspring.com

Web Site: www.pcasc.org

Tennessee
Lynne Luther, Executive Director
Prevent Child Abuse Tennessee
333 South Gallatin Road, Suite 10
Madison, TN 37115
Phone: 615-868-4468
Fax: 615-868-2169
Email: capoftn@aol.com
Web Site: www.pcat.org

Texas
Wendell Teltow, Executive Director
Prevent Child Abuse Texas
12701 Research, Suite 303
Austin, TX 78759
Phone: 512-250-8438
Fax: 512-250-8733
Email: pcatx@juno.com

Utah
Jennifer Saunders Bean
Executive Director
Prevent Child Abuse Utah
40 East South Temple, Suite 350-12
Salt Lake City, UT 84111-1003
Phone: 801-532-3404
Fax: 801-359-3662
Email: ucpca@bitcorp.net
Web Site: www.bitcorp.net/ucpca

Vermont
Linda Johnson, Executive Director
Prevent Child Abuse Vermont
94 Main Street, P.O. Box 829
Montpelier, VT 05601
Phone: 802-229-5724
Fax: 802-223-5567
Email: pcavt@together.net

Virginia
Stephen Jurentkuff, Executive Director
Prevent Child Abuse Virginia
4901 Fitzhugh Avenue
Suite 200
Richmond, VA 23230
Phone: 804-359-6166
Fax: 804-359-5065
Email: sjurentkuff@juno.com
Web Site: www.preventchildabuse.org

Wisconsin
Sally Casper, Executive Director
Prevent Child Abuse Wisconsin
214 North Hamilton
Madison, WI 53703
Phone: 608-256-3374
Fax: 608-256-3378
Email: wcpca@juno.com

Wyoming
Rose Kor, Executive Director
Prevent Child Abuse Wyoming
1902 Thomes Avenue, Suite 215
Cheyenne, WY 82001-3549
Phone: 307-637-8622
Fax: 307-635-7755
Email: pcawyo@juno.com

Appendix G About the Speakers

Stephen M. Blain, DDS, MS: Dr. Blain is a clinical professor of pediatric dentistry at the UCLA School of Dentistry and director of the UCLA Children's Dental Center. He has a private practice in Santa Monica, California, is co-chair of the California P.A.N.D.A. Coalition and was a founding member of the UCLA SCAN (Suspected Child Abuse and Neglect) Team. His teaching and publications have focused on child abuse and neglect as they relate to dentistry, child development and behavior management.

Donald C. Bross, JD, PhD: Dr. Bross is Professor in Pediatrics (Family Law) at the University of Colorado School of Medicine. He is also Director of Education and Legal Counsel for the Kempe Children's Center, a subdivision of the Department of Pediatrics. The Kempe Children's

Center was known formerly as the C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect. He holds a Juris Doctorate degree from the University of Colorado and a PhD in Medical Sociology from the University of Wisconsin.

Dr. Bross' areas of interest include child welfare law, legal representation of maltreated children, medical sociology, child protection policy, sexually transmitted disease control, risk management and pediatric law. He is a founder of the National Association of Counsel for Children, and author or co-author of over 70 articles, chapters and books.

Robert J. (Skip) Collins, DDS, MPH: Dr. Collins is the deputy executive director for the International and American Associations for Dental Research in Alexandria, Virginia. As a U.S. Public Health Service Commissioned Officer, Dr. Collins served in the Indian Health Service for many years and was the Chief Dental Officer for the U.S. Public Health Service from 1991-1995. He is a Diplomate of the American Board of Dental Public Health and is the immediate past president of the American Association of Public Health Dentistry.

Edward E. Cotton: Mr. Cotton began his career as a junior high school teacher. He then worked with a private child welfare agency as a social worker for five years and a federal Head Start program for two years. Mr. Cotton has been involved in child protective services for the State of Illinois since 1980. He first worked as a child protection investigative social worker, then joined the Illinois State Central Child Abuse Registry upon its creation. He became administrator of this agency in 1985. During that time Mr. Cotton distinguished himself as a highly effective leader in the development of statewide information systems for the centralized tracking system of child abuse and neglect reports. Mr. Cotton was the driving force behind improvements in the investigation system that, within a span of ten years, more than doubled its volume of calls. In 1994 Mr. Cotton was appointed Deputy Director of Child Protection within the Illinois Department of Children and Family Services (DCFS) where he has spearheaded several new initiatives. Most noteworthy was development of a Child Endangerment Risk Assessment Protocol to determine immediate safety decisions to be made during investigations. This protocol has resulted in a decrease of nearly 30% in the number of children who are abused for a second time after contact with the Department of Children and Family Services.

Mr. Cotton is the father of two grown children and has raised more than 20 foster children, including a nine year old who is currently in his care. Mr. Cotton was president of the Springfield Committee for Children and has been involved with the Big Brother/Big Sister program for ten years.

A. Sidney Johnson III, MSW: Mr. Johnson has been President of Prevent Child Abuse America (PCAA), formerly the National Committee to Prevent Child Abuse, since January 1998. In that capacity he oversees the activities of PCAA's 43-state network of chapters; a nationwide public service media campaign; a national center on child abuse prevention research; the national Healthy Families America effort; and a variety of other activities including an extensive training and technical assistance program and advocacy efforts. Mr. Johnson holds a Bachelor of Arts degree from Williams College and a Master of Social Work degree from the University of Michigan.

Prior to joining PCAA he served as the Executive Director of the American Public Welfare Association (APWA) for twelve years. APWA represents all fifty state human service departments, 800 local departments and 4,000 individuals and promotes their national human services policy making.

Mr. Johnson's career in public policy began as special assistant to the Health, Education and Welfare Secretary Wilbur Cohen. He next served for seven years as legislative aide to Senator Walter F. Mondale and staff director of the primary Senate Subcommittee on Children and Youth. That was the Subcommittee that led the successful effort to enact the Child Abuse Prevention and

Treatment Act. In 1976 he founded the Family Impact Seminar in Washington, the nation's first organization to examine the impact of public and private policies on American families. From 1982 to 1985 he served as Executive Director of the American Association for Marriage and Family Therapy.

From 1988 to 1992 he was a member of the National Commission on Children. From 1992 to 1994 he served on the Carnegie Task Force on Meeting the Needs of Young Children. This Task Force produced the *Starting Points* report and led to the current *I Am Your Child* public engagement campaign about brain development in children from birth through age three.

John P. Kenney, DDS, MS: Dr. Kenney completed his master's thesis on orofacial injuries in child abuse in 1979, and has authored numerous chapters and articles on the subject. A pediatric dentist in private practice, he is chief
odontologist for the Cook County (IL) Medical Examiner, and consults for the National Transportation Safety Board on air disasters. He lectures internationally on child abuse/domestic violence and forensic dentistry and is a past-president of the American Board of Forensic Odontology.

Paul E. Kittle, Jr., DDS: Dr. Kittle is a 1975 graduate of the Creighton University School of Dentistry. Following graduation, he entered the U.S. Army and completed a general practice residency. Dr. Kittle later attended the University of Texas at San Antonio for his postgraduate training in pediatric dentistry. Dr. Kittle was the Director of the U.S. Army's Pediatric Dentistry Residency Program at Fort Lewis, Washington from 1991-1993, and retired from the Army as a Colonel in 1994. He is board certified in Pediatric Dentistry, was a Trustee-at-Large for the American Academy of Pediatric Dentistry from 1994-1997, and is a member of the American Academy of Pediatric Dentistry, the American Society of Dentistry for Children and the American Dental Association. He currently maintains a private practice in pediatric dentistry in Leavenworth, Kansas.

John D. McDowell, DDS, MS: Dr. McDowell is an Assistant Professor in the Department of Diagnostic and Biological Sciences at the University of Colorado School of Dentistry. He presently serves as the Director of Oral Medicine and Forensic Sciences and Chairman, Division of Oral Diagnosis, Medicine and Radiology.

Dr. McDowell also has an oral medicine practice at the University of Colorado with primary emphasis on oral manifestations of systemic disease and the infections and tumors associated with HIV/AIDS. He is the Dental Representative for the Mountain/Plains AIDS Education and Training Center in Denver, Colorado and a representative to the National AIDS Education and Training Center in Washington, DC.

Dr. McDowell has been active in the forensic sciences for more than 20 years. He is a board certified forensic odontologist serving as a consultant to various forensic organizations including the University of Colorado School of Medicine Kempe Medicine Center for the Diagnosis and Treatment of Child Abuse and Neglect. He presently serves as the Secretary of the American Academy of Forensic Sciences. He is also the Immediate Past President of the American Society of Forensic Odontology. He serves on several mass disaster teams including the State of Colorado's and the New York City Medical Examiner's Go Team.

Dr. McDowell has multiple publications in the professional literature. He is a reviewer for the *Journal of the American Dental Association* and is a member of the editorial board of the *American Journal of Forensic Medicine and Pathology*. He is also the diagnosis section editor for *Clark's Clinical Dentistry*, a multi-volume annual publication dealing with all aspects of clinical dentistry.

Lynn Douglas Mouden, DDS, MPH: Dr. Mouden speaks nationally and internationally on the clinical aspects of child abuse and family violence. He received his Doctor of Dental Surgery degree from the University of Missouri at Kansas City (UMKC) and his Master's degree in Public Health from the University of North Carolina at Chapel Hill. Dr. Mouden owned a private dental practice for 16 years and now serves as deputy state dental director for the Missouri Department of Health. He is also an assistant clinical professor at UMKC. Dr. Mouden founded the Prevent Abuse and Neglect through Dental Awareness (P.A.N.D.A.) program in Missouri. He is vice chairman of the ADA Council on Access, Prevention and Interprofessional Relations and provides seminars on child abuse and family violence for the ADA's Seminar Series.

Robert J. Musselman, DDS, MDS: Dr. Musselman has been Head of the Department of Pediatric Dentistry at LSU School of Dentistry in New Orleans since the school opened in 1967. In collaboration with other faculty, Dr. Musselman developed the undergraduate and postgraduate curriculum in Pediatric Dentistry at LSUSD. That curriculum contains an important section on child abuse and neglect. In addition, Dr. Musselman's experience has involved lecturing to dentists on behavior management and the dental treatment of children throughout the United States, Europe and South America. He is a past president of the American Academy of Pediatric Dentistry. He maintains a limited private practice of Pediatric Dentistry at LSUSD and is director of the Special Patient Dental Clinic at Children's Hospital in New Orleans.

Howard Needleman, DMD: Dr. Needleman is the Associate Dentist-in-Chief at the Children's Hospital, Boston and Clinical Professor of Pediatric Dentistry at Harvard School of Dental Medicine. In addition, he maintains a private practice in pediatric dentistry in a suburb of Boston. His 1978 article entitled, "Child abuse and dentistry: Orofacial trauma and its recognition by dentists" was a landmark paper in the field of child abuse and its relationship to the dental profession. He has since lectured and published widely on the subject. Dr. Needleman was the founding member of the Massachusetts Dental Coalition against Abuse which was established in 1991 and was the prototype for the P.A.N.D.A. organizations.

Mark Nehring, DDS, MPH: Dr. Nehring is the Senior Program Management Consultant for the Emergency Medical Services for Children (EMSC) program, within the U.S. Maternal and Child Health Bureau (Health Resources and Services Administration). His areas of activity include administration and technical assistance to states receiving funding for projects designed to integrate children's needs into existing EMS systems. These EMS systems cover the entire spectrum of emergency care for children including prevention, pre-hospital care, transportation, acute care, rehabilitation and return to the community. Dr. Nehring received his Doctor of Dental Surgery degree from Boston University in 1981. He also possesses a Master's degree in Education from the University of Maine and a Master of Public Health degree from Johns Hopkins, and has completed residency training in Dental Public Health.

Dr. Nehring served for several years in clinical service at multiple U.S. Public Health Service sites including the National Health Service Corps and the Indian Health Service. Dr. Nehring was then assigned to the Washington, D.C. metropolitan area to assume responsibilities involving program development and the delivery of health services to populations. Although not formally trained in emergency medicine, Dr. Nehring's public health perspective, knowledge of federal programs and ability to collaborate with federal, state, and nongovernmental partners have served to meet EMSC goals and objectives. Dr. Nehring has fostered renewed interest in improving the existing EMS system's ability to meet the needs of children.

John C. Nelson, MD, MPH: Dr. Nelson has been active in organized medicine for 15 years and was elected to the American Medical Association's Board of Trustees in 1994. He is a board certified obstetrician-gynecologist in private practice in Salt Lake City. Dr. Nelson is also a fellow of the American College of Obstetrics and Gynecologists. Dr. Nelson completed medical school and residency at the University of Utah School of Medicine; he completed his internship at Providence Hospital in Portland. Dr. Nelson spent two years in the Army, one of which was

spent in Vietnam. He earned a Master's degree in Public Health from the University of Utah in 1993. Dr. Nelson is former Deputy Director for Utah's Department of Health and led the governor's task forces on child abuse and neglect as teenage pregnancy prevention. He is a frequent invited speaker on the issues of family violence, alcohol and substance abuse prevention and teen pregnancy prevention.

The Honorable Nancy Sidote Salyers, MA, JD: Judge Salyers has been Presiding Judge for the Child Protection Division of the Cook County (IL) Circuit Court since 1995 and heads the metropolitan Chicago Court's efforts to protect abused and neglected children. She is responsible for overseeing the 16 judges who handle Cook County's children's advocates in the community. Judge Salyers is also the mother of two teenage boys.

Since Judge Salyers became Presiding Judge in February of 1995, her focus on the best interests of children has led to the initiation of procedural reforms at Juvenile Court with dramatic results. For the first time, the court is closing cases that it brings in each month and previous backlogs have decreased significantly. In the last six months, Judge Salyers has personally reviewed the cases of over 4,000 children who had been wards of the court for several years and were still not adopted. As a result of that project, nearly 1,000 children are on their way to having permanent homes through adoption. Under Judge Salyers' leadership, a community-funded Children's Room was established to offer a quiet place for children who must spend long hours in the courthouse and a regular series of concerts and special learning opportunities was inaugurated at the court. In addition, Judge Salyers' concern led to the development of work groups to focus on temporary custody hearings, subsidized and expedited adoptions, permanency planning, new legislation and overhauling court procedures.

Judge Salyers holds a Juris Doctorate degree from DePaul University College of Law and a Master of Arts degree from Rosary College. Judge Salyers was with the Cook County State's Attorney's Office from 1977 until 1992. In 1992 she served as a trial judge in the Juvenile Division. The National Association of Women Lawyers presented Judge Salyers with its President's Award in 1996.

Paul E. Stubbs, DDS: Dr. Stubbs is chairman of the ADA Council on Access, Prevention and Interprofessional Relations. He received his Doctor of Dental Surgery degree from Baylor Dental College in Dallas. Dr. Stubbs is in full-time general dental practice in the Austin area and participates in a variety of volunteer activities in district and state dental organizations. Dr. Stubbs' accomplishments and leadership as president of the Texas Dental Association brought legislative accord in the state dental practice act. Dr. Stubbs has also served on the Title XIX Dental Care Advisory Board and is dental liaison to the Advisory Board of the Texas Institute of Medical Assessment. After spending time in volunteer dental clinics in Haiti, he became organizer and director of several dental mission trips to the Texas/Mexico border as well as to the Yucatan (Mexico) and Nicaragua. He is currently a dental staff member of a local hospital. Dr. Stubbs participates in dental-related research projects and is an examiner for both the dental and dental hygiene sections of the Western Regional Examining Board.

Kathleen Todd, JD: Ms. Todd works for the American Dental Association as associate general counsel. She also serves as director of the ADA's Council on Ethics, Bylaws and Judicial Affairs, which has bylaw authority for the ADA's *Principles of Ethics and Code of Professional Conduct*. Ms. Todd came to the ADA after graduating from DePaul University College of Law in 1986. She worked in the ADA's Legislative Division before moving to the Legal Division in 1990.

Ms. Todd has responsibility for a broad range of legal issues of concern to the profession, including the Occupational Safety and Health Administration and the Environmental Protection Agency. She is the attorney for the ADA Council on Scientific Affairs and advises the Council on the legal aspects of wide variety of scientific issues. She also responds to inquiries from

members about the legal aspects of these issues in their daily practices. Ms. Todd is also the attorney for the ADA Council on Federal and State Government Affairs and Federal Dental Services.