Section 6: Drug Endangered Children

In This Section:

Methamphetamine: Children At Risk, Source: Maine Methamphetamine Prevention Project

National Guideline for Medical Evaluation of Children Found in Drug Labs, Source: www.nationaldec.org

Drug Affected Children: Roles and Responsibilities of Child Protective Workers, Source: Maine Dept. of Health and Human Services

Links:

National Alliance for Drug Endangered Children, www.nationaldec.org

Methamphetamine/Dexatroamphetamine and Pregnancy, Organization of Teratology Information Specialists (OTIS), Raising Mom's Awareness, Reducing Baby's Risk. Source: http://www.otispregnancy.org/files/methamphetamine.pdf

METHAMPHETAMINE: CHILDREN AT RISK

Risks to children include:

- Exposure to explosive, flammable, toxic ingredients stored in kitchen cabinets, bathrooms and bedrooms
- Access to methamphetamine and paraphernalia
- Presence of loaded weapons in the home and booby traps (due to paranoia of methamphetamine users)
- Physical and sexual abuse
- Exposure to high risk populations (sexual abusers, violent drug users)
- Neglect including poor nutrition, poor living conditions
- Presence of pornography

If a pregnant woman uses meth, the baby may experience:

- Premature birth
- Growth retardation
- Withdrawal symptoms including abnormal sleep patterns, high pitched cry, poor feeding
- Cerebral injuries
- Limpness
- Apparent depression
- Shaking and tremor
- Irritability
- Fits of rage
- Sensitivity to stimuli including human touch and regular light
- Coordination problems
- Birth defects (6 times more likely) including effects on the central nervous system, heart and kidneys
- Cerebral palsy and paralysis are common

The effects of meth last longer than crack and can lead to more damage. Levels of meth present in breast milk are higher than the level in blood.

Sources: Dr. Rizwan Shah, Iowa Child Protection Council; Dr. Michael Sherman, Chief of Neonatology at UC Davis; Dr. Annette Grege, Yellowstone Pediatric Neurology.

Parents who use meth often exhibit:

- Extreme mood fluctuations
- Violent behavior
- Depression
- Poor impulse control
- Bizarre behaviors
- Lack of attention to hygiene
- Acute psychotic episodes
- Poly-drug use

As meth use continues, the parent is unable to provide basic needs to the child. Due to changes in brain chemistry, the parent loses the capacity to care about anything but meth.

Children whose parents use or manufacture meth may experience:

- Respiratory problems
- Delayed speech and language skills
- Higher risk for kidney problems and leukemia
- Malnourishment
- Poor school performance/attendance problems
- Isolation
- Physical, sexual and emotional abuse
- Poor dental health
- Hyperactivity and attention disorders
- Lice
- Obesity
- Other developmental problems
- Violent behavior
- Drug usage
- Lack of boundaries/easy attachment to strangers

Medical personnel may notice:

Agitation, inconsolability, tachycardia, respiratory problems (often meth kids present with asthma), nausea, protracted vomiting, hyperthermia, ataxia, roving eye movements, seizures, and headaches.

Source: Mesa Center Against Family Violence

If you suspect meth production, leave the area immediately and contact local law enforcement!

NATIONAL GUIDELINE FOR MEDICAL EVALUATION OF CHILDREN FOUND IN DRUG LABS

NATIONAL ALLIANCE FOR DRUG ENDANGERED CHILDREN

LAB SITE

ACTIVATE

If explosion, obvious chemical exposure, active lab, or child appears ill
TRANSPORT IMMEDIATELY VIA EMS

IMMEDIATE STEPS ON-SITE

LAW ENFORCEMENT

NARCOTICS

1. Identify chemicals present
2. Clan lab certified & DEC trained personnel to photograph living conditions and collect evidence
3. Submit data to appropriate databases

DECONTAMINATION per local protocol when medically stable

MEDICAL FACILITY

1. Perform Medical Assessment/Screening
2. Collect Urine via Chain of Custody within **12** hours after removal

PLACEMENT per local protocol

CHILD PROTECTIVE SERVICES

Emergency Department
1. Neurological status
2. Respiratory status:
   - O2 sat
   - CXR
3. Blood: CBC
   - Chemistry panel
   - LFT's
   - BUN/Cr
4. Urine toxicology via chain of custody

Within 24-72 hours

Conduct Forensic Interview jointly with CPS

1. Complete Medical evaluation:
2. Dental examination
3. Developmental and Mental Health Evaluation

1. Identify all siblings and obtain tracking information
2. Gather medical history

Follow-up

Developmental & mental health assessment

Update databases

Medical follow-up: Within 30 days, 6 mos, 1 yr

PERSONNEL DECONTAMINATION

Decontamination of the children should occur prior to transport to the medical facility as medically appropriate. Basic life support takes precedence over decontamination. Removal of clothing, cleansing of the skin and hair with running water and new clothes are the minimum requirements of decontamination. DO NOT USE WETWIPES!

LAW ENFORCEMENT

Immediate

1. Document the quantity and types of chemicals present and document how found i.e. uncapped, in tin cans, so that the exposure of the child can be determined. Document the condition of the home. Document odors and state of lab (actively cooking, decanting stage, drying stage etc.) Document the people at the scene and those who also reside in the home. This information should be conveyed to medical facility.
2. Personnel on scene should be both clan lab and DEC certified in order to be able to accurately collect, document and photograph the scene as to aid in the child endangerment prosecution i.e. height of chemicals, location of drugs, general state of children, guns, pornography.
3. Collect and submit all the required data to appropriate databases.
4. Transport child as per local DEC protocol in conjunction with CPS.

Within 24-72 hours

1. Children need to be interviewed by personnel trained in the forensically correct method for children. Coordinate this process with CPS.

Follow-up

1. Update databases as needed.

NATIONAL ALLIANCE FOR DRUG ENDANGERED CHILDREN

NATIONAL GUIDELINE FOR MEDICAL EVALUATION OF CHILDREN FOUND IN DRUG LABS

MEDICAL PERSONNEL

Symptomatic - Immediate

1. Head to toe exam of the children within 2 to 4 hours to ensure medical stability and document any acute findings that might need treatment or change over time. This may occur in an ED, physician's office or by EMT's on scene. This should include but not be limited to a good pulmonary exam, skin exam, neurologic exam and affect (scared, happy, detached). May include observations by EMT's, RN on scene or other personnel to document the affect of the children.
2. Collect urine for toxicology. This should happen as soon as possible but must occur within 12 hours for optimal results. Submit to a lab that screens for any detectable level (quantitative or confirmatory) and reports for the level of detection of the test not just at NIDA standards. Chain of Evidence forms may be utilized or usual medical protocols for urine toxicology screens may be followed.
3. Blood tests. Can be done acutely or within 24-72 hours: a CBC (anemia, cancers, thrombocytopenias), Chemistry Panel to include BUN/Cr and LFT's (kidney and liver damage, electrolyte imbalances), Hepatitis B and C panels.

Asymptomatic - Within 24-72 hours

1. A complete medical evaluation.
2. If seen within 12 hours, collect urine for toxicology
3. Blood tests as above.
4. Developmental evaluation using an age appropriate standardized tool.
5. Mental health evaluation.
6. Dental evaluation.

Follow-Up

1. Repeat medical evaluation in 30 days, 6 mos. & 1 yr.
2. Follow up developmental evaluations as needed based on the initial evaluations.
3. Follow up mental health interventions and assessments as needed.

EMERGENCY ACTIVATION

Transport immediately to the ED by emergency personnel if there is an explosion, active chemicals at the scene or the child appears ill or has obvious chemical contamination i.e. fast breathing, obvious burns, lethargy or somnolence.

CHILD PROTECTIVE SERVICES

Immediate

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

Within 24-72 hours

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

Follow-up

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

EMERGENCY DEPARTMENT

1. Complete medical evaluation to assess acute medical needs.
2. Specific attention to the pulmonary exam as the chemicals can cause acute respiratory problems. RR's, O2 saturation and a CXR in the symptomatic child are the minimum required.
3. Blood tests as needed in addition to a CBC, Chemistry Panel to include BUN/Cr and LFTS.
4. Collect urine for toxicology. This should happen as soon as possible but must occur within 12 hours for optimal results. This should be submitted to a lab that screens and reports for the level of detection of the test not just at NIDA standards. Chain of Evidence forms may be utilized or usual medical protocols for urine toxicology screens may be followed.

Drug Endangered Children
Roles and Responsibilities of Child Protective Services

Office of Child and Family Services, DHHS, 2 Anthony Avenue, Augusta ME 04330

If you suspect that a child has been harmed/affected by drugs, call the DHHS 24-hour Hot Line at 1-800-452-1999.

The DHHS organizational unit based in the Augusta Central Office operates a 24-hour "hot line" which is responsible for the receipt, screening, and disposition of reports of suspected child abuse and/or neglect.

	Program Administrators	
District 1	Mark Dalton (PA) Biddeford	286-2400/286-2508
	Kristen Brown (APA)	
	Sanford office	490-5400
District 2	Julie McShane (PA) Portland	822-2000/822-2231
	Brian Walsh (APA) Portland	
District 3	Cathy Lachapelle (PA) Lewiston	795-4300/795-4620
	Farmington office	778-8400
	South Paris office	744-1200
District 4	Ilene Ford (Acting PA) Rockland	596-4200/596-4262
District 5	Ellen Beerits (PA) Augusta	624-8000/624-8088
	Martha Proulx (APA Augusta	
	Kim Miller (APA) Skowhegan	474-4800/474-4850
District 6	Bobbi Johnson (PA) Bangor	561-4100/561-4220
	Robin Whitney (APA)	
Districts 7 & 8	Marie Kelly (PA) Ellsworth	667-1600/667-1625
	Rebecca Bolstridge (APA)	
	Machias office	255-2000/255-2024
District 8	Caribou office	493-4000/493-4140
	Houlton office	532-5000/532-5106
	Ft. Kent office	834-7700/834-7720

Drug Affected Infants - DHHS has the responsibility to respond to reports from health care providers that an infant has been born that is affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure to either legal or illegal drugs regardless of whether the infant is abused or neglected.

Drug Affected Baby (DAB) Reports - All reports from health care providers alleging that an infant has been born that is affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure (legal or illegal substances) will have the report type of "drug affected baby." All reports of the type "drug affected baby" are appropriate and are sent to the District.

For more information:

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