MiPSAC

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

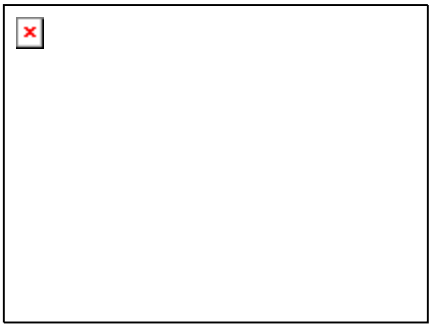
Volume 8, Issue 1 **January - March, 2003**

PRESIDENT'S CORNER

THE STATE OF MiPSAC

By Patricia Siegel, PhD, Children's Hospital of Michigan

The Michigan Professional Society on the Abuse of Children (MiPSAC) is the state chapter affiliate of the American Professional society on the Abuse of Children (APSAC). MiPSAC was formed in 1995 and incorporated in 1996 by several committed professionals from a variety of disciplines that accepted the challenge of improving Michigan's response to child maltreatment. Since it's formation seven years ago, MiPSAC has continued to strive for improved methods of responding to child maltreatment, to foster networking, to be an information resource for the media, legislators, and policymakers, and to sponsor quality training for Michigan professionals.



The MiPSAC Newsletter has been an excellent mechanism to increase communication and foster networking among Michigan professionals involved with child maltreatment, with three special issues on Child Sexual Abuse, Munchausen by Proxy Abuse, and Subpoenas and Court Appearances last year. The June 2003 issue of the MiPSAC Newsletter will review relevant state legislative and policy issues that involve Michigan children and the September 2003 issue will look at the special problems associated with responding to medical neglect.

In keeping with its mission, MiPSAC collaborates with the University of Michigan Medical School by sponsoring a featured speaker at the annual Michigan Statewide Conference on Child Abuse and Neglect in Ypsilanti. This year, the conference is scheduled for October 20th and 21st, so be sure to save the dates. The annual general meeting and election of the MiPSAC board is scheduled during this conference and is an excellent opportunity for new members to introduce themselves, network, and become more involved with MiPSAC projects.

Last year's president, Annamaria Church, M.D. formed several workgroups to help focus and direct MiPSAC's efforts. A number of challenging goals were identified during the brainstorming meetings of workgroup subcommittees but by years end, it became clear that time constraints precluded the development of any definitive action plans. My primary objective for MiPSAC is to isolate one clear and feasible goal from those identified last year that has the potential of making a positive impact on Michigan's children. Dr. Charles Enright has agreed to facilitate a group session at the next board meeting that will help identify one such goal. The initial phases of this decision-making process, known as Opportunity Mapping, are being discussed on our listserve and all members are invited to participate.

My second goal for MiPSAC is to strengthen ties with other organizations involved with child maltreatment. I recently met with leaders of the Michigan Psychological Association to discuss several options to inform local and state officials of the best practices regarding for our state. We decided to develop a list of professional experts on child abuse in Michigan that would be willing to serve as consultants to state legislators. Anyone willing to be added to this list should contact me. Other groups I hope to collaborate with include the Family Independence Agency, the FIA Medical Advisory Committee, Michigan's Children, and Child Abuse Prevention Councils in each county. There is an enormous amount of talent and experience in these groups and collectively we could be a powerful voice for Michigan's children. It is with pride and humility that I assume the presidency of MiPSAC and look forward to working with all of you and thank you for your continued commitment to MiPSAC and its mission.

MiPSAC ANNOUNCEMENTS AND UPCOMING MEETINGS

14th National Conference on Child Abuse and Neglect
March 31 – April 5, 2003 Saint Louis, MO
Office of Child Abuse and Neglect Pcamissouri@earthlink.net

MiPSAC BOARD MEETING
April 11, 2003 12-3 PM (2nd Friday of even months)
Office of the Children's Ombudsman, Lansing
Contact Harmonm@state.mi.us

7th Bi-Annual Child Maltreatment Conference
DeVos Children's Hospital at Spectrum Health
April 22, 2003 Grand Rapids, MI
Contact: Tracy.Cyrus@Spectrum-Health.org

Supporting Policies for Families with Young Children:
Michigan at a Crossroad.
Sponsored by ARCAN and Prevent Child Abuse America
April 23, 2003, Lansing Center. (800)-CHILDREN

APSAC 11th Annual National Colloquium
July 23-26, 2003 Orlando, FL.
Tricia-williams@ouhsc.edu

7th MiPSAC Annual Meeting

Monday, October 20, 2003, 5-7 P.M.
Ypsilanti Marriott / 1275 Huron Street South
Ypsilanti, MI 48197 Info: (734) 487-2000
1. Election of 2004 Officers & Board of Directors
2. Presentation of 2003 MiPSAC Child Advocate Award

22st Annual Michigan Statewide Conference on Abuse and Neglect
October 20-21, 2003, Ypsilanti, MI
University of Michigan (734) 763-0215 sasmi@umich.edu

15th ISPCAN International Congress on Child Abuse and Neglect
September 19-22, 2004 Brisbane, Australia
ISPCAN2004@icms.com.au

MiPSAC's Goals

- To bring together professionals working in the area of child maltreatment
- To foster networking
- To be an information resource
- To sponsor quality training

In this issue of the MiPSAC Newsletter…

LEGAL ISSUES

New Court Rules Won't Help Children

Frank E. Vandervort, J.D.
University of Michigan

The Michigan Supreme Court recently adopted new rules for handling child protection cases. Unfortunately some of these rules are hostile to children and have the potential to seriously damage the quality of decision-making in abuse and neglect cases.

Courts must apply the rules beginning May 1. Of particular concern is the rule regarding changes to the tender years exception to the hearsay rule.

The Michigan Rules of Evidence prohibit the use of hearsay in a trial. Hearsay is a statement made outside the courtroom that is offered to prove the fact asserted in the statement. There are at least 24 specific and one general exception to the rule against hearsay. One of the specific exceptions relates to children of tender years. It permits a statement made by a child under 10-years of age describing an act of abuse perpetrated upon the child to be admitted into evidence if the circumstances under which the child made the statement provide adequate indications that the statement is trustworthy. Michigan law has permitted such statements to be admitted for many years, and it has helped ameliorate the need for children to endure the trauma of directly confronting their abusers in the courtroom.

The basic requirements of this rule have not changed. Two important provisions, with the potential for harming children and misleading courts, have been altered. First, when a child testifies, the child can be cross-examined by use of any statement that the child has made denying maltreatment. The purpose of this new rule, according to the Committee that drafted the rule, is to ensure fairness. Everyone recognizes the need for fairness in our legal system. If an adult makes statements that are inconsistent with the statements she or he makes on the witness stand, he or she may be questioned regarding the inconsistencies. But is this really fair?

Children sometimes make inconsistent statements about having suffered abuse or neglect. This happens for a number of reasons: fear, threats by the perpetrator, the devastating consequences they have suffered as a result of their disclosures, such as removal from their family and placement with strangers. But the new rules for cross-examination do not take account of these well-known, empirically supported reasons. Rather, the rules permit a child victim to be intimidated into recanting and then to be called a liar in court because of that recantation in precisely the same manner as an adult charged with committing bank fraud. In short, in fashioning a rule to ensure fairness, the Court has ignored the reality of why children make inconsistent statements about maltreatment.

The second way in which the new rules are hostile to children is that, if the tender years rule is used to admit the child's statements describing maltreatment, any inconsistent statement the child made may be admitted using the same trustworthiness test as the child's statement describing the maltreatment. While on the surface this seems fair, it ignores the reality of children's statements describing abuse and neglect. Because there are objective means to verify a child's statement describing maltreatment, such as physical injuries to the child, behaviors consistent with having been victimized, descriptions of when, where and how the abuse took place, a child's statement describing abuse is frequently accompanied by independent indicators that he or she was abused. Indeed, before these amendments, a person offering a child's tender years hearsay statement describing maltreatment was required to offer such "corroboration" before the child's hearsay statement could be admitted. This corroboration requirement has been eliminated. More importantly, denials contain no independent indicators of their truthfulness. The Family Independence Agency recognizes this point, and its policy prohibits a PS worker from closing a case simply because a child says he or she was not maltreated.

In its asserted effort to ensure fairness, the Michigan Supreme Court has only assured that children will be treated with none.

Join the MiPSAC member email listserv (sponsored by Wayne State University) by contacting Vince Palusci at
Vincent.Palusci@Spectrum-Health.org
or leave a message for MiPSAC at (616) 391-2297.

Summaries from San Diego

By Howard Fischer, M.D. and Elaine Pomeranz, M.D.
Children's Hospital of Michigan University of Michigan

The following are summaries of selected sessions at the 17th Annual San Diego Conference on Child and Family Maltreatment, February 3 – 7, 2003.

Connections Between Child Maltreatment, Youth Violence, and Adult Domestic Violence.

By Jeffrey L. Edelson, Ph.D.

Edelson started by pointing out that it has become well-known that families in which domestic violence (DV) occurs have a significant (~ 30 – 77%) rate of child maltreatment, and vice versa. However, the relationship of youth violence (not only gang activity) to DV and to child abuse and neglect (CAN) has only recently been explored. He then listed risk factors and protective factors for these 3 types of violent behavior.

For child abuse and neglect, these are 1) Perpetrator Risk Factors: poverty; parenting skill deficit; lack of knowledge of child development; mental health problems; childhood victimization. 2) Family Risk Factors: social isolation; family dysfunction; lack of community resources. CAN Perpetrator Protective Factors include: supportive partners, high school education or higher,; ability to access services; positive attitudes toward parenting. CAN Family Protective Factors are: supportive social network and presence of community resources.

For youth violence (YV) there are also 1) Perpetrator Risk Factors: peer rejection; involvement with deviant peers; disintegration of bond with school; low frustration tolerance; low self-control. 2) Community Risk Factors: high levels of violence; lack of community resources. YV protective factors are: strong family functioning and positive peer and neighborhood factors.

For DV these factors are 1) Perpetrator Risk Factors: childhood exposure to DV; being young and male; use of severe verbal abuse; general use of violence; under – or unemployment. 2) Family Risk Factors: male dominant family with lower status employment; economic dependence of women; isolation; lower income. DV protective factors are described only as "absence of risk factors".

Strategies for prevention, by category, are:

A. Preventing CAN: Home visitation – parent education; parent support groups; child assault prevention programs; public awareness and education.

B. Preventing YV: Peer group interventions; teacher training; community policing and ownership. The value of psychopharmacological intervention is unclear. There is no literature support for mentoring, intensive psychotherapy, or casework.

C. Preventing DV: Edelson ended with an appeal to researchers in the 3 varieties of interpersonal violence to communicate across disciplinary lines and get some awareness of the others' literature. Websites for information on the 3 types of violence include:www.mincava.umn.edu; www.vaw.umn.edu; www.thegreenbook.info
--Howard Fischer, MD

Summaries from San Diego

Biochemical Markers of Brain Injury: What Are They and What Can They Tell Us?

By Rachel P. Berger, M.D., MPH and Mary Clyde Pierce, M.D.

The presenters started by describing how traumatic brain injury (TBI) is an important cause of morbidity and mortality in children. Every 12 minutes a child in the U.S. dies from TBI. In one year, 600,000 children are seen in Emergency Departments because of TBI, and 250,000 are admitted to the hospital. TBI can be a result of a fall, motor vehicle collision (66% injure adolescents, 20% involve children < 4 years old), pedestrian-car collisions, bicycle-related injuries, and inflicted TBI (I-TBI)

Inflicted TBI is the leading cause of TBI death in children < 1 year old. There are more than 1,000 I-TBI deaths in infants/year. American children have a 1:1100 risk of I-TBI by 1 year of age. TBI costs society over $20 billion yearly. It costs $1 million to provide 3 years' care for a child in a vegetative state.

The diagnosis of I-TBI is difficult because the history is often falsified and symptoms may be nonspecific. Physical examination may be unrevealing or nonspecific as well. They cite a recent study (Jenny et al, 1999) showing that 1/3 of patients with I-TBI are misdiagnosed, and about 1/3 of these are sent home and re-injured. Many I-TBI deaths could be prevented with better diagnostic techniques. One way to improve this situation would be to identify the brain's biochemical response to TBI to help identify I-TBI, especially in its subtle form.

Biochemical markers of injury are used to aid diagnosis in many organ systems, e.g. Heart – CPK-MB band and C-troponin; Liver – liver enzymes; Pancreas – amylase, lipase; Muscle – CPK-MM, myoglobin. A biochemical marker of injury would allow quantitative evaluation of injury, allow outcome to be predicted, and improve our understanding of the injuries. A marker (or markers) for brain injury would ideally have these characteristics: 1) high specificity for brain injury; 2) high sensitivity for brain injury; 3) rapid appearance after injury; 4) a time-locked sequence with injury; 5) rapid and immediate testing available.They then briefly discussed quinolinic acid and glutamate, excitatory amino acids which are increased in the CSF (cerebro-spinal fluid) after severe TBI in children. Next, they focused on their own work with 2 biochemical markers found in the CSF after TBI, neuron-specific enolase (NSE) and protein S100B:

1. NSE is a glycolytic enzyme located primarily in the neuronal cytoplasm. In adults, CSF concentration of NSE increases with a variety of neurologic disorders. NSE is found in the CSF and serum of adults after TBI. Berger and Pierce described their work looking at CSF levels of NSE in infants and children after TBI. They found elevated levels of CSF NSE after TBI. In addition, they noted, consistently, 2 peaks of CSF NSE concentration after I-TBI.

2. Protein S100B is a calcium-binding protein localized to astroglial (supporting) brain cells. Its function is not well understood, but it too is found in CSF after TBI. S100B concentrations in CSF are also elevated after TBI in children. There was also some correlation of CSF S100B levels and severity of injury, as measured by Glasgow Coma Score.

These researchers have also shown increases in <u>serum</u> NSE and S100B after TBI. Serum testing may turn out to be a fairly simple way to screen for intracranial injury after trauma, and to identify occult I-TBI in selected patients. Serum screening tests for these 2 biochemical markers are being commercially developed.

--Howard Fischer, MD

Summaries from San Diego

Report from the NACHRI breakfast meeting at the San Diego Conference on Child and Family Maltreatment

NACHRI, which stands for the National Association of Children's Hospitals and Related Institutions, sponsored a breakfast meeting on February 5th to discuss their efforts to support programs for the prevention and treatment of child abuse and neglect across the country. Those of us fortunate enough to attend were addressed by their head of public relations and by their Washington, D.C. lobbyist. In addition, the lobbyist for the AAP attended and participated in the ensuing discussion.

In 2001, NACHRI's Board of Trustees voted to make child abuse and neglect a legislative advocacy priority. Their stated rationale for doing so is that children's hospitals are often already at the frontlines of dealing with this problem through multidisciplinary teams and emergency care of children, as well as in their care of medically fragile children at higher risk of abuse and neglect. They state that "With an exclusive focus in pediatrics, missions of striving to serve all children, and a commitment to family-centered care" they have "unique expertise in both prevention and treatment". Furthermore, "a number of children's hospitals also have become leaders in research in identification, diagnosis, treatment and prevention of abuse and neglect".

The Association therefore undertook a survey of children's hospitals' child abuse programs in 2001 and concluded that costs are not recovered, that children's hospitals heavily subsidize these programs and that it is very difficult for many of the hospitals to calculate the costs associated with their child abuse programs.

In a search for solutions to this funding problem, NACHRI profiled 2 different successful models for funding child abuse services: the New Jersey approach and that used at he Arnold Palmer Hospital for Children and Women in Orlando, Florida. Summary reports of both were distributed and discussed.

The New Jersey program is spearheaded by Dr. Martin Finkel and is a network of 4 regional child abuse diagnostic and treatment centers. After 10 years of work by child advocates, the New Jersey legislature approved the appropriation of $2 million/year to be distributed among the four sites to cover staff, overhead and equipment. This is augmented with fee-for-service contracts that each regional center has with New Jersey's Department of Youth and Family Services to cover forensic medical examinations, mental health services and expert testimony. These contracts range from $250,000 to $500,000/year. It was pointed out to legislators that when the long-term public health costs associated with child abuse and neglect are considered, this multi-million dollar cost per year seems very reasonable.

The Florida program profiled is one that is focused on prevention and is the result of teamwork between Orlando Regional Healthcare and Arnold Palmer Hospital. Healthy Families Orange is a voluntary home visiting program offered to families with newborn babies residing in areas of Orange County with the highest rates of child abuse. It has had dramatic results in reducing the incidence of child abuse in the areas it services in the first five years of the program. A coalition of statewide advocacy organizations has secured Department of Children and Families funding for such local programs. Healthy Families Orlando's 2001-2002 budget totaled $2.3 million and came from multiple sources.

Other models of successful funding around the country were also briefly discussed at the meeting. The NACHRI public relations group supplied a list of services they already provide to support members in their endeavors to prevent and treat child abuse and neglect. The NACHRI lobbyist discussed the challenges as well as the importance of fighting for national funding of programs such as those profiled. Both he and the AAP lobbyist vowed to work toward the goal of obtaining funding for programs to prevent and treat child abuse and neglect on the national level. Please contact me at pomeranz@umich.edu for course materials or further information about NACHRI. –Elaine Pomeranz, MD

Summaries from San Diego

Infant Death Investigations by the Coroner

by Leslie C. Meader, Senior Deputy Coroner, Orange County (California) Sheriff-Coroner
Presented at the San Diego Conference on Child and Family Maltreatment, February 6, 2003

Three components of a coroner's investigation were identified as postmortem examination, scene investigation and review of clinical history.

The speaker included full body x-rays in all children 2 years of age or less, a complete autopsy and toxicological screen as necessary elements of the postmortem exam. (Audience participants asked where the x-rays were obtained and she apparently has the equipment to do them in her facility. This is not true everywhere, but hospital facilities can be used otherwise.)

In Orange County, all unexpected child death investigations include checking the child abuse registry and running criminal checks on the parents, regardless of how the deaths are initially thought to occur. The child's medical history is also reviewed.

Death scene investigation discussion included various illustrative cases in which transport of the child from the scene to be pronounced dead at a hospital complicated the investigation. These examples included transport within the first couple of hours interfering with lividity that would otherwise have clarified the position the child was in at the time of death. Likewise, if medical intervention and transport occur once rigor mortis has set in, the rigor is broken and information about the time of death is lost. In addition, items such as the bedding, baby's clothing, last bottle, etc., can be lost during the transport process.

One of the cases presented to illustrate the importance of the death scene investigation was that of an infant with large quantities of a white powdery substance found in his lungs. At the home, baby powder was found in a large area of the floor identified as where the car seat holding the baby had been located. That investigation eventually led to the discovery that the parents would spray a little baby powder in the baby's face to stop his crying. The pre-school sibling then tried the same thing, using the whole bottle of baby powder, resulting in death by aspiration.

Some of this presentation was also devoted to discussion of SIDS and concluding once again that SIDS is a diagnosis of exclusion and that the only difference between diagnosing SIDS and suffocation is a confession or an investigation.

Shaken Baby Syndrome and Munchausen by Proxy were also reviewed in this talk, which was presented well for a multi-disciplinary audience despite being listed on the law enforcement track.

Time was spent on how variable the cause of death listed can be under the same circumstances but with different personnel and equipment used in the investigation. This then complicates our ability to track fatal child abuse, one of the points of lively discussion at the end of the session.

Although this presentation did not cover any new, exciting breakthroughs, I found it valuable to learn what standards are being set for death scene investigations in this national and international venue. If only we could make it mandatory for all our investigators to attend talks like this one! --Elaine Pomeranz, MD

REMINDER!

Please renew your annual membership to APSAC.
You must have APSAC membership to be a member of MiPSAC.
Part of you dues to APSAC pays for MiPSAC membership automatically!

American Professional Society on the Abuse of Children

C/O Gethsemani Center
2449 Beacon Street
Charleston, S.C. 29405
Phone: (843)744-6901 Fax (843) 744-7188
Membership info: gethesemani@comcast.net, www.apsac.org

MiPSAC 2003 Child Advocate Award

MiPSAC is currently seeking nominations for the 2003 Child Advocate Award. The award will be presented in October 2003, at the Annual Statewide Child Maltreatment Conference, in Ypsilanti.

ELIGIBILITY

Nominees should be individuals who have made substantial contributions to practice relevant to child maltreatment/welfare and who have demonstrated the potential to continue such contributions. Nominees need not be current members of MIPSAC and can be from any discipline/level of service. Ideas for potential nominees include CPS workers, law enforcement, judges, individuals in the medical field, volunteers, attorneys, foster care workers, and social workers.

TO NOMINATE, Send 2 copies of:

1) A cover letter outlining the nominee's accomplishments to date and anticipated future contributions. This letter should describe the nominee's major accomplishments related to the field of child maltreatment and how the nominee's work has had an impact on the field;

2) The nominee's current curriculum vitae;

3) Two letters of support; and

4) If possible, other relevant supporting material, as appropriate

NOMINATION DEADLINE: Postmarked by June 1, 2003.

SEND NOMINATIONS OR DIRECT QUESTIONS TO: Rosalynn Bliss, MSW, CSW Child Protection Team, DeVos Children's Hospital, 100 Michigan Street NE, Mail Code 178 Grand Rapids, MI 49503, or (616) 391-3834.

Website resources for information on child maltreatment, local and national organizations, statistics, legislative updates and prevention

by Rosalynn Bliss

www.apsac.org
www.michiganschildren.org
www.michigan.gov/fia
www.childtrauma.org
www.firststar.org
www.nationalcalltoaction.com
www.preventchildabuse.org
www.cwla.org
www.childrensdefense.org