MiPSAC

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

Volume 8, Issue 4 **October - December, 2003**

PRESIDENT'S CORNER

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

As my term as President of MiPSAC draws to an end, I would like to share with you some of the developments and activities of the past year. As you may recall my primary objective for MiPSAC in 2003 was to identify one clear and feasible goal that would make a positive impact on Michigan's children. Over the course of several meetings Charlie Enright facilitated our discussions using the Pareto Method that resulted in a consensus that the goal for the MiPSAC Board in 2004 is to develop training modules to educate/train professionals who work in Michigan to know how to prevent, identify, and treat victims of maltreatment. At our last meeting in December the Board will develop an action plan that will target one training area of focus as well as identify who will prepare the training materials and how, when and where the training will be implemented. There is a wealth of talent and experience within the MiPSAC membership and I would like to invite each of you to participate in these training programs during the planning stages as well as join in the actual training workshops as they are scheduled. The easiest way to get involved is by making your interest known in a message on the MiPSAC listserve.

My second goal for MiPSAC was to strengthen ties with other organizations in Michigan involved with child maltreatment. We have made real progress in this effort. First, Lynne Martinez, Director of the Ombudsman Office, has been attending all of the MiPSAC Board meetings and was recently elected as an honorary board member. Welcome Lynne! Second, we have met with Nanette Bowler, Director of the Family Independence Agency (FIA) and she has agreed to continue to meet with us and to collaborate in developing multidisciplinary regional assessment centers throughout Michigan. Third, Nancy Skula, the new Director of the Michigan Chapter of the National Children's Alliance gave an interesting and helpful overview of the Children Assessment Centers in Michigan at the MiPSAC Annual Meeting in October. Nancy has expressed a willingness to attend future meetings with Ms. Bowler to facilitate collaboration and integration of potential new regional assessment centers with the eleven that already exist. Finally, we have been successful in expanding involvement in MiPSAC from both the legal and law enforcement professions. One new member, Deborah McKelvy, a Guardian Ad Litem in Oakland County, wrote an article for this issue of the MiPSAC Newsletter. We have not yet met, but Elizabeth Bonello, a detective at the Lansing Police Department, hopes to attend our December meeting. Welcome Deborah and Elizabeth.

As is MiPSAC's tradition, we sponsored one guest speaker at the Annual Michigan Statewide Conference on Child Abuse and Neglect. This year we sponsored keynote speaker, John E. B. Meyers, JD, Professor of Law at McGeorge School of Law at the University of the Pacific in Sacramento, California, who gave an interesting and informative history of child protection in America. Another MiPSAC tradition is to honor one Michiganian whose dedication and professional focus has made a significant impact on improving the response to children who have been abused and neglected. It was my pleasure to present the 2003 Ray Helfer Child Advocate Award to James A. Henry, Ph.D., an Associate Professor in the School of Social Work at Western Michigan University. Congratulations Dr. Henry for all you do for the children in our state.

This years MiPSAC Newsletter has provided practical and important information to the membership about MiPSAC and APSAC, law and policy, medical neglect, and prevention. A warm thank you to all contributors and guest editors who gave so generously of their time and expertise. Finally, I want to thank all of you for the opportunity to serve as your President. MiPSAC is a very special organization with a talented and dedicated membership and it has been a pleasure to work with you. I wish each of you a happy holiday season and a healthy, happy, and successful New Year.

In this Special Issue on Prevention (with Guest Editor Ms. Deborah Strong)...

MiPSAC ANNOUNCEMENTS AND UPCOMING MEETINGS

San Diego Child Maltreatment Conference
January 26-30, 2004, San Diego Children's Hospital
APSAC Pre-conference Institutes, January 26, 2004
www.chadwickcenter.org

MiPSAC Board Meeting (Next Meeting- February 13)
2nd Friday, even months, 12 noon – 2 PM
Harmonm@michigan.gov
Michigan Children's Ombudsman's Office, Lansing

20th National Symposium on Child Abuse
National Children's Advocacy Center, Huntsville, AL
March 16-19, 2004 **mgrundy@nationalcac.org**

FIA Physicians Child Abuse Conference
Holland MI, May 18-19, 2004. **hofstrah@michigan.gon**

University of New Hampshire, Victimization of Children and Youth Conference, July 11-14, 2004, Portsmouth, NH www.unh.edu/frl

APSAC 12th Annual National Colloquium
August 4-7, 2004 Hollywood, FL.
Tricia-Williams@ouhsc.edu

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

DeVos Children's Hospital 8th Biannual Child Maltreatment Conference
October 5, 2004 Grand Rapids, MI
Tracy.Cyrus@spectrum-health .org

Michigan Professional Society on the Abuse of Children, Inc.
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MiPSAC was founded in 1995 and incorporated in 1996 as the Michigan non-profit 501(C)3 state chapter of APSAC.

The comments expressed in this newsletter reflect the views of the author(s) and do not necessarily represent the views of MiPSAC or the American Professional Association on the Abuse of Children. (APSAC).

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

Defining Prevention in Human Services

Children's Trust Fund Citizens Review Panel
Prevention Definition Subcommittee
By Greg Jones & Stephen Thomas, Jr., Co-Chairs

Background:
The Citizen's Review Panel on Prevention determined that a major barrier to a comprehensive approach to prevention services in Michigan was the lack of a common language for developing preventive approaches. Although the original charge was to review efforts to prevent child abuse and neglect, the Subcommittee quickly concluded that a common definition of prevention was needed to facilitate coordination of preventive efforts across disciplines and agencies. A common definition can help bridge the gaps between the different systems and disciplines working with children (e.g., the public schools, public health, social services and churches) and help communities develop a more effective range of responses to the needs of families.

The Subcommittee reviewed a range of prevention definitions that are currently in state law and policy, as well as definitions from other states. It decided to enumerate the major components of a definition of prevention, and to use those components to develop:

- A generic definition of prevention; and

- Sub-definitions that relate to three major areas of child development: (1) child safety; (2) child health; and (3) early childhood education and care.

Components of the Definition of Prevention:
I. *Prevention should he broadly defined to encourage interdisciplinary and community-wide efforts:*
- The causes of child abuse and neglect are complex, and strategies to prevent child maltreatment will need to address the social and economic context in which it occurs.
- A broad definition can encourage interdepartmental coordination in developing services for children and families by ensuring a common language and analytical approach.
- Communities need to agree on a definition of prevention to craft community-wide efforts to improve outcomes for children and families.
- A broad definition must recognize the role of both the public and private sectors.

2. *The definition of prevention should recognize the need for a continuum of services or initiatives ranging from the promotion of child and family well-being to the protection of children from further harm.*
- Children and families need a continuum of educational and direct services ranging from the general promotion of healthy lifestyles and good parenting skills, to treatment and rehabilitation.
- Traditionally, the public sector assumed responsibility for treatment an rehabilitation services by intervening only when behavior was serious enough to threaten public safety or health. More recently, there has been growing interest in prevention but the scarcity of public funds has restricted the reallocation from treatment to prevention.
- Service definitions are not standardized, and interventions for any single child or family do not always fall exclusively into one part of the continuum. For example, some families with substantiated child abuse and neglect can receive both mandatory treatment services and voluntary prevention services that connect them to needed supports after the case is closed.

3. The definition should describe the different levels of prevention.

- The most commonly adopted categories of preventive services have been borrowed fromthe public health model. They include:

Primary prevention: Programs and services that are designed to stop problems before they start. Primary prevention services are voluntary and aimed at the general public, or at entire population groups without identifiable risk factors. The services are available to the general public or large groups, and the cost per individual is generally low.

Examples of primary prevention include:

X prenatal care
X childhood immunization
X parent education programs
X public awareness campaigns

Secondary prevention: Secondary prevention services are voluntary and aimed at families and children with documented risk factors. Secondary prevention services are designed to lower or counter identifiable risk factors, and prevent negative behaviors or harm. The services are available to smaller, targeted groups and the cost per individual is increased.

Examples of secondary prevention include:

X home visitation programs
X preschool programs for at-risk children
X EPSDT health screenings
X outreach programs

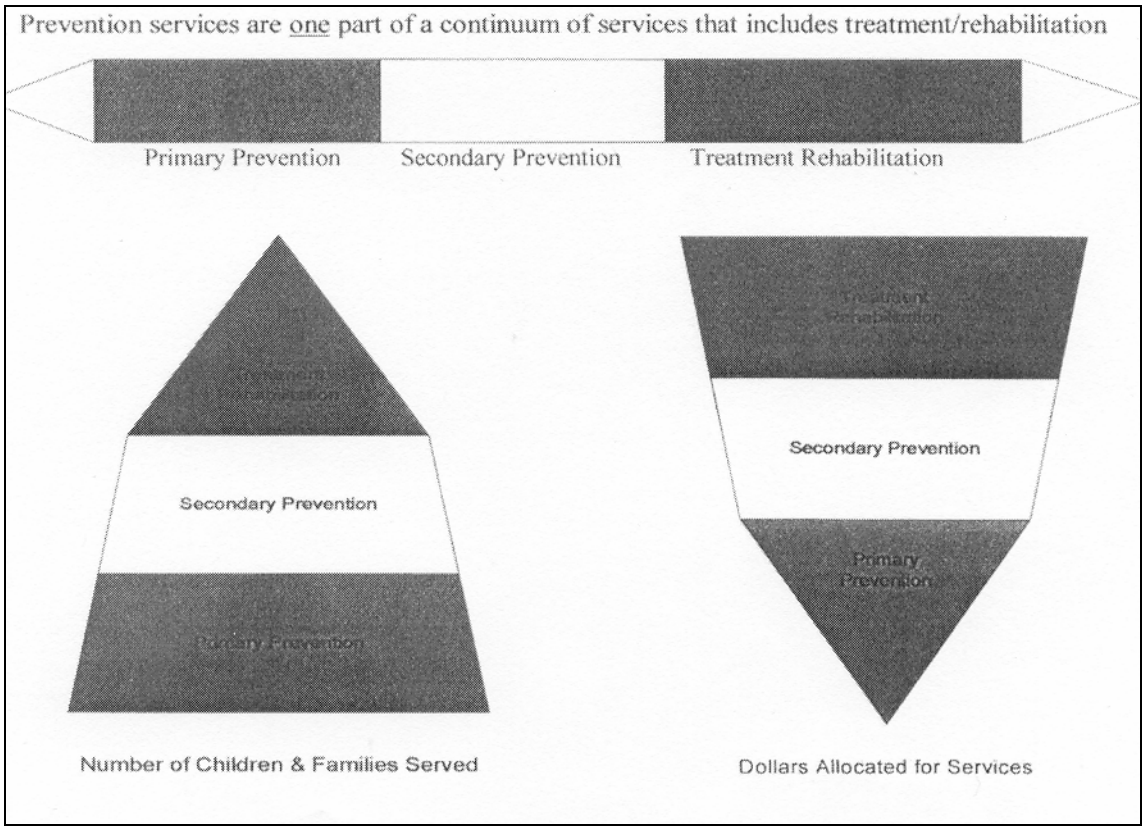
A Proposed Definition of Prevention

Prevention services and programs are part of a continuum of supports, services and interventions that promote child and family well-being. The goals of prevention services are to:
(1) promote social, emotional, physical and intellectual growth in children and their families;
(2) reduce the incidence or severity of risk factors that are associated with negative outcomes for children and their families, or;
(3) eliminate or limit harm to children and families that have experienced serious emotional, physical, educational, safety or health problems.

Prevention programs and services operate at two levels:
1. Primary Prevention: programs and services to promote the optimal development of all children.
2. Secondary Prevention: programs and services to support families and children with identified risks for poor social, emotional, physical and intellectual outcomes.

Prevention program are designed to promote (tailor a prevention definition for each domain):

- child and family safety (child abuse and neglect, violence prevention, public safety)
- child and family health (primary health care, health education, etc.)
- optimal child development and education (child care, early education services, etc.).



While primary prevention programs serve a larger portion of the population, these types of services receive minimal funding. On the other hand, tertiary programs serve a small number of individuals and families, but require large amounts of funding.

CTF Funded Shaken Baby Prevention Program Completes Demonstration Year

By Rosalynn Bliss MSW CSW, DeVos Children's Hospital
& Wilma Zeemering RN, BA, Spectrum Health.

We are pleased to provide this report of our activities in the first demonstration year of the Shaken Baby Syndrome Prevention Program at DeVos Children's Hospital at Spectrum Health. This report summarizes information for the entire year (October 1, 2002 – September 30, 2003). The program is thriving and we look forward to continued success. The direct one-on-one education offered by nursing staff to parents before discharge from the hospital after the birth of their child includes:

1. The Nurse discussing the dangers of shaking a baby with the parent(s)
2. Setting up the video "Portrait of Promise: Preventing Shaken Baby Syndrome" in English or Spanish for the parent(s) to view
3. Offering solutions to deal in an appropriate manner with the frustrations of caring for an infant
4. Providing pamphlets on the dangers of shaking a baby that can be shared with other caregivers
5. Parents completing the initial contact form acknowledging the dangers of shaking a baby and giving written consent for a follow-up telephone contact

Outcome Data for First Year

- There were a total of 8111 births at Spectrum Health from Oct. 1, 2002 – September 30, 2003, of which 4274 families were educated about the dangers of SBS, and 3930 families participated in the program. 3930 families were educated about the dangers of shaking a baby (48.5% of births at both campuses). Of these, 2364 husbands/significant others were present and 2847 families consented to a follow-up telephone call in 9 months. The participation rate for the year reflects the current high rate as compared to the low participation rate during program implementation. The participation rate for the year is 66% of target and 48.45% of all births, reflecting the small numbers of families participating in the first two quarters during implementation.

- 3783 (96.2%) of the participating parents indicated on the consent form that the information they learned was helpful, although most (94%) had already heard shaking was dangerous.

- 3717 (85%) of parents completing the initial contact form indicated that they have learned at least one technique to avoid shaking their baby and 97.4% would recommend the information for new parents.

- 342 telephone follow-up surveys were attempted and 131 families were successfully contacted. These families had infants born during the first two quarters of the program, with births through February 28, 2003. A large proportion of calls resulted in "No answer" or were connected to "Wrong numbers" or families had moved. Parents were asked several questions to determine whether SBS information presented was retained and whether they remembered specific parts of the program. Specific responses were obtained regarding the health of their infant, whether they had shared information about the program and the dangers of shaking, and their assessment of their overall experience with the program. No families reported that their infant had suffered from SBS since birth. Most (85%) remembered the nurse presenting the information, 94% remembered signing the form, and 88% remembered the video 9 months later. Three-quarters remember reading the information and over half (52%) had shared the information with others since leaving the hospital. All had a positive overall experience with the program, with most (73%) responding "very positive" and 27% responding "positive." There were no "negative" or "very negative" responses.

- Members of the health care team were surveyed about their knowledge of Shaken Baby Syndrome and their comfort with presenting the information to new parents. Of over 300 surveys distributed, 73 were returned (24% return rate). Most (76%) had received an inservice lecture and had provided the program for 1-20 parents per week. 84% of nurses found the information and training helpful, 89% think all new parents should receive SBS education, 30% learned a new strategy to respond to infant crying, and 38% learned a new strategy for coping. Overall, most nurses rated the program as "very effective" or "somewhat effective". Of the potential challenges to providing the program, "lack of time", "lack of patient access" and "added documentation" affected the program 'sometimes' or 'usually'. "Personal discomfort," "lack of training " and "lack of support" from supervisors and the program were noted less frequently. Despite efforts at providing videos and materials in more than one language, "language" remained a barrier 'sometimes.' In addition to Hispanic/Latino families, we care for families from other cultures, including Bosnian, Korean and Vietnamese.

- The Program Consultant and Nurse Coordinator facilitated seven Shaken Baby Syndrome Prevention Program presentations for 107 nurses and the community.

- There were no infants admitted to DeVos Children's Hospital with SBS among families who had received the program. During the 8 years prior to beginning the SBS program, there were an average 5.9 admissions per year to DeVos Children's Hospital for children less than 5 years of age with a medical diagnosis of SBS. 44% of these were children from Kent County, the remaining 56% were for children from the other 12 West Michigan Counties (Allegan, Barry, Ionia, Lake, Mason, Mecosta, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Ottawa). Just over one-fourth (28%) were born at Spectrum Health Butterworth or Blodgett campuses.

- The overall rate for children with SBS during the prior 8 years before the program was 6.1 per 100,000 children ages under 5 years. The moving three-year average at the end of 2002 was 6.6 per 100,000. During the first 9 months of 2003, the rate has been 4.2 (annualized = 5.6). Three-fourths of the DeVos Children's Hospital patients have been

infants less than 1 year of age, similar to published national reports. While the precise incidence of SBS has not been established nationally, a conservative estimate of 20 per 100,000 among infants has been reported, yielding an estimated 26 SBS cases annually among Michigan infants (2000 infant population 132,361) and 3-4 SBS cases in West Michigan infants (estimated 2000 infant population 18,876), with 5 cases overall among children <5 years. While we cannot be sure that all children with SBS have been admitted to our institution (some children may die before coming to the hospital or go to other institutions), the numbers seen are comparable with published estimates.

Future Plans: In the future, the program will continue at DeVos Children's Hospital but the focus will more heavily include collaborating and working with other hospitals locally and throughout Michigan to develop similar programs. The Program Consultant and Nurse Coordinator created an outreach letter and binder of materials that can be sent to OB Managers and Supervisors at area hospitals. This letter provides a description of the SBS Prevention Program, offers training and orientation to staff members, and offers support in developing and implementing a similar program at their hospital. Hospitals who are interested in beginning a program will be provided a binder start-up kit that contains all of the materials, forms, documents, and resources needed to begin the program. The Nurse Coordinator will then act as a trainer and consultant throughout implementation. Please contact Rosalynn Bliss MSW, CSW at (616) 391-3834 for further information.

Children's Safety and Mental Health: What Works?

Steven J. Ondersma, PhD
Wayne State University

Resources with which to prevent and/or treat child abuse and neglect are precious and limited. Therefore, what little we have must be put to the best use possible. My goal in this brief article is to outline the research on the efficacy of mental health interventions for children generally, including those focused on child maltreatment. First, I will provide a brief review of available research regarding mental health treatment. Second, I will provide a description of effective treatment types, with recommendations regarding when each approach is indicated.

What does research say about the effectiveness of mental health treatment for children?
It is crucial to begin this discussion with a reminder that not all mental health services are effective. In fact, just as with medications or other medical interventions, some such services are not effective or can even make things worse. Unfortunately, however, there is no Food and Drug Administration for mental health treatments; they can be presented, changed, or invented at will without permission from any governing body. This is why it is so important that therapists, policy makers, and advocates be up to date on the most recent research regarding what is best for children and families.

Empirically-supported interventions are those that: (1) are not counter-indicated by rigorous, peer-reviewed research; (2) are justified based on rigorous, peer-reviewed research; and (3) have quantifiable outcomes. This means, first, that studies have been conducted to evaluate that particular intervention, and that the results of those studies have appeared in scientific journals in which other scientists have had the opportunity to scrutinize the study's methods and conclusions. Just as with documentation in the child welfare field—where if the documentation is not there, the event never occurred—if a study does not appear in a peer-reviewed journal, for most intents and purposes it simply never happened. This also means that the evidence against a particular intervention, if any, is outweighed by the evidence in support of that intervention (and not vice-versa). Finally, this means that progress using a given therapeutic approach must be measurable in an objective manner.A great deal of research has examined the effectiveness of mental health interventions for children. The results of this research can be summarized in the following ten points:

1. *Treatment, at best, has a moderate effect*. Even under the best of circumstances, mental health treatment will on average lead to some improvements in some treated individuals. These changes, however, are of sufficient size to make treatment important for those with clear mental health issues.
2. *Manualized and structured treatments are more effective*. Improvement is more likely when treatment is provided according to a proven manual, than when a therapist uses "eclectic" or unstructured approaches.
3. *Caregiver training is the best treatment for under-controlled behavior for children 12 and younger*. Play therapy and other individual approaches are not effective with children who are disruptive, defiant, and/or aggressive (also known as

"externalizing" disorders). These children require clear contingencies for positive and negative behavior outside of the therapist's office, and the only way to achieve this is through direct work with the caregiver.

4. *Family-based approaches are best for under-controlled behavior in adolescents.* Individual work with aggressive, disruptive, and/or delinquent teens is also unlikely to be effective. Multi-systemic and family therapies can lead to crucial changes in the environment of the adolescent.
5. *Group therapies with under-controlled teens can make things worse.* Research suggests that putting aggressive, disruptive, and/or delinquent teens together, even in "therapeutic" settings, leads to negative mutual influences.
6. *Individual therapy is best for anxiety and depression.* Children with what are known as "internalizing" disorders such as anxiety, depression, and withdrawal respond well to individual therapy. Work with the whole environment is certainly still important, however.
7. *It is unclear to what extent additional services and coordination help.* A major study known as the Fort Bragg Evaluation Project found that providing additional mental health services did not lead to better outcomes for children, even though far more money was spent (Bickman, Lambert, Andrade, & Penaloza, 2000). While this study has been criticized, clear evidence to the contrary is not available. The best current conclusion is that more services are not necessarily better.
8. *Length of time in treatment may not predict outcome.* In several areas of research, it appears that extended treatment is no more effective than brief treatment. This is an important finding given severe limitations in resources.
9. *Inpatient or day treatment has not been proven to be more effective than less intensive treatment.* Some research has shown that intensive home-based research is as or more effective for some children (Mattejat, Hirt, Wilken, Schmidt, & Remschmidt, 2001). Other research has questioned the strength of evidence suggesting that inpatient services are helpful (Pottick, Hansell, Gaboda, & Gutterman, 1993). As of 1998, inpatient services accounted for 33% of the 11.7 billion spent on children's mental health services for children in that year (Ringel & Sturm, 2001).
10. *Mental health treatment as provided in the community is less likely to be effective.* Most research studies are conducted by and within universities. Studies of interventions as conducted in the community often show much less positive outcomes. This may be because agencies in the community work with more complex cases, focus on multiple problems instead of just one, use therapists with less training, and/or because structured manuals are very rarely used in the community.

Empirically-supported treatments -Given the above, what types of treatments are supported by research? Fortunately, there are a number of options. The best supported of these are reviewed below:

Behavioral parent training. Disruptive behavior disorders in children age 2-10 are one of the most frequent reasons for referral to treatment, and also one of the most frequent reasons for shifts in school, day care, or foster care placement. Behavioral parent training is the best-supported intervention for this problem. The best supported approaches, including Parent-Child Interaction Therapy and the "Incredible Years" model, proceed in two phases: one phase in which parents are taught play therapy skills to use in establishing a strong non-coercive relationship with their child, and a discipline phase in which parents are taught to use non-violent discipline appropriately. Skills are coached directly—not just talked about—and mastery in one set of skills is required before moving on to the next phase. Treatment normally takes approximately 12 weeks with sessions occurring once per week. One approach, PCIT, has recently been validated as an approach for physically abusive parents. More information on the "Incredible Years" protocol can be found at http://www.incredibleyears.com/, and more information regarding Parent-Child Interaction Therapy can be found at http://www.pcit.org/.

Multi-systemic therapy (MST). MST is an intensive ecological treatment approach involving a therapist who works closely with a family, in the home, using any empirically-supported technique that the situation demands. It focuses on individualized assessments and building on existing strengths. It has been proven to be remarkably effective with delinquent, substance-abusing, and disruptive teens. MST is intensive: it is typically conducted in 60 hours of contact over a period of 4 months. For more information, see http://www.mstservices.com/.

David Olds' Nurse Home Visitation Model. Early home visitation is remarkably popular, despite a great deal of research suggesting that it is ineffective (despite a recent and very misleading report from the Centers for Disease Control and Prevention; Centers for Disease Control and Prevention, 2003). The Nurse Home Visitation Model is an exception, in that it has repeatedly shown strong and positive effects (although not when domestic violence is present).

Brief Strategic Family Therapy (BSFT). BSFT is also a 12-15 session, proven approach to adolescent behavior problems, but is also applicable to children as young as 8. It is often used for substance abuse in adolescents. BSFT involves reducing risk factors and enhancing protective factors in a highly ecological, multisystemic approach. Much of its development has been with Hispanic youth. For more information, see www.ncjrs.org/html/ojjdp/jjbul2000_04_3/contents.html

Cognitive-behavioral individual therapy (CBT). CBT (e.g., Cohen, Mannarino, Berliner, & Deblinger, 2000; Deblinger, Stauffer, & Steer, 2001) has been proven effective in the treatment of anxiety (including trauma) and depression in children, adolescents, and adults. Treatment for anxiety involves gradual exposure to feared stimuli while teaching coping skills. Treatment for depression involves learning to recognize, challenge, and replace maladaptive beliefs that lead to depression while also actively participating in activities that are incompatible with depression. CBT treatment is approximately 12 sessions.

Pharmacotherapy. A wide range of medications is clearly effective when used with adults. Medication to treat symptoms of ADHD is also clearly effective, and a wide range of medications—including antidepressants—is effective with adolescents. The effectiveness of medications with pre-adolescent children is much less clear, although medications to treat obsessive-

compulsive disorder (a form of anxiety) do appear to be effective and medications to treat depression in children may be effective.

Summary- Many assumptions regarding mental health treatment have been proven wrong. For example, one cannot assume that treatment is effective, whether or not a trained "expert" conducts it. More treatment is not necessarily better, and group work with under-controlled adolescents is contra-indicated. A wide range of proven treatment approaches is available. In addition, a well-done guide is available to assist professionals in identifying empirically-supported treatments. This guide, published by the Medical University of South Carolina's Center for Victims of crime, is available at http://www.musc.edu/cvc/guide1.htm.

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Lawyer-Guardians Ad Litem on Trial

By Deborah H. McKelvy, Esq.

There used to be a time when being a Lawyer-Guardian Ad Litem (LGAL) meant something meaningful deep down in one's soul. This was an opportunity to help preserve one of our nation's most prized resources -- our children. Corny as that may sound, as a former teacher and a court-appointed attorney in Oakland County for the last thirteen years, I continually reap singular rewards every time my efforts have given even one child the respect and love they deserve though sadly rarely receive. Simply put, that is why their family is most likely involved in the family court system in the first place.

But, alas, such altruistic thoughts have recently been replaced with attorneys significantly questioning whether they will continue to accept LGAL appointments, especially in the area of abuse and neglect. Anyone reading this article who is familiar with this debate will probably say that if an attorney has to think about accepting such an appointment, then maybe that is why the State Court Administrative Office Child Welfare Services Division became involved in the controversy in the first place.

As is in any profession, there are those who do not live up to the standards set out by their profession. The shame is that it is usually a small percentage of the profession whose behavior can be called into question. The larger numbers who do their job and do it extremely well receive little or no recognition. Now both groups are the subject of a campaign by the State Court Administrative Office Child Welfare Services to, for a lack of a better way of stating it, "clean up" the work of the Lawyer-Guardian Ad Litem, and to no surprise, without additional compensation for their services.

Now I am not naïve in understanding that in choosing to do court-appointed work, one recognizes that one will not be adequately or appropriately compensated for the time spent when representing these clients. You generally choose this line of work because you want to, consequently you know the pros and cons going into it.

According to MCL 712A.13a(f), a "lawyer-guardian ad litem" is an attorney appointed by the court to represent a child(ren) in child protection cases. Their duty is to the child, and not to the court. The powers and duties of a LGAL are stated in MCL 712A.17d. The controversy in question involves MCL 712A.17d(d) that states:

> (d) *Before each proceeding or hearing, to meet with and observe the child, assess the child's needs and wishes with regard to the representation and the issues in the case, review the agency case file*

and, consistent with the rules of professional responsibility, consult with the child's parents, foster care providers, guardians, and caseworkers." (emphasis added).

This is not an issue of doing the job you have been appointed to do, and I will not dispute that there are those LGALs who do not do their jobs. Rather, it is the unnecessary involvement of governmental agencies attempting to regulate people and not attempting to improve the job being done by those people.

In a recent article that appeared on November 7, 2003 in the *"Oakland County Legal News,"* Debra A. Gutierrez-McGuire, special assistant on Foster Care Issues to Chief Justice Maura D. Corrigan, stated that *"in any other setting, there would be no question about whether or not an attorney has an obligation to meet with a client."* However, what Ms. Gutierrez-McGuire fails to address in her statement is that in those other settings some compensation is provided.

As a LGAL, I have traveled 4.5 hours one-way to visit with LGAL clients in the State of Ohio. I have LGAL clients throughout the State of Michigan -- as far west as Grand Rapids and as far north as Mancelona. I have attended weekly therapy sessions on behalf of my LGAL clients in order that there be no confusion in court hearings when parents state to the Court one thing with respect to what their child(ren) are alleged telling them they want and what these same children are verbalizing in therapy. I have attended supervised parenting time sessions to again prevent confusion in court hearings between parents and what they believe their children want. I do not shirk my responsibilities as a LGAL. However, I have become disheartened when I am told that after January 1, 2004, I will have to sign an affidavit that I visited with my LGAL clients before I can receive payment for my court appearances. Further, the State Court Administrative Office Child Welfare Services Division is encouraging local panels of the Foster Care Review Board to report LGALs who are not meeting with their child-clients and recommend that the State Court Administrative Office file a request for investigation of attorney misconduct with the Michigan Attorney Grievance Commission. The Foster Care Review Board was created by the Michigan Legislature to review abuse and neglect cases where the children have been placed in foster care. The local panels are made up of volunteers who meet once a month to review the cases of children in care.

How will these policies improve the quality of LGALs representation? Just recently I have heard a number of attorneys I know and respect indicate how many LGAL appointments they have turned down. Some are no longer taking abuse and neglect cases period. And these are the good ones -- the dedicated ones who untiringly give of their time and money because this is the law they have chosen to practice. And this is how they are being treated. With these policies in place and many of the experienced LGALs questioning whether they will continue to take these appointments, I can only speculate that the county judicial communities must be concerned about the quality of the LGALs available to them for appointments.

If LGAL appointments are currently a part of your practice or you are a new attorney seeking such appointments, do not let this article turn you off from accepting them. It will not stop me. There continues to remain great joy in representing this population regardless of the current tempestuous nature surrounding such representation. The best advice I can offer would be the same regardless of the profession under discussion, and that is -- know what your job is, i.e., become intimately familiar with the court rules and statutes that govern child protective proceedings (MCL 712A.1, et seq. and MCR 3.901 et seq.) and then do that job to the best of your ability every day.

Deborah H. McKelvy, Esq. has been in private practice for thirteen years in Birmingham, MI. Much of her practice centers on court-appointments in the areas of adult criminal, juvenile neglect/delinquency, probate and family law.

Book Review

Leni Cowling, M.Ed., LPC, HRD

"Predators: Pedophiles, Rapists, and Other Sex Offenders: Who They Are, How They Operate, and How We Can Protect Ourselves and Our Children" by Dr. Anna C. Salter, Ph.D.

Dr. Salter, a psychologist and consultant for the Wisconsin Department of Corrections, has studied and interviewed sexual offenders and their victims for over twenty years. In this book she addresses the myths about sexual abuse and explains how sexual abuse is far more prevalent than most people would imagine. Predators cover their tracks well and know how to elude the law. Dr. Salter feels that our misconceptions about sexual predators contribute to our vulnerability. Abusers come in all shapes and sizes, including respected community leaders, teachers, priests, doctors

and trusted family friends as well as relatives. When we do not recognize the total aspects of sexual abuse, we put our children at extreme risk, often legally giving custody to abusers. At the very least, all professionals who work with children and especially in the field of child abuse and neglect, have no excuse to ignore this work. The psychological and emotional damage done to victims of sexual abuse has contributed to the overwhelming burden on mental health services and the correctional systems. She gives anecdotes, some of which are graphic, and offers specific strategies to avoid high-risk situations. While disturbing to read, it is a must for all parents and especially single moms. Until we understand the whole picture, we will continue to put children at risk. Each of us is accountable in the protection and prevention of abuse and neglect to children. I am very grateful for Dr. Salter's work. It is unfortunate that Child Protective Services does not offer its workers important information such as this to enable them to do a full investigation in their work.

A Prayer for Children

By Ina J. Hughes

We pray for children
who put chocolate fingers everywhere,
who like to be tickled,
who stomp in puddles and ruin their new pants,
who sneak popsicles before supper,
who erase holes in math workbooks,
who can never find their shoes.

And we pray for those
who stare at photographers from behind barbed wire,
who can't bound down the street in a new pair of sneakers,
who never "counted potatoes,"
who are born in places we wouldn't be caught dead,
who never went to the circus,
who live in an X rated world.

We pray for children
who bring us sticky kisses and fistfuls of dandelions,
who sleep with the dog and bury the goldfish,
who hug us in a hurry and forget their lunch money,
who cover themselves with Band Aids and sing off key,
who squeeze toothpaste all over the sink,
who slurp their soup.

And we pray for those
who never get dessert
who have no safe blanket to drag behind them,
who watch their parents watch them die,
who can't find any bread to steal,
who don't have any rooms to clean up,
whose pictures aren't on anyone's dresser,
whose monsters are for real.

We pray for children
who spend all their allowance before Tuesday,
who throw tantrums in the grocery store and pick at their food,
who like ghost stories,
who shove dirty clothes under the bed and never rinse out the tub,
who get visits from the Tooth Fairy,
who don't like to be kissed in front of the carpool,
who squirm in church or temple and scream in the phone,
whose tears we sometimes laugh at and whose smiles can make us cry.

And we pray for those
whose nightmares come in the daytime,
who will eat anything,
who have never seen a dentist,
who aren't spoiled by anybody,
who go to bed hungry and cry themselves to sleep,
who live and move, but have no being.

We pray for children who want to be carried and for those who must,
For those we never give up on
and for those who don't get a second chance,
For those we smother...and for those who will grab the hand of any-
body kind enough to offer it.

Included in Marian Wright Edelman's book, **The Measure of Our Success: A Letter to My children and Yours;** © 1993, Harper Collins, Avenue of Americas, New York, NY 10019; ISBN 00609751350.

Submitted by Patricia Siegel, with permission.

REMINDER!

Please renew your annual membership for APSAC.

You must have APSAC membership to be a member of MiPSAC.

Part of you dues to APSAC pays for MiPSAC membership automatically!

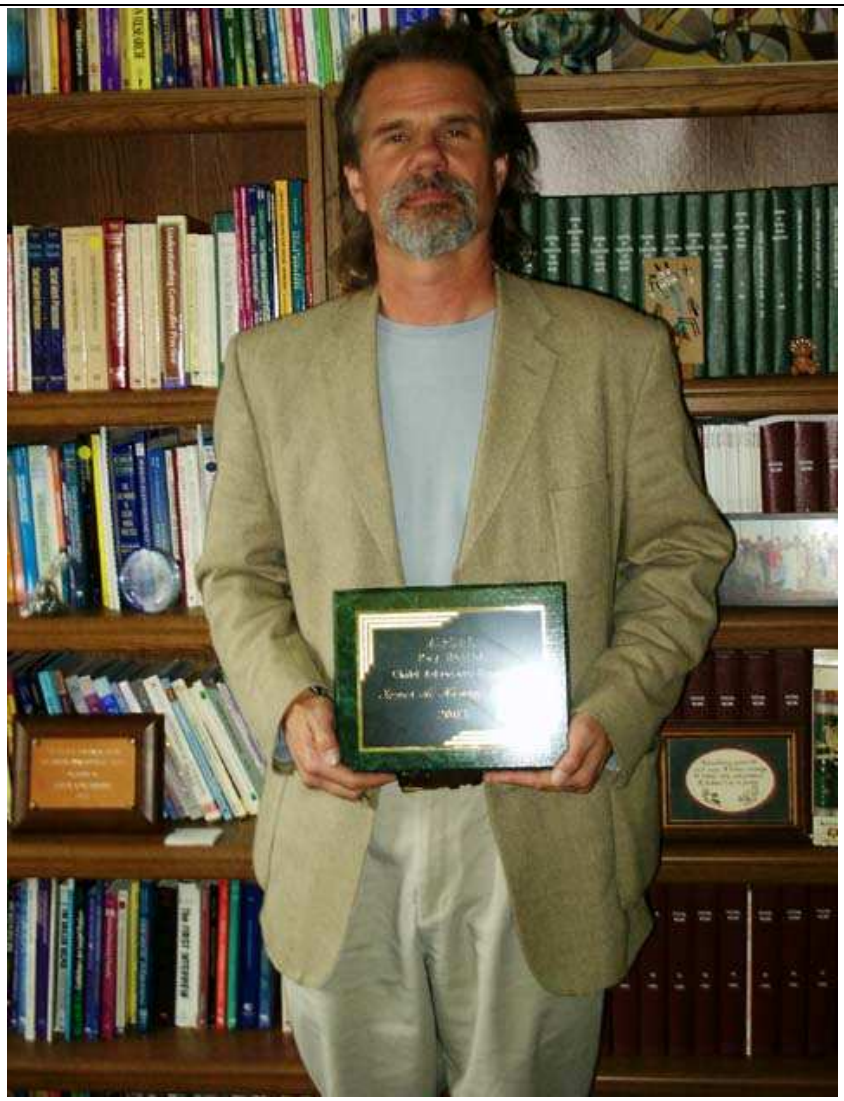
American Professional Society on the Abuse of Children

P.O. Box 30669
Charleston, S.C. 29417
Phone: (843) 225-2772 Fax (843) 225-2779
Membership info:apsac@knology.net, www.apsac.org

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

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



James Henry, PhD received the MiPSAC Ray Helfer Child Advocate Award
on October 22, 2003 at the Michigan Statewide Conference.

CONGRAULATIONS HARRY FREDERICK!

APSAC member Harry Frederick, Medical Director of United for Kids-Children's Assessment Center of Saginaw County, was named Emergency Physician of the Year by the Michigan Chapter of the American College of Emergency Physicians in 2003. Good professional practice helps children, and we are proud to have our member recognized for his excellent care, warmth and compassion.

Way to go Harry! (*Ed*.)