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RESEARCH ARTICLE

Lessons for Child Protection Moving Forward: How to Keep From Rearranging the Deck Chairs on the Titanic

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Abstract

The Gary B. Melton Visiting Professorship was created to honor and celebrate the legacy of Dr. Melton and to encourage scholars and advocates to continue to build on his impressive body of interdisciplinary work on children's rights, global approach to child health and well-being, and social frameworks of family and community. A collaboration of the Haruv Institute and the Kempe Center for the Prevention and Treatment of Child Abuse and Neglect at the University of Colorado, the Melton Lecture was designed to be interdisciplinary, with the inaugural professorship and lecture given by a pediatrician and an anthropologist. This set of award recipients encompassed Gary Melton's concerns from the individual and family to the larger context of culture and community. In this inaugural Melton Lecture, we take as our starting point Gary Melton's quote, "Child abuse is wrong…." On this, we all can agree. Agreement lessens in response to the second part of the quote, "…the nation's lack of an effective response to it is also wrong…." Indeed, the field continues to grapple with long-standing issues on how to ensure an effective response to child abuse. We use this lecture to consider how to move toward an effective response without simply rearranging the deck chairs on a sinking ship.

Keywords Child protection · Prevention · Community

Introduction

"Child abuse is wrong. Not only is child abuse wrong, but the nation's lack of an effective response to it is also wrong. Neither can be tolerated" (US Advisory Board on Child Abuse and Neglect, 1990, p. 6).

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The mistreatment of children has occurred across time and space. In the early 1960s, concerted public and professional attention was stimulated with the coining of the term *the battered child* (Kempe et al., 1962). In the ensuing 60 some years, hundreds of state and federal laws have been passed; a "field" has been established with professional specialties, national and international conferences, and targeted journals; child protection agencies have been established; and research has made significant progress in better understanding the etiology, distribution, and outcomes of child maltreatment. There is wide agreement that child maltreatment is an egregious and far-too-common experience for children and that there must be a way to prevent this harm and to intervene to mitigate its effects. Finding the way to that end remains elusive after more than a half century of effort. Nevertheless, looking at almost any aspect of research, practice, and policy, the literature is rife with competing ideas and questions about whether the field is adequately serving children and families, with calls for a rethinking and reworking of approaches to child protection — its recognition, its treatment, and its prevention.

How Ought We To See and Understand the Problem of Child Maltreatment?

First, we need to recognize that *child maltreatment* is a very broad term that encompasses both abuse (physical, sexual, and emotional or psychological) and neglect (physical, nutritional, emotional, educational, and medical). Multiple forms may co-occur. Some broad interventions (e.g., reducing poverty, addressing housing issues) have been shown to positively impact several types of maltreatment (e.g., physical abuse and neglect) (see, e.g., Drake et al., 2022), but such approaches have little influence on sexual abuse, emotional abuse, and emotional neglect.

Second, the field still lacks adequate diagnostic/definitional criteria to assure that we are capturing all cases. The reliance has been on those cases reported to (and accepted for investigation by) child protective services (CPS), which rarely gets involved in out of family cases and does not share its data with law enforcement (which theoretically is involved with both intra and extra familial cases). The reality is that the majority of reports of abuse reported to either CPS or law enforcement are not investigated and do not get counted (Sedlak et al., 2022). Conversations with adult survivors of abuse over the years underscore the reality that psychological abuse may be the most prevalent form of all maltreatment and is generally ignored by everyone. Gilbert and colleagues used prevalence data to predict the annual incidence of abuse and neglect and found CPS data to underestimated incidence by a factor of 10 (Gilbert et al., 2009).

Third, each of these forms of maltreatment can occur within the nuclear or extended family and/or in community or other settings (e.g., schools, religious institutions, scouting) (see, e.g., Sedlak et al., 2022, for more details.). The setting in which maltreatment occurs can impact the definition, identification, and response.

Fourth, there is ample evidence that culture, context, community, and social determinants of health influence the distribution and etiology of child maltreatment, specifically physical abuse and neglect (Coulton et al, 2007; Nadan & Korbin, 2018; National

Research Council Panel, 1993). Community and cultural factors have been largely neglected; instead, the focus has been on individual and family characteristics (National Research Council Panel, 1993). This lack of attention to societal factors and structural racism has contributed powerfully to disparities and disproportionality in incidence and prevalence of child maltreatment (Dettlaff, 2020; Dettlaff & Boyd, 2022). In many places in the USA, the perception is that CPS is discriminatory in how it approaches families in the community (Roberts, 2022).

Fifth, the impact of child maltreatment on the child and the child's later development as an adult is quite variable. Indeed, there are several factors that influence later outcomes for individuals who experienced abuse as children. For example, it can depend on the type of abuse or neglect, the relationship of the child to the abuser, the dosage (i.e., number of experiences and length of time that the child experienced the abuse), whether there was treatment (formal or informal), and the socio-cultural and community context surrounding the child and family (Widom, 2022).

Sixth, the adverse consequences of child maltreatment, while also variable, can include poor physical and mental health, reduced life expectancy, and increased likelihood of anti-social or criminal behavior (Felitti et al, 1998). The outcomes of failing to prevent and/or treat child maltreatment have significant economic costs (Fang et al, 2012).

Seventh, 60 years into this problem, the amount of research has been and still is inadequate, which has and continues to hamper prevention and intervention efforts. While the amount of research being done as represented by the numbers of journals dedicated to child maltreatment has increased over the years, there have been repeated calls for better funding and application of research (Institute of Medicine, 2014; National Research Council Panel, 1993). Nevertheless, as these reports make clear, this abundance of published research remains fraught with contradictions, hampering prevention and intervention efforts. And further, better attention needs to be directed to making research evidence accessible to frontline users. In fact, in contrast to nearly all other common causes of infant and child morbidity and mortality, there has been no decrease in the mortality from child abuse and neglect for the past 60 years.

Eighth, a key component in effective child protection is that it is interdisciplinary. From the beginning, child maltreatment work has relied on the expertise of a range of disciplines. Years later, there are functional multidisciplinary teams at work in hospitals, child advocacy centers, and some communities (Rosenberg, 1988), but no such collaboration occurs within the municipal, county, state, and national governments to assure that the children and families being reported to them receive appropriate assessment and treatment. This was highlighted as a problem by the US Advisory Board on Child Abuse and Neglect in 1990 and has not yet been addressed.

A Brief History of Protecting Children from Maltreatment

Although the field of child maltreatment measures its beginning to the *Battered Child Syndrome* paper (Kempe et al., 1962), the field of child welfare marks its child protection beginning with the Mary Ellen Case in New York City in 1885. Child

abuse and neglect have been present for centuries. Several chapters and articles describe this history, each coming from a slightly different perspective (Krugman, 2017; Lynch, 1985; Myers, 2011; Ten Bensel et al., 1997). These different perspectives demonstrate both a strength and weakness of the work in the field. The strength is that each discipline — e.g., medicine, social work, law, anthropology, and psychology — brings a different perspective on the issue. The weakness is that none of these disciplines can alone "fix" the problem. And, although a multidisciplinary approach was modeled and taught by Kempe and his colleagues 60 years ago, as noted above, few, if any, government child protection systems are truly multidisciplinary. From our perspective, *rather than reinventing approaches to child maltreatment in response to the current inadequate systems in place, we should go back to the early work and actually implement it on a broad scale*. Rereading from cover-to-cover, *Helping the Battered Child and his Family* (Kempe & Helfer, 1972), would be a good start.

One reason for the failure of our current approach, in our view, is that the current child protection systems in the USA and Australia rely on *mandatory reporting*, a legal requirement for all professionals and others working with children. Matthews and Bross (2015) have explored mandatory reporting extensively and support the approach. Others (e.g., Melton) have spoken eloquently against it (Melton, 2005). Neither opinion is grounded in any empirical data to support the approach for the populations in the countries that have these laws.

Kempe lobbied state and federal governments in the USA to address "battered children." The initial work was *exclusively* focused on physical abuse and neglect within the family, and physicians at that time were for the most part oblivious to or not interested in the topic ("not in my practice"). Further, many were worried about losing their patients or (worse) being sued if they "accused" the parent of abusing the child. As a result, Kempe lobbied for mandatory reporting statutes. Reports needed to go to child welfare agencies, which in the 1960s and early 1970s were actually providing services to the affected families and seemed to be helpful. Family courts (civil) were sometimes engaged to provide structure to families that did not voluntarily agree with the fact that the child was abused or neglected (Kempe & Helfer, 1972).

The recognition (re-recognition, really) of sexual abuse dramatically altered the ability of child welfare to provide services (US Advisory Board, 1990) because sexual abuse was a criminal offense, and the approach to it was not geared to "helping the family." Both the mental health and public health nursing systems that were providing services in the early days changed their direction in the 1980s. Mental health became responsible for the thousands of deinstitutionalized mentally ill persons when inpatient hospitals were closed. And the visiting nurse services that were providing maternal–child health care were transformed into fee-for service home healthcare for the elderly. In our view, the child protection system in the USA has been "stuck" for at least the past 30 years with a nearly exclusive focus on investigation and with few, limited or no services available for affected child victims and/or their families. Most distressing, there are no outcome data to guide county, state, or federal child protection policy which, for decades, has been driven largely by scandal (Gainsborough, 2010).

The first phase of the response to abuse and neglect was to remove children from their homes and place them in foster care. Each year from the late 1960s to the 1970s, more and more children, particularly poor and inner-city children, were placed out of their homes. It only took a few years before cases of abuse in foster care began to grab headlines in local media. The legislative reaction to these cases led in the late 1970s to a swing in policy away from "saving children" to "preserving families," and efforts were made to keep children with their biologic families. Over the next decade (the 1980s), there were numerous media reports in several states on child abuse fatalities, 30–50% of which were children who had an open case with the local CPS agency. The pendulum of removal versus family preservation began to swing again.

The latest swing in the policy pendulum is toward a public health approach to child welfare. Lonne and colleagues (Higgins et al., 2022), the Commission on Child Abuse Fatalities, and Casey Family Programs advocate for this approach (Commission to Eliminate Child Abuse & Neglect Fatalities, 2016). Legislation (the Families First Act of 2018) allowed the drawing down of child welfare funding to support "preventive programming," although the "prevention" is targeted at keeping children from entering and re-entering foster care. It is too soon to know whether this policy will be effective. It has taken more than 2 years for the federal regulations to be written and the money to actually flow to the states in the USA. It should be noted that states have the option to participate and not all states have yet developed plans. What has been true from the earliest work in the 1960s is that the approach to child maltreatment has to be multidisciplinary and interprofessional. While there has been some success with this in hospital (e.g., child protection teams) and community settings (e.g., child advocacy centers), with the exception of the "confidential doctor system" (Marneffe, 1997) in The Netherlands and Belgium from 1973 to 2004, which was a health-based child protection system dismantled after child abuse deaths and a public outcry, we are unaware of many, if any, city, county, state, or national government that has been able to create such a multidisciplinary approach to addressing child maltreatment effectively in their jurisdiction.

There has been an emerging interest in adding *experience as expertise*, which involves seeking the perspectives of those who have experienced maltreatment as children (Andresen, 2019, 2021; Poland, 2022; President of the State of Israel, 2021) as well as the perspectives of children themselves (Bruck et al., 2022; Kosher & Ben-Arieh, 2020). The absence of sufficient information on whether the interventions by child welfare, law enforcement, the family, and criminal courts have actually *helped* children and families and left them physically and mentally healthier than when they were reported to the system is a huge problem. Having the perspectives of survivors of abuse — whether they have been part of the public child protection system over the years or not — could be enormously helpful to the field.

Government agencies are often balkanized by the source of their budget. ICPS is funded through the Administration for Children and Families (ACF), an agency on the Human Services side of the Department of Health and Human Services (HHS), which has no history of funding investigator instigated, peer reviewed research. This is in sharp contrast to the National Institutes of Health on the health side of HHS, which has funded hundreds of billions of dollars of basic, clinical, translational, and

outcomes research. This research is associated with the dramatic reduction in morbidity and mortality for nearly all childhood (and adult) diseases (other than child maltreatment) over the past 50 years.

What the Lessons Should Be Drawn from Our Successes and Failures in Prevention and Protection?

A previous issue of this journal discussed the challenges the field faces in research, education, and clinical policy. This special issue included a series of Disruption Papers commissioned by EndCAN. These papers responded to the question, "If we could have a do-over and, knowing what we know now, structure the child protection system (with research, training and prevention) that would actually work, what would it look like?" (Krugman & Poland, 2020).

Lack of a trained professional multidisciplinary workforce is a significant issue. The individual professionals who do this work come from medical, social work, graduate, or law enforcement training, which often includes minimal exposure to child maltreatment. There may be a few hours of lecture but little clinical practice. Furthermore, those professionals doing child abuse work in medicine, law, mental health, and law enforcement are the least supported financially and the least valued in their professions.

Try to Rationalize the "Archipelagos" Approach to Program Development Most of the service delivery to children and families impacted by child abuse and neglect is delivered by individual nongovernmental organizations that are usually chronically fiscally hungry and compete for funding every year. And the fact that within the public systems, every state, county, and municipality does not have published child protection policies and takes different approaches, complicates our ability to know whether they (and we) are accomplishing anything.

We Need Not Wait for All the Data To Be in To Act The 50 years of work on home visitation provide a good example of what has plagued the child abuse prevention community. Gray et al. (1976) showed the positive impact supportive home visitors had on high-risk (for abuse) mothers. Olds has more than 35 years of data from randomized controlled trials in three different communities from 1979 to the present in the USA. This data has shown that nurse home visitation reduces abuse (as well as having a myriad of other positive outcomes for the infant, mother and community). The Nurse Family Partnership https://www.nursefamilypartnership.org/about/proven-results/published-research/ has served > 58,000 families. Healthy Families America has hundreds of sites and has served > 78,000 families in the (https://www.healthyfamiliesamerica.org/). Family Connects in Durham (https://www.ccfhnc.org/programs/family-connects-durham/) now expanded to Guilford and other counties in North Carolina and has further demonstrated the efficacy of home visitation there (Goodman et al, 2021). Foundation funding has been critical to the support of all these home visiting programs, but there were 3.4 million births in the USA last year. That means that if Gray et al. (1976) were correct in assuming as many as 20% of

the parent(s) of new babies are at higher risk for abuse and neglect, these programs reach less than 15% of those in need. Further, all are operated out of nongovernmental organizations that rely on grant funding or donations to meet their annual budgets. Given the reality that *all* new parents can use help sometime in their new role, why is home visitation not embedded in health systems in the USA and elsewhere? In our view, home visitation has enough data behind it to make it a basic health benefit. For those believing "more data are needed," health systems in the USA and Europe now have a culture of measuring the quality and outcomes of their practice. If going to scale with home visitation brings unintended consequences, it should be recognized early and corrected. We should just do it.

A Call to Action: What Is Needed To Bring About an Integrated System for Earlier Intervention and Prevention Strategies Being in the Forefront of Our Endeavors?

While no threats to health and well-being have been successfully addressed without a broad public health approach, addressing child maltreatment in all of its forms will require more integration of health, mental health, social services, and community into a seamless system of care for children and families. Research toward this end must be ongoing and consistent and not subject to the vagaries of funding priorities but longitudinal as well as cross-sectional and sustainable over time. Many of the important health and public health problems that have been studied over the past decades have thrived because of the open spigot of funds coming from NIH and from nongovernmental organizations (e.g., the March of Dimes, American Cancer Society) that raise funds for research and training and advocate with congress for more funding for their interest area. Obesity, eating disorders, depression, suicide, and substance abuse are examples of disorders that have dramatically increased their funding for research over the past decades. All are disorders that have been noted to have higher rates in previously maltreated children than the general population. Yet few of these areas acknowledge the relationship of their issue to child maltreatment and have not adequately funded research on the relationship (Krugman, 2019).

There may be a helpful syzygy (i.e., a rare alignment of things) at this time. While child welfare systems talk about "public health approaches to child welfare," health systems are increasingly talking about addressing "social determinants of health." Further, health systems have increasingly embedded behavioral health professionals into primary care and other settings to make it easier for their patients to receive more comprehensive and effective care (Miller-Matero et al, 2015). Clinical cancer centers have behavioral health, nutrition, and other supports for patients and families and could be a model for dealing with child maltreatment (Babcock, 2020). A public health approach alone will not be sufficient. Getting to a completely integrated system that can assure that child maltreatment will be appropriately recognized and treated will be more difficult (Krugman, 2021). And even with this approach, one that is focused on the child and family unit, is not sufficient either. There need to be serious efforts made to engage the community to transform neighborhoods where

families feel isolated to those that are "Strong Communities for Children" (McLeigh et al, 2022).

Community-based programs have been proposed and promoted, but these are largely individual- and family-based programs in their implementation. There has been an increasing interest in community-based programs (Gross-Manos et al, 2020; Molnar et al, 2022). However, such programs are rarely aimed at addressing larger social determinants of health or community-based risk factors and are instead aimed at high-risk or previously identified families in targeted communities. There are outstanding examples of programs based in communities (Molnar et al, 2022). For example, the Nurse Family Partnership (https://www.nursefamilypartnership.org/), Family Connects and the Guilford Project (https://www.ccfhnc.org/programs/family-connects/), and Healthy Families America (https://www.healthyfamiliesamerica.org). These programs are delivered in a community context but are individually based and targeted at families who need and/or accept them. Rarely are these programs universal but more often based on risk because of resource and budget constraints. There also may be a range of programs in communities aimed at assisting families broadly, with child maltreatment prevention not the central goal, but these programs are often without evaluation and do not find their way into the literature on child abuse and neglect.

A notable exception is Strong Communities for Children, which was developed by Gary Melton and colleagues in South Carolina, USA, and adapted and implemented in Tel Aviv, Israel (McLeigh et al, 2022). This was the most ambitious project seeking to change the community context to protect children rather than changing at risk individuals within the community. Strong Communities for Children relied on a relatively small coordinating staff and large group of community volunteers engaging in a range of activities aimed at child and family well-being and prevention of parenting problems, including maltreatment. In its relatively short lifespan, Strong Communities for Children provided encouraging evidence that community-level intervention to provide a better context for children and families, reducing risks for child maltreatment (Melton and Holaday, 2008; Melton & McLeigh, 2020). Additional programming and research using this approach would add important value to public health approaches.

Concluding Remarks

After years of effort, it is clear that neither tweaking nor redirecting the hundreds of independent county and state CPS is likely to be successful. *Swinging the pendulum of child protection policy yet again without a way to measure its success (and potential failures) is unwise*. The lessons we have learned from the decades of work done by Gary Melton does suggest that change should begin with the community and the families that live there. They best understand their situations and their needs in contrast to the agencies that have their own missions. Listening to the hundreds of thousands of those who have had lived experience with our half century of trying to protect children would be a good step forward. Let us not waste another half century doing the same thing over and over — it is time to start over before we sink.

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