



MiPSAC

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

Volume 9, Issue 3

October - December, 2004

PRESIDENT'S CORNER

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

A few words about the Family Independence Agency Medical Resource Services contract

As you all know, we have been talking for a long time now in MiPSAC as well as in other venues, about trying to provide better medical evaluation and treatment coverage for children throughout the state of Michigan who are suspected of being victims of child abuse or neglect. We of the Child Protection Team at the University of Michigan are now in our fourth year of providing some of this coverage through a Medical Resource Systems (MRS) contract with the Family Independence Agency. An earlier version of the MRS awarded to DeVos Children's Hospital included reimbursement for medical examinations of children in several counties. The current version does not pay for any medical exams, but does provide telephone triage for Protective Services workers throughout the state, provides for medical case reviews of problematic cases, and reimburses for the training of physicians and other professionals around the state to better recognize and evaluate suspected child abuse.

The contract mandates that the trainings be at least 5 hours long and provided at no cost to the registrants. As we see it, 5 hours is a large time commitment for practicing physicians, although the fact that free Continuing Medical Education credits are offered does make it more attractive. We had suggested that 5 hours was more time than needed for a practitioner update on recognizing abuse, and not enough time to train more "specialists". Nevertheless, we have provided six basic and 3 advanced trainings per year for the last three years, with the number of participants per training ranging from three to 150 in locations across the state (although none in the UP as of yet). There seems to be a lot of enthusiasm for the trainings on the part of those who have participated, but I fear that the 5 hour time mandate is a barrier to reaching more professionals who might otherwise be interested.

The contract reimburses for the triaging of up to 1200 telephone calls per year, and we have received more than that in each year that we've held the contract, so there is clearly a need for such "24/7" telephone coverage in Michigan. It allow any professional working for Michigan FIA to reach a medical social worker and/or physician at any time to discuss issues such as whether a medical exam is needed, how urgently, and where it should be done. There are also frequent requests for medical interpretation or questions about medical procedures. The Physician Advisory Committee to FIA has proposed that a new version of the MRS maintain such central triage support, but with the proviso that the services recommended be provided on a more regional basis whenever possible.

Medical case reviews are accepted when we feel that we may be able to bring a new perspective to a difficult case, or when differing medical opinions have been offered and there is a need for the perspective a child abuse team to move forward. However, they are not separately reimbursed through the contract, although they can be very time consuming. Moreover, the goal of the requesting Protective Services worker is usually to obtain an "expert opinion" that can be used in court, and court testimony is not addressed by the MRS. This will be an important factor in the planning of future versions of MRS in that a network of regionalized centers would be a more effective way to provide expert opinions that can be provided from initial chart review through court testimony.

What a new MRS for Michigan may look like is not clear at this point, but all of us at MiPSAC are in a position now to help shape its future as it is re-examined in the next few months in Lansing. It's been an honor for me to have been part of MRS for the last several years, but I believe we can do better in the future, and that our MiPSAC work will be an important part of shaping what's to come.

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MiPSAC ANNOUNCEMENTS & UPCOMING MEETINGS



MiPSAC Board Meeting (Next Meeting- Dec 10)
2nd Friday, even months, 12 noon – 2 PM
Michigan Children's Ombudsman's Office, Lansing
Harmonm@michigan.gov

National CAC Medical Training Academy: Basic
Battle Creek, MI, December 8-10, 2004
www.nationalCAC.org

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

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

FIA Physicians' Medical Conference
May 24-25, 2004, Frankenmuth, MI
Forrestt@michigan.gov

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

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).

Join the MiPSAC member email listserv

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by contacting Vince Palusci at

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or leave a message for MiPSAC at (616) 391-2297

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Some Good News...for a Change

By Carol A. Siemon, J.D.

Michigan Office of the Children's Ombudsman
Lansing, MI

Reading the newspaper, you might believe that the entire child welfare system is in chaos and never operates effectively to protect children and help families. Perhaps it is human nature to focus on the negative. Certainly, too many children are injured or die at the hands of their caregivers and too many times FIA workers, law enforcement, medical personnel, lawyers, judges, and others fail the children it is their duty to help. However, what is lost in the focus on the negative is that most of the people in "the system" are doing their best to aid children, despite inadequate staffing and limited resources to effectively do their job.

Creative partnerships, new protocols and policies, and innovative programs are created each year by dedicated, hard-working professionals in the child welfare system. They strive to improve safety, reduce the necessity for removal of children from their homes, support families with appropriate services and interventions, and achieve meaningful permanency for children.

One program that deserves our attention is "Family to Family". Designed in 1992 and now being implemented in several counties in Michigan, the principles of "Family to Family" are designed to do all of the following:

- Utilize a network of family foster care that is culturally sensitive, neighborhood-based, and located primarily in the communities in which the children live.
- Reserve the use of scarce foster homes for children who truly must be removed from their homes and reduce the overall number of children coming into out-of-home care.
- Reduce the number of children served in institutional care, shelters, and psychiatric, medical, and correctional facilities by meeting the needs of those children in the community.
- Reunify children with their families based on the children's and families' needs, instead of time frames created by law and court rules.
- Become a neighborhood resource for children and families and build upon the strengths of the members of the community.

None of these goals is new or unique. What is new is the commitment to making real changes in how child welfare services are delivered. The Annie E. Casey Foundation provided grant funding for three years and will continue to provide on-going technical assistance to the state to facilitate the successful implementation of "Family to Family."

My interest in "Family to Family" was sparked by a June 2004 article in the New York Times dealing with one aspect of this best practice model that I found particularly appealing. In 1998, New York City, as part of the "Family to Family" strategy, undertook system changes to nurture an open relationship between foster and birth parents. The birth and foster parents share in decision-making during the out-of-home placement and the foster parents remain a continuing source of support and counsel after the child returns to the birth parent. Birth parents, foster parents, and caseworkers initially meet in a controlled setting to exchange information and build connections. Birth parents involved in "Family to Family" report a much

more positive experience with their caseworkers and the child welfare system. Children involved in the program are returned an average of three months earlier.

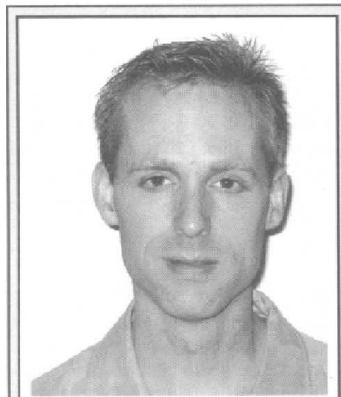
The program has been shown to improve the likelihood that families will reunite. Due to increased contact with the children, it arguably makes the removal from the parental home a less traumatic experience. The New York program has also found that it aids in a more timely termination of parental rights in situations where reunification is not possible because the birth parents, through their involvement, are more confident that their children will find permanence in good homes.

Only time will tell how effective the "Family to Family" concept will be in Michigan, but it is a positive step utilizing both common sense and research. It deserves our open-minded consideration.

CONGRATULATIONS DR. STEVEN ONDERSMA!

ONDERSMA APPOINTED EDITOR IN CHIEF OF *CHILD MALTREATMENT*

Steven L. Ondersma, PhD, has been appointed editor in chief of *Child Maltreatment* by the APSAC Board of Directors. Dr. Ondersma is an assistant professor in the departments of psychiatry & behavioral neurosciences and obstetrics & gynecology at Wayne State University in Detroit, Michigan. He will assume the editorship of *Child Maltreatment* with Volume 9, Number 1 (February 2005).



Steven L. Ondersma, PhD,
appointed editor in chief
of *Child Maltreatment*

Dr. Ondersma is a graduate of Calvin College and Wayne State University, where he earned a PhD in clinical psychology. He went on to receive clinical training via an internship and fellowship at the University of Oklahoma Health Sciences Center. His current program of research is in the area of brief motivational interventions in the perinatal period, and it focuses on parents at risk of child maltreatment, especially those with substance use disorders.

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A Child Abuse Course for Physicians: “The Medical Care Paradox: Too Much, Too Little, Too Late, for Foster Children”

by N. Debra Simms, M.D.

Child Protection Specialist, Holland Community Hospital Foundation
Holland, Michigan

On May 18th and 19th, 2004 the Tenth Annual Medical Conference on Child Abuse and Neglect sponsored by the Medical Advisory Committee of the Family Independence Agency and the University of Michigan Department of Pediatrics was held in Holland Michigan. The target audience each year includes any health care provider in the state of Michigan that examines or evaluates children suspected of being victims of child abuse and/or neglect. The goal of the conference is to provide practical information and training to providers in a variety of practice settings. Physicians, nurse practitioners, sexual abuse nurse examiners and physician assistants were all welcomed. Speakers include physicians and other professionals who have experience and have developed expertise in the field of abuse and neglect, they are eager to share this knowledge and look forward to the opportunity to meet with their peers who are coping with the same concerns

As is customary in recent years, attendees were invited the evening before the conference, May 18th, to an informal case presentation/discussion. This was moderated by the members of the Medical Advisory Committee. Everyone was encouraged to bring cases that had teaching points for discussion or to get input in any perplexing dilemmas. I personally benefited from presenting a puzzling physical abuse case that was preparing to go to trial the following week. After receiving input for my esteemed colleagues from around the state I was more assured and confident in my testimony and the ability to face the defense council. Based upon the reviews of this part of the conference, a good time was had by all.

On Wednesday, May 19th we were welcomed to the full day of conference activities by Annamaria Church, MD and Loren Snippe, Director of the Ottawa County FIA. A continental breakfast was provided that included ‘pigs in a blanket’ as this is the land of the Dutch. We were reminded that the Tulip Festival had just concluded and everyone was invited to view the beautiful blossoms in full bloom.

Moira Szilagyi, MD PhD, was our featured speaker. Dr. Szilagyi is the Director of the Task Force on Health Care for Children in Foster Care in Rochester New York. She is nationally recognized as an expert on the health care issues of children placed in care. Her presentation was titled “Health Care Issues for Children in Foster Care.” Dr. Szilagyi noted that medical care prior to foster care is often fragmented, and poorly documented. This may be due to neglect of basic needs, absence of a stable environment, multiple caregivers, exposure to violence, and abuse. Children enter foster care with multiple unmet health needs. This may have begun with lack of prenatal care and prenatal drug exposure in the young infant. There are many barriers to quality health care even after children are placed in foster care. These barriers include the transient nature of the system (multiple placements), inadequate health care funding, lack of past medical history, confidentiality and consent issues, and the complexities of the foster care/legal system. Adequate funding for medical and mental health care is essential. Dr. Szilagyi stressed that every child in foster care needs a medical home with a primary care practitioner that understands the needs of this special population.

A panel discussion of resources for children included Elaine Pomeranz, MD presenting the Medical Resources Services through the University of Michigan/Family Independence Agency. A review of the services provided by the state-wide network of Child Advocacy Centers was done by Nancy Skula, president of the Michigan Chapter of the National Children's Alliance. Steve Yager, director of the Office of Family Advocate/FIA spoke on the availability of Mental Health Services for children. Victims Advocacy/Rights was discussed by Joseph Kozakiewicz, JD, MSW, director of the Chance at Childhood Program at MSU. Vivien Vandenberg concluded the presentation by sharing information about the Michigan Children's Ombudsman Office, where she currently works as an investigator.

The afternoon sessions of the medical conference has in recent years been divided into Basic and Advanced tracks. This is done with the hope that individuals in need of basic training and individuals that have attended the conference in the past, will all be able to benefit.

The "Basic" courses included a follow-up presentation by Dr. Szilagyi on "Models of Health Care Services for Children in Foster Care." Then Dr. Howard Fischer, medical director of the CPT at Children's Hospital in Detroit shared his expertise in the evaluation of "Physical Abuse". And finally the basic presentations concluded with evaluation of "Sexual Abuse" by Dr Debra Simms, child protection specialist for the Holland Community Hospital Foundation.

The "Advanced" track single presentation showcased several individuals that have been working with the Governor's Task Force on Children's Justice to develop a collaborative approach to the investigation, assessment and treatment of Muchausen By Proxy. They were Dr. Annamaria Church, Dr. Elaine Pomeranz, Patricia Siegel, PhD, and Bob Zivian, JD.

Our day started at 8:30am and concluded at 4:00pm. We came, we listened, we learned. There was delicious food, stimulating conversation, excellent company, and comfortable surroundings. This conference was provided at no charge to any of the attendees and continuing medical education credits were given by the University of Michigan. It doesn't get any better! Mark your calendars for next years conference to be given on May 24-25, 2005 in Frankenmuth, Michigan.

From the Editors...Changes...

Leni Cowling named Editor Emeritus of the MiPSAC Newsletter, GRAND RAPIDS, December 1, 2004

In the Spring of 1996, Leni Cowling called on us to begin a Chapter of the American Professional Society on the Abuse of Children in Volume 1, Issue 1 of the MiPSAC newsletter. She designed a logo, wrote the entire issue, and raised issues we are still addressing today. She received the MiPSAC Child Advocacy Award in 1999. Leni has continued as newsletter editor and co-editor since that time and continues to contribute her passion, experience and understanding for all of us to help Michigan's children.

Beginning in 2005, I have suggested that she be promoted to Editor Emeritus, which will require less of her energy while giving her the chance to continue prodding us to improved professional practice. As part of this promotion, I am requiring her to continue sending emails and articles for the newsletter and to keep us all in line with her wit, humor and reality. Thank you Leni! -Vince Palusci

The Medical Passport: An update

By Annamaria Church, MD

Director, MSU/DeVos/MERC Pediatric Residency Program
Grand Rapids, MI

An experienced foster mother brings her new four-year-old foster child to your pediatric office. She just received the child over the weekend. The child was removed from her birth home because of neglect. The foster mom was told that the child has a seizure disorder and must take her medicine every morning. She also was told the child is up to date with immunizations. To your dismay, the foster mom has no more information. She does not know what type of seizure disorder the child has, when or how it was diagnosed, how long she's been on the medication, when she last had any blood levels checked. The foster mom was not told of any other medical problems with the child. Over the weekend though, she has noticed that the little girl's speech is difficult to understand. She seems to hear o.k.. Your examination shows a small girl with somewhat unusual facial features. She has a definite speech delay. You also note mild fine and gross motor delays. The foster mom is not aware of any occupational, physical or speech therapy the child receives. She does not know if the girl has ever been seen by a geneticist, developmentalist or neurologist for that matter. She doesn't even know if the child had a primary care provider.

This is a familiar scenario for anyone who provides medical care to children.

In the mid-1990's, the Binsfeld Children's Commission was charged to "Review current laws, programs, procedures, policies and training procedures that affect children and create recommendations to help improve the quality of life for Michigan's Children". The Commission arranged multiple hearings throughout the state to learn from families, foster parents, foster care and protective service workers, medical providers and a multitude of other disciplines what would help improve the lives of children. As a result of these hearings, and the Binsfeld Commission's subsequent recommendations multiple legislative changes were made, referred to as the "Binsfeld Legislation". Public Act 172 of 1997 (approved by the Governor on December 29,1997) was a part of that legislation. This act amended 1994 Public Act 203 entitled "An act to establish certain standards for foster care and adoption services for children and their families; and to prescribe powers and duties of certain state agencies and departments and adoption facilitators". Specifically, PA172 of 1997 amended section 2 (MCL722.952) and added sections 4a, 4b, 4c and 4d:

" 722.954c Release of child's medical records; medical passport; contents; transfer; performance of assessment or psychological evaluation; medical examination.

Sec. 4c.

(1) The supervising agency shall obtain from the parent, guardian, or custodian of each child who is placed in its care the name and address of the child's medical provider and a signed document for the release of the child's medical records. The supervising agency shall require that a child's medical provider remain constant while the child is in foster care, unless the child's current primary medical provider is a managed care health plan or unless doing so would create an unreasonable burden for the relative, foster parent, or other custodian.

(2) The supervising agency shall develop a medical passport for each child who comes under its care. The medical passport shall contain all of the following:

- (a) All medical information required by policy or law to be provided to foster parents.*
- (b) Basic medical history.*
- (c) A record of all immunizations.*
- (d) Any other information concerning the child's physical and mental health.*

(3) Each foster care worker who transfers a child's medical passport to another foster care worker shall sign and date the passport, verifying that he or she has sought and obtained the necessary information required under subsection (2) and any additional information required under department policy. The supervising agency shall provide a copy of each medical passport and updates as required by the department for maintenance in a central location.

(4) If a child under the care of a supervising agency has suffered sexual abuse, serious physical abuse, or mental illness, the supervising agency shall have an experienced and licensed mental health professional as defined under MCL 330.1100b(14)(a) or (b) or a social worker certified under section 1606 of the occupational code, 1980 PA 299, MCL 339.1606, who is trained in children's psychological assessments perform an assessment or psychological evaluation of the child. The costs of the assessment or evaluation shall be borne by the supervising agency. This subsection applies only to a child who is made a state ward on or after the effective date of the amendatory act that added this section.

(5) A child's supervising agency shall ensure that the child receives a medical examination when the child is first placed in foster care. One objective of this examination is to provide a record of the child's medical and physical status upon entry into foster care. “

So, that was 1997, effective date March 31, 1998. Where is the medical passport?

The medical passport is reportedly filled out as required by law. The foster care worker does this at the time of the child's entry into foster care. The passport is then placed in the foster child's central file. Neither the foster mother, nor the foster child's medical providers have copies of those records. In a very random, non-scientific survey of 15 pediatricians, I asked if any of them had ever seen a foster child's medical passport or if they had ever been asked by a foster care worker for assistance in completing such a form. The result, unanimously “no” to both questions. Most providers followed up their responses with surprise that there actually is such a document.

Two years ago, the medical community was able to gain the attention of the then director of the FIA. They made her aware that though reportedly the “letter of the law” was being followed; the intent of the medical passport legislation was missing. Foster children were at tremendous risk when their medical information was not moving with them and accessible to their providers. Several of the physicians volunteered their time to assist the state in whatever way necessary to assure that a functional medical passport was developed. The FIA director developed a team and several meetings ensued. Information Technology specialists worked with foster care workers and a pediatrician (this writer) to develop an electronic passport. The envisioned passport would be a dynamic document accessible to medical providers in much the way MCIR is. The medical provider at each medical encounter would access the passport and relevant information (new diagnoses, medications, doses, laboratory results, etc) could be added.

Changes occurred in the FIA structure. Budgetary constraints were placed. This writer suddenly stopped receiving information regarding the progress of the passport project. Finally, I was told that IT was working on some technical parts of the passport and I would be contacted when they were ready to proceed further in the development. My most recent e-mail to the FIA project manager came back with a message of “unrecognized address”. The team leader is no longer there. The project has been assigned to another worker. I am told that “phase one” of the project is continuing to be developed. “Phase one” is linking the Michigan Immunization Registry (MCIR) with the foster child. However, “phase two”, developing the electronic medical passport, has been placed on hold.

It has been 7 years since PA 172 was approved by the Governor. I fear the only way a functional medical passport will ever be developed will be if a child dies as a result of not having medical information available to the provider. Stay tuned.

Building Meaningful Relationships with Policymakers

Excerpted from the Second Edition of *FROM VISION TO ACTION*

By the Michele Strasz, Director of Community Outreach
Michigan Council for Maternal and Child Health, Lansing, MI

You know that expression 'All politics is local'. Politics is also personal. In the business of advocacy, the relationships you develop with policymakers are just as valuable as any campaign contribution. Just like a marriage, these relationships take communication and nurturing.

The policy process involves a give and take between professionals, community leaders, consumers, and policymakers. When these stakeholders share a knowledge base and mutually agreed upon values, manage conflict, create ownership, and develop strategies to solve problems, policy change can occur.

We are all advocates. Sometimes you advocate for a patient to get the services they need. Sometimes you present your findings to your peers. Sometimes you lobby. In its simplest terms advocacy means speaking up on behalf of someone or something.

Advocates typically provide their expertise on "technical information" or data on particular subjects to policymakers. As a health care professional you can and should engage elected officials by providing them with your technical expertise on the needs of children, the cost of child abuse on the emotional and physical health of a child, and the cost to our society.

As the playing field and political landscape has changed over the past few years because of term limits, declining state revenue, and the lost infrastructure for prevention programs, the focus of advocates has shifted to include non-traditional policymakers and stakeholders. Elected officials including Congressional representatives, state representatives and senators, county commissioners, mayors or city and township officials are the usual suspects when we talk about policymakers. Judges, the school board, and the sheriff of your community are also elected officials who touch the issues and the constituents that you advocate for on a daily basis.

But other players in your community also play critical decision-making roles that either influence elected officials or decision-makers, and have a stake in the economic and social vitality of your community. Business leaders, religious leaders, civic clubs, charitable organizations such as United Way or a community foundation also represent leaders with influence and relationships that you can cultivate as partners in your advocacy.

These stakeholders are your patients, your neighbors, your fellow members of a civic club or faith community. How do you engage them as a partner in your advocacy to promote the well-being of the vulnerable children that you see in your practice?

We like to call our philosophy of advocacy *Come As You Are Advocacy*. Here is how to start:

1. **Be An Informed Advocate.** Join listserves to receive information on policy issues, data, and advocacy opportunities. We recommend: Michigan Kids Count www.milhs.org,

Comment [K1]:

Comment [K2]:



Connect for Kids www.connectforkids.org, or the Michigan Council for Maternal and Child Health www.mcmch.org

2. **Develop a relationship with your local policymakers and stakeholders.** They need your expertise! To find out who your legislators are see <http://senate.michigan.gov> and <http://house.michigan.gov>
3. **Communicate with policymakers and local stakeholders.** Phone, write, email, or visit to share your issues and concerns about child health and well-being. For information on current bills see www.michiganlegislature.org.
4. **Talk to your patients about their concerns and translate that into advocacy issues.** For more information on Michigan child welfare issues and Court Appointed Special Advocates contact Children's Charter of the Courts at www.childcrt.org
5. **Vote with Children in Mind!** For a copy of your Michigan ballot and links to candidate information and polling data see www.publius.org or see www.everychildmatters.org.

To order your copy of

From Vision to Action and the Companion Video, please contact the Michigan Council for Maternal and Child Health at

(517)482-5807 or info@mcmch.org or on the web at www.mcmch.org

From the Editors....More Changes....

Governor Signs Executive Order Creating Michigan Department of Human Services, LANSING - November 12, 2004 - 517-335-6397

Governor Jennifer M. Granholm today signed Executive Order 2004-35 creating the Michigan Department of Human Services. The order renames the Family Independence Agency to more accurately reflect the department's current mission. "This executive order renames one of our largest and most progressive departments of state government," said Granholm. "It better reflects this administration's commitment to reach out to all of those in Michigan who need a helping hand." Department of Human Services director Marianne Udow said the name change has been under consideration for many months and was made only after careful deliberation. "Our new name better reflects the comprehensive range of programs we provide," said Udow. "The name also better represents our mission to reduce poverty, give every child a great start in life, and help our clients achieve their full potential." "Changing the name of our agency is the result of our ongoing strategic planning effort," Udow added. "In this months-long effort, we involved our staff, local communities, our partners outside government and many inside government to evaluate our direction and the way we do business." Udow said there will be no direct administrative costs related to changing department products such as new letterhead, business card templates, forms, etc., since these items are managed on-line. The department will phase-in new office signs on an ongoing basis, as funds are available. The Department of Human Services employs about 10,300 people in more than 100 offices across the state and provides assistance to nearly 1.5 million Michigan citizens every year. The order changing the name takes effect on January 30, 2005 unless rejected by both houses of the Michigan Legislature.

Better Practice: A call for more consistent and thorough assessment and treatment of the unique needs of abused and neglected children

By Kevin DeKam

Director, KIDSFIRST Shelter Program, St. John's Home, Grand Rapids, MI

The fact that abused and neglected children and adolescents present with diverse, unique, often significant needs requires no explanation to most professionals who work with them. That much too often in the field of child welfare those needs go unnoticed or unmet may be even less surprising, but perhaps cause for greater concern.

Plagued by restrictive confidentiality constraints, inadequate training, and ever-insufficient financial and human resources, we make the frequent and unfortunate mistake of failing to thoroughly assess and address the medical, dental, psychological, developmental, academic and other deficits that tend to be pervasive among this population. Comprehensive and consistent care is further complicated by the transience of children moving in and out of care and between foster or conjugate care placements.

Uniquely equipped to address this problem is the KIDSFIRST Program at St. John's Home, an innovative emergency shelter care program whose mission is to identify and respond to the most basic and immediate needs of abused and neglected children in Kent County. Every one of the nearly 700 children removed from his or her home in Kent County due to abuse or neglect each year enters the foster care system through KIDSFIRST.

While not designed as a treatment program, the mission of KIDSFIRST is to provide a safe and comfortable environment where every intervention with children is designed to be therapeutic and prepare them for success in subsequent placements. Through a unique partnership with DeVos Children's Hospital, children at KIDSFIRST also receive outstanding medical care through a streamlined emergent process, or in a biweekly clinic that occurs at the program.

While progressive steps have been taken to ensure the highest quality of care for these often ignored children, a commitment to both the complete assessment of each child's unique needs and the consistent provision of full medical and mental health services throughout their time in care has yet to be made feasible. Currently, children who linger in care receive a brief psychosocial screening to assist in their placement planning, and more intensive assessments are reserved for when emotional or behavioral problems become overt and problematic. Better practice, however, would incorporate the use of thorough mental health assessments for more children, even at a younger age, to assist in the early detection of cognitive and neurological concerns.

Currently, children are often seen by as many different health care providers as they have placements while in care, and accessing a child's medical and mental health care information is a laborious and restrictive process. Better practice would finally include the adequate use of a medical passport system, the development of a comprehensive and accessible client information database, or a true medical home model. Fortunately for the cause, Kent County has historically been a pioneer in child welfare, and several key leaders have already expressed their support. The unique presence of the KIDSFIRST Program as most children's gateway to the system and temporary home also provides for a logical and convenient place for them to receive such care.

As its Director, I have seen thousands of children enter the KIDSFIRST Program and hundreds, unfortunately, return multiple times. I have often wondered how many disrupted placements could have been avoided by earlier detection of and appropriate response to underlying cognitive, psychological, emotional, even physiological problems instead of reacting to their behavioral manifestations in the home and school. I have also wondered how many of us would accept for our own children the often sporadic and superficial attention given by "the system" to the physical and mental health of these children while they are in our care.

We already know that by virtue of their having been abused, neglected, or otherwise subjected to trauma, children are at increased risk for a wide array of complications in their life. We also understand that multiple placement disruptions create or further exacerbate such problems. My hope remains that a more proactive approach may be adopted toward addressing the unique needs of abused and neglected children, so that appropriate supports can be offered before failure is experienced, and these children may achieve the success they so desperately need and deserve.

CONGRATULATIONS DR. GERALD BUCHANAN!



Dr. Buchanan (center) receives his 2004 Ray Helfer MiPSAC Child Advocate Award and Certificate of Congressional Recognition from nominator Eddie Kessler and Claudia Kerr-Fairbanks. He is Director of the Emergency Department at Hackley Hospital in Muskegon and has served as the volunteer Medical Director of the Claudia Kerr-Fairbanks Child Advocacy Center since 1997.

REMINDER!

Please renew your annual membership for APSAC.

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

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

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www.apsac.org

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