



MiPSAC

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

Volume 9, Issue 2

April - September, 2004

PRESIDENT'S CORNER

By Elaine S. Pomeranz, MD
University of Michigan Health System



I'm very pleased that this issue of the MiPSAC Newsletter is devoted to the issue of the evaluation of suspected sexual abuse cases. This is an area of child abuse and neglect fraught with anxiety and frustration for all involved and misunderstanding for many. In this issue, Mary Smyth concisely dissects the issue of who needs a medical exam, what the timing issues are, what the options are, and how to sort them all out. Nancy Skula explains how the child advocacy center is uniquely designed to provide a multi-disciplinary response to such cases and why this is so important. She goes on to describe some new exciting approaches that we as a group are helping to pursue—i.e., exploring the potential of videoconferencing to help bring our geographically large state's resources closer together to ensure better care for Michigan's children.

I believe this represents some early fruits of our labors to bring some of formerly uncoordinated efforts together through MiPSAC as we begin to speak with one much more powerful voice on behalf of these children. We have all been working hard in our respective fields for a long time, but have rarely had our individual voices heard. I am hopeful that our networking via MiPSAC will produce more and more alliances that will become a powerful united presence at the state level in Michigan.

I look forward to seeing all of you in Ypsilanti next month so that we can continue our discussions and planning!

In this Special Issue on CSA & CACs (with Guest Editors Nancy Skula and Dr. Mary Smyth)...

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MiPSAC ANNOUNCEMENTS & UPCOMING MEETINGS



MiPSAC Board Meeting (Next Meeting- Oct 25)
2nd Friday, even months, 12 noon – 2 PM
Michigan Children's Ombudsman's Office, Lansing
Harmonm@michigan.gov

Children's Trust Fund 2004 Annual Conference
"Insights and Innovation" October 10-12, 2004
Mission Point, Mackinac Isl, headleyp@michigan.gov

20th Annual Midwest Conf on Child Sexual Abuse
October 18 – 21, 2004, Middleton, Wisconsin

National CAC Medical Training Academy: Advanced
St. Paul, MN, October 21-23, www.nationalCAC.org

MiPSAC Annual Meeting & Elections
Monday October 25, 2004 Ypsilanti, MI

University of Michigan 23rd Statewide Child Abuse Conference, Ypsilanti, October 25-26, 2004
Sue Smith sasmi@umich.edu

The Association for the Treatment of Sexual Abusers
23rd Annual Research and Treatment Conference
October 27-30, 2004, Albuquerque, NM. www.atsa.com

Midwest Regional Children's Advocacy Center
Conference on Child Abuse
November 2 – 4, 2004, Bloomington, Minnesota

Supporting Families With Young Children Conf
Children's Trust Fund, Grand Rapids, Nov 8-9, 2004
headleyp@michigan.gov

The San Diego Child Maltreatment Conference
January 24-28, 2005 sdconference@chsd.org

NCA National Symposium on Child Abuse
March 8 – 11, 2005, Huntsville, Alabama

FIA Physicians' Medical Conference
May 24-25, 2004, Frankenmuth, MI

Michigan Professional Society on the Abuse of Children, Inc. 2004 MiPSAC Board of Directors

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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).



Compliments of

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

A Guide to the Sexual Abuse Medical Exam

By Mary E. Smyth, MD

William Beaumont Hospital, Royal Oak, MI

In the last ten years several published articles in the medical literature have confirmed what has been the experience of most physicians when they examine young people who are alleged to have been sexually abused – the exam is normal. In 1994 Adams et al. looked at case files of 236 children where there was legal confirmation of sexual abuse -conviction, confession etc. (Pediatrics 1994; 94: 310-317). 9% had suspicious findings and only 14% were considered clearly abnormal. More recently, Berenson and her colleagues looked at children between age 3 and 8 who gave clear history of vaginal penetration, either digital or penile (Am. J. Obstet. Gynecol. 2000; 182:820-834). Less than 5% of these cases had significant findings. In January of this year Kellogg et al reported on the genital anatomy of pregnant adolescents. Only 2 of the 36 pregnant girls examined had definitive findings indicative of penetrating trauma (Pediatrics 2004;113 e67-e68). Clearly, as their title states “normal” does not mean “nothing happened”. This raises a few questions. Why examine these kids at all? If some kids need exams, which ones? Who should examine these kids and when?

Why should a child/teen (hereafter = child) who has been sexually abused have a medical exam? First, and foremost, to reassure the child (and the family) that their body is OK. Sexual abuse causes a great deal of anxiety, much related to investigation and prosecution, but kids and parents often worry about physical issues- are they “damaged”? These issues can be addressed during a sensitive, thorough exam. The possibility of sexually transmitted disease, pregnancy, and other medical concerns can be evaluated. Finally, an examiner can provide expert testimony if necessary.

Does every child need an exam? Probably. Any time there is reason to believe that a child may have been sexually abused a medical exam is a good idea. Exceptions, however, would be cases of non-specific physical or behavioral concerns. For example, “she’s red down there and I just want to make sure that no one’s messing with her” or “my three year old masturbates” may require a medical, but perhaps not sexual abuse, evaluation.

Who should perform the exam? Here are the pros and cons of the various options; (not all doctors are equal).

- Family doctor a.k.a. Family Practice, General Practitioner, Pediatrician.
Advantages: this person may have a long- standing relationship with the child. The child may be more comfortable being examined in familiar surroundings.
Disadvantages: a family doctor may not have experience with this type of case. Any physician is capable of examining genitalia; some may not know what to look for or how to interpret what they see. Busy family doctors may be reluctant to get involved in situations that would take them away from their practice.
- Emergency room physician.
Advantages: always available. They can evaluate acutely injured patients, collect forensic evidence, and give prophylactic treatment for STD and pregnancy prevention.
Disadvantages: not all ER physicians are experienced and comfortable with this type of problem in children. The ER is a **scary** place and should be used for emergencies.
- Child abuse specialist-this may be a pediatrician, ER physician, OB/GYN, or a nurse with special training and experience in child sexual abuse evaluation.
Advantages: very familiar with all aspects of these cases. Usually able to accommodate an emergency evaluation when necessary. Willing and able to go to court and cooperate with the investigation.
Disadvantages: the child usually does not have a previous relationship with this person. There are a limited number of individuals who have this expertise; there may be a “wait” for a routine appointment.

When should the exam take place? Not every case of sexual abuse is an emergency. Understandably, a parent(s) who just learned that their child was sexually abused may feel compelled to rush the child to the ER, even if the incident occurred months ago. This may result in undue stress for the child and the family, and misutilization of medical resources. In general the following guidelines may be useful:

<u>Time from the incident</u>	<u>When/who</u>
<72 hours	within 24-48 hours, child abuse specialist if available, ER if necessary
3-14 days	within 2-3 days, child abuse specialist when possible
>14 days	next available appointment, family physician or best qualified available

We know that injuries, when they occur, from sexual abuse of children heal very quickly. Redness and swelling can resolve within a few days. Most healing is almost complete in two to three weeks.

Some final suggestions: think carefully about the “when”, “who” and “where” of the medical examination. As with other resources, medical resources are limited. Most importantly, we do not want to add to the trauma that the child has already experienced. When in doubt- **CALL AHEAD**. Ask to speak to the examining physician if possible, or contact a child abuse expert to give guidance on your specific case.

One Stop Child Advocacy Centers

By Nancy Skula

Chair, Michigan Chapter of the National Children’s Alliance

A New Reason Foundation policy study on child advocacy centers shows how child advocacy centers bring multiple agencies together under one roof, placing an increased importance on prosecuting the offender while simultaneously providing therapeutic services to the victim and non-offending family members.

“Children’s advocacy centers stress coordination and ensure kids are not re-victimized by the very system designed to protect them,” said Lisa Snell, author of the report and director of child welfare at the Reason Foundation.

One-stop child advocacy centers (CAC) are designed to help alleviate many of the inherent conflicts in the current child protection system. Child advocacy centers’ number one goal is to reduce trauma to the child abuse victim by coordinating a child’s interview to include professionals from multiple agencies, reducing the number of interviews and improving the quality of the investigation.

Under traditional child protection services (CPS), the investigation, assessment, and prosecution of child abuse cases involve many state and local government agencies. The concept behind the development of one-stop systems is that services can be made more accessible and service delivery can be more efficient through co-location and coordination of services that are normally provided by more than one agency.

Children’s advocacy centers stress coordination of investigation and intervention services by bringing together professionals and agencies as a multidisciplinary team to create a child-focused approach to child abuse cases. The goal is to ensure that children are not re-victimized by the very system designed to protect them through multiple interviews in strange and forbidding environments.

Representatives from law enforcement, child protective services, district attorneys, victim advocacy groups, and medical and mental health providers are synchronized by child advocacy centers. The centers organize regular meetings to discuss the investigations, treatment of the victim, and prosecution of the child abuser.

The Reason plan recommends updating existing child abuse laws to encourage district attorneys to file charges in clear-cut cases. Currently, less than 20 percent of substantiated abuse cases are prosecuted.

“As more child advocacy centers seek local, state, and federal funding, it is important to establish a model that is based on performance and directly connects funding to outcomes,” said Snell. “To ensure high performance from child advocacy centers, we should tie future funding to specific measures such as reducing the number of interviews abuse victims are subjected to, and increasing conviction rates of child abusers.”

The full report, *Child Advocacy Centers: One Stop on the Road to Performance-based Child Protection* can be found online at www.rippi.org/ps306.pdf. (Continued on page 6)

Michigan Chapter of the National Children's Alliance

Full Members

*Safe Harbor Children's Advocacy Center (Allegan County), 402 Trowbridge, Allegan, MI 49010, Phone (269) 673-3791

Nathan Weidner Children's Advocacy Center (Bay County), 715 N Euclid Avenue, Bay City, MI 48706, Phone (989) 671-1345

The Children's Advocacy Center of Kalamazoo, 2618 Stadium Drive, Kalamazoo, MI 49008-1654, Phone:(269) 343-1651 X118

*Children's Assessment Center (Kent County), 901 Michigan NE, Grand Rapids, MI 49503 Phone: (616) 771-6400

Macomb County Child Advocacy Center/Care House, 131 Market Street, Mt. Clemens, MI 48043, Phone (586) 463-0123

Child Abuse Council of Muskegon County, 1781 Peck, Muskegon, MI 49441, Phone (231) 728-6410

CARE House/ Child Abuse and Neglect Council of Oakland County, 44765 Woodward Ave, Pontiac, MI 48341, (248) 332-7173

Andre Bosse Center (Oceana County), 302 Hansen, Hart, MI 49420 Phone: (231) 873-1707

*Children's Advocacy Center of Ottawa County, 280 East 8th Street, Holland, MI 49423, Phone: (616) 393-6123

Associate Members

The Children's Assessment Center of Berrien County, 4938 Niles Road, St. Joseph, MI 49085, Phone (269) 556-9640

CAC of Calhoun County, P.O. Box 843, Marshall, MI 49068, (269) 727-0077

Hannahville Indian Community, Potawatomi, N14911 B-1 Road, Wilson, MI 49896, Ph. (906) 466- 9233

Angel House (Ingham County), Child and Family Services, 4287 Five Oaks Dr, Lansing, MI 48911 (517) 882-4000 ext. 156

Child and Family Enrichment Council (Isabella County), 902 E. Preston, Mount Pleasant, MI 48804, Phone (989) 773-6444

CAC of Monroe County, P.O. Box 2462, Monroe, MI 48161, Ph. (734) 242-3800

United For Kids-Children's Assessment Center (Saginaw County), 1311 N. Michigan Ave, Saginaw, MI 48602, (989) 759-5437

The Guidance Center Child Advocacy Program/ Kids-TALK, Taylor Human Services (Wayne County), 26650 Eureka Road Taylor, MI 48180, (734) 942-0837

Developing programs

Bay Mills Indian Community, Melissa Hagen, 12124 West Lakeshore Drive, Brimley, MI 49715 Ph. (906) 248-3204

Cass County Prosecutor's Office, Victor Fitz, 60296 M-62, Suite 6, Cassopolis, MI 49031, Ph. (269) 445-4460

Child Advocacy Center of Genesee County, Polly Sheppard, Executive Director, 515 East Street, Flint, MI 48503, Phone: (810) 629-0525

Grand Traverse Band of Ottawa & Chippewa Indians, Helen Cook, 2605 North West Bayshore Drive, Suttons Bay, MI 49682 (231) 271-7681

Keweenaw Bay Indian Community, Judith Heath, 107 Beartown Road, Baraga, MI 49908, Ph. (906) 353-6623

Marquette County Prosecutor, David Payant, 234 W. Baraga Avenue, Marquette, MI 49855, Ph. (906) 225-8310

Midland County Child Protection Council, Karen Adams, 5103 Eastman Ave., Suite 175, Midland, MI 48640, Ph. (989) 835-9922

Community Sexual Abuse Victim Task Force for Ogemaw County, Glenn Addis, P.O. Box 307, West Branch, MI 48661, Ph. (989) 345-5135

St. Clair Child Abuse and Neglect Council, Nancy Szlezzyngier, CPS Supervisor/CAN Board Chair, (810) 966-2133
Port Huron, MI 48060, Ph. (810) 966-9911

Sault Tribe CAC, Linda Oberle, 60 Kincheloe, Kincheloe, MI 49788 , Ph. (906) 495-1232

Shiawassee Council for Child Abuse Prevention, Robin Stechshulte, P.O. Box 426, Owosso, MI 48867, Ph. (989) 723-5877

Washtenaw Child Advocacy Center, 2201 Hogback Road, Ann Arbor, MI 48105, Ph. (734) 973-4539

**These centers share common medical triage with DeVos Children's Hospital at (616) 391-2295.*

(Continued from page 4)

Children's Advocacy Centers, or CACs, are facility-based community partnerships dedicated to a team approach by professionals pursuing the truth in child abuse investigations. Professionals from child protective services, law enforcement, prosecution, victim advocacy agencies and the medical and mental health communities come together to investigate and intervene in cases of suspected child abuse. Attention to the needs and abilities of children is the hallmark of a Children's Advocacy Center. These centers are designed as a safe and welcoming place for children to be heard. CAC's ensure that children are not further victimized by the systems intended to protect them.

The CACs multidisciplinary team approach brings together all the professionals and agencies needed to offer comprehensive services including law enforcement, child protective services, prosecution, mental health, and the medical community. Children's Advocacy Centers are community based, private non-profit agencies.

In Michigan, Children's Advocacy Centers provide a coordinated community response to child victims of sexual and physical abuse. These centers provide for a child- focused, child friendly facility where representatives from many disciplines meet to discuss and make decisions regarding investigation, treatment and prosecution of child abuse cases. The centers also work to prevent further victimization of children.

The CAC movement began in Michigan over 15 years ago with just three CACs in the state of Michigan. Since that time, CACs have been established in over 27 counties. These CACs are members of our state organization at differing levels of development: 9 Full members, 8 Associate members and 12 Developing task forces. All are members of the Michigan Chapter of the National Children's Alliance and associated with the National Children's Alliance (NCA) in Washington, D.C. The Michigan Chapter is one of the 41 state chapters of the National Children's Alliance, the national umbrella organization for CACs dealing with child abuse. This movement has now grown into over 500 Full and Associate members nationally with more CACs emerging every day (www.nca-online.org). Their mission is to promote and support communities in providing a coordinated investigation and comprehensive response to child victims of abuse. The NCA's vision is that every child should have access to the services of an accredited Children's Advocacy Center.

Counties with Children's Advocacy Centers experience benefits such as more immediate follow-up to child abuse reports, more efficient medical and mental health referrals, a reduction in the number of child victim interviews, increased successful prosecution and consistent support for child victims and their families.

For more information or to find out about the CAC in your community, please contact Nancy Skula, Chair of the Michigan Chapter of the National Children's Alliance at (586) 463-0123.

Video Conferencing and CACs

By Nancy Skula

Chair, Michigan Chapter of the National Children's Alliance

MIPSAC, in partnership with the Michigan Chapter of the National Children's Alliance will act as the lead in coordinating and scheduling monthly video conferencing for CACs. Video Guidance in Edina, Minnesota will provide the technical assistance

Our goal is that this video-conferencing network will grow to increase the level of expertise that each and every child requires, even if that expertise doesn't physically reside in their community and will help keeping children safe. The goals for the project are: 1) to enhance the quality of documentation of physical findings in cases of suspected child abuse; 2) to provide the opportunity to discuss findings and interpretation of findings in cases of suspected child abuse or neglect; and 3) to increase the knowledge of medical providers in children's advocacy centers statewide.

As sites continue to be added, more and varied expertise can be brought to the video conference calls. This conferencing will provide for a statewide mentoring network for professionals working in the areas of child abuse and neglect. This project provides for geographically isolated areas an opportunity to connect with peers.

While the primary use of videoconferencing has been for the peer review, medical review and educational calls, there is also a far broader potential use of videoconferencing.

This networking conference can be used for case consultation with the sites choosing whomever they require for expertise on any particular problematic case. The under-served areas as well as tribal communities can be included as they may have difficulties in finding medical expertise for their teams. We are now exploring funding, technical solutions and partnerships to bring videoconferencing to these areas so that we may provide the medical support needed for these programs.



CONGRATULATIONS VINCE PALUSCI!

APSAC member Dr. Vince Palusci, Medical Director of DeVos Children's Hospital Child Protection Team and Kent County Children's Assessment Center, received the 2004 Ray E. Helfer, MD Award.

The Award is given annually by the American Academy of Pediatrics and the National Association of Children's Trust and Prevention Funds to recognize a distinguished pediatrician for child abuse prevention activities.

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

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**

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Charleston, S.C. 29417

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Fax (843) 225-2779

**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

RESEARCH ABSTRACT

Urgent Medical Assessment after Child Sexual Abuse

Vincent J. Palusci, MD MS, Edward O. Cox, MD, Eugene M. Shatz, MD, DeVos Children's Hospital; Joel M. Schultze, BS, Michigan State Police Crime Laboratory, Grand Rapids, MI

Background: Immediate medical assessment has been recommended for children after sexual abuse to identify physical injuries, secure forensic evidence, and provide for the safety of the child. However, it is unclear whether young children seen urgently within 72 hours of reported sexual contact would have enhanced interview or examination findings as compared to those seen non-urgently or whether forensic findings would be affected by child characteristics, type of reported contact or later events.

Design/Setting: We evaluated 191 consecutive cases of children under 13 years of age referred during a five year period in 1998-2003 to a community child advocacy center and compared physical examination findings, and any sexually transmitted infections or forensic evidence with child gender, pubertal development, type of contact, whether there was reported ejaculation or later bathing or changing clothes, time to examination, gender, age and relationship of alleged perpetrator.

Results: Children seen urgently were younger, had less CPS involvement, more disclosure, more positive physical examinations after contact with older perpetrators than those seen non-urgently. Overall, most children seen were female and had normal or non-specific physical examinations. Certain case characteristics were predictive of evidence isolation in those 9% who had positive forensic evidence identified. Semen or sperm was identified in body swabs only from non-bathed female children older than 10 years or on clothing or objects.

Conclusions: Female children over 10 years old who report ejaculation or genital contact without bathing have the highest likelihood of having forensic evidence of sexual contact beyond disclosure. While there are other potential benefits of early examination, physicians seeking to identify forensic evidence should consider the needs of the child and other factors when determining the timing of medical assessment after sexual abuse.