APSAC ADVISOR

American Professional Society on the Abuse of Children

Volume 22
Number 4
Fall 2010

Special Issue
Child Fatality Reviews
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Regular Features

Journal Highlights 26
APSAC News 30
Washington Update............................32
Conference Calendar 35

Also in this Issue

APSAC on Forensic Certification 31

At Issue: Shaken Baby Syndrome as Portrayed in Pathology Textbooks..2
Carl J. Schmidt, MD, MPH, & Vincent J. Palusci, MD, MS
In this *At Issue,* Schmidt and Palusci identify a lack of consistency in the medical literature regarding shaken baby syndrome (SBS) and address the practical problems resulting from misinformation and bias often communicated in mainstream medical textbooks.

Child Death Review: The State of the States in 2010 5
Theresa M. Covington, MPH
This article describes the evolution of child death reviews from a fledgling movement in 1994 to today's well-established, institutionalized process in the majority of states and identifies variations to meet unique state or local needs.

Using Citizen Review Panels to Review Child Maltreatment Fatalities 9
Vincent J. Palusci, MD, MS
This article discusses the use of citizen review panels, established specifically to review deaths of children known to governmental child protective services (CPS) agencies and to recommend changes in state public child welfare system.

Fatality Board Review of Near Deaths Due to Inflicted Trauma......13
Tricia D. Gardner, JD, & Lisa P. Rhoades, BA
This article reports on the activities of the Oklahoma Child Death Review Board, which also reviews near-death cases as another strategy to identify and address systemic problems to reduce the number of preventable child deaths.

Supporting Child Protective Services (CPS) Staff Following a Child Fatality and Other Critical Incidents.................16
Mary L. Pulido, PhD, & Janine M. Lacina, MA
This article describes a critical incident debriefing program implemented in New York City to support agency staff who have experienced child deaths on their caseloads in order to strengthen their coping capacity and prevent secondary trauma.

An Interview With Dr. Michael Durfee 24
The *Advisor* interviews Dr. Michael Durfee, who, in 1977, established the first standardized child death review process. He evaluates the evolution of child death reviews and shares his perspective on the elements of a successful review system.

APSAC

Enhancing the ability of professionals to respond to children and their families affected by abuse and violence.

AT ISSUE:

Shaken Baby Syndrome as Portrayed in Pathology Textbooks

Carl J. Schmidt, MD, MPH, and Vincent J. Palusci, MD, MS

The controversies regarding shaken baby syndrome (SBS) continue to be widely aired and debated in the popular press, reflecting the often intense disagreement within the medical community itself, particularly between forensic pathologists and pediatricians. Among pathologists, the mere existence of shaken baby syndrome as a causal mechanism for abusive head trauma is debated. The reasons for this are unclear. Shaking as a causal mechanism for abusive head trauma continues to be noted in case series, and there is ample indirect supporting evidence. Still, the absence of *direct* evidence for shaking as a causal mechanism of head trauma in children continues to be proffered as sufficient reason to summarily discount it (Gill et al., 2009). Of greatest concern is the vehemence of pronouncements from individuals in the mainstream medical community who deny that shaking without direct impact can cause abusive head trauma, reinforcing the presumed accuracy of such claims to the uninformed.

To better understand the information available for professional practice, we reviewed what has been written about shaken baby syndrome in some currently available pathology textbooks. Legal professionals and medical students often consult textbook chapters under the assumption that they represent the best available knowledge on the topic. Yet, these books may not be consistently peer reviewed and may reflect biases of the authors or editors. In this article, we have limited our review to books that are readily available in the fields of general pathology, neuropathology and forensic neuropathology. We apologize in advance if we have overlooked other important books.

Reviewing Currently Available Texts

DiMaio, D., & DiMaio, J. M. (2001). *Forensic Pathology*, 2nd ed. Boca Raton, FL: CRC Press; Taylor & Francis.
In an older book that is still widely used, DiMaio and DiMaio unapologetically state that SBS doesn't exist. They state as fact many ideas that are unproven, such as the following: "the unchallengeable detection of impact trauma in cases alleged to be due to SBS" (p. 360). Later, they talk about the rare case of traumatic intracranial bleeding in children where there is no evidence of impact, stating, "The authors have seen numerous cases of witnessed impact involving both adults and children who subsequently died of head trauma in which there was no evidence of impact in the scalp or skull at autopsy" (p. 361). The book includes an entire paragraph on how the absence of neck injuries precludes the existence of SBS, but without explicit references or experimental evidence. The authors also assert that people charged with injuring a child would confess to shaking a baby rather than admit to slamming the baby's head against a firm surface or throwing the child "across the room like a football" (p. 360). They conclude, "The authors have grave reservations as to the existence of SBS" (p. 362).

Dolinak, D., Matshes, E. W., & Lew, E. O. (2005). *Forensic Pathology*. Burlington, MA: Elsevier.
Forensic Pathology has a well-referenced, excellent discussion of child abuse. It also has a section dedicated to the SBS controversy. This probably represents the mainstream opinion of forensic pathologists today, who believe that significant impact has occurred in most cases of inflicted head injury, whether or not it can be demonstrated. And yet, they "do not discount that severe shaking may be harmful to an infant" (p. 388). Their discussion should probably be read by anyone who testifies in court on these cases.

Whitwell, H. L. (2005). *Forensic Neuropathology*. London: Hodder Arnold.
Forensic Neuropathology was published in England. The authors have dedicated a section to the shaking versus impact controversy in their chapter on head injury in children. The tone of the review implies that shaking probably doesn't exist, but they acknowledge that some professionals believe it does exist. The authors appear to stay above the fray, and the review of abusive head trauma is otherwise adequate and surprisingly readable.

Spitz, W. U. (Ed.). (2006). *Spitz and Fisher's Medicolegal Investigation of Death*, 4th ed. Springfield, IL: Charles C. Thomas.
Among the general forensic pathology textbooks, *Spitz and Fisher's Medicolegal Investigation of Death* is the venerable old timer now available in a revised edition. It includes a comprehensive discussion of pediatric head trauma, and overall it offers a well-balanced view of the major issues in the subject, including a critique of Plunkett's (2001) oft-cited paper on short falls. The chapter, written by Marvin Platt, Werner Spitz, and Daniel Spitz, covers major autopsy findings, such as the significance of the presence or absence of skull fractures, subarachnoid and subdural hemorrhage,

injury to the brain, retinal hemorrhages, and comments on the presence or absence of a lucid interval. Although the authors tread carefully between the shaking versus nonshaking camps, a glimpse of their bias can be seen in the first paragraph of the discussion: "The mechanism associated with shaken baby (impact) syndrome is forceful shaking, causing the head to jerk back and forth followed by impact, against a surface such as a wall or floor, sometimes a piece of furniture, other times a firm cushion or other type of upholstery" (p. 376).

Oehmichen, M., Auer, R. N., & König, H. G. (2006). *Forensic Neuropathology and Associated Neurology.* Berlin; Heidelberg; New York: Springer-Verlag.
Forensic Neuropathology and Associated Neurology is a German text, with ponderous language and comprehensive detail. It has a chapter on the physical abuse of children, which goes into great detail on SBS. The authors don't question the existence of SBS and, indeed, point out that SBS is a diagnostic consideration in children with intracranial findings, retinal hemorrhages, and so on. In addition, they discuss each major physical finding and the arguments for and against it being diagnostic of SBS.

Itabashi, H. H., Andrews, J. M., Tomiyasu, U., Erlich, S. S., & Sathyavagiswaran, L. (Eds.). (2007). *Forensic Neuropathology: A Practical Review of the Fundamentals.* Burlington, MA: Academic Press.
Forensic Neuropathology: A Practical Review of the Fundamentals is a modern book written by staff at the Los Angeles County Medical Examiner-Coroner's Office. It is a comprehensive review of all aspects of neuropathology, and it has sections that are technical to the point of being hard to read. Rather than discussing the controversies on abusive head trauma, the chapter on child abuse is a lengthy exposition on the process to be used when evaluating these cases, including an entire section on the best approach to writing the report. It even includes a list of questions to ask in individual cases. The authors suggest the importance of going to conferences, including the bi-yearly conference on SBS, to maintain up-to-date knowledge on the state of the blunt impact versus shaking controversy. They appear to want readers to know what information is current, but seem not to want the responsibility of guiding a reader's conclusions in individual cases. They also seem to assume a position of neutrality, apparently not wanting readers to conclude they favor one position over the other.

In the chapter on child abuse, the section on subdural hemorrhage consists of one paragraph that refers to other chapters in the book, or directs readers to the medical literature to the latest trend in the SBS controversy (p. 205). The discussion on the various pathologic findings in abusive head trauma does not have a specific focus on child abuse, with the exception of retinal hemorrhages. The references are comprehensive, but they exclude authors who have published data contradicting SBS, such as Plunkett and Leestma.

Love, S., Louis, D. N., & Ellison, D. W. (Eds.). (2008). *Greenfield's Neuropathology*, 8th ed. London: Hodder Arnold.
Among the specialized neuropathology titles, an often-consulted and comprehensive book is *Greenfield's Neuropathology*. This is a traditional, weighty two-volume text with at least a cursory mention of "everything" a neuropathologist needs to know. The chapter on trauma was written by two neuropathologists and a neurosurgeon and covers the basics of traumatic syndromes and the molecular consequences of trauma. However, its discussion of shaken baby syndrome is cursory and noncommittal. It does say that current concepts of the syndrome are being reviewed, that it is rare, and that each case should be analyzed on its individual circumstances.

Leestma, J. E. (2009). *Forensic Neuropathology*, 2nd ed. Boca Raton, FL: CRC Press; Taylor & Francis
Forensic Neuropathology unabashedly argues against SBS. The chapter titled "Child Abuse: Neuropathology Perspectives" is really Leestma's critique of the literature and his reasons for not believing that SBS is a serious diagnostic consideration in the absence of impact injury to a child. The section on SBS is titled "The So-Called Shaken Baby Syndrome" (p. 596). He goes into exquisite

detail outlining what he thinks are the flaws in the papers supporting SBS. He describes in even more detail the content of papers that do not support SBS. He also says that research experiments do not prove the existence of SBS and are hampered because of ethical issues associated with studying real babies rather than dummies or computer models.

He does allow himself some wiggle room when he says, "Does this criticism mean that there is no such thing as injury in connection with shaking (in the absence of impact)? Not at all" (p. 606). He finishes with a description of all the rare conditions that could cause what are, at first impression, traumatic head injuries, and how, when an infant is brought to medical attention, these rare diseases "become less so in the context of the evaluation of child abuse…" (p. 607). This also contradicts his past work, when he wrote that SBS was a noncontroversial entity (Chapter 11, "Forensic Neuropathology," in *Neuropathology: The Diagnostic Approach*, edited by Julio Garcia, Mosby, 1997).

Troncoso, J., Rubio, A., & Fowler, D. (Eds.). (2009). *Essential Forensic Neuropathology.* Philadelphia, PA: Lippincott, Williams & Wilkins.
Essential Forensic Neuropathology is an edited text written by multiple authors. The chapter on abusive head trauma and the neuropathology of brain trauma in infants and children was written by Dragovic and makes no attempt to obscure its slant. In discussing the controversy between nonimpact versus impact in SBS, he writes the following: "The concept, albeit not supported by an adequate objective postmortem evaluation, has grown into a major misconception among professionals in clinical medicine, with a rather widespread notion of its absolute prevalence as the most important form of brain injury in physically abused infants and small children" (p. 181). In one fell swoop of the pen, and without citing any evidence, he essentially claims that clinicians are imagining things.

Considering the currency of this book, his failure to cite important recent studies is distressing. Such studies include the work of Roth, Raul, Ludes, and Willinger (2007), which uses mathematical models to demonstrate that subdural hemorrhage can plausibly occur after shaking. Dragovic does stop short of saying that SBS doesn't exist, but he preferentially cites papers that argue against diffuse axonal injury, subdural hemorrhage, and retinal hemorrhage being indicators of SBS.

Implications for Practice

The discussion of abusive head trauma and, in particular, SBS, varies widely in the currently available pathology textbooks. Medical students, residents, practicing physicians, and attorneys are confronted with significant variations in the information about SBS in these sources. If professionals rely solely on the textbooks, they are left in a state of limbo, believing there is legitimate controversy regarding SBS as a causal mechanism in severe head trauma in children. Clearly, all concerned will need a much deeper understanding of SBS beyond that which is currently being provided if the dynamic science regarding SBS is to be properly understood and integrated into practice.

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Child Death Review: The State of the States in 2010

Theresa M. Covington, MPH

In 1994, when the first *APSAC Advisor* special issue on child fatalities was published, the process of child death review (CDR) was a fledgling movement in most parts of the United States. Sixteen years later, CDR is a well-established, institutionalized process in all but a few states. Review teams meet regularly at either the state or community level to share information on the circumstances of child deaths in order to improve investigations, services, and agency systems and to prevent other child deaths. However, despite many efforts to standardize the review process, beginning with the Missouri National Symposium in 1994 and continuing through today's federally funded National Center for Child Death Review,[1] there remains quite a bit of variation among states in the review process, much of it to meet state and local needs. Each year the National Center for Child Death Review conducts a survey of CDR to track the status of state and local review processes. This article provides an update using data from the December 2009 survey.

The Purpose

Following the landmark study in the journal *Pediatrics*, which documented the significant under-ascertainment of child abuse and neglect fatalities (Ewigman, Kivlahan, & Land, 1993), child death review gained momentum as a methodology to better investigate and identify child deaths from abuse and neglect (Durfee, Gellert, & Tilton-Durfee, 1992; Ewigman et al., 1993). Many states were able to generate support for legislation and funding by basing their reason for existence on this sole purpose. Subsequent CAPTA legislation helped by making reviews of abuse and neglect a requirement for federal funding. As states organized their reviews, it became apparent to most that focusing reviews only on suspicious deaths would, in fact, limit their ability to identify all maltreatment-related deaths, especially neglect. Some states opted for an expanded purpose when CDR was first organized, using it as a process to focus on all child deaths resulting from SIDS, accidents, homicides, and suicides. This expansion was furthered when the U.S. Maternal and Child Health Bureau issued a report encouraging CDR as a public health approach for all preventable deaths. The U.S. Healthy People 2010 objective was expanded in 2001 to encourage all states to conduct reviews for 100% of all accidents, homicides, and suicides. By 2010, every state except Idaho had a CDR process in place, and all states cited their primary purpose as the prevention of child deaths.

Types of Deaths Reviewed

Every state reviews deaths in children up to age 18, and most review deaths from accidents, homicides, and suicides. Twelve states reported that they met the Healthy People 2010 objective by reviewing 100% of all the above. Eighteen states reported that they also review a large percentage of deaths from natural causes. A few states reported that they review all child deaths. Ohio is the most notable example, in that state legislation requires county-based teams to review 100% of deaths of children through age 17.

Many states reported that by reviewing more deaths, they were actually identifying more deaths from child abuse and neglect. For example, Michigan's state level review team matched caregivers of children in all accidental deaths to caregivers on the state's CPS central registry over a 3-year period, and then it reviewed deaths that matched. This led the team to more than double the number of reported deaths due to maltreatment (Schnitzer, Covington, & Wirtz, 2008). Today, only a few states limit the types of deaths they review to suspected abuse and neglect, or to cases in which the child had a history with the state's child welfare system. Florida's state statute is the most restrictive, limiting reviews to only those children whose deaths were substantiated as abuse or neglect. Several states have formal protocols in place to include near deaths and serious injuries from maltreatment as a part of their review process, but only Wyoming requires these reviews through statute (see article by Gardner in this issue).

State Leadership for CDR

In the 1990s, most CDR programs were coordinated by the state department of social services or the state attorney general's offices. With an expanded focus on prevention, there has been a shift toward moving administrative leadership to public health departments, and currently, 27 state programs are based in state health departments, 11 in social services, 3 in the attorney general's office, and the remainder in an assortment of agencies, including the state child advocate's office (2), the courts (2), a state university (2), and others. However, even as the shift occurs to public health, in most states, social services and other agencies collaborate closely with public health. In every state, at least one person has been designated to be the state CDR program manager. Such persons typically

1 The Center is funded, in part, by grant No. U93 MC 00225-02-00 from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services.

manage the state CDR teams and advisory boards, provide training and consultation to local teams, and coordinate the state's CDR reporting requirements.

Funding

CDR continues to be poorly funded at the state level. No states reported funding increases in 2010, and a number of states reported their funds were significantly reduced. The mean level of funding is $125,000, but there is a wide gap in funding levels between states. At the top tier, 10 states have annual budgets of $200,000–$800,000, and at the bottom tier, 16 states have budgets of less than $30,000. There is no dedicated source of federal funds for CDR to the states: Most use their CAPTA, CJA, or Title V MCH block grants to support their programs.

Legislation

Thirty-nine states have laws mandating CDR, and four states have statutes permitting CDR. Statutes generally include requirements related to state and/or local team meetings and team member composition, and the production of annual reports to legislators. Most important for team functioning is that they include provisions allowing teams to access case information and hold confidential discussions. Even in states such as Wisconsin, which requires CDR meetings to be open to the public, the teams can convene a closed session when discussing an individual case.

State and Local Reviews

In the very early years of CDR, teams were established at the local level with little state guidance or oversight. For most states, the value of community-based reviews is well accepted. Thirty-eight states now support a network of local CDR teams at the county level (28), city teams (4). and/or regional level (11). In the past couple of years, a number of states have worked diligently to move from state-level to local team reviews, including Wisconsin and Minnesota. New York provides significant funds through a competitive process to encourage local reviews. Even in a few states that support a state-only team, local teams may meet independently, such as in Colorado. Most of the states without local reviews are either primarily rural, or have relatively small numbers of child deaths that can be easily reviewed by one state-level panel, or both. Thirty-five states have state-level advisory boards that either review individual cases, or review local findings to generate recommendations for state level policy, practice, and program improvements, or do both of these.

Coordination With Other Types of Reviews

As child death review has expanded throughout the United States, so too have other review processes—many similar to CDR in methodology but with a different population focus. Today, CDR program coordinators report that the following types of reviews exist in their states:

- Child Welfare Citizens Review Panels..............................42
- Domestic Violence Review Boards 27
- Maternal Mortality Review...23
- Fetal and Infant Mortality Review...................................29
- Specialized SIDS Review Boards..6
- Others, including Elder Abuse Reviews 9

CDR sometimes coordinates with these other reviews, and in a number of cases, one panel in a state or community serves multiple functions. For example, 13 states report that their state CDR panel serves as the state's Citizen's Review Panel for Maltreatment Fatalities (see related article in this issue by Palusci). A number of state or local teams will hold a CDR meeting followed on the same day by a domestic violence or elder abuse panel meeting, making only a few changes to team membership. Most of these review processes share common purposes and have only small variations in their protocols and processes.

CDR Reporting

Forty-two states issue annual reports of their child mortality data, their CDR findings, and their recommendations to improve their systems and prevent child deaths. Twenty-three states also issue specialized reports from their findings, such as reports on youth suicides, firearm deaths, or child maltreatment deaths. As states began to build their review programs, most created their own reporting tools while borrowing heavily from other states' tools. Missouri was the first state to develop a comprehensive reporting system, followed by Arizona. In 2001, when the Maternal and Child Health Bureau first funded the National Center for Child Death Review, the Bureau charged the center with exploring the feasibility of a standardized national reporting system. States were so eager for standardization that within 2 years, more than 30 persons from 19 states helped design such a system.

Thirty-four states, soon to be 37, now utilize the National Child Death Review Case Reporting System, a comprehensive web-based tool. The system is housed and managed by the NCCDR. There are over 80,000 reviewed deaths in the database as of October 2010. What makes the system unique is that comprehensive data are being collected in one place, including data on the child, caregivers, supervisors, perpetrators, circumstances of the deaths, findings from the investigation, services provided, and team recommendations for prevention. NCCDR is working with states and national partners to develop a protocol for researchers to access this database. A project is also underway to develop linkages of the system's maltreatment data to the data in CDC's National Violent Death Reporting System. The system is also being used as the core component of the CDC's pilot project to establish a national case registry of sudden and unexpected infant deaths.

Seven states are using an expanded version of the report tool for this effort (CO, GA, MI, MN, NH, NJ, and NM).

Outcomes

Child death review appears to have had a significant impact on improving death investigations and in helping improve the identification and diagnosis of maltreatment deaths. A study conducted by Scripps Howard News Service found that states with both local and state CDR programs had more than twice as many deaths recorded as suffocations instead of unknown or SIDS than a state with no CDR, and a significant increase in homicides (Hargrove & Bowman, 2010).

Type of Review	Accidental Suffocation	Homicide
No CDR	7.1%	7.1%
State only	9.2%	7.5%
Local only	12.4%	8.0%
State and local	15.3%	9.0%

The CDC-funded Child Maltreatment Surveillance Project found child death review to be the best source for identifying child maltreatment, as compared with death certificates, law enforcement reports, and child welfare system reports (Schnitzer et al., 2008).

However, several years ago, a chief prosecutor sitting on a local review team chastened his team by saying, "The review process was wearing on my soul because we aren't using our findings to prevent other deaths." At about the same time, a study conducted in California analyzed over 1,000 CDR recommendations from state reports throughout the United States and found the quality of these to be lacking in specificity, attention to evidence-based approaches, and processes to monitor their implementation (Wirtz, Lob, & Rose, 2008). One state reported that in 10 years of reviews, they could not identify a single result that prevented deaths. There were limited examples of reports in which teams did use their data for prevention, some of them published (Rimsza, Schackner, Bowen, & Marshall, 2002; Azrael, Hemenway, Miller, Barber, & Schackner, 2004). It seemed as if CDR in the U.S. had reached a tipping point: Many teams knew how to conduct reviews but not how to move forward toward translating their reviews into efforts to improve systems and prevent deaths.

Technical support and training for teams, as well as exemplary efforts to systematically focus on translating review findings into action, have catalyzed CDR throughout the United States, leading to renewed emphasis on systems improvements and prevention. Today, NCCDR catalogues initiatives developed by teams throughout the U.S. and has lists of thousands of outcomes being implemented by teams. They range from the simple, such as changing the speed limit in school zones, to the complex, such as implementing home visitation programs for low-income first-time mothers. Many of these can be found by reading state annual CDR reports.[2]

Several of the exemplary efforts to improve the focus on and skills in implementing prevention included the following:

The Harborview Injury Prevention and Research Center in Seattle obtained a special issues grant from the HHS Emergency Services for Children Program. This grant allowed Harborview to work closely with five local CDR teams in Washington state over 3 years to provide technical assistance, peer support, and a web-based decision-making tool on best practices. This support led to significant improvements in those counties' prevention and system improvement outcomes as compared with the nonsupported counties (Johnston, 2009).

The California Health Department developed curricula and then provided training and technical support to local teams to assist them in writing recommendations that would be specific, action oriented, and based on best practices.

Michigan and Nevada developed a systematic approach in their reviews of maltreatment deaths in order to match their findings with specific areas needing improvements, and then developed and implemented recommendations tied to those findings. Nevada counties have been implementing action plans for the past several years, leading to improved interagency coordination, major systems improvements, and additional resources in child welfare. These are continually tracked and monitored by the state.[3] The Michigan experience led to significant decreases in child deaths associated with agency system problems (Palusci, Yager, & Covington, 2010).

CDR in the Next Decade

Budget crises throughout the states have led to decreased funding to support many state and local CDR; yet, all states except Idaho continue to support the process. The hard work underway in states to conduct reviews, report on their findings, and translate those findings into systems improvements and prevention is strong evidence that child death review is a powerful and effective process to keep children safe and healthy.

Improvements and renewed commitments to the process at the national, state, and local level will help ensure that CDR thrives through 2020. Some of these include the following:

2 Reports can be found by state at www.childdeathreview.org/state.htm

3 Retrieved May 20, 2010, from: http://www.dcfs.state.nv.us/DCFS_ChildFatalities_BlueRibbon.htmNevada

At the National Level

- Healthy People 2020 will expand to two objectives, to add that all states should review 100% of sudden and unexplained infant deaths as well as all homicides, suicides, and accidents. Last year, Senator Frank Lautenberg (D, NJ) introduced the Stillbirth and SUID Prevention, Education, and Awareness Act (S 1445). As of June 1, there were 12 senate and 21 house co-sponsors of the bill. This bill includes a section that supports child death review, and if approved, would help allocate dedicated funds to every state specifically to support the review process.
- Numerous federal and national organizations are working with the NCCDR to utilize data from the CDR Case Reporting System for policies and improvements at the national level. For example, the NCCDR recently received funding from HRSA, MCHB to conduct secondary data analysis of the infant sleep-related deaths in the system. However, more work is necessary to ensure that the data on case findings entered at the local and state level are actually used.
- Efforts to better coordinate with other types of reviews and to improve near death reviews are needed at the national level, as well as within states and locally.

At the State and Local Level

- States will continue to struggle with competing budgetary demands to maintain robust CDR programs, and local teams will struggle to engage a wide range of stakeholders as resources diminish. It is imperative that teams continue to keep their eyes on the mission—translating review findings into improved knowledge about how and why children die, and then taking action to prevent more deaths.
- CDR can continue to grow at the local and state level. Teams will expand their reviews to include natural deaths, especially those of infants, to identify and address medical neglect.
- Teams will expand their membership, adding injury prevention expertise, child advocates, and in some cases, bringing the voices of parents to the reviews. We will be able to learn from the innovations in the United Kingdom, as they work to involve parents in the review process by sending out information on the reviews and offering parents the opportunity to share information with a team. Teams will also expand membership to be sure they represent the children most at risk in their communities, by race, gender, income, and other demographics.
- Teams will continue to improve in their ability to translate review discussions and findings into recommendations and actions to improve agency systems and to prevent other children from dying.

In summary, child death review has great potential, metaphorically not to wear on our souls but to heal our souls—collectively as a community, in our own agencies, and within ourselves. It will require renewed commitments and a focus on working together to ensure that what is learned from the deaths of too many children can save lives in the future.

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Using Citizen Review Panels to Assess Child Maltreatment Fatalities

Vincent J. Palusci, MD, MS

During 2007, an estimated 1,760 children died from abuse or neglect at a rate of 2.35 deaths per 100,000 U.S. children (US DHHS, 2009). Although child abuse rates are declining in the United States, there has been no real change in the number of child maltreatment (CM) fatalities. Agencies have their own legal mandates, protocols, and practices, which may lead to differences and inconsistencies in how potential cases are investigated and defined. Associated with maltreatment fatalities are a number of risk factors, such as residing in homes with unrelated adults, young age of the child, and prior involvement with child protective services, and this information can aid in improving child welfare services and developing initiatives to prevent further deaths. It is widely accepted that by conducting child fatality reviews professionals can better identify and respond to child deaths (Schnitzer, Covington, Wirtz, Verhoek-Oftedahl, & Palusci, 2008; Christian, Sege, et al., 2010).

Additional opportunities for improvement and prevention within the child welfare system itself are also available (King, Kiesel, & Simon, 2006). Even though the death of a child is a rare event and most children known to the child welfare system do not die, some of them do. In 2007, children whose families had received family preservation services within the child welfare system in the past 5 years accounted for 11.9% of child fatalities. Slightly more than 2% (2.6%) of the child fatalities had been in foster care and were reunited with their families in the past 5 years (US DHHS, 2009). This suggests that all concerned may take steps to improve outcomes in child protective services and foster care agencies. New strategies include using a children's ombudsman (Bearup & Palusci, 1999), a state child advocate (Faith VosWinkle, Connecticut Child Advocate, personal communication, 2009), and the establishment of federally-mandated citizen review panels (CRPs).

Development and Function of CRPs

CRPs were first required for U.S. states in 1996 as part of the reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA). Many states have instituted CRPs specifically to review child maltreatment fatalities (Child Abuse Prevention and Treatment Act, 1998; U.S. DHHS, 1998). CRPs are ideally made up of a representative sample of community volunteers, are required to meet at least quarterly, and fulfill a broad mandate which includes ensuring that the state is in compliance with CAPTA, Title IV-E programs, and other requirements (Jones, Litzelfelner, & Ford, 2003).

Medical examiners, law enforcement, child protective services, and legal professionals are usually part of the CRP, and many teams add child abuse pediatricians, education professionals, and public health officials to their panels. Efforts are also made to include nonprofessional citizens, such as former clients of the child welfare system and other members of the community at large. States are required to provide panel members with case-level information that the panels deem necessary for them to carry out their mission (US DHHS 1998). Panel members are bound by confidentiality requirements and cannot disclose identifying information about cases reviewed. States are also required to provide staff to enable the panels to carry out their functions.

CRPs have been implemented variably across the United States, and their effectiveness has been evaluated only to determine the extent of citizen participation or implementation of their recommendations (Jones, 2004). At least 15 states have populated fatality CRPs from among members of their state or local child fatality review boards (National Center for Child Death Review, 2008). CRPs are required to report to their state child protective services agency and are also expected to prepare an annual report for the public describing their activities.

CRPs—Similar to or Different From Other Child Death Reviews?

While child fatality review teams (CFRTs), fetal-infant mortality review teams (FIMRs), and fatality citizen review panels (CRPs) all review child deaths, CRPs review deaths only of children known to the governmental child protective services (CPS) agency. These CRPs are charged with making recommendations primarily to the CPS within the child welfare system (Table 1). Child fatality review teams (CFRTs) have been instituted in most U.S. states to provide a multidisciplinary, multiagency review of all or most child fatalities (Durfee, Gellert, & Tilton-Durfee, 1992; Durfee, Durfee, & West, 2002; Webster, Schnitzer, Jenny, Ewigman, & Alario, 2003; National Center for Child Death Review, 2008). All have reviewed fatalities from child maltreatment and have identified abuse cases that had been misdiagnosed or misclassified as being due to natural causes or unintentional injury (Levene & Bacon, 2004; Kellogg & Lukefahr, 2005; Jenny & Isaac, 2006; Schnitzer et al., 2008).

For example, in Philadelphia, most child homicides were found to be preventable, and the review process was thought to provide one source of comprehensive data to allow policymakers to formulate solutions (Onuwuachi-Saunders, Forjuoh, West, & Brooks, 1999). In Arizona, the state CFRT was able to identify and correct an incorrect cause of death in 13% of death certificates, and it suggested that 38% of all child deaths after the first month of life could be prevented (Rimsza, Schackner, Bowen, & Marshall, 2002).

The National Fetal and Infant Mortality Review Program (FIMR) is a collaborative effort between the American College of Obstetricians and Gynecologists and U.S. Health Resources and Services Administration Maternal and Child Health Bureau (www.acog.org, accessed October 12, 2010). This process brings together key members of the medical community—including obstetricians, pediatricians, nurses, and public health officials—to review information from individual cases of fetal and infant deaths. The purpose of this type of review is to identify general community, social, economic, cultural, and health systems factors that are highlighted by those infant deaths to determine if they represent problems in the service delivery system or resources that require change, and to develop recommendations and assist in the implementation and monitoring of the changes. Case reviews are anonymous and confidential. FIMR projects have been conducted since 1988, but the majority of existing FIMRs were formed after 1990.

In contrast, CRP reviews are limited to child deaths known within the state child welfare agency or to child protective services (CPS). The purpose is to identify issues related to state law, policy, or practices within the state agency that can contribute to fatalities. Specific practices examined can include receiving and responding to reports of suspected child maltreatment, case investigation, outcome determination, and the provision and types of services. While foster care and adoption services are often part of child welfare practice, these are typically examined by CRPs separate from the fatality CRP. CRPs can also assess agency staffing levels, caseworker caseload size and training, the availability and allocation of resources by the state child welfare agency, and compliance with the state CAPTA plan. Although factors outside the CPS system are often reviewed, the focus of recommendations remains within the CPS systems, their contribution to CM fatality, and CPS's ability to influence and improve the lives of children and prevent deaths in other parts of the child welfare system.

Experience Using CRP for Fatality Review

A recent review identified over 300 recommendations in 11 categories from child death reviews in the United States, and some professionals believe that child death review teams can make significant contributions to the overall protection of children and the prevention of child deaths and serious injury (Douglas & Cunningham, 2008; Hochstadt, 2006). Published experience with fatality CRPs is limited. Jones, Litzelfelner, & Ford (2003) surveyed CRP members and CPS staff and found differences in their perceptions of the importance of citizen involvement in the review process. They also differed in their perceptions regarding the need for change and the steps to be taken to improve the child welfare system.

The authors concluded that better communication between CRP and CPS was needed about agency-community partnerships and the value of citizen participation. They recommended a training program to educate lay CRP members about the policies and daily struggles of CPS. Bryan, Jones, Allen, and Collins-Camargo (2007) examined the impact of CRPs in a southern state and found that CRP member perceptions of their own effectiveness were mixed, noting ineffective communication, poor implementation of recommendations by CPS, and lack of CPS responsiveness. State CPS personnel particularly valued CRP's ability to serve as a neutral group that viewed the system with "fresh eyes" and provided additional evidence as the basis for the need for additional support. In addition to recommending steps to improve communication, the authors also cited the need for more systematic reporting and implementation of CRP recommendations as well as improved selection processes and training for CRP members.

We (Palusci, Yager, & Covington, 2010) evaluated changes in the state of Michigan after implementation of a CRP that reviewed CM deaths known to the state child welfare system over a 6-year period. The review specifically identified the number of child deaths, problem areas in the state child welfare system, and any specific changes in child welfare law, policy, and practice that could be associated with fewer child maltreatment deaths. During the first 3 years of the study, a number of findings and recommendations were made that were linked to changes made by CPS in the child welfare system. Those same findings were assessed in a second 3-year period to determine any change on the incidence of fatal CM related to them. In the first period, there were 186 deaths (2.4 per 100,000 children) with 264 findings; in the second period, there were 170 deaths with 172 findings (2.2 per 100,000), which represented a 35% decrease in findings and a 9% decrease in deaths associated with those findings.

Table 2 reviews a selection of findings from Palusci et al. that show significant decreases pertaining to CPS. Most findings were noted in more than one child death and decreased over time, with some exceptions. Twenty-seven specific finding areas were noted after combining findings from all the cases; most findings were categorized as occurring because of failures during CPS case investigation, assessment, and services (19 findings), followed by failures in mandated child abuse and neglect reporting (4 findings) and problems during court petition and adjudication (4 findings). Specific changes were made in law, policy, or practice for 24 of these 27 findings areas. Although causation cannot be inferred, the findings with the greatest degree of change could be directly related to changes in CPS practices that were consistent with recommendations made by the fatality CRP during the first 3 years of the study.

Table 1. Comparison of Reviews by Different Child Death Review Systems

	Child Fatality Review Teams (CFRT)	**Fetal-Infant Mortality Reviews (FIMR)**	**Fatality Citizen Review Panels (CRP)**
Composition	Multidisciplinary professionals and community members (medical examiner, law enforcement, CPS, public health, prosecutors, others)	Medical and public health professionals (obstetricians, perinatologists, geneticists, nurses, pediatricians, public health workers, others)	Multidisciplinary professionals and community members (medical examiner, law enforcement, CPS, public health, prosecutors, pediatricians, former clients, others)
Source of cases	All or selected child deaths (often homicides, accidents, suicides)	All infant deaths (<1 year), maternal deaths, and fetal demise	All child deaths among children known within the CPS or child welfare systems
Purpose of Review	To improve our understanding of how and why children die; to demonstrate the need for and to influence policies and programs to improve child health, safety, and protection; and to prevent other child deaths	To identify general community, social, economic, cultural and health systems factors highlighted by those infant deaths, to determine if they represent service delivery system or resource problems that require change, and to develop recommendations	To evaluate the effectiveness of the agencies charged with child protection responsibility and examining the policies, procedures, and where appropriate, specific child deaths handled by state and local agencies providing child protective services. Also to evaluate compliance with state CAPTA plans, standards, and other criteria as determined
Reporting and Implementation of Recommendations	Variable. CFRTs may report to specific agencies, the governor and/or legislators, and/or the public at large. There is no legal mandate for implementation.	Variable. FIMRs report to private and public organizations and the community. There is no legal mandate for implementation.	Federally mandated response by the state child protective services agency. CRPs are required to monitor the impact and implementation of their recommendations.

Table 2. Fatality CRP Findings Related to CPS and Significant Changes in CM Deaths

CRP Finding	**Problem Area**	**Change in CM Deaths**	**CPS System Change**
Inappropriate screening out of reports and delays in assignment	Non-compliance	ˉ 85.1%	Systemwide peer review
Unacceptable delays between assignment and contact with families	Non-compliance	ˉ 82.5%	Systemwide peer review
Risk assessment completed incorrectly or not at all	Non-compliance	ˉ 86.3%	Statewide training and data system upgrades
Totality of case inaccessible to caseworker	Other issues	ˉ 90.0%	Data system upgrades

Source: Palusci et al., 2010.

Limitations of CRPs in Identifying Deficiencies in the CPS System

While CRP fatality review leads to potentially promising outcomes, there are several limitations to the CRP process. Some changes in law, policy, or practice can be implemented only on a county-by-county basis and cannot be implemented effectively by a statewide team. CRPs cannot influence elements in the child welfare system outside the state CPS agency, and an important number of CM deaths cannot be addressed if changes are made only within CPS. Effectiveness is enhanced when CRP and CFRT work together to address needs across systems, but the fatality CRP generally does not have access to cases in which there is no CPS involvement, or the case does not become known to the state's CFRT, or both.

It is difficult to measure the number of CM fatalities and the effectiveness of CRPs in reducing those deaths given the small numbers of deaths in any one jurisdiction and the difficulty in constructing an experimental model with a control group to measure improvements in a statistically sound way. Our study (Palusci et al., 2010) had wide variations and small numbers that precluded statistical significance for many of the changes in the frequencies of deaths. Any trends in deaths are also affected by changing community practices and policies plus other factors unrelated to the CRP, such as trends in overall child death.

Conclusions

Child maltreatment (CM) fatalities are often preventable, and reviewing these cases often highlights problems in law, policy, or practice that can be addressed to prevent future deaths. Citizen review panels (CRPs) comprising medical and child welfare professionals were first established in 1996 by the federal government to review Child Protective Services (CPS) practices as a requirement of the federal Child Abuse Prevention and Treatment Act.

While these panels have traditionally been used to review cases with living children in the child welfare, foster care, and adoption systems, there is growing use of CRPs in CM fatality cases. CRPs are different from and complementary to reviews by child fatality and infant mortality review teams and are able to specifically address deficiencies in CPS professional practice during case identification and reporting, investigation, and in other child welfare services. Though published research regarding their effectiveness is limited, CRP recommendations are federally required to be reported to and answered by the state's department of social services and can result in significant improvements in the child welfare system.

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Fatality Board Review of Near Deaths Due to Inflicted Trauma

Tricia D. Gardner, JD, & Lisa P. Rhoades, BA

Multidisciplinary child fatality reviews began in 1978 in Los Angeles County (Durfee, Gellert, & Tilton-Durfee, 1992) and have proved to be an important development in efforts to minimize or eliminate untoward deaths of infants and children. Much of the success of child fatality reviews has resulted from enhancing the ability of multiple agencies to share their expertise (Tilton-Durfee, 2007). In the years since the late '70s, a variety of teams have been established, some locally and others on a statewide basis. While some of these groups review all child deaths, others review only fatalities from child maltreatment.

The Oklahoma Child Death Review Board (OCDRB) was created by the Oklahoma legislature in 1991 and began reviewing child death cases in 1993. Its mission is to reduce the number of preventable child deaths through multidisciplinary case review. It seeks to accomplish this through several means: the collection of statistical data relating to the deaths of children from birth through 17 years of age; an analysis of system failure; and development of recommendations to improve policies, procedures, and practices within and between agencies that protect and serve Oklahoma's children (Oklahoma Child Death Review Board, 2008). An annual summary of the deaths that have been reviewed is made available to agencies, the legislature and the public.

Originally, the OCDRB reviewed all child deaths in Oklahoma, except for infants who died immediately after birth without having left the hospital. As the Board continued to develop and expand its scope, reviews of near deaths associated with alleged child maltreatment were added, as were annual joint reviews with the Oklahoma Domestic Violence Fatality Review Team.

The OCDRB includes a state team and four regional teams. The state team consists of 27 legislatively mandated members who represent a variety of agencies across the state. This team reviews cases from both metropolitan and rural areas and high-profile cases. The four regional teams, consisting of 9–17 locally affiliated members, perform reviews for specific counties in a geographical region.

Nationally, as child death reviews progressed, professionals quickly realized that reviews of near deaths thought to be associated with child maltreatment were very important. Thus, in 1999, the federal government disseminated recommendations to track such events to gain a better understanding of the most serious episodes of child maltreatment, including estimates of the rates of such occurrences. Accordingly, in 2000, Oklahoma legislation was amended to charge the OCDRB with the responsibility of reviewing these near-death cases.

For purposes of the OCDRB, an injury is classified as a *near-death occurrence* when it results in the hospitalization of a child in serious

or critical condition and when injuries are judged to be the result of abuse or neglect, or both. Examples include head trauma, near drowning, overdose, and other injuries incurred as a result of parental abuse or neglect. To begin the process of near death review, OCDRB created a subcommittee charged with determining the kinds of data that should be collected and the most appropriate process for referral of near deaths to the Board. The intent was that emergency rooms across the state would make such referrals. However, it was quickly determined that most near deaths were transferred to metropolitan hospital facilities to access the higher level of expertise and equipment necessary for the treatment of these injuries. The Child Protection Committee (CPC) at Children's Hospital of Oklahoma already had a program for internal review of all cases of suspected child maltreatment seen at the facility. As the Chair of the Oklahoma Children's Hospital CPC was also a member of the OCDRB, it was relatively simple to implement a protocol that all near-death cases reviewed by the CPC would automatically be referred to OCDRB.

Another important source of referrals to the Board was the Oklahoma Department of Human Services (OKDHS), which already had a program to refer child deaths to the OCDRB. Since the OKDHS was also a member of the OCDRB, it was again rather easy to expand its referrals to include cases of near death.

Upon receiving a referral of a case of suspected near death associated with child maltreatment, staff of the OCDRB begin collecting information from a variety of sources, including medical records, law enforcement investigative reports, child welfare history, and reports from child welfare's investigation of the near-death event. As in the case of fatality reviews, this information might also include Emergency Medical Services reports, mental health records, and school history. When all information has been compiled, the file serves as the basis for review by the OCDRB.

Perhaps the major difference between child death and near-death reviews is the requirement in the latter case for compliance with Health Information Protection and Accountability Act (HIPAA) regulations, made necessary by the fact that children involved in near-death reviews are still alive. As is true for all providers required to comply with HIPPA regulations, the OCDRB was concerned about its liability as well as the ability to obtain health information. It requested an official opinion from the Oklahoma Office of the Attorney General (OAG) regarding the Board's authority to access medical records. The OAG concluded that, under authority involving investigation and surveillance of matters of public health, the OCDRB has statutory authority to request and receive information that would normally fall under the protection of HIPAA (Edmondson & Schwartz, 2004). This final opinion (2004 OK AG 28) is now cited in all letters from OCDRB that request health information on a child fatality or near death incident. The legislation that established the OCDRB also specifies that other entities (i.e., nonhealth-related) are required to provide information surrounding death and near-death events when such information is requested by the Board.

The Board had several concerns when it began implementing near-death reviews. Perhaps the most significant was that referring agencies would feel overly scrutinized. By giving this serious consideration, and by taking pains to establish trust, the Board created an environment in which multidisciplinary reviews came to be regarded not as fault finding but, rather, as collaborative efforts to focus on needed improvements of the entire system. Responding to local agency concerns involved several open and candid discussions with Board representatives about the outcome and purpose of near-death reviews. As a result, all agencies involved on the Board felt comfortable implementing near-death reviews. As expected, the process of receiving referrals for near-death cases began slowly, but the pace of referrals accelerated when referring agencies became familiar with the system and as a result of growing levels of trust.

As is true in child fatality reviews, the OCDRB compiles statistical data in near-death reviews relating to causes and types of trauma, as well as demographic information, such as race/ethnicity, gender, and age. The Board compiles an annual report, which is disseminated to the legislature and to the public in order to monitor trends. This report also contains the OCDRB's annual recommendations for both legislative and procedural improvements.

Implementation of near-death reviews has posed certain challenges for the OCDRB. One key difference between child fatality and near-death reviews is that a child death is definite and unambiguous, while determining a child's injury or illness to be a "near-death" event requires judgment.

In spite of the potential for ambiguity, there are many reasons to routinely conduct near-death reviews. They include the following:

- Near-death reviews provide increased insight into the prevalence of child maltreatment in Oklahoma.
- They provide an additional format for systematic review of children's injuries from maltreatment.
- They promote increased communication and joint investigation opportunities between law enforcement and child welfare.
- They provide an additional safety net for maltreated children and their siblings.
- They highlight additional opportunities for prevention and intervention.

There are also challenges to implementing near-death reviews, which include the following:

- Near-death cases are more difficult to close, due to the need to ensure the safety of child victims and their siblings, and to conduct appropriate treatment and placement planning, which together result in extended review periods.
- Many families involved with child welfare agencies feel overly scrutinized.
- Board members experience more frustration regarding the outcomes of case review because of their concern for the welfare of the child victims.
- As the number of referrals increase, the Board could easily become overwhelmed with cases for review.

Overall, the process of near-death review has had a positive impact on the child fatality review process in Oklahoma. Reviewing near-death cases adds to the knowledge obtained from child death reviews. In addition, the collection of statistics surrounding serious child maltreatment injuries and fatalities provides data that can be used to identify areas in need of system improvement, from first responders to primary prevention and intervention. And, finally, this process allows for one more safety net to be in place for the protection of the victims of serious child maltreatment.

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Supporting Child Protective Services (CPS) Staff Following a Child Fatality and Other Critical Incidents

Mary L. Pulido, PhD, and Janine M. Lacina, MA

In 2009, over 64,700 reports of child abuse and neglect involving more than 90,000 children were made in New York City (NYC Administration for Children's Services, 2010). As *first responders* to these difficult and demanding cases, Child Protective Service (CPS) workers often deal with traumatic events related to their casework, such as child fatalities, severe child physical and sexual abuse, and violence directed toward them while in the field. In 2006, the New York City Administration for Children's Services (ACS) selected the New York Society for the Prevention of Cruelty to Children (NYSPCC) to develop and implement a crisis debriefing program to respond to the needs of CPS workers in New York City (NYC). This administration recognized the heightened potential for staff to develop secondary traumatic stress (STS) resulting from exposure to traumatic events in the course of their daily work.

The contract with ACS required the NYSPCC to conduct a series of focus groups for managers and front-line staff in NYC's five boroughs. The goals were to elicit information to inform development of the crisis debriefing protocol and to obtain input on the types of supports that would best help CPS staff in their work. NYSPCC would provide feedback and recommendations to ACS based on the analysis of focus group information. Consequently, NYSPCC developed the Restoring Resiliency Response (RRR) crisis debriefing protocol and currently uses it in crisis debriefings with New York City's CPS staff. The purpose of this article is to describe the process used to develop and implement the crisis debriefing model and to identify strategies for designing a child fatality review process that supports CPS staff.

A Brief Review of the Literature on Crisis Debriefing

Critical incident stress debriefing (CISD) was developed by Jeffery T. Mitchell and George Everly (2006). It is a multicomponent crisis intervention system designed to mitigate and prevent the development of disabling posttraumatic syndromes and stress disorders (Mitchell, 1988). The program was originally used by emergency services personnel, specifically firefighters; emergency medical technicians; and police (MacDonald, 2003). Treatment usually consists of one session—although more are possible—scheduled between one day and two weeks following the traumatic event. The session is a seven-phase, structured group meeting and is designed to achieve psychological closure after a traumatic event (Mitchell & Everly, 2006).

Studies monitoring CISD's effectiveness in reducing trauma symptoms have shown results along a continuum from positive (Campfield & Hills, 2001; Eid, Johnsen, & Weisaeth, 2001; Herman, Kaplan, & LeMelle, 2002; Mangone, King, Croft, & Church, 2005) to negative (Giddens, 2008; Van Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002; Harris, Baloglu, & Stacks, 2002; Orner et al. 2003; Van Wyk & Edwards, 2005; Marchand et al. 2006; Stallard et al., 2006). Other studies have reported mixed results concerning the efficacy of CISD (Humphries & Carr, 2001; Richards, 2001; Dwairy, 2005). This might suggest that some symptoms of posttraumatic stress disorder are reduced by the intervention, while others are not or are exacerbated. Seemingly, there is a lack of agreement in the research regarding the efficacy of CISD. It appears that although the intervention is not optimal for all cases, it works very well for others.

What Is Different About the RRR Model?

Following a child abuse fatality, intense scrutiny is placed upon every aspect of the case. Many questions need to be answered and reports need to be generated, all of which usually requires a rapid, multidisciplinary response from the legal, law enforcement, medical, and CPS systems. The central office's managers usually coordinate the CPS response. In the current program, it was important to ACS managers that the crisis debriefing protocol would not interfere with internal investigatory procedures.

The RRR sessions are not investigatory in nature, nor do they entail retelling the details of the event. The reasoning behind this approach is twofold. First, in direct contrast to the CISD model, care is taken to ensure that the RRR protocol focuses on the current stress reactions experienced by the workers rather than on discussing the details of the case. This allows workers to participate in the sessions without worrying about having to disclose factual information about the case currently under investigation. Second, there is rising debate over whether retelling the event does more to harm

certain individuals than to heal them. Many workers do not benefit from retelling the facts and reliving graphic details about the traumatic event (Blythe & Slawinski, 2004; Devilly & Cotton, 2004).

The goals of RRR sessions are to mitigate the impact of the critical incident and to accelerate the recovery process. Activities during the session are primarily focused on discussion of current levels of stress symptoms, validation and normalization of the reactions to the crisis, identifying support systems, and practicing coping-relaxation techniques. The sessions integrate education, emotional expression, and cognitive restructuring. The NYSPCC clinical team is trained in the RRR protocol and also has extensive training in traumatic grief and loss counseling. This expertise allows them to support CPS staff as they regain their sense of balance following crisis events in their workday.

Several important points drive the RRR model:

- Everyone experiences crisis differently. Each situation calls for an individualized response. The RRR clinician tailors the session outline, materials, and the types of stress management techniques to be used to the specific type of crisis event and the primary concerns of the staff involved.
- RRR utilizes a strengths-based perspective. Each individual is viewed as the authority in his or her personal recovery process. Crisis often causes people to lose connection with their past skills and strengths. Workers often state that they "feel that the rug was pulled out from under them." The RRR model enhances their competence by helping them reconnect with their strengths to access the supports and resources available to them.
- Each person may be at "a different place" in terms of participation in the RRR sessions. Some staff may still be in a state of denial or shock and may not participate fully, while others may engage in every exercise. The goal is to provide a safe zone for participants, which allows them to share their thoughts if they feel comfortable.
- The participants learn about typical stress reactions to traumatic events. They receive instruction on how to monitor their reactions to determine if there is a need for longer-term support. A self-assessment stress checklist with timeframes helps staff members decide if they are either making progress in recovering from the crisis incident or not recovering sufficiently. This enables them to manage their specific needs.
- NYC thrives due to a myriad of cultures, religions, and healing therapies all offering different types of support. The RRR approach is culturally sensitive. Participants define the support systems that will be most meaningful for them.

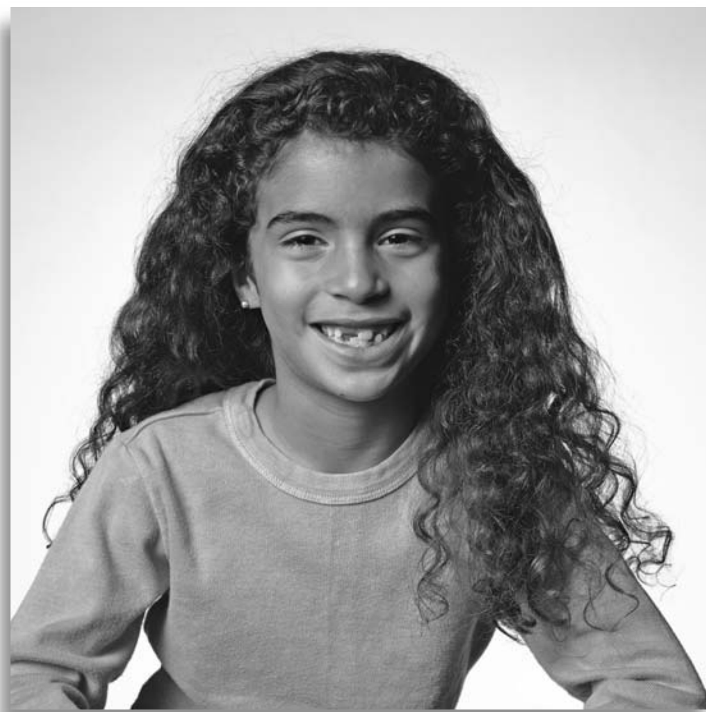
Focus Groups in the Five Boroughs of NYC

The NYSPCC conducted 13 focus groups with the New York City ACS staff. It was agreed in advance that managers and front-line staff would participate in separate groups to foster greater participation. Eight groups were conducted with 59 managers. Five groups were conducted with 46 front-line staff members. All participants were selected by the Borough Director's office with the intent to include workers with a wide range of experience—from those who recently completed their CPS training to those who had over 10 years of experience.

The groups answered 11 questions designed to gain insight into CPS staff needs after a child fatality or another critical incident. This article reports on the results of two of these questions:

1. What types of crisis situations do ACS staff encounter that should generate a crisis debriefing session?
2. How can this service be structured so that staff members are able to debrief regarding an incident?

Data analysis was completed in June 2006 and a report was prepared for ACS with recommendations on how best to implement the program



Situations That Warrant Crisis Debriefing

Child Fatality

Both management and front-line staff agreed that crisis debriefing services should be provided following a child fatality. One participant noted the following:

> I think child fatalities are the situations where we need this kind of debriefing. It's a family you've known for awhile. You've been working with them. You have a direct spiritual and physical connection to this child that was just killed. The media is looking at you to see what you've not done to save the child…and now you're seeing it as your fault for not saving that child. The stress is enormous. Meanwhile, they are demanding 24-hour reports, 48-hour reports, everybody is reporting to everywhere, Albany, central office, your director….

Child Sexual Abuse and Physical Abuse

Child sexual abuse and severe physical abuse cases were commonly cited among participants in both groups as needing crisis debriefing support. One participant stated,

> With sex abuse, if I go and see a little 6-year-old and some man sexually abused her, I'm ready to go after them. You can't separate yourself. You are only human.

Workers also asked for support following serious cases of child physical abuse. For example,

> I was thinking about a removal I did, seeing that child all burned up—the mother threw water on the child. Does anyone care about whether you are okay? It's just, next pending. And ever since that experience, I think workers need to have some kind of debriefing.

Violence or Danger During Field Visits

All groups agreed that debriefing should be conducted following situations of threatening behavior or actual violence against staff members while in the field. One group member stated,

> I have staff members who were traumatized, attacked by the client's dogs in the home. And not being able to escape, no help from the clients.

Staff also indicated that debriefings would be helpful following a stressful removal of a child, bereavement due to the death of a staff member, and citywide disasters such as the terrorist attacks of 9/11. They also requested regularly scheduled debriefing sessions to talk about the daily stressors of cases, not just after a fatality.

> I think everybody needs this once a month. I guarantee you if you put a counselor here, it's going to be over-packed.

Optimizing Participation in Debriefing Sessions

Both front-line and management staff reported they were willing to attend crisis debriefing sessions if offered. Additionally, they thought it best if debriefings would be considered a normal part of the procedure following a crisis, which would help staff feel more comfortable taking time to attend the sessions.

> As with the police or emergency responders, it is built into their protocol that this is what you do. They have the support from upper management… and then it becomes part of their schedule.

Both managers and front-line staff reported that it would be important to have full support from their supervisors in order to attend a debriefing session. One staff member stated,

> I think that since people feel so stretched and are stressed to just find time to do everything, that it needs to be packaged by management that this service is so valuable that it is worth me taking the time out—even though I feel like I have ten million other things I need to do right now. That debriefing will ultimately help me to better manage these ten million other things.

Focus group participants also recommended that staff members "spread the word" among each other (that is, if they had a good experience in a debriefing session) so that more staff would consider participating. Similarly, respondents believed that trust and security were essential for staff to feel comfortable participating in these sessions.

> Show them that this is a secure place; this is confidential. You are freely open to express how you feel. Until that message gets to the staff, there is going to be some hesitation. They need a place—a really safe place—to talk.

Putting the RRR Protocol Into Practice

One important factor that helped the launch of this service was support from the Commissioner of the NYC Administration for Children's Services (ACS), John B. Mattingly. As a firm proponent of offering debriefing support to his staff, he commented as follows:

> Child Protective Specialists perform the difficult tasks of conducting investigations and making decisions that are necessary to ensure a child's safety. As such, they encounter families at their most trying times, in situations that can be emotionally wrenching. In the course of doing their jobs, CPS workers may find themselves the victim of violence; they frequently hear threats of violence to themselves or their colleagues.
>
> Occasionally, some are hurt in the course of doing their job. It is most important that their needs be tended to, even while they devote their time to ensuring the safety of children. When our workers must deal with a fatality they are investigating, or when they or a colleague has experienced violence while on the job, ACS has turned to the New York Society for the Prevention of Cruelty to Children (NYSPCC) to provide crisis debriefing services for CPS staff to manage stress and to enhance their coping skills. ACS recognizes the importance of providing this support to caseworkers so that they can maintain their passion and compassion for doing this very difficult work. (S. Stein, personal communication, March 11, 2010)

The NYSPCC subsequently gave presentations to over 200 ACS managers regarding the new crisis debriefing service available to staff. In these sessions, the presenters discussed the benefits of timely support for staff and managers following a crisis in the workplace. The NYSPCC emphasized that management support for the sessions was critical to ensuring that front-line workers could attend and feel safe in the session. The NYSPCC also discussed managers' roles in helping coordinate the debriefings, helping to schedule the sessions, and providing information to the NYSPCC prior to the sessions. This information included the following:

1. What is the nature of the crisis incident?
2. How many staff members are involved?
3. How would you characterize their reactions?
4. What symptoms of distress are they displaying?
5. Are there particular staff members you are very concerned about?
6. Are you aware of other concurrent stressors for them?
7. Has there been media coverage?
8. Are group members willing to come to a debriefing or are they being told to come?

Having access to this information in advance of the debriefing helps determine how many clinicians should be assigned to the session; whether or not certain staff members require separate groups; and whether managers and front-line staff should be scheduled for separate sessions to maximize participation.

The ideal time to hold a debriefing session is between 24 and 72 hours after the incident. However, there may be a benefit in delaying the session if staff members need more time to become psychologically receptive to the intervention. Staff may also request support after several weeks have passed and individuals find they are not rebounding as they had hoped. Managers should select a time when the staff members are most likely to free themselves from other work to attend the 90-minute session. Debriefings should not be scheduled during their lunch hour. The NYSPCC clinicians conducting the debriefing arrive 30 minutes prior to the session to meet with management and to obtain information that was not available when the referral was made.

The RRR Session

The following steps are taken in an RRR session:

1. The clinician explains the crisis debriefing process. (If more than six staff members are present, two clinicians lead the session.)

2. Rules of the debriefing are discussed. The rules are as follows:
   a. Confidentiality is protected (what is said in the room, stays in the room). Participants do not have to speak but are encouraged to do so. Content of the meeting is not reported back to ACS. Creating a "safe space" is important. Confidentiality is not protected if a participant poses a risk to oneself or someone else.
   b. The session runs approximately 90 minutes. It is hoped that everyone will stay for the entire session. Computing devices and cell phones should be turned off.
   c. All personnel have equal status during the debriefing, regardless of their positions.
   d. Participants are encouraged to ask questions during the debriefing.

3. The clinician references the incident that led to the debriefing, asks the participants to share how they are currently managing the impact of the event, and facilitates discussion of participants' current emotions and stress reactions.

4. The clinician normalizes and validates participants' reactions as appropriate. The participants complete a stress reactions checklist. A discussion follows regarding the emotional, physical, behavioral, cognitive, and social reactions the participants are currently experiencing.

5. The clinician leads a discussion to help participants draw on their past experiences of handling stress and learn new ways of coping from each other. Cognitive behavioral therapy and relaxation techniques are practiced to enhance coping skills.

6. The participants receive handouts on self-care and discuss both professional and personal ways of coping during stressful times. A grounded breathing exercise is practiced.

7. Two exercises might be used to conclude the group. These are "Prideful moment at work" or "One thing I will do to relax tonight." It is helpful to have participants share positive thoughts at the end of the session.

8. The group is told that the NYSPCC clinician will be available for private discussion following the session. ACS Employee Assistance materials are also provided.

Ideally, staff members should have 5–10 minutes after a session to gather their thoughts or talk among themselves to offer support privately before they transition from an emotionally charged debriefing session to their daily routine.

Example of a Debriefing Session

A group debriefing session was requested following a critical incident in which a father killed his wife and child by slashing their throats. The unit was distraught and deeply affected by the incident, and several staff members were described as being in shock.

Nine workers were present for the debriefing session. The NYSPCC clinician introduced herself and explained the purpose of the session. Emphasis was placed on creating emotional safety by maintaining confidentiality and being respectful of others' perspectives and experiences.

Upon exploring participants' stress reactions, staff reported visceral reactions such as upset stomachs, headaches, and neck and backaches. Several participants reported sleep and eating pattern disturbances. They described feeling lethargic and experiencing "a fatigue that does not improve with sleep." Others expressed feeling enraged against the perpetrator. Several participants described how overprotective the incident made them toward their own children. One participant described feeling shock and disbelief that this fatality had occurred. This participant shared her relative inexperience with death in her personal life. As a result, the facilitator provided psychoeducation on the stages of grief and loss. The facilitator validated and normalized these reactions and provided psychoeducation on how stress symptoms can manifest following a traumatic incident.

Time was devoted to discussing self-care during times of acute stress. The oxygen mask analogy was used to emphasize the need to prioritize one's own self-care to be able to help others. Members shared coping strategies that included spending time with their own children, meditation and prayer, listening to music, exercise, and having a ritual to transition from work to home life, such as calling a friend or family member.

In an effort to place the fatalities into the larger context of work, the group shared a "prideful moment," an example of how the members' work had made a positive impact. The stories included seeing a baby with failure to thrive gain weight, having a client be thankful for helping him or her enroll in a substance abuse treatment program, and watching children be safely reunited with a parent after removal for neglect. Emphasis was placed on how these moments can help retain perspective when faced with a tragedy on the job. A focused breathing exercise was utilized to end the session.

Table A. Number of Debriefing Sessions and Participants by Different Types of Crisis (38 months)

Crisis Type	Sessions[a]	Participants[b]
Child fatality	38	168
Violence against staff in the field	32	149
Bereavement	23	274
High workplace stress	23	158
Client bereavement	7	31
9/11 support group	6	10
Violence against staff in court	5	14
Workplace threats	4	14
Severe physical abuse (severe burn)	2	20

Note: Data collected between November 2006 and December 2009
[a] *n = 140*
[b] *n = 838*

The facilitator provided contact information and information about Employee Assistance Programs, and explained that a follow-up session or individual counseling referrals could be arranged.

Feedback From CPS Staff

> I think that the debriefing was a great idea. It helped me to understand the anger and denial that I have been going through since this tragic death. (Comment on the evaluation survey form by CPS staff member)

As indicated in Table A, 140 sessions serving 838 staff have been conducted since November 2006. An evaluation survey was designed to elicit participants' opinions in the following areas: ability to identify their personal stress reactions, perceived safety regarding expressing their feelings in the session, future use of stress management techniques taught in the session, encouraging fellow staff members to attend a future session, and the helpfulness of the social work clinicians in addressing their stress concerns. Participants also were given the opportunity to provide written feedback in two sections of the survey.

There was a 69%-return rate for evaluation surveys following the crisis debriefings. As noted in Table B, surveys were returned from 578 of the 838 people who participated in a session over the 38-month period. Overall, the majority of the responses were positive in all categories. Following is a sample of participants' comments:

> This session should be mandatory for all workers who have a child fatality on their caseload.
>
> This session gave me more insight into how to take care of myself.
>
> It's good for the staff to be able to express themselves without worrying about judgments or confidentiality.
>
> At first I was skeptical about attending this session because I feared that what I shared could end up in my personnel file. However, once the session started, I felt very comfortable, relaxed, and at ease with discussing my feelings. I do feel better and will utilize the self care suggestions."
>
> I think that this session helped everyone open up and express their feelings. I would participate in another. The facilitator was very informative and helpful. Thank you so much for your time and support!

Table B. Percentage of Participants' Responses on Crisis Debriefing Evaluation Forms (N=578; 38 months)

Evaluation Questions	Very	Somewhat	Not
How helpful[a] was the session in helping you identify your stress reactions?	71	27	1
How safe[b] did you feel talking about your feelings in this session?	73	24	2
How likely[c] are you to utilize techniques discussed in this session for stress reduction in the future?	66	31	1
How likely[d] would you be to encourage a coworker to attend a debriefing following a crisis?	82	17	1
How effective[e] were the facilitators in addressing your concerns?	82	17	1

Note: Data collected between November 2006 and December 2009

[a] Answer choices were Very Helpful, Somewhat Helpful, Not Helpful.

[b] Answer choices were Very Safe, Somewhat Safe, Not Safe.

[c] Answer choices were Very Likely, Somewhat Likely, Not Likely.

[d] Answer choices were Very Likely, Somewhat Likely, Not Likely.

[e] Answer choices were Very Effective, Somewhat Effective, Not Effective.

Implications for the Field

Providing a safe space for CPS staff to voice feelings about traumatic events is important for strengthening personal coping and stress management skills and is instrumental in returning staff to previous levels of functioning. During the first 38 months implementing the RRR crisis debriefing protocol, the NYSPCC provided 140 crisis debriefing sessions to 838 CPS staff members. The evaluation results indicate that crisis debriefing is welcomed in CPS work. The adoption of similar intervention strategies would significantly benefit CPS staff nationwide.

The model developed for CPS in New York City did not interfere with the ongoing internal investigatory work needed after most critical incidents. Union and other legal concerns need to be addressed when implementing a program; otherwise, participants may be reluctant to engage in the session. When developing the protocols, all appropriate parties should have the opportunity to have their concerns addressed. This can expedite the launching of a crisis debriefing initiative.

Administrators also need to be cognizant of the sense of vulnerability experienced by front-line workers. The focus group data indicated that front-line staff would be less likely to use the intervention if it was internally administered. Comments from workers stated that they would be suspicious about how the information could be "used against them" and would be hesitant to participate. CPS staff were pleased that an outside agency that did not send reports back to the administration was conducting the sessions. Over the past 4 years, the development of a trusting relationship between the NYSPCC and the ACS staff has increased the number of staff members willing to attend a session. In turn, they recommend the sessions to their colleagues, enabling more workers who have encountered trauma on the job to benefit from the intervention.

To be able to respond to the daily challenges of child fatalities, severe child abuse and neglect, and violence against them during the course of their work, CPS workers need support systems that promote resilience and reduce their intense levels of stress. Services designed to help staff following traumatic events help reduce these levels because staff feel supported during their most challenging times.

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An Interview With Dr. Michael Durfee

Carolyn Beeler

In 1977, Michael Durfee was working as a child psychiatrist in the Los Angeles County foster care program when he initiated the first child death review. The project started small; he recruited a public health nurse to help him go through coroner's reports. Reviewing the cases, he says, was a way for him to cope with the fear of a child dying under his care, and an attempt to hold accountable those persons charged with protecting children.

The following year, Durfee launched the first organized, multi-agency child death review process. He thought that the anger people naturally feel when a child dies could potentially be channeled into something positive. If he could get the involved professionals to meet together, they could share what they knew about the child, and they might also find out what went wrong and how they had missed it. A group would also have the strength to face an issue individuals don't typically want to deal with.

For the first review group, Durfee gathered representatives from the Los Angeles police department, the sheriff's office, the coroner's office, and the district attorneys office, as well as workers in child protective services, mental health, and public health. Durfee indicates that at first, they were hesitant to talk about child deaths, but they soon saw the value in the reviews.

His model caught on. In 1982, the second child death review group was launched in San Diego County. Since then, teams have been organized in every U.S. state as well as in Canada, Australia, New Zealand, Hong Kong, Singapore, Japan, the UK, Lebanon, Malaysia, and the Philippines.

The *APSAC Advisor* spoke to Dr. Durfee about the evolution of child death review over the last 30 years. We have included a summary of his responses.

What are the greatest advancements that have been made in child death reviews since the first one you started in 1978?
First, there's more acknowledgment among the general public and among professionals that child abuse and child death exist. That allows teams to grow, and it gives their work more acceptance in the community. I could not have started this in 1968. At that time, there wasn't the cultural ability to accept new ideas about the potential for parents to seriously harm their children. And now, I think the review groups have encouraged even more acceptance by making child death something we can talk about and deal with.

Second, child death review is a fairly simple, self-sustaining process. Reviewing cases one by one allows agencies to share what they know about a child and family. The simplicity of the model, combined with the growing cultural acknowledgement of child death, helped to expand the model to 11 nations with almost no major source of support. Very few interventions have done that.

What are the elements of a successful child death review?

- **An inclusive case intake policy.** You need inclusive intake so you're not just looking at the notorious cases. In an ideal world, you'd look at all coroners' cases for people under age 18. If you have a 16-year-old who everyone knows committed suicide, and you're not sure if she was pregnant, you need to ask, "I wonder if she was molested and that's why she killed herself." You have to look at all the cases, not just the ones you want to, so cases don't fall through the cracks.
- **A review group that incorporates all professionals who were involved with the family.** Every group and agency that was involved with the case should be at the review. Preferably, you need to have line-level workers from all the agencies there.
- **A good system to collect and share information.** If you have five agencies that know the same family, you need to have one central way to share all that is known about that family. The most common way is to talk about it—which is better than nothing—but it's even better to put all that information into a database for everyone's reference.
- **A program to address nonfatal severe cases.** Some states already have these, and many death review groups also occasionally look at nonfatal severe cases. But there needs to be a systematic, organized review of all serious nonfatal cases. A child shouldn't have to die before agencies work with each other.
- **Grief and mourning programming for kids and families.** An ideal child death review program would have a systematic intake program for kids and families who are traumatized, including programming, like kids' groups and parents' groups that meet following a child death.
- **A way to meet other child death review teams in the area.** If you meet other teams, you may ask yourself, "Should we do what they're doing?" And it also creates connections among people in different jurisdictions, so if there's a multi-county case, line workers can talk to each other and communicate rather than going through managers, or not talking at all.

Child death reviews have been conducted for more than 30 years. What are some of the remaining challenges?
There's a major technical deficit with child death reviews: the failure to systematically act on lessons that come from the death.

Why is that?
To really learn from what we're doing, we have to examine ourselves, and we don't want to do that. If you unearth an old case to review and reveal that it was mismanaged, what are you going to do with that? Do you tell the defense the wrong guy is in jail; do you admit that your agency was at fault? Georgia's child death review team got an outside group (Emory University) to do an evaluation of their program, and I would recommend that for all teams.

In a perfect world with unlimited resources, what would child death reviews look like?
In a perfect world, groups would be more focused, their outcomes would be more predictable, and their activities would be more integrated—both within the group and with other programs. Part of this would be because of new computer programs and software. But the biggest change in a perfect world would be that teams would be tolerant of failure. If I can't say "I screwed up" in a child death review, there's a limited amount of learning that can happen for the future. Some people tell me they don't point fingers. I say, "If I screw up and a kid dies, you're going to be *nice* to me?" Pointing fingers is ok when it's done constructively and without placing blame. We keep score when young children play sports. We can measure ourselves when we address the death of a child. We must be able to learn from our mistakes.

Michael Durfee, MD, is retired after having worked with child abuse programs for 35 years. He now serves as the chief consultant to the ICAN National Center on Child Fatality Review.

About the Author
Carolyn Beeler is a freelance journalist. She works in both print and public radio and enjoys reporting on issues of social inequality. She has worked for National Public Radio, National Geographic Traveler, and Condé Nast Traveler.

Journal Highlights

Patti A. Beekman, BS, Stacey Saunders, MSW,
Judith S. Rycus, PhD, and Pam Quigley, MSW

Parents Who Kill Their Children

The authors of this article provide information about *filicide* (homicide of a child by parent) and the physician's role in prevention and in identification of at-risk children. Approximately 60% of child victims of homicide are victims of filicide by a parent or stepparent, and children under age 5 are at most risk.

In filicide cases, the child's death is most commonly an unintended outcome of intentional neglect or abuse, most often after severe head trauma. Other causative factors include birth of an unwanted child, altruistic motives, an acutely psychotic parent, or spousal revenge. "Altruistic" filicide occurs when parents kill their children believing they are doing what is best for the child, as in euthanasia of a severely chronically ill child or a depressed suicidal parent not wanting to leave the child behind. Alternatively, in "acutely psychotic" filicide, a psychotic parent kills the child for no rational reason, as in response to hallucinations. Least frequent is "spousal revenge" filicide, when a parent kills a child to punish the other parent.

Neonaticide is infant homicide by a parent the first day after birth. Mothers usually either have denied or concealed pregnancy and do not deliver in hospitals. Perpetrators are in their late teens to early 20s and unmarried, of lower socioeconomic status, and living with their parents. They may have experienced abuse, family dysfunction, and psychological issues, and the pregnancy may be the result of sexual abuse, incest, or a secret illicit relationship. To minimize family discord or coercion, physicians should meet with a pregnant teen without parents present at some time during the appointment. The physician can give information about prenatal care, Safe Haven laws, and help available from children's services and community programs. Ultrasonography of the developing fetus can help break through denial by providing a convincing visual aid.

Infanticide is child homicide by parents within the first postnatal year. Mothers are likely to be younger than age 19 with more than one child, receive no prenatal care, and experience mental illness or infant anomalies. Postpartum depression occurs in approximately 10% to 25% of mothers, who experience depression and anxiety leading to neglect, difficulty bonding with the baby, or even suicidal thoughts. Postpartum psychosis is more rare and usually occurs in the first weeks after delivery; data show elevated rates of both suicide and infanticide. Pediatricians and protective services personnel play an important role in recognizing postpartum depression or psychosis by evaluating maternal-infant interaction and bonding or having mothers complete the Edinburgh postnatal depression scale. Both postpartum depression and postpartum psychosis are treatable, and most mothers retain custody of their infants.

Mothers who commit filicide often are poor; are primary caregivers and socially isolated; and have experienced sexual abuse or domestic violence, substance abuse, or mental illness. Much less evidence exists regarding fathers who kill; typically, the father's age is mid-30s, and he has history of physical abuse or mental illness. Suicide occurs frequently in cases of both maternal and paternal filicide, but more so with father perpetrators. In addition to parental factors, infant characteristics including colicky infants, autism, and developmental disabilities or chronic illness may elevate risk.

Because child homicide by parents is not common and characteristics of filicidal parents also occur in parents who would never harm their children, identification and prevention is difficult for physicians. Pediatricians ‘ role includes asking new parents about problems and feelings of being overwhelmed, recognizing stressors, knowing mandatory reporting laws and procedures, and referring patients to psychological treatment, children's services, or specific social programs.

Friedman, S., & Friedman, J. (2010). Parents who kill their children. *Pediatrics in Review, 31*(2), e10–e16. Retrieved from: pedsinreview.aappublications.org/content/vol31/issue2/index.dtl

AAP Policy Statement on Child Fatality Review

The American Academy of Pediatrics (AAP) policy statement highlights the importance of child fatality review to prevent child deaths and advocates improving child fatality reviews through policy development, training, data collection, and data dissemination.

Child fatality review teams (CFRTs) are multidisciplinary committees with representatives from law enforcement, child protective services, coroner's/medical examiner's office, prosecuting attorney's office, the medical community, public health, and other community stakeholders. CFRTs were originally developed to improve identification and prosecution of fatal child maltreatment. The CFRT role has recently evolved toward a public health mode by attempting to prevent child deaths through systematic reviews of deaths in children from birth through adolescence. CFRTs also seek to develop and implement community prevention strategies and use evaluation results to modify and improve interventions.

Both the AAP and the American Bar Association (ABA) have endorsed local and state CFRTs. The AAP Division of State Government Affairs offers assistance and guidance to AAP chapters in developing public policy on CFRTs. This collaboration enhances understanding of the epidemiology of child deaths locally, regionally, and nationally; improves the accuracy of vital statistical data; and informs public health and legislative strategies to reduce preventable child fatalities. CFRTs exist at both the state and local levels but vary by state in team membership, relationship between state and local teams, criteria for case review, and policies and procedures for data collection. Currently there is movement to develop standards for child death review, and many states are working to adopt such standards. Despite these advances, however, no federal funding is available for state or local child death review, and not all states have attained the level of funding or leadership commitment necessary to meet national standards.

AAP Recommendations. National leadership and support are critical for expanding child death review to reduce the number of preventable child deaths in the United States. AAP recommends a uniform national approach to improve the child fatality review process, including standardizing child death reviews and data collection, providing training and technical assistance, enabling interstate and cross-jurisdictional data sharing, establishing confidentiality and legal protocols, and publishing reports of CFRT data. The AAP supports the development of federal and state legislation to enhance the child fatality review process and recommends that pediatricians work with state AAP chapters to advocate for death certification legislation and policies to establish funded local and state-level child death review systems. Additional AAP recommendations concern the consultative role of pediatricians and other physicians on the CFRTs and collaboration on local, state, and national policies to reduce preventable child deaths.

Christian, C., & Sege, R., et al. (2010). American Academy of Pediatrics Policy Statement: Child fatality review. *Pediatrics, 126*(3), 592–596.

Child Maltreatment Fatalities in Children Under Age 5

According to the National Center for Injury Prevention and Control, homicide is the fifth leading cause of death for children under 5 years of age, and child maltreatment is the cause for almost half of homicides in young children. Children in this age group consistently account for more than 80% of fatal cases of child maltreatment. This study describes the distribution of child maltreatment fatalities in children under age 5, as recorded in the National Violent Death Reporting System (NVDRS). NVDRS integrates data from multiple other data systems and, consequently, may provide a more comprehensive picture of child maltreatment fatalities than other data systems.

The authors of this article reviewed deaths reported to NVDRS in 16 states from 2003 to 2006. Of 1,374 deaths of children under 5, 600 (44%) were the result of child maltreatment. Over half of these children were under 1 year, and the reported cause of death was abusive head trauma (AHT). In children under age 5, two thirds of child maltreatment fatalities resulted from abusive head trauma (AHT), 27.5% were caused by other types of physical abuse, and 10% resulted from neglect. These data are consistent with the National Child Abuse and Neglect Data System (NCANDS), which identified a child's first year, and particularly first day, of life as a period of heightened risk. Fathers or their substitutes were found to be significantly more likely than mothers to be identified as alleged perpetrators for AHT and other types of physical abuse, while mothers were more likely to be responsible for neglect.

These data demonstrate AHT as a major cause of fatalities in child maltreatment. Educating new parents in maternity wards prior to discharge about dangers of shaking infants and about coping strategies for persistent infant crying could potentially reduce serious injuries from AHT. Additional research would establish whether similar activities during home visits, in pediatricians' offices, or through the media would be effective. However, information and home visitation strategies typically involve mothers and focus on prevention of neglect. The authors stress that to address AHT and other forms of physical abuse, preventive efforts must also focus on fathers and their substitutes.

Klevens, J., & Leeb, R. (2010). Child maltreatment fatalities in children under 5: Findings from the National Violence Death Reporting System. *Child Abuse & Neglect, 34*(4), 262–266.

Sibling Removal After a Child Maltreatment Fatality

Child protective services (CPS) agencies have a responsibility to protect siblings when child fatalities occur. Although researchers have explored factors related to risk of death from child maltreatment, there has been little examination of factors that increase risk of maltreatment or fatality for siblings of child victims.

In this research, Damashek and Bonner attempted to determine if socio-ecological factors related to child maltreatment deaths also predicted sibling removal. These socio-ecological factors included sibling age, history of CPS involvement, caregiver relationship to the child, gender of child, age of caregiver, family composition, and the type of maltreatment that caused the fatality. To answer this question, they reviewed 250 child fatality cases from a 10-year period in Oklahoma.

Findings from a bivariate analysis suggested that cases in which siblings were younger in age, had younger fathers, had a history of CPS reports, had an unmarried caregiver, or in which the fatality was a result of abuse rather than neglect were more likely to be removed by CPS. Results from logistic regression confirmed that the factors with the greatest capacity to predict the likelihood of sibling removal were sibling age, number of previous CPS reports, and type of maltreatment. In some cases, these findings were not consistent with factors related to risk of child fatality. Victims of child maltreatment fatalities in this sample were less likely to have had a history of child maltreatment and more likely to have died as a result of neglect rather than abuse. The researchers speculated that although more fatalities occur as a result of neglect, workers perceive a greater risk for fatality from abuse.

From this research, one can conclude that worker decision making about the removal of siblings following a child maltreatment fatality is not based solely on empirically supported risk factors. Rather, workers seem to be influenced by their perceptions of events, and they appear to perceive greater risk for siblings when children died as a result of abuse and had a prior CPS history. The authors conclude that when considering other factors, decisions about sibling removal should align with empirically-supported child fatality risk factors. They suggest that more investigation is needed of effective worker decision making about protecting siblings following a child fatality.

Damashek, A., & Bonner, B. L. (2010). Factors related to sibling removal after a child maltreatment fatality. *Child Abuse & Neglect, 34*(8), 563–569.

Effects of Citizens Review Panels in Preventing Child Maltreatment Fatalities

Most U.S. states have instituted child fatality citizens review panels (CRP) to review child maltreatment deaths and to make recommendations to state child protection agencies for changes in child welfare law, policy, and practice. In this study, the authors sought to identify changes in factors associated with child deaths after data from CRP reviews had been communicated to CPS. The study examined the annual number of child maltreatment deaths associated with each problematic finding during two 3-year periods: 1999–2001 (Period I) and 2002–2004 (Period II). These two periods provided adequate time for the recommendations made in Period I to be implemented and to affect future cases in Period II.

With the cooperation of state CPS, public health, law enforcement, and local district attorneys, the CRP created a comprehensive case file on each death to be reviewed. The problematic findings were logged into one of four categories: noncompliance with state law or policy; poor practice and decision making; inadequate existing law, policy, or procedure; or other barriers outside the child welfare system. The state child protective services agency developed action plans in response to the findings and recommendations in the CRP report. This study tracked the actual changes made in law, policy, or practice in accordance with the plan.

From Period I to Period II, there was a 35% decrease in problematic findings and a 9% decrease in child deaths associated with those findings. The CPS agency problem factors that had been statistically significant during the first period included screening out referrals, a time lapse between case assignment and direct family contact, improper completion of risk assessment, and the inability of a CPS worker to thoroughly assess all relevant data in the case. These problems were found to have decreased dramatically in Period II, suggesting that action had been taken to improve professional practice. However, the barriers existing outside the child welfare system had become more prominent during Period II, suggesting that while child welfare practices improved, other problem areas had not. Increases were identified in several areas. Medical professionals continued to fail to report suspected maltreatment to CPS, even after statewide physician training; child deaths were found to be a result of unaddressed mental health conditions; and medical examiner findings were often inaccurate.

As a result of the CRP review, Michigan addressed most of the problem areas associated with child maltreatment fatalities by making changes in law or child protective services agency policy and practice, thereby reducing the number of deaths related to these particular problem areas. The greatest positive effects came from changes in CPS investigation, assessment and service provision, training for workers and supervisors, peer review, and upgrades to the state's data system.

The authors conclude that citizens review panels can potentially reduce child deaths from child maltreatment by improving CPS practices. They further theorize that Michigan's CRP experienced success because its members were familiar with the child welfare system, and it employed a formal process to use data from reviews to

make recommendations for state action. The authors recommend further research to explore the relationship between CRP reviews and decreases in child maltreatment fatalities.

Palusci, V., Yager, S., & Covington, T. (2010). Effects of a citizens review panel in preventing child maltreatment fatalities. *Child Abuse & Neglect, 34*(5), 324–331.

The Seasonality of Child Homicide

Previous data indicate that the overwhelming majority of child homicides are due to child abuse committed by a caregiver. Small-scale research has not supported the anecdotal belief that the incidence of child abuse homicide, particularly abusive head trauma (AHT), increases during the winter months and around the winter holidays due to increased caregiver stress. However, significant seasonal effects are well documented in adult homicides, suicides, and violent crime rates, making parallel seasonality for child abuse homicide at least plausible.

This study examined seasonal and monthly variation in homicides in a large population of young children to determine if a relationship existed. The authors examined death certificates from 1999 through 2006 in Indiana, Ohio, Oklahoma, Missouri, and Washington for all children (N=797) younger than age 5 who were homicide victims.

The total population of children under age 5, and study subsets of children younger than 2 and between ages 2 and 5, indicated no statistically significant variation by either season or calendar month. The researchers conclude that there was no seasonality associated with child homicides. The authors suggest year-round preventive strategies that address caregiver responses to common stressors, including crying, toileting accidents, and normal childhood behaviors such as temper tantrums.

The authors also note that even though AHT is the leading cause of child abuse-related homicides against children younger than 4 years of age, they found no specific AHT code on death certificates reviewed for this study. They speculate that it may be possible that AHT deaths are seasonal or may increase around holidays, but further study would require a larger precise data source or multiple sources, including child fatality review program data.

Laskey, A., Thackeray, J., Grant, S., & Schnitzer, P. (2010). Seasonality of child homicide. *Pediatrics, 157*(1), 144–147.

Predicting Child Fatalities Among Less-Severe CPS Investigations

In an effort to better understand why child maltreatment-related fatalities have increased over the past decade, the researchers in this study attempted to identify variables present in maltreatment cases in which child fatalities occurred. The study sample included both cases that involved child fatality and a control group of nonfatality cases. The researchers considered both the severity and the chronicity of variables for both groups. Initially, the researchers conducted a comparative analysis and found that in the most severe cases, workers had recognized the severity and had responded appropriately.

In cases where these "actionable" variables existed (i.e., easier to identify and typically more acceptable as legal evidence of child maltreatment), these variables tended to be associated with decreased risk of child fatality. In other words, recognition of an immediately dangerous situation increased the likelihood that an effective safety plan would be put in place. Consequently, the most severe cases were not included in the predictive analysis. In cases where a "less actionable" variable was present, such as poor quality of attachment between a caregiver and a child, the risk of a child fatality increased. From the analysis, the researchers concluded that it was possible to identify specific sets of variables with "reasonably good predictive power" (p. 277) in less-severe physical abuse child fatality and nonfatality cases. However, the analysis also revealed that variable sets were considerably different for neglect cases. Therefore, while a model can be used to help identify child fatality risks in less-severe physical abuses cases, a similar model does not have the same predictive power in less-severe neglect cases.

The authors highlight the need for improved risk assessment instruments to better guide staff in recognizing risk factors in these cases. They further conclude that staff training is also needed, specifically around skills in gathering and recognizing information indicative of risk for future maltreatment and child fatality, and on the importance of consistent documentation and providing complete information about family histories of maltreatment.

Graham, J., Stepura, K., Baumann, D., & Kern, H. (2010). Predicting child fatalities among less-severe CPS investigations. *Children and Youth Services Review, 32*(2), 271–280.

APSAC News

APSAC Offers Advanced Training Institutes in January

Three APSAC Advanced Training Institutes are being held on Sunday, January 23, 2011, in conjunction with the 25th Annual San Diego International Conference on Child and Family Maltreatment.

APSAC's Advanced Training Institutes offer in-depth training on selected topics. Taught by nationally recognized leaders in the field of child maltreatment, these seminars offer hands-on, skills-based training grounded in the latest empirical research. Participants are invited to take part by asking questions and providing examples from their own experience. The 2011 Institutes include the following:

Teaching Caregivers to Talk With Children About Feelings: Implications for Treating Child Trauma
Presenters: Monica Fitzgerald, PhD, and Kimberly Shipman, PhD. 8 AM–noon, lunch break on your own, continuing 1–4 PM (7 hours)

Advanced Sexual Abuse Evaluation for Medical Providers
Presenters: Lori D. Frasier, MD, and Suzanne Starling, MD 8 AM–noon, lunch break on your own, continuing 1-4 PM (7 hours)

Advanced Forensic Interviewing
Presenters: Lynda Davies, BA, Michael Haney, PhD, Tom Lyon, JD, PhD, and Julie Kenniston, LSW. 8 AM–noon, lunch break on your own, continuing 1–4 PM (7 hours)

Details and registration information are available on the APSAC website under the *Events & Meetings* tab, *Event List*. APSC members should login with your username and password to save time during registration.

APSAC Issues Statement: Certification of Forensic Interviewers

At its Sept. 21, 2010, meeting, the APSAC Board of Directors voted unanimously to approve the association's *Position on Certification of Forensic Interviewers*, according to its President, Ronald C. Hughes, PhD, MScSA, who is Director of the Institute for Human Services, Columbus, Ohio.

Dr. Hughes explained that APSAC's Board spent a good deal of time reviewing the issue, discussing implications for APSAC and its members, and collecting feedback from members and other interested parties. He said,

> It is a complex issue, and that is why the Board worked diligently to get as much information as possible before issuing this statement. The bottom line is that APSAC believes that more research and development are needed before it can support a professional certification initiative of forensic interviewers.

A complete copy of the APSAC position statement is available on the organization's website at www.apsac.org. It also appears in this issue of the *APSAC Advisor* on page 31. In the meantime, the association urges its members and others to stay involved in the discussion. Toward that end, APSAC has established an email address, forensicinterview@apsac.org, where interested individuals can send comments and questions.

Now Available: *APSAC Handbook on Child Maltreatment, Third Edition*

Covering all aspects of child maltreatment—from prevention to intervention to treatment to the legal system—this seminal resource covers the latest research and practical information from leading scholars.

Key features of the revised edition, edited by John E. B. Myers, include the following:

- With approximately 80% new material and a completely reorganized structure, this resource has been thoroughly updated to reflect the most current scholarship.
- Some of the most notable experts from social work, medicine, mental health, nursing, law enforcement, and law have contributed to this volume.
- The editor and contributing authors deftly incorporate both theory and practical guidance throughout.

The *Handbook* offers additional resources for use by educators, including a test bank, quizzes, and supplemental journal articles for students. These can be found on the web at www.sagepub.com/myers3e.

To order your copy of the *Handbook*, visit the publications page of the APSAC website, www.apsac.org, and complete the order form. You may order online or download the order form in pdf format.

Mark the Dates: APSAC Advanced Forensic Interview Clinics

APSAC will host two Advanced Forensic Interview Clinics in the spring of 2011.

Feb. 28–March 4, 2011 — Virginia Beach, Virginia.

June 20–24, 2011 — Seattle, Washington.

Details and registration information are posted on the APSAC website, www.apsac.org.

APSAC's Position on Forensic Interviewer Certification

The APSAC Board has been gathering information on the question of professional certification of forensic interviewers. Throughout this process, the Board has sought insights from professionals across the country. In an effort to gather this information, we asked, Should APSAC support certification of forensic interviewers? The question assumed and was clearly framed in such a way that any certification program considered would be based on research and evidence-based practice. This resulted in a rich conversation among professionals both supporting and not supporting certification of forensic interviewers. The input has been extremely helpful.

For clarification, the child forensic interview is the neutral fact-finding investigative interview conducted in child abuse and other cases in which violence is witnessed. There are several national and state training models that provide information and training on how to conduct these interviews.

Professional certification is akin to licensing. Both are based primarily on rigorous psychometric testing and other empirically-supported eligibility requirements. Principal differences are that professional certification is nongovernmental and voluntary, whereas licensing is governmental and nonvoluntary. Certification, as a method of promoting worker competence and public safety, has strong theoretical and historical legitimacy when properly implemented, for appropriate populations, at the right time in a profession's developmental history.

There has been much discussion over the last several years among APSAC membership regarding the development of a certification program for forensic interviewers. In January 2009, APSAC established a subcommittee to research the issue of certification of forensic interviewers and to recommend an official APSAC position. APSAC has worked diligently over the last several months to engage members in fact finding and discussion.

At the September 21, 2010, Board meeting, the following APSAC position regarding the professional certification of forensic interviewers was adopted:

When properly implemented with appropriate populations, at the right time in their developmental history, professional certification, as a method of promoting worker competence, has a strong theoretical and historical legitimacy. The practice area of forensic interviewing has evolved to a point that an empirically-based universe of core competencies could be identified to underpin consensus training, guidelines, and professional certification. The development of consensus, empirically-based training of core competencies and forensic interviewer guidelines should precede any attempt to finalize professional certification for forensic interviewers.

Proper legal, administrative, and governance structure would be essential for any organization providing professional certification for forensic interviewers. This would include, but not be limited to, nonprofit status, a board governance structure that assures proper professional representation, and adherence to the guidelines of the Institute for Credentialing Excellence.

Irrespective of the general legitimacy of professional certification for forensic interviewers, there are context-specific issues regarding its effects on various professions that have not been appropriately researched. Research regarding potential negative repercussions should be assessed before a decision is made whether to proceed with professional certification of forensic interviewers.

APSAC believes that more research and development are needed before it can support a professional certification initiative of forensic interviewers.

If you have any questions, please contact:
forensicinterview@apsac.org

Washington Update

Thomas L. Birch, JD

Congress Postpones Action Until Lame Duck Session

In September, the House and Senate returned from their August break; however, with just two weeks left before adjourning again at the end of the month, there was little time—and even less political will—to accomplish much. Congress had been scheduled to work through the first week in October, but legislators chose instead to leave town with a backlog of bills waiting for the post-election session.

Again this year, Congress did not finish with its appropriations bills before the beginning of the new fiscal year. As their last official business before adjourning on September 30, the House and Senate passed a continuing resolution to keep federal agencies funded in the 2011 fiscal year, which began October 1. The continuing resolution sets spending through December 3 at current levels for most existing programs. The likely outcome when Congress reconvenes for the lame duck session is an omnibus funding bill that rolls all appropriations into a single measure to carry business through the entire 2011 fiscal year.

Before adjourning for the August recess, the Senate Appropriations Committee did approve the FY-11 Labor-HHS-Education appropriations bill with Child Abuse Prevention and Treatment Act (CAPTA) funds set at $105,519 million. The Senate bill includes level funding both for the basic state grants, at $26,535 million, and for community-based child abuse prevention grants, at $41.689 million. The measure includes an increase of $8,275 million over the current 2010 funding, with $10 million designated for new funding requested by the Obama administration to support a program of competitive grants for evidenced-based child maltreatment prevention programs focused on families with very young children who are at the greatest risk of child maltreatment.

In July, the House Labor-HHS-Education Appropriations Subcommittee approved its version of the spending bill. Details of the 2011 funding bill have not been made available, but summary information distributed following the subcommittee vote shows an overall increase in programs within the HHS Administration for Children and Families at $1,838 billion more than in 2010. Within that funding increase, children and family services programs would see an additional $1,037 billion in the coming year, although the distribution of those funds has not been specified. In addition, the subcommittee's plan would provide growth in funding for the Child Care and Development Block Grant with an increase of $700 million, and $866 million in new money for Head Start. However, both child care and Head Start funds would come in at some $100 million each below the President's proposed dollar levels.

The bill in the House does not appear to include the additional spending for CAPTA proposed by the President. In that case, when the final measure is resolved—reconciling the funding levels proposed by the House with those from the Senate—some difficult decisions will have to be made. The outcome for any new funding, such as that proposed in the Senate bill for CAPTA, will depend upon negotiations between the House and Senate setting final funding levels for FY-11. These decisions are expected to be made when Congress returns after the November elections.

Prior to adjournment, Senate Majority Leader Harry Reid (D-NV) announced his intention to deliver a final spending bill for 2011, which would set total discretionary spending at $20 billion below that requested in the President's budget, similar to a discretionary spending cap proposed earlier in the year by Sens. Jeff Sessions (R-AL) and Claire McCaskill (D-MO). For his part, Sen. Daniel Inouye (D-HI), who chairs the Senate Appropriations Committee, has indicated an intention to deliver discretionary spending totaling $14 billion below the President's budget. The House would be the more generous of the two chambers: Rep. David Obey (D-WI), Appropriations Committee chair, plans a target of $5 billion less than the President's budget in discretionary funds. However it goes, CAPTA spending and all other discretionary programs in the federal budget would be at risk coming into the final resolution for 2011 spending.

Senate Introduces CAPTA Reauthorization Bill

On September 22, long-awaited legislation to reauthorize the Child Abuse Prevention and Treatment Act (CAPTA) was introduced in the Senate by Sen. Christopher Dodd (D-CT) with Sens. Michael Enzi (R-WY) and Tom Harkin (D-IA). However, the fate of this legislation, S. 3817, remains in limbo. The bill was scheduled for markup by the Senate Committee on Health, Education, Labor, and Pensions (HELP) before Senators left for election campaigning, but the meeting was postponed until some time in November when Congress reconvenes. While no companion bill has been introduced in the House, there is an understanding between the two chambers that the House would follow after the Senate has acted on CAPTA reauthorization.

The CAPTA Reauthorization Act of 2010, S. 3817, addresses such themes as promoting differential response in child protective services, addressing the co-occurrence of child maltreatment and domestic violence, and sharpening the prevention focus of the community-based child abuse prevention grants.

The bill clearly reflects Sen. Dodd's interest in a differential, or alternative, response to child protective services, as he expressed at the HELP Committee's 2008 hearing on CAPTA. His bill intersperses provisions throughout CAPTA with multiple references to an alternative approach to protecting children from harm. It also charges HHS to address best practices in differential response through the dissemination of information, research, and training of personnel. It includes use of basic state grant funds to child protective services in support of differential response, and establishes a state grant eligibility requirement to identify policies and procedures around the use of differential response. The bill also would require state policies and procedures that encourage the involvement of families in decision making in cases of child abuse and neglect.

The bill's findings also include a new provision recognizing the co-occurrence of child maltreatment and domestic violence in up to 60% of families in which either is present, and it calls for the adoption of procedures aimed at enhancing the safety both of children and of victims of domestic violence. Other provisions in S. 3817 follow this theme, with directions to HHS to disseminate information on effective programs and best practices to promote collaboration between child protective services and domestic violence services; in research, technical assistance, and training; and through support for the development of collaborative practice. Services for children exposed to domestic violence would be an eligible expenditure of basic state grant funds, and states would be required to have procedures to address the co-occurrence of child maltreatment and domestic violence. The bill also includes services for children exposed to domestic violence and their nonabusing caregivers through an extensive list of services that can be financed through CAPTA Title II community-based child abuse prevention grants.

The Dodd bill sharpens CAPTA's focus on prevention with a broad mandate to support a broad range of community-based and prevention-focused strategies, services, and activities. The bill also seeks to enhance the involvement of parents in planning and implementing prevention services.

Finally, the Senate bill seeks to address the relationship between child maltreatment and substance abuse through research, technical assistance, program innovation, policies promoting collaborations with substance abuse treatment services, and improving the child welfare system's ability to intervene in situations when substance abuse contributes to child maltreatment.

Sen. Christopher Dodd (D-CT), who chairs the HELP Subcommittee on Children and Families and is retiring at the end of this year, announced early in 2010 that he fully intends to have CAPTA reauthorization passed out of the committee before the close of the current 111th Congress. The committee chair, Sen. Tom Harkin (D-IA), apparently assured him that this would happen. The work remains to be done.

McCarthy Introduces School Corporal Punishment Ban

On June 29, Rep. Carolyn McCarthy (D-NY) introduced the Ending Corporal Punishment in Schools Act (H.R. 5628). This legislation is aimed at eliminating the use of corporal punishment by schools, which is still legally permitted as a form of school discipline in 20 states. The bill would amend the General Education Provisions Act to deny federal education funds to any state or local education agency that has a policy or practice allowing school personnel to inflict corporal punishment upon a student, either as a form of punishment or for the purpose of modifying undesirable behavior. The bill defines corporal punishment as paddling, spanking, or other forms of physical punishment, however light, imposed upon a student.

The bill's provisions state that school personnel would be allowed to use reasonable restraint on a student whose behavior presents an imminent danger of physical injury to the student or others when less restrictive interventions would be ineffective in stopping the danger of physical injury.

When a local school district receives its federal education funds through the state, and the state permits corporal punishment but the locality does not, the local school board would receive its funding directly from the federal government. The legislation does not apply to home schooling.

To assist school boards in improving school climate and culture related to discipline, the bill authorizes the U.S. Department of Education to award 3-year grants for coaching and training of principals, teachers, and other school staff aimed at implementing evidence-based systematic approaches to supporting school-wide positive behavior. While the legislation is not likely to be on the list of bills Congress plans for action during the lame duck session this year, it will be ripe for consideration in 2011 when the House and Senate take up the reauthorization of federal elementary and secondary education law.

Funds Continue for CAPTA Evidence-Based Home Visiting

The 17 grantees funded under the Child Abuse Prevention and Treatment Act (CAPTA) for the 5-year evidence-based home visiting (EBHV) grants awarded 2 years ago will continue to be funded, despite suspension of that support by Congress last year. In allotting funds to each state for the new home visiting program authorized in the health care reform legislation, HHS has added to the allotment for each of the 15 states in which the grantees are located approximately $673,000 per year (equal to the EBHV grant amount) to continue support for these programs.

The FY-10 appropriations bill for CAPTA had dropped funding for home visiting on the assumption that health care reform legislation with a major new program of funding for home visiting—yet to be enacted—would take over support for those grants. That has now happened.

The grants will continue to be administered through 2013—the end of the EBHV grant period—by the Administration for Children and Families. The EBHV funding is contingent upon a state submitting an approvable plan in its application for the home visiting program. If a state does not apply for or receive home visiting program funds, the EBHV grantee will not receive an allocation under this program. A state has no flexibility not to fund these programs. Funding will also continue for the next 3 years for EBHV cross-site evaluation.

Conference Calendar

January 22-28, 2011
25th Annual San Diego International Conference on Child and Family Maltreatment
Chadwick Center for Children & Families
San Diego, CA
858.966.8572
jnelson@rchsd.org
www.sandiegoconference.org

January 23, 2011
APSAC Advanced Training Institutes
American Professional Society on the Abuse of Children (APSAC)
San Diego, CA
877.402.7722
apsac@apsac.org
www.apsac.org

February 28-March 4, 2011
APSAC's Child Forensic Interview Clinic
American Professional Society on the Abuse of Children (APSAC)
Virginia Beach, VA
877.402.7722
apsac@apsac.org
www.apsac.org

March 27-30, 2011
National Conference on Juvenile and Family
National Council of Juvenile and Family Court Judges (NCJFCJ)
Reno, NV
775.784.6012
dbarnette@ncjfcj.org
www.ncjfcj.org

March 27-30, 2011
2011 CWLA National Conference
Child Welfare League of America (CWLA)
Washington, DC
703.412.2400
state2011@cwla.org
www.cwla.org

March 28-31, 2011
27th National Symposium on Child Abuse
OJJDP, Child Protection Division
Huntsville, AL
256.327.3863
mgrundy@nationalcac.org
www.nationalcac.org

April 17-20, 2011
29th Annual "Protecting Our Children" National American Indian Conference on Child Abuse and Neglect
National Indian Child Welfare Association (NICWA)
Anchorage, AK
503.222.4044
info@nicwa.org
www.nicwa.org

May 15-17, 2011
2011 Black Administrators in Child Welfare Annual Conference
Black Administrators in Child Welfare, Inc. (BACW)
Philadelphia, PA
202.783.3714
bacw@blackadministrators.org
www.blackadministrators.org

June 1-4, 2011
48th AFCC Annual Conference
Association of Family and Conciliation Courts (AFCC)
Orlando, FL
608.664.3750
afcc@afccnet.org
www.afccnet.org

June 8-10, 2011
One Child, Many Hands: A Multi-discplinary Conference on Child Welfare
Children's Hospital of Philadelphia/Penn School of Social Policy and PracticePenn LawPenn MedicineWharton/Philadelphia Department of Human Services
Philadelphia, PA
215.573.9779 fieldctr@sp2.upenn.edu
www.onechildmanyhands.org

June 8-11, 2011
2011 American Humane Conference on Family Group Decision Making and Other Family Engagement Approaches
American Humane Association (AHA)
Henderson, NV
303.792.5333
info@americanhumane.org
www.americanhumane.org

June 20-24, 2011
APSAC's Child Forensic Interview Clinic
American Professional Society on the Abuse of Children (APSAC)
Seattle, WA
877.402.7722
apsac@apsac.org
www.apsac.org

July 13-16, 2011
19th APSAC Annual Colloquium
American Professional Society on the Abuse of Children (APSAC)
Philadelphia, PA
877.402.7722
apsac@apsac.org
www.apsac.org

August 25-27, 2011
11th National Conference on Child Sexual Abuse and Exploitation Prevention
National Children's Advocacy Center (NCAC)
New Orleans, LA
256.533.KIDS (5437)
mgrundy@nationalcac.org
www.nationalcac.org

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