Medicine, Mental Health and Child Welfare: “Three different worlds that need to amalgamate”

June 2021 marked the 50th anniversary of the completion of my pediatric residency. Looking back over that half-century, it is remarkable how many of the conditions that shortened, disabled, or ended children’s lives are now either controlled, ameliorated or eliminated. Child abuse and neglect, a health issue that few people want to talk about, is an exception. The mortality from physical abuse in infancy has not changed in 50 years – mostly, I believe, because it is viewed as a social or legal issue, and not the health, mental health and public health issue it is. I have spent 20 years doing general pediatrics, 25 years overseeing $400,000,000 research and $600,000,000 clinical enterprises as Dean of a medical school, and 40 years working in field of child abuse and neglect. What strikes me, on reflection, is that success in any of these arenas only happens when there is an interprofessional, multidisciplinary approach to the problem at hand that includes the involvement of the children and families touched by the issue. What do we need to make such a vision more than hallucination?

The concept of a “medical home” surfaced in Hawaii in the late 1960’s during my residency and was championed by pediatrician, Cal Sia (Sia, 2004). He believed in having a “home” where the physicians knew the patients and could address their issues over time. There was no question that we believed that having continuity of care was less costly for parents and provided better care (even though we did not measure quality or outcomes in those years). More recently, the recognition that many patients need a mental health provider has led to the movement towards integrated care, greatly improving access to more comprehensive services.

On May 4, 2021, the National Academies of Sciences, Engineering & Medicine issued a report entitled, “Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care” (National Academies of Sciences, Engineering & Medicine, 2021) It advocates for high-quality primary care as “the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams that are accountable for addressing the majority of an individual’s health and wellness needs across settings and through sustained relationships with patients, families, and communities.” It is an outstanding report. Whether it will have any traction is testable – since it follows by 25 years the original Institute of Medicine (IOM) report on Primary Care (Institute of Medicine, 1996), whose recommendations got no political or professional traction.

Meanwhile, the field of child welfare is stuck. In the 1960’s and early 1970’s, child welfare appeared to be working, providing services to the children and families who were substantiated as dealing with physical abuse and neglect. The system crashed when it had to deal with sexual abuse in the 1980’s, all of which had to be investigated as criminal acts. Child welfare morphed from “helper” to “investigator”. The clinical social workers left for private practice and the workforce was mostly entry level baccalaureate graduates who go little to no training and lasted less than a year. Most importantly, there was no agreed upon child protection policy for communities, states, or the nation. By 1990, the US Advisory Board on Child Abuse and Neglect called the situation in the US a “national emergency” (Krugman, 1991).

In 1993, the IOM published its first ever report on Child Abuse Research with many recommendations to the National Institutes of Health (NIH). Unlike all other pediatric subspecialties, there had never been support for the training of researchers, much less funding on etiology, treatment, or prevention of child abuse. The second IOM report on child maltreatment, two decades later (2013), noted the lack of attention to the recommendations of the first. In 2014, after 24 years away from child abuse work while being Dean of a school of medicine, I was struck that nothing had really changed in how our nation was dealing with child abuse. The “emergency” still existed. So, I went back to work.

Today, there are some limited signs of movement. Casey Family Programs has been working to get the Directors of Child Welfare Systems in the U.S. to take more of a “public health approach” and “prevention” focus to their practice and move away from investigation-only. Many county or state agencies *are* supporting *differential response* (Merkel-Holguin, (2019) which responds to reported abuse with “How can we help?” rather than “We are here to investigate,” Meanwhile, primary care health professionals have increasingly talked about addressing social determinants of health, and as noted previously, there are systematic efforts to embed mental health into primary care practices. Both are laudable, and perhaps will give us the opportunity we need to finally get the amalgamation of health care, mental health, and child welfare systems we need for optimal child and family futures.

There are, of course, barriers that will need to be addressed, maybe even hundreds of them. They are similar to those that have been experienced in integrating mental health into primary care but may be even more complex. Let me list three as a start:

1. Workforce: The professionals working in child maltreatment come from medicine, social work, psychology, law, and law enforcement. Their training is siloed, and child abuse is a small part of the curriculum for any of these professions. There is no formal training in working across disciplines as a team with the purpose of helping children and families. The National Foundation to End Child Abuse and Neglect recently asked the field for “disruption papers” that might address training for the future. Several approaches were suggested, none of which have yet been tested (Krugman and Poland, 2020).
2. Funding: Physicians and the clinics in which they practice are mostly fee for service. So are behavioral/mental health workers (but at a lower rate). Child welfare is mostly funded by federal passthrough and state dollars. Blending and braiding funds across these separate funding streams would support shared accountability across sectors. The ideal practice of a team of these professionals is to have a capitated rate that can provide appropriate salaries to all members of the team.
3. Quality and Outcomes of Practice: The child welfare system in the U.S. (which has hundreds, if not thousands of iterations depending on which state or county one resides) has no idea what happens to the children and families they serve. Child welfare policy is driven by scandal, not data. That also needs to change, and having these teams based in a health care setting where measuring quality and outcomes is required for accreditation would be is a great start. Data sharing by the health, mental health, child welfare and education systems which is then available to the health provider *and* the family is critical. It wouldn’t hurt for family court judges to participate in this either.

If health and mental health professionals could get involved in prevention and treatment of child abuse and neglect, working with their child welfare colleagues who, today, have the legal authority to step in and treat, it could work. Getting from where we are to where we need to be will not be easy since each profession and agency, whether health, mental health and child welfare are so overwhelmed with the volume of work they have, there is no time for innovation. Further, I have noticed a surprising lack of understanding of the basic principles different disciplines take for granted. For example, the landmark 1998 paper on the long-term health effects of adverse childhood experiences (Felitti, 1998) took 15 years before the child abuse field began to notice, and last month I listened to a highly respected adult cardiologist and health outcomes researcher talk on social determinants of health and he made no mention of (and was completely unaware of) Felitti’s work! Working together in teams will accelerate cross fertilization and understanding among us.

There is no conclusion to this story – there is only evolution. One hopes that some of the major foundations that work exclusively in the health, mental health and child welfare spaces can also get together and collaborate to help us pilot and study models that will help us move toward the interprofessional system our patients and we need.

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