MiPSAC

Newsletter of the Michigan Professional Society on the Abuse of Children, Inc., the Michigan Chapter of APSAC.

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PRESIDENT'S CORNER

By Annamaria Church, MD

Henry Ford Health System

Munchausen Syndrome by Proxy, Meadows Syndrome, Munchausen's, Pediatric Condition Falsification, Factitious Disorders, Polle's Syndrome…with so many names, is it any wonder we find the syndrome confusing?

In the 1990's a consensus paper clarified and defined our terminology surrounding this topic. This allowed professionals to all speak the same language. Pediatric Condition Falsification (PCF) is the medical diagnosis made when a child's condition is either actively or passively falsified by a caretaker, no matter what the caretaker's motivation is. Factitious Disorder by Proxy (FDP) is the psychological diagnosis given to the caretaker if the motivation for the action and the psychological make-up of the caretaker meet certain diagnostic criteria. When a child is diagnosed with PCF and the caretaker is diagnosed as FDP, the combination is Munchausen by Proxy (MBP).

For a professional in the field, MBP poses many challenges. When is a mother an overly concerned parent and when is she an abuser? When is the condition I am evaluating PCF and when am I missing an esoteric diagnosis? Should I believe the caretaker's description of events? Is it possible that I have been tricked?

Now that the various disciplines are speaking the same language surrounding this very complex syndrome, the next step is the development of evaluation and management guidelines. A task force in the state of Michigan is currently working to establish these guidelines. In the meantime, this issue of the MiPSAC newsletter will try to provide you with a multidisciplinary discussion of this very complex topic.

In this Special Issue on Munchausen by Proxy (MBP)…

NOTE FROM THE EDITORS: We have noticed that the field uses different names for the abuse called 'Munchausen by Proxy' (MBP). The May, 2002 editions of APSAC's journal, Child Maltreatment and ISPCAN's Child Abuse & Neglect have excellent reviews which use Munchausen by Proxy (MBP) to reflect the combined diagnoses of Pediatric Condition Falsification (PCF) and Factitious Disorder by Proxy (FDP). For this issue of the MiPSAC newsletter, we have also decided to use MBP throughout. ----- Pat Siegel (Guest Editor), Vince Palusci, & Leni Cowling

MiPSAC ANNOUNCEMENTS AND UPCOMING MEETINGS

7th MiPSAC Annual Meeting
Monday, October 28, 2002, 5-7 P.M.
Ypsilanti Marriott / 1275 Huron Street South
Ypsilanti, MI 48197 Info: (734) 487-2000
1. Election of 2003 Officers/Board
2. Presentation of 2002 MiPSAC Child Advocate Award

10th Annual APSAC Colloquium
May 29 - June 1, 2002, New Orleans, LA
Contact: Gethesemani@comcast.net

14th International ISPCAN Conference
July 7-10, 2002. Denver, CO.
Contact: Kempe Center at www.kempe.org

Victimization of Children & Youth: Research Conf
August 4-7, 2002, Portsmouth, NH
University of New Hampshire www.unh.edu/frl

1st Symposia on Abuse Prevention Programs & Evaluation
MI Applied Research Consortium on CAN/ CTF / FIA
September 13th, 2002, Detroit, MI sondersma@wayne.edu

4th National Conference of Shaken Baby Syndrome
September 12-15, 2002, Utah
National Center on SBS, www.dontshake.com

21st Annual MI Statewide Conference on Abuse and Neglect
October 28-29, 2002, Ypsilanti, MI
University of Michigan (734) 763-0215 sasmi@umich.edu

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REMINDER!
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You need APSAC membership for MiPSAC.
Part of you annual dues to APSAC pays for MiPSAC membership automatically!

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A Victim's Voice

By Mary A. Bryk RN, BSN

As a child, I was physically abused by my mother from the ages of two to ten. Her intent was to induce symptoms of infection in my extremities. Many times the injuries would start out in appearance as a sprain, tendonitis or a fracture. Eventually, there would be open wounds from surgical incisions allowing my mother to use plant soil and coffee grounds to produce serious infections.

Often, I have been asked in interview "why did you not tell someone?" The answer is not simple. My mother's love was connected to my physical abuse. It was a shameful secret never to be discussed. Her power and control over me physically and emotionally kept me silent.

Mother would tell me the "treatments" were for my own good, "I am helping you" and this is what the doctor had told her to do. If I would not fight her, if I were better behaved, she would not have to do these "treatments". The messages were confusing. Did my father and medical personnel know what she was doing to me? Did anyone really care?

Her stories about my injuries were unbelievable to my own ears, yet everyone else took her seriously. They lauded her for all her hard work and dedication to caring for her poor, sickly daughter. "You are so lucky to have a mother who cares so much for you". "Look at all your mother has done for you". "You would not be alive if it were not for your mother". These words spoken frequently by my father, family and friends added to my confusion. Maybe they did know what she was doing to me, look at how they respect her.

At the age of five, I did try to tell my father. Asking him, "why does mommy use a hammer on me?" My father immediately went to my mother and asked "what is she talking about?" My mother began to cry saying, "I don't know what your talking about." My father then turned to me and told me never ever to lie again, after all my mother was doing to help me how could I say such things about her? So, I kept my mouth shut. My father would not believe me so who could I tell?

Lies and manipulation were how my mother controlled everyone around her. I learned to tune her out when she was telling a story about my latest injury to doctors, nurses or family. I kept silent and learned to respond, "fine" to anyone who asked, "How are you doing". What did they care? I was mad at everyone. No one stopped her. No one could see through her lies. No one was going to save me.

I was very scared of what my mother could get away with. All of my physical injuries were explained away including the third and fourth degree burn to my right arm, listed in my medical chart as a "skin deficit" the doctor though was due to a massive infection. If my mother could get away with this, what else would she do to my body if I told the truth? She was capable of anything. More then once there had been talk of a possible amputation of my arm or leg. I had had gangrene and was not responding to medical treatment. Each time, I miraculously recovered. Would I be so lucky the next time? Would my mother take it one step farther if I tried to tell the truth?

Mother threatened me often with the words, "if you tell someone, they will think you are crazy and take you away from us". "They will lock you up in the mental hospital and you will never see us again." I knew what a mental hospital looked like. We lived less then a mile away from a state institution, those big dark buildings with bars on the windows and cages instead of porches. I did not want to go there. Everyone believed in my mother. I would be labeled as the "sick one".

By the age of eight, I also had to worry about my little brother. He was nine months old and had fractured his hip. (A spiral fracture confirmed for me many years later by our treating physician). My mother's story was that he had fallen out of his crib. I came home from school to find him lying on a board with his foot in the air. A pin through the heel of his foot. My mother was such a good nurse and knew so much about taking care of a sick child, they let him come home in traction. My life was an unending nightmare. I pleaded with my mother not harm my brother. "I'll be good, "I'll be good" "Do whatever you want to me, just don't hurt him". His fracture healed and for two more years it was enough to keep my brother safe.

When I finally stood up to my mother at the age of ten, I did not think it would be so easy. I agonized over what to say, what to do. I lived in constant fear and anxiety over her "treatments". I could not take it anymore and no one was going to rescue me. Would I have carried out my spoken threat to her? Would I have told my doctor or teacher? I do not know if I would have had the strength or if I thought I would have been believed.

Mother's "treatments" did stop. Was it because I was physically stronger and fighting her harder? Or was it because my three-year-old brother was an easier target? (For the next two years he was her target, he had the same symptoms I had had) Yes, the physical torture stopped for me but the emotional turmoil would not be abated for many years. I spent the next year in constant fear that she would start my "treatments' again. While everyone was celebrating my recovery, I lived in silent fear for myself and for my brother. I was too much of a coward to speak the truth. I could not save him. I was not strong enough to fight my perpetrator emotionally. I did not want to lose the love of my family.

For child victims, the dilemma is how to be loved and accepted. The message received from perpetrators, most frequently a highly respected and trusted member of the family, is to keep quiet. Telling the truth is a greater fear because of the unknown consequences. The perpetrator may become more violent and the victim fears not being believed along with the possibility of losing the love of family. If someone had asked me as a child "Are you safe at home?", before the age of eleven, I would have answered, "yes". By the time I reached eleven, I was angry enough at what my mother had gotten away with I would have been more truthful. It would have been a relief to have someone else voice their own suspicions. But, no one ever asked and I could not be the one to give away my mother or the love of my family.

Dealing With Munchausen by Proxy Syndrome – A Nurse's Perspective

By Karen L. Braniff, RN, MSN, CPNP
Children's Hospital of Michigan

One of the most challenging yet frustrating situations for a pediatric nurse to encounter is that of a suspected Munchausen by Proxy (MBP) case, also known as factitious disorder by proxy. This is true whether the nurse works on an inpatient unit in a hospital setting, in an outpatient clinic setting, is a staff nurse or a pediatric nurse practitioner. These cases are not only time consuming but also physically and emotionally encompassing. As an advance practice nurse whose duties include care of pediatric patients in both the inpatient and outpatient setting I have encountered five situations where MBP was suspected and these cases proved to be the most time consuming and emotionally draining of my professional career.

One reason these cases are so difficult to deal with is that nurses are not effectively trained to recognize MBP. The undergraduate pediatric clinical rotation is often less than a ten-week period and the training emphasis is on normal childhood development and common pediatric disease entities. There is no time dedicated to the complexities of this form of abuse and how to recognize it. Frequently, the first time a nurse becomes aware of MBP is when she is in the middle of dealing with a parent who is demonstrating excessive health seeking behaviors. In one of the only studies that evaluated the impact of MBP on nurses, 55% had never heard of the disorder, 70% felt personally and professionally unprepared to deal with MBP and only 10% had previous experience with MBP (1). In addition, there are almost no articles about MBP in journals commonly read by pediatric nurses. However, there is one recent book on MBP that devotes a whole chapter to the nurse's role in dealing with MBP (2).

It is extremely difficult for most health care providers to believe that a parent, especially a mother, would intentionally cause harm to their child. This is like saying one is against the flag or apple pie. However, MBP parents are very good at fooling us. They appear very concerned and knowledgeable about the child's illness; almost too knowledgeable and concerned. They are very invested in their child's illness and appear to be the "perfect, caring parent". With the current state of health care and the decreasing number of professional nurses and the emphasis on "family centered care", the nurse welcomes with open arms the parent who actively participates in their child's care. In the hospital setting, the nurse has more exposure to the child and parent than any other member of the health care team. These parents will often befriend the nurse and empathize with how difficult it is to care for sick children. In the outpatient setting, it is often the nurse who will receive the many phone calls from the parent because of health related issues. Again the nurse's contact with the perpetrator may exceed that of other members of the health care team.

Because the nurse's contact with the parent is often greater than other members of the health care team she is often instrumental in recognizing the warning signs of pathological health seeking behavior in a suspected parent perpetrator.

There is a fine line between the parent who is overanxious and/or worried about their child's health and contacts the nurse for reassurance compared to the parent who is making up stories and possibly inflicting harm to obtain unnecessary medical intervention for their child. It is imperative that the nurse diligently documents every interaction with the parent. The nurse's observations and notes are often critical when the health care team is trying to determine if a suspected parent's overall health seeking behaviors reflect a pattern of fabrications and exaggerations that are deceiving physicians and leading to unnecessary medical interventions.

When the nurse is the first member of the health care team to suspect MBP in a parent's behavior, the nurse needs to alert the other members of the health care team by providing objective data that the mother is exaggerating, fabricating or somehow producing symptoms in the child. For example, the nurse can point out that she has never witnessed the child's symptoms, that the child's symptoms are not as severe as described by the parent, or that the diagnostic test results are either negative or not definitive. It is imperative not only to have input from the physician, but all health care providers including the social worker, dietitian and the psychologist. When there is a lack of consensus among the medical team, it is important that the nurse does not give up put continues to document her concerns. In such cases, it may be helpful for the case to be reviewed by the Child Protection Team, if one is available. Also, the nurse can decide to personally file a suspected abuse report with Protective Services. If she does not the child's life may be in jeopardy.

As previously stated, I have personally dealt with five MBP cases. In one case, the health care team collaborated with Protective Services and was successful in having the child removed from the mother's care before any serious consequences occurred. In other cases a variety of interventions or services were implemented to protect the child from additional harm and to modify the mother's health seeking behaviors. The most difficult situations to deal with involved those cases when members of the health care team disagreed about whether or not the child was in danger. It was in these cases that the need for clear institutional policies and procedures became most apparent.

References

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2. Levin, A, Sheridan. Munchausen Syndrome by Proxy Issues and Treatment 1995, New York, Lexington.

THE ROLE OF THE PHYSICIAN IN MUNCHAUSEN BY PROXY CASES: MEDICAL RECORD REVIEW

By Elaine S. Pomeranz, M.D.
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A treating physician will often be the first person to suspect a diagnosis of Munchausen by Proxy, but he or she should not make the final diagnosis.

There are at least two reasons for this: the first is that it is difficult for a treating physician, like anyone else directly involved with the suspected perpetrator, to be totally objective. These perpetrators are consummate actors and manipulators and treating physicians, no matter how experienced, are by no means immune to their influence. Physicians in general rely heavily on the medical history given to them and pediatricians often rely almost exclusively on the history given by the patient's mother because their patients are too young to give their own histories.

A second important reason the treating physician should not diagnose Munchausen by Proxy when the diagnosis is uncertain is because he/she will be open to the criticism that the true medical diagnosis has been missed or not yet recognized.

Therefore, it is recommended by most experts that a non-treating physician with experience in Munchausen by Proxy cases complete a comprehensive review of ALL the medical records to independently confirm the diagnosis. In an ideal world, where there would be an abundance of such experts, it would be preferable to have the reviewing

physician be someone from an institution not involved in that child's treatment. However, given the relatively small number of such experts, and the large number of medical facilities where these children are often treated, this institutional independence may not be possible.

Practically speaking, if the reviewing physician is a pediatrician, his or her role is actually to confirm the diagnosis of Pediatric Condition Falsification abuse regarding the child-victim while a psychiatrist or psychologist colleague should assess/diagnosis Factitious Disorder by Proxy in the accused parent.

The physician who completes the medical record review faces an onerous task. First he must gather together all of the medical records of the child thought to have Pediatric Condition Falsification. This can be done either by getting the mother to sign a medical release for all such records or by having Protective Services or legal authorities obtain a court order for such records. Once authorization has been obtained, the treating facilities are often reluctant to spend the time required to copy the huge documents and several calls may be required before all the information is available.

The medical records of these children are often voluminous. Before an attempt is made to get through the huge pile of papers, the physician must first feel assured that he indeed has all the relevant records. It may be difficult to determine this since the perpetrators are very deceptive and may have taken their children to an enormous number of different doctors and facilities. If there is a third party payor involved, it may be possible to enlist their aid as they may have a complete list of health care encounters for which reimbursement has been sought. It is certainly in their financial interest to offer any possible assistance.

If this task were not daunting enough, it is also important to review the medical records of the mother and any siblings of the child whenever possible, as patterns of behavior may emerge with such review.

Once all the records have been gathered, they must be organized, or their sheer volume will be overwhelming. Various strategies for such organization have been proposed. Seibel and Parnell in chapter 4 of Munchausen by Proxy Syndrome : Misunderstood Child Abuse by Parnell and Day have some very useful suggestions. These include starting out by developing a chronology of medical evaluations, procedures and therapies.

This chronology is then scrutinized for any discrepancies between mother's reports and what is reported by the health care providers. Unfortunately, sorting this out is complicated by the fact that the medical records often report history as given by the mother without stating that she is indeed the source. In order to accurately categorize symptoms and findings as either seen only by mother or seen by health care professional, it is usually necessary to contact each health care provider by phone to get an accurate description of what can be objectively substantiated versus what is medical lore based upon mother's report alone. Sometimes, laboratory findings or the results of medical procedures speak for themselves, but often their interpretation has been colored by mother's reports. This too, can often be teased out only by individually speaking to each treating physician.

Notes by nurses and other staff must be carefully read to gather information regarding mother's behavior (and that of any other family members) during hospitalizations. There are often discrepancies among mother's reports to different professionals that will be discovered in this process. If there have been witnesses to medical episodes besides mother and health care professionals, they should be directly contacted to confirm what they observed.

Once the records have been carefully read, a timeline developed, and confirmatory phone calls made, symptoms and findings should be classified in a report to the court as legitimate, exaggerated, fabricated and/or induced.

Sometimes, previous concerns of possible Munchausen by Proxy are unearthed through the written record review or in telephone conversations with previous providers and these must be documented.

Once the review is completed, the reviewer must write a summary that will be clear to the non-medical protective services and law enforcement professionals, yet detailed enough for the mental health expert interviewing the mother to be able to specifically refer to the described medical encounters in the psychological assessment of the accused mother. This medical record review will be referred to frequently in the ensuing legal procedures, and must be accessible to a wide variety of personnel with varying medical knowledge.

The medical record review of suspected Munchausen by Proxy cases is vital to confirming the diagnosis and is extremely labor and time intensive. It is unfortunate that there are not many physicians with both the expertise and the will to undertake this task.

Seibel MF and Parnell TF, The physician's role in confirming the diagnosis. In Parnell TF, Day DO, Eds. Munchausen by proxy syndrome: Misunderstood child abuse. Thousand Oaks: Sage Publications, 1998.

Siegel PT and Fischer H. Munchausen by proxy syndrome: Barriers to detection, confirmation and intervention. Children's Services: Social Policy, Research, and Practice, 4(1), 31-50, Laurence Erlbaum Associates, Inc., 2001

THE ROLE OF THE PSYCHOLOGIST IN MUNCHAUSEN BY PROXY CASES

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DEFINITION

Munchausen by proxy (MBP) is form of child abuse that involves pathological health seeking behaviors, usually by a mother, who uses her child to meet her own psychological needs. MBP abuse is the result of a complex interaction between a parent, a physician(s), and a child. Specifically, the Parent-Perpetrator exaggerates, fabricates, simulates or lies about a child's medical status, consciously distorts the child's medical history, deliberately fails to adhere to the child's medical regimen, or directly produces symptoms in the child to deceive unwitting Physician-Facilitators into performing unnecessary medical procedures and prescribing unnecessary medications that are harmful to the Child-Victim. The impact of MBP abuse has significant medical, physical, psychological, educational, and emotional consequences on child-victims. Some children die (6-9%).

MBP DIAGNOSTIC CODES

MBP abuse involves two diagnoses, one that refers to the child victim and another that refers to the parent perpetrator. The child who is harmed by pathological health seeking is a victim of Pediatric Condition Falsification (PCF) and should be coded using the DSM-IV Child Abuse Code 61.21; physical type, emotional type, or combined type. PCF abuse is a medical diagnosis and is made by a physician experienced in PCF abuse after completing a retrospective, comprehensive review of all of the child's medical records (see Pomeranz article this issue). The adult who intentionally and persistently falsifies a child's medical history or symptoms to meet their own psychological needs is diagnosed with Factitious Disorder by proxy (FDP) and should be coded using the DSM IV diagnostic code Factitious Disorder Not Otherwise Specified 300.19. FDP is a psychiatric diagnosis and is made by a psychologist or psychiatrist experienced in this form of abuse who completes a comprehensive forensic evaluation of the child-victim, the accused perpetrator, spouse, and other parties involved in the child's care and medical treatment.

MBP CASE MANAGEMENT

The management of MBP cases is complex, involves the collaboration of several professional disciplines (medical, psychological, legal, child protection and law enforcement) and occurs over time in three stages including a Detection Stage, Assessment/Investigation Stage, and Intervention Stage. The Psychologist's role varies depending on the stage involvement occurs and the same psychologist SHOULD NOT function in more than one role for a given MBP case. For example, during the Detection Stage, one Psychologist can function as a member of the medical treatment team or as a consultant to a physician who suspects MBP abuse. During the Assessment/Investigation Stage, a different Psychologist should be selected as the court-ordered Forensic Evaluator of the Suspected Parent, Child-Victim, and Family. Finally, during the Intervention Stage, a third Psychologist should be identified as the court-appointed therapist for the Offending Parent and Non-Offending Parent, and a fourth Psychologist selected as the court-appointed therapist for the Child-Victim. All of the Psychologists should be experienced in MBP abuse and have a clear understanding of their role. The role of the psychologist in each stage of MBP case management is discussed below.

THE DETECTION STAGE

The primary goal during the Detection Stage is to determine if the suspected parent is engaging in harmful health seeking behaviors by falsifying illness in her child and deceiving health care providers into providing unnecessary medical interventions. Although this task is primarily the responsibility of the treating physician/pediatrician, a pediatric psychologist who is part of a multidisciplinary medical team or child psychologist who is asked to serve as a consultant to the physician, can play a helpful role. The most important task a psychologist can play at this juncture is to help the physician or medical treatment team distinguish Pediatric Condition Falsification (PCF) abuse from a case of a parent with exaggerated but sincere anxiety about the child's health. The psychologists needs to interview the suspected parent to assess maternal functioning, observe the quality of the parent-child relationship, identify inconsistencies and/or contradictions in the medical/social history, assess the role of illness in the suspected parent's life, determine the presence of secondary gain from having an ill child and also assess the child's developmental status and attachment to the suspected parent. A thorough psychological understanding of the suspected parent's behavior will help the physician and/or treatment team determine the likelihood of PCF abuse or if the mother's action appear to be a function of other factors.

THE ASSESSMENT/INVESTIGATION STAGE

The role of the psychologist in the Assessment/Investigation Stage is to complete a comprehensive and objective forensic evaluation. The forensic evaluation occurs after Probable Cause of PCF abuse has been established at the Preliminary Hearing and before the Trial. The forensic psychologist should be court appointed and serve as the court's expert, not the expert of any of the individual parties. The forensic psychologist should be experienced in MBP and not a part of the medical team that provided treatment to the child. Because the forensic psychological evaluation is court ordered, the usual restrictions of patient confidentiality do not apply and the forensic psychologist needs to obtain information from as many sources as possible. At minimum, the forensic psychologist should have access to the summary of the medical record review, be authorized to talk with the physicians involved in the child's medical treatment, and allowed to review any documents or medical records necessary to complete a comprehensive evaluation.

The primary goal of the forensic psychologist is to establish the probable explanation of the accused parent's motivation for MBP abuse and also to determine if the criteria for the psychiatric diagnosis of MBP are met. A comprehensive forensic psychological evaluation of MBP should include an intellectual assessment, personality evaluation and mental status exam of the accused parent and spouse to first rule out mental retardation and severe mental illness and establish competency. Assessment of the perpetrator's parenting skills and potential for physical abuse is also recommended. Finally, other family members, especially fathers and grandparents, should be separately interviewed to obtain their reactions to the allegations of abuse, inquire about other children in the family, assess the validity of the history provided by the accused parent, determine the presence of general life stressors, and evidence of collusion with the accused parent. The forensic evaluation will help guide treatment and interventions necessary for family reunification or determine if the underlying pathology is so severe and irremediable that parental rights be terminated.

THE TREATMENT/INTERVENTION STAGE

Another role for a psychologist in MBP cases is to provide psychotherapy to the offending parent, the non-offending parent and for the child-victim. The therapist(s) should be a psychologist(s) other than the one who completed the court ordered forensic evaluation, should be initiated after the court has made it's final ruling, and should be selected from a list of therapists recommended made by the GAL, psychologist or judge.

Treatment for the offending parent will need to include intensive, long term, individual psychotherapy. The therapist should be experienced in the treatment of personality disorders and also must accept the diagnosis of Factitious Disorder by Proxy. The therapist should be given a copy of the medical record review summary and a copy of the psychological evaluation of the offending parent and the non-offending parent. It is also advised that the therapist agree to a meeting between the medical treatment team, foster care worker and forensic psychologist to set up the terms of the therapy and also determine to whom the treating psychologist

should communicate during treatment; the forensic psychologist is recommended. The treatment plan for the offending parent should then be presented to the judge for approval. The treating psychologist should communicate regularly with the forensic psychologist who can choose what is relevant to report to the court regarding treatment compliance and progress when re-unification issues are being considered. This process allows the treating psychologist to safeguard the offending parent's confidentiality in areas unrelated to MBP abuse and helps to maintain a trusting therapeutic relationship. However, the treating psychologist is not exempt from mandatory reporting of suspected abuse if concern should surface during treatment

Therapy for the non-offending parent should focus on helping him or her to accept responsibility for failing to protect the child in the past and to determine if s/he can protect the child in the future if the child is returned to the family. Therapy may also need to address the marital relationship and the impact the MBP diagnosis has had on the marriage.

Therapy for the child-victim should be with a therapist experienced in child abuse and, ideally, familiar with MBP abuse. Therapy will need to address attachment problems, possible post traumatic stress symptoms, distorted belief systems, stunted social development and trust related issues. The therapist should be in contact with the physician providing the child's medical care, the foster care worker and forensic psychologist.

Psychological education and support of the extended family is also important in a comprehensive intervention plan for this form of abuse. Before a child is returned home, the extended family should accept that the abuse occurred and agree to protect the child from further medical abuse. If supportive and capable, the alert and educated family may be able to provide the necessary protection that allows the child to be safely reunited with the family.

THE QUESTION OF REUNIFICATION

The determination of reunification versus termination of parental rights should be based on the results and recommendations of a comprehensive psychological re-evaluation of the mother, father, and child following treatment, usually after one year of psychotherapy and close monitoring of the parents and child-victim by FIA. Ideally, the re-evaluation should be completed by the same forensic psychologist who completed the original evaluation of the family. This re-evaluation, may yield important supportive data about changes that have occurred in psychotherapy, and provide additional documentation to support that the parent(s) demonstrates decreased denial and defensiveness and are ready for the re-unification process to begin.

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What a pediatrician wants the PS worker to know about Munchausen syndrome by proxy

By Howard Fischer, M.D.
Child Protection Team, Children's Hospital of Michigan

What is it?

Munchausen syndrome by proxy (MBP) is child abuse. In this form of abuse, illness in a child is simulated (faked) and/or produced by a parent, usually the child's mother. The child is brought repeatedly for

medical assessment and care, often resulting in multiple medical procedures. The perpetrator denies knowing the origin of the child's symptoms, and the symptoms stop when the child is separated from the perpetrator.

Is it really rare?

Unfortunately, no. It's hard to tell how common MBP is since it is only suspected when the deception fails. In England, a survey of pediatricians found an annual frequency of nearly 3 cases per 100,000 children less than a year old, and 1 case per 200,000 older children. These rates are similar to fatal child abuse. If these proportions hold true, there are 625 new cases a year in the U.S.

Why would mothers do this?

The motivation of perpetrators to injure or kill their children is not clear. Some perpetrators need to be the center of attention and praised for their patience and strength in coping with such ill children. Some have no empathy for their children and use them as a means to an end, namely, focusing attention on themselves. In some cases, falsified childhood illness is used by the mother to keep a disinterested father involved in the family. MBP, unlike much of physical abuse, is not reactive, but is premeditated and repetitive.

What kind of illnesses may be lied about or produced?

The list is enormous. The perpetrators are very inventive and sometimes have some medical background. The most common medical "presentations" are bleeding (from anywhere in the body), convulsions, changes in consciousness, repeated diarrhea, repeated vomiting, fever, or rash. Sometimes symptoms are simply lied about, other times samples may be tampered with to suggest disease (for example, a mother adding her own blood to a child's urine sample). Parents may make a child ill, by poisoning, smothering or other means. Sometimes the production of illness results in the death of the child.

When should doctors (and other observers) start to suspect MBP?

There are warning signs which, when clustered together, should create suspicion. A complete list will not fit in this brief article (but see references). These children will come in with unexplained, prolonged illness causing multiple hospitalizations. The child's appearance, physical examination findings, and laboratory results do not support the given history of illness. The symptoms may be difficult to verify and there is poor response to usual treatments. The mother seems loving, attentive and cooperative; she is unhappy, however, if her child has normal test results, seems to be recovering, or is being discharged home from the hospital. She may immediately consent to painful or invasive investigations for her child. The child's symptoms diminish or cease when the mother is not present.

Can MBP coexist with a real illness?

Yes. A child can have a real problem, such as asthma, but the parent may also make up a story of convulsions, for example. A child may have asthma which doesn't respond to usual medications because the mother is not giving the medications, although saying she is.

Why may doctors disagree about the MBP diagnosis in a given child?

Often more than one doctor is involved in the care of these children – they often have multiple complaints. Some doctors do not want to believe that parents are capable of this form of abuse. Others don't deny its existence, but don't think that "these parents" could be guilty of it. Pediatricians are taught to believe parents and rely on them in the diagnosis and treatment of children's illness. Doctors don't want to admit that they have been fooled and have become active participants in providing needless and/or harmful medical treatment. Confirming the diagnosis will start with a physician reading **all** of the child's medical records from **all** sources.

What is my role in a suspected case of MBP?

As always, the PS worker's first responsibility is the protection of the child. Additionally the worker should help locate and obtain medical records for a complete record review. The PS worker should remember that MBP is a **pediatric** diagnosis, and that only with complete information can the pediatrician make the diagnosis. The most effective way to confirm a MBP diagnosis is to separate the mother and child (i.e. a planned hospitalization for "diagnostic separation") and see if the symptoms cease or do not even appear when the mother's access to the child is limited.

Suggested Reading:
Parnell TF, Day DO, eds. *Munchausen by proxy syndrome: Misunderstood child abuse.* Thousand Oaks: Sage Publications; 1998.
Siegel PT, Fischer H. Munchausen by proxy syndrome: Barriers to detection, confirmation, and intervention. *Children's Services: Social Policy, Research, and Practice.* 2001, 4(1) 31 –50.

THE ROLE OF CHILDREN'S PROTECTIVE SERVICES IN MUNCHAUSEN BY PROXY CASES

By Laura Schott, MSW
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It is important to remain in a neutral position when beginning any child abuse investigation, especially when investigating Munchausen By Proxy (MBP) abuse. MBP is premeditated abuse. The suspected perpetrator, usually the mother, is often knowledgeable about the child's medical problems. Sometimes the suspected perpetrator has been trained and/or works in the medical field and is familiar with the terms and jargon used by medical professionals. The suspected perpetrator is an expert at convincing most professionals that the child is suffering from some kind of horrible illness. Risk of harm to the child must be the first consideration in all decisions made concerning the investigation of MBP and how to intervene. Failure to intervene on behalf of the child victim could result in serious if not fatal consequences for the child. If enough credible evidence exists to present to the court to demonstrate harm or significant risk of harm to the child when the abuse report is first filed, then removal may be necessary at the outset of the investigation. If the child is not immediately removed, the Children's Protective Services (CPS) worker needs to closely monitor the child while the investigation is proceeding. It has been shown that symptoms often disappear after the child victim has been removed from the care of the suspected perpetrator.

Once a suspected abuse/neglect report has been filed by a physician or other health care provider *(not all cases have been reported by a physician or health care provider)* the CPS worker should immediately contact the physician or health care provider that filed the abuse report because in MBP cases it is essential to work as a team with all the professionals (medical, school, law enforcement) involved with the family. Coordination of efforts is a must among all the professionals in MBP cases so it may be necessary for the CPS worker to exceed the usual standard of promptness mandates in order to coordinate efforts with the other team members. This can be accomplished by using the FIA 140 form. Approval from the supervisor is required before failing to meet face to face and/or 30-day investigation deadline.

Information gathering is critical to the successful investigation, evaluation and diagnosis of MBP. It is necessary to get the most complete family history with all medical and mental health records available. This can be very time consuming. CPS workers can have access, under the law, to medical records [Michigan Public Health Code, PA 368 of 1978, Sections 2640, (2)-(5) and 16281, (1)-(5)] and mental health records [Michigan Mental Health Code, PA 258 of 1974, MCL 330.1748, Sec. 748a.] when investigating child abuse or neglect. It is critical to gather as many of the records as possible. Only then can a comprehensive picture emerge. The parent with MBPS will doctor shop and may have been to many doctors and hospitals in the area where they reside. In one investigation it would not be unusual to send out as many as 50 requests for information depending on the age of the child. Once all of the medical information has been collected it must be reviewed by a physician experienced in MBP abuse. If the medical record review indicates that the child has been

abused, often the best course of action is to remove the child, and the siblings, from the home. Research has shown that MBP is often resistant to treatment and may eventually result in termination of parental rights.

COURT PROCESS

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USE THE TEMPLATE OF EXISTING LEGAL PROCESS

Although MBP may be an unusual form of child abuse, there is no need for special legal procedures to respond to it. The legal response to a diagnosis of MBP is best done using the same template set out in state law for all other types of child maltreatment cases. The short timelines of Michigan law present a challenge to the professionals involved to act promptly and quickly to assess the case and prepare it for presentation to the court. The following is a summary of Michigan's legal process and some recommendations:

1. Preliminary Hearing

a. Time

The Preliminary Hearing is the first court appearance in a child protection case and is required within 24 hours of a child being involuntarily detained out of the parents' custody.[i] At the Preliminary Hearing, the petitioner, generally the FIA, must present probable cause to believe that the child is abused or neglected.[ii] The physician or physicians should testify at this hearing and spell out the child's medical condition, medical history and the reasoning behind their diagnosis of Pediatric Condition Falsification.

b. Medical Testimony

Medical testimony at the Preliminary Hearing to authorize the petition and control visits between the parents and child is very important. These are not cases in which a caseworker can appear at the Preliminary Hearing relying on hearsay statements from the doctors. Direct medical testimony is required, not as a matter of law, but in order to educate and persuade the court of the severity of the child's risk. Medical testimony is best if the physician appears in court, but it could be taken by phone as permitted by Michigan Court Rules. Medical and other records could supplement live testimony. Expert testimony is certainly required to assist the trier of fact to understand the evidence and determine the facts.

It is a clearer legal case at the Preliminary Hearing if the medical expert is able to testify that he or she has already made a diagnosis of Pediatric Condition Falsification abuse. The doctor should testify to the medical history of the child and draw the inferences from that history. The medical diagnosis of PCF abuse will carry great weight with the court at this stage. As a matter of law, the court is neither obliged to follow the physician's recommendation nor to give decisive weight to the expert opinion. Nonetheless, because the medical diagnosis requires a fairly high level of certainty (although not absolute certainty), informing the court of the factual background and process of coming to that diagnosis will have great weight at the Preliminary Hearing (and later at Trial). The level of certainty behind a medical diagnosis, if clearly communicated to the court, reasonably translates into at least *probable cause* in legal terms.

c. Placement

If successful in convincing the court, by probable cause, that the child is abused, the FIA may ask the court to protect the child pending trial by placing the child in a home separate from the parents. A period of separation, although generally necessary to protect the child from further physical and mental harm, could also serve as a "diagnostic separation" to further confirm the MBP diagnosis.

Michigan law permits the family court to order placement of the child in a protection case after a Preliminary Hearing if the petitioner shows that there is probable cause to believe that the child abuse has occurred and that continued placement with the parents presents a "substantial risk of harm".[iii] If a child is to be removed from the parents, Michigan law prefers that the child be placed with a relative if consistent with the safety and needs of the child.[iv] The safe setting should be a placement in which the parent does not have the ability to have unsupervised contact with the child and does not have the capacity to impact on the daily care and medical treatment of the child. Some commentators urge that the child always be placed in non-relative foster care,[v] but in some carefully controlled circumstances, relative care may be appropriate. The FIA caseworker will come to a recommendation based on the FIA

Placement Selection Criteria.[vi] The placement, whether relative or non-relative foster care, could include terms and conditions. The FIA worker should be aware that there are reports of intergenerational MBP abuse, so one needs to be very careful with relative placements unless there is convincing proof the relative will protect the child.

The conditions of placement could include court orders that parental contact be limited and supervised. The court could require that no parental conversation about the child's health occur in the presence of the child, that all medical care be provided through a single medical caregiver, and that the accused parent not be involved in the child's medical care pending trial. Such protective orders may increase the likelihood that relative care could still be protective of the child. If, after a thorough assessment, workers have reason to believe that the relatives can and will control access to the child, relative placement is appropriate. If, after placement, there is good cause to believe relatives have not demonstrated that they are dependable in controlling access, non-relative foster care may be necessary. Another option would be for the court to exclude the offending parent from the home, control his or her access to the child, and leave the child in the custody of the non-offending parent.[vii] Because this is such an important issue, it is best determined on a case-by-case basis and the decision based on the potential risk of harm to the specific child.

Where there is concern about parent contact with the child, the FIA might ask that there be no visits or carefully controlled parenting time. Parents are entitled to regular visits (parenting time) with a child in care unless "parenting time, even if supervised, may be harmful".[viii]

If the petition is authorized, the court should enter any orders for further investigation, including a psychological examination by an evaluating psychologist selected as the court's expert and not an expert for any single party. More commonly, orders appointing an expert and for psychological exam would be considered at a pretrial, but the psychological exam in a MBP case is more complex and will take a longer time to prepare and thus should be ordered at the Preliminary Hearing whenever possible. The lawyers and the court will want the psychological available prior to Trial.

2. Pretrial Conference

Typically the court schedules a Pretrial conference about three weeks after a Preliminary Hearing, although it could be sooner. The Pretrial addresses a whole range of technical matters necessary for the case to proceed to Trial. Prompt and diligent action is important to the child and the aggressive timelines of Michigan law will challenge all the professionals involved. Matters such as court orders for discovery, for visitation, for psychological assessment should be handled at the Preliminary Hearing if possible, but could be addressed at Pretrial. Parents have a right to a jury trial and could ask the court to schedule the trial with a jury or before the judge. The trial dates are set at the Pretrial Conference. The Trial is required within 63 days after the child is removed from the home by the court: 63 days from the Preliminary Hearing.[ix] It may be that the parents will accept the court's jurisdiction without trial and will enter a plea of admission or "no contest" at this time.[x]

3. Trial

The next step in the legal process is to adjudicate the case at Trial by demonstrating the history of invasive or otherwise harmful medical evaluation and/or treatment and psychological harm premised on the offending parent's false or fabricated reports of the child's condition or his or her induction of the child's symptoms. The testimony at trial should focus on harms suffered by the child due to the parent's conduct. Is this child being abused or not? Presenting the case in the child protection court proceedings as nothing more and nothing less than a child abuse case has more force than trying to persuade a judge about the existence of an abstract syndrome and this case's conformity with it. The court process will test the evidence and reasoning of the professionals. If successful, before a judge or a jury, in proving by preponderance of the evidence that the child is abused or neglected, the case proceeds to the dispositional phase.

4. Dispositional Phase

A court-ordered disposition depends on a comprehensive, objective forensic psychological assessment of the offending parent, the other parent and the child. The child's medical and psychological needs should also be assessed as a foundation for the court's dispositional order. If the prognosis for rehabilitation is poor, perhaps termination of parental rights is appropriate? Perhaps referral for criminal prosecution is appropriate? If the psychological assessment indicates that rehabilitation of the offending parent is possible, to the point that the child would be safe in his or her custody or in the custody of other family members, a period of appropriate treatment should be pursued with the quarterly court reviews as set out in statute. If rehabilitative efforts are not successful, existing law provides avenues for permanency planning for the child – either in placement with relative caretakers, a guardian, or perhaps termination of parental rights and adoption.

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[i] MCR 5.965(A)

[ii] MCL 712A.13a(2)

[iii] MCR 5.965(C)
[iv] (MCR 5.965(C)(4)
[v] Parnell, T.F. (1998). Coordinated Case Management Through the Child Protection System. In T.F. Parnell & D.O. Day (Eds), *Munchausen by Proxy Syndrome: Misunderstood Child Abuse* (pp 95-116). Thousand Oaks, CA: Sage.
[vi] FIA Children's Foster Care Manual, CFF 722-3.
[vii] MCL 712A.13a(4)
[viii] (MCL 712A.13a(11)
[ix] MCR 5.972(A) Trial is required within 6 months if the child is not in placement.
[x] MCR 5.971

The Role of Foster Care Caseworkers in Munchausen by Proxy Cases

By: Jill M. Griffin, BSW
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A lot has been written on the identification of MBP and what to do in preparing for a Trial on such a case. But what about after the trial? What happens to the child and family after a trial, or after the parents plead to a petition, and the child becomes a Temporary Court Ward? What can be done, or needs to be done, to help them become a healthy, appropriately functioning family? The Foster Care (FC) Caseworker becomes involved with a family after the Children's Protective Services Worker and the Courts have removed a child from the parents' care. The roll of a FC Worker in any child abuse/neglect case is to work with the family to: 1) assure the safety of the child by determining the best placement, 2) identify the services that the family needs to participate in and complete, and 3) identify the criteria for reunification. The FC Worker's roll is no different in MBP cases. However, because of the medical and psychological complexities of MBP cases, the Foster Care Worker needs to closely collaborate with physicians and psychologists experienced in this form of abuse.

The Foster Care Worker is responsible for developing a Case Services Plan. This Services Plan details the requirements of the family, the caseworker, the caretakers, and the child(ren). The Services Plan also details the visitation requirements. In cases where there has been severe abuse, the legislation provides for termination of parental rights. For all other cases the plan would be for services to be put into place for the reunification of the family. The difficulty in MBP cases is in balancing what the legislation and FIA policy tells the FC Worker to do, and the particular dynamics of MBP cases that prevents the FC Worker from following the input of the parents.

Services for the family need to focus on resolving the problems that necessitated removal and need to be developed by the Foster Care Worker in collaboration with a multidisciplinary team consisting of the medical team that identified the MBP abuse, the forensic psychologist that evaluated the family, the Guardian Ad Litem, (Child(ren)'s Attorney), and the Protective Service Worker that investigated the abuse allegation. Specifically, the Foster Care Worker must follow legislation (P.A. 480 of 1998)(P.A. 479 of 1998)(FIA Policy CFF 722-6) that requires a Physician to Review the Case Services Plan if the physician has diagnosed

- Failure to thrive,
- Munchausen by Proxy (MBP)
- Shaken baby syndrome,
- A bone fracture that is diagnosed by a physician as being the result of abuse or neglect, or
- Drug exposure in utero

Thus the Foster Care Worker must meet with the medical treatment team or with the child's primary care physician as soon as the child is placed in foster care to ensure that the Case Services Plan addresses the child's specific medical needs due to the abuse and neglect. Ideally, the medical treatment team/primary care physician that identified the MBP abuse will be the same medical team/primary care physician that provides the child's medical care when the child is in foster care.

Placement:

When placing a victim-child and sibling(s) of MBP outside of the home, just as with the services, consideration has to be given to 1) the legislation and policy that dictates where a child can be placed, and 2) the particular dynamics of MBP cases which may prevent certain placements. The Foster Care Worker and the multidisciplinary team should collaborate and make recommendations regarding placement options. FIA Policy CFF 721 states that "Selection of a

placement for a child outside of the child's own home must be dictated by safety, the needs of the child and the child's 'best interests.' This placement is to promote a safe return home; or, when return home is not possible, promote safe alternative plans for the benefit of the child (i.e., placement with relative, adoption or independent living)." Although Michigan Law prefers that the child be placed with a relative, the child's needs and safety are paramount. There are proponents that advocate that in MBP cases the child should always be placed in non-relative foster care. However, in some MBP cases relative placement may be appropriate; each case should be looked at individually and recommendations made by the multidisciplinary team based on the dynamics of each case.

It is important to note that the Court may not agree with the placement recommendations developed by the multidisciplinary team. For example, the team may recommend placement with a foster family but the Court may order placement with relatives. Therefore, the FC Worker needs to be prepared for whichever direction the Court orders and have a Case Services Plan that will safeguard the child. Specifically, the placement in MBP cases should preclude the parent from unsupervised contact with the child and not allow the parent to be involved with the care and medical treatment of the child. If relative placement is selected, the relative caregivers have to agree to protect the child from the parents. There should also be clearly defined conditions of placement included in the Court Order and listed in the Case Services Plan. The conditions should include (but not limited to): 1) Parents are not to talk about the child's health in the presence of the child, 2) All medical care is to be coordinated through a single medical caregiver, 3) The offending parent is not to be involved in the child's medical care, and 4) the parents will not perform any medical treatments on the child and will not request that the caregivers perform any medical treatments on the child.

Services:

The PS Worker should have requested the Court to order a forensic psychological evaluation of the perpetrator, non-offending spouse and child-victim after Probable Cause of MBP abuse is established at the Preliminary Hearing. The Forensic Psychologist should be someone experienced in diagnosing MBP. The psychological evaluation, at a minimum, needs to contain: 1) a review of the medical history of the child (P.A. 163 of 1997 requires the Court to order release of Medical Records when parents refuse consent); 2) Interviews of all involved Physicians, past and present; and 3) Interviews of all involved parties, i.e. parents, siblings, grandparents, foster parents/caregivers, etc. Specific treatment recommendations for the perpetrator, non-offending spouse, and child-victim should be detailed in the psychologist's report to the Court along with recommendations for placement, visitation and reunification. The perpetrator will almost always require intensive, long-term, individual psychotherapy and the FC Worker is often a valuable resource in finding an appropriate therapist. The treating therapist should be a psychologist other than the one who completed the forensic evaluation, and needs to be experienced in treating personality disorders and accept the diagnosis of MBP. In order to properly treat the parents and extended family, the treating psychologist needs to be given a copy of the medical record review and a copy of the psychological evaluation. The treating psychologist needs to maintain regular contact with the FC Worker to report compliance with attendance and progress in treatment. Also, the FC Worker should keep the psychologist appraised on parent/child interactions, and the medical/health progress of the child and/or siblings.

The Service Plan should also include a detailed medical treatment plan for the victim-child, developed by the child's primary physician or the medical treatment team that identified the MBP.

The Services Plan should also detail the visitation requirements. The FC Worker should consult with the multidisciplinary team to decide if the child can safely visit with the parents and whether visits must be supervised. The FC Worker also plays a valuable role in assessing the quality of parent-child interactions during Court ordered supervised visitations. For example, The FC Worker should document whether the child runs and jumps into the parents arms when they arrive or does the child ignore them; whether the child approaches the parent(s) during the visit; goes to the parent(s) for attention/comfort or engages the parent(s) in any type of play? The FC Worker should also note how the child reacts to the parents' attempts to engage the child. Specifically, does the child reject, pull away, and stiffen or is the child receptive and open. Finally, the FC Worker should document the interactions and relationship of the child-victim and his/her sibling(s). If the child is placed with a relative and the Court allows the relatives to supervise the visits, the FC Worker should observe the parent/child visits at least 2 times per month to get an accurate assessment of family functioning. The FC Worker's observations from these visits need to be shared with the treating psychologist and the evaluating psychologist when decisions about reunification are discussed.

Reunification:

The decision to place the child-victim and sibling(s) back with the family begins with the FIA Reunification Assessment, (FIA policy CFF 722-9A). The Reunification Assessment has 3 steps:

1) An assessment of compliance with the parenting time plan

2) An assessment of barrier and risk reduction
3) A determination of the child's safety.

The FC Worker and the Court of jurisdiction should notify the multidisciplinary medical team of the time and place of a hearing where consideration is given to returning the child to his/her home. In MBP cases reunification should be based on the recommendations of the multidisciplinary team after the results of a detailed psychological re-evaluation of the parents and child, typically following one-year of treatment, or as recommended by the Court. The re-evaluation should be completed by the same psychologist that conducted the forensic evaluation and address the 3 steps of the reunification assessment.

Once the decision is made to return the child home, in Counties that have this service available to them, the Family Reunification Program should be utilized for the maximum time allowed, generally 4 months with a 2 month extension for a total of 6 months. The Family Reunification Program (FRP) provides intensive, home-based services to monitor the family. The FRP provides family, individual, sibling and/or couple therapy, direct teaching/modeling, mentoring, environmental needs, vocational/educational, and leisure/recreation activities. The FRP team provides direct services in the home for 8-10 hours a week for the first two weeks, then a minimum of 4 hours per week of direct service in the home for the duration of the program. In MBP cases, even though the FRP team is working intensively in the home with the family, it still remains important for the FC Worker to maintain close contact with the family. The FC Worker would then be able to monitor the family's level of functioning, as well as being able to report directly on the family's progress to the rest of the Multidisciplinary Team. In Counties where the Family Reunification Program is not available the FC Worker would need to provide the intensive, home-based monitoring of the family. FIA Policy (CFF 722-6) dictates that when a child is returned home the FC Worker is required to have weekly in-person contacts with the parent(s) and child(ren), during the first month. This period of contact may be extended to ninety days, if necessary. In subsequent months the FC Worker is required to have in-person visits at least twice a month. The FRP team is able to meet those requirements for the FC Worker; however, if the FRP is not available then the FC Worker would need to meet those requirements. The intensive home-based monitoring of the family is especially important in MBP cases as the FC Worker must be able to monitor the family after return home to assess whether the parent has benefited from services and is now providing a safe environment for the child(ren).

Summary:

The FC Workers primary responsibility is to first protect the child and secondly to provide services to the family. From the time the child is placed in protective custody, the FIA Foster Care Worker should maintain regular contact with the members of the multidisciplinary team in order for the team to monitor progress and formulate recommendations to the Court. This is very important in MBP cases because without informed decisions the child's safety is at risk. MBP cases are very labor intensive and require a considerable amount of contact with the family and the multidisciplinary team. Each case should be looked at individually with recommendations and decisions made based on the specific dynamics of each case. MBP cases are too complex to apply generalities.

Commentary: MBP & 'Systems' in Michigan

This special issue of the MiPSAC Newsletter highlights the complexities of MBP and the work of several practitioners across the state (most of whom are MiPSAC members) to distill and refine a system of evaluation, diagnosis, referral and treatment which is soon to be published as a statewide guideline. A recurring theme is noted: professionals who interact with MBP cases must be knowledgeable, experienced and thorough in their work to protect the child and the family. Referral has to experienced professionals been recommended, yet the mechanisms, legalities, and reimbursement for such systems does not yet exist.

Michigan has several strengths to build upon. Child Death Review Teams are active across the state and serve as a local and national model for multidisciplinary review. Centers of excellence for evaluation already exist, and expertise is available. Many communities have constituted multidisciplinary teams to review cases known to CPS. Michigan FIA has created a 'Medical Resource System" which can provide case review services for CPS workers. CPS has the legislated authority (and responsibility) to investigate cases and has legal protections to facilitate such community and professional reviews.

But where are the 'systems' of care? Michigan lags far behind states such as Florida and New Jersey, which have regionalized teams and requirements (and state funding) for CPS to use them. In Kentucky, pediatricians work for the state Medical Examiner. In Oregon, a formal network of child advocacy centers cooperates to have all kids seen for concerns of ALL types of abuse and neglect. The list goes on and on of potential 'systems' of evaluation and referral to meet the needs of children and families.

The time has come to formalize and fund such a system in Michigan, not just for MBP, but for all types of child maltreatment. Let's do more than just provide training. I call on MiPSAC and its members to create such a system in Michigan by working with each other, our state government and the many people across our state who really care about children and the professional response to child maltreatment. *Vincent J. Palusci, MD MS, MSU / DeVos Children's Hospital*