Advances and Retreats in Child Protection:
Lessons learned – challenges remaining
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• I have co-edited books that I will mention in the course of this talk.
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Objectives

• To review (briefly) the history of the field of child abuse and neglect.
• To highlight specific advances in the field over the past half century.
• To highlight specific retreats in the field over the past half century.
• To make several personal observations.
• To propose a change that could stabilize child protection systems for the foreseeable future.
A little history from a Colorado perspective

There are several well done histories written by several scholars that are less Colorado-centric (Ten Bensel, Lynch, Myers etc. As professionals in the field, it is worth knowing where we came from, why we did what we did and what mistakes we made.
Colorado General Hospital: 1925-2007
The Battered-Child Syndrome

C. Henry Kempe, M.D., Denver, Frederic N. Silverman, M.D., Cincinnati, Brandt F. Steele, M.D., William Droegemueller, M.D., and Henry K. Silver, M.D., Denver
Lessons learned from Henry

• Abusive parents love their children very much, but not very well. Our job is to help them do better.
  • Abused children also love their parents – they just want the abuse to stop.

• No single profession can effectively help abused and neglected children and their families: a multidisciplinary approach is crucial.

• “One at a time.”
Lessons learned from Brandt

• If you don’t understand someone’s behavior, you don’t have enough history. Sit down and have a conversation!

• Longitudinal follow-up studies on abusive families are important, but the very act of being interested in the abusers and coming back to see how things are going provides them an experience they may never have had in their own family.
Lessons learned from Ray

• “To prevent something bad, you need to enhance what is good”.

• Focus on stopping WAR – world of abnormal rearing.

• Created the idea of Prevention Trust Funds in the mid 1970’s which now pump an aggregate $200 million dollars into community based prevention programs annually.
Books I suspect most have not read

1972

Helping the Battered Child and His Family

Kempe, C. Henry

Note: This is not the actual book cover

1997

THE BATTERED CHILD

Mary Edna Haller / Ruth S. Kempe / Richard D. Hogman
Fitzsimons Army Medicine Center: 1918-1996
University of Colorado Anschutz Medical Campus
(What I was doing the last 25 years while you were all working)
Every significant advance is accompanied by a retreat

(Someone said that once)
Advances and retreats in the protection of children.

Krugman RD.
International approaches differ

• In the 1960’s, the US gave the responsibility for dealing with child maltreatment to the child welfare system.
  • By 1990, the US Advisory Board on Child Abuse and Neglect called the system “A National Emergency”.

• In the 1970’s, The Netherlands and Belgium created “Confidential Doctor Centers” in their health systems.

• Scandalous cases have driven policy change in the US and Europe.
• The US and Australia have mandatory reporting.
• Canada and European countries do not.
Advances:

• Recognition of child maltreatment as a health, public health, social and legal issue affecting children and families.

• Significant efforts worldwide through ISPCAN and National Professional Organizations (APSAC, BAPSCAN, NePSCAN, etc.) to improve knowledge, do training and disseminate research findings.

• Child Abuse Prevention Trust funds in the US

• Progress in evidence based programs for prevention and treatment.
  • Nurse-family partnership (Olds); Strong Communities for Children (Melton); SEEK (Dubowitz) and several examples of evidence based treatment (see Timmer and Urquiza).
Newer books I suspect most have not read

2013

Handbook of Child Maltreatment

2014

Evidence-Based Approaches for the Treatment of Maltreated Children
PHYSICAL ABUSE
1990-2012

54% Decline (1992-2012)

4.9% Increase (2011-2012)

Source: National Child Abuse and Neglect Data System
SEXUAL ABUSE
1990-2012

62% Decline (1992-2012)

2.1% Increase (2011-2012)

Rate per 10,000 Children (<18)

Source: National Child Abuse and Neglect Data System
Neglect Substantiation Rates: 1990-2012

Source: National Child Abuse and Neglect Data System
The preceding graphs are clearly progress and probably are an “advance” if we actually knew why the declines happened.

Thanks to David Finkelhor and his colleagues for the slides and the work.
Retreats

• Decades of inadequate funding for research in the USA – basic and clinical. NIH, in particular, viewed maltreatment not in its purview.

• The inadequacy of the research base has meant that practitioners in the child abuse and neglect (from most professions) are not as supported in their clinical practice as they need to be.
  • Example of misdiagnosis of sexually abused children in the 1980’s.
  • Dueling experts in civil and criminal court in Abusive Head Trauma cases
  • Dueling experts in physical abuse cases (e.g. rickets, glutaric aciduria).
Retreats

• No culture of measuring quality and outcomes in the various sectors of the child protection system worldwide.

• No implementation science driven practice diffusion.
  • How do we get what we know is effective for the 100 or 1000 children or families in our pilot prevention and/or treatment programs delivered, with quality, in all 50 states and more than 3300 counties to all the children and families who need them?
Advance, retreat or neither?

• The creation of “Child Abuse Pediatrics” as a formal subspecialty.
  • May be the only pediatric subspecialty that started before there was a reliable funding stream for research and training which significantly hampers the funding for fellows and sustainability of fellowship programs.
  • After an initial flurry of certification for the hundreds of pediatricians doing child abuse work before the subspecialty was approved, the most recent exam was postponed this past year.
  • Only five new fellows nationally for a 2016-2017 CAP fellowship.
    • “People don’t want to do research and don’t want to do three years”.
• Does provide “experts in child abuse pediatrics” for court testimony.
  • Not yet clear whether this has impacted effectiveness of primary care pediatricians and family physicians who are asked to testify in their local civil court setting.
Some personal observations

• There have been differing approaches to child protection which have different goals and use different legal approaches (if any).
  • One approach uses criminal courts to prosecute the abuser and works with the rest of the family to help them move on (evolved from adult rape crisis centers’ treatment of adult sexual assault victims in the 1970’s).
  • The other approach intervenes with the family using civil courts with the goal that the abuse will not recur in the family (which has been “preserved” when possible).

• Over the past 30 years both the civil and criminal court processes (particularly in the US and the UK) have become more adversarial with the use of the experts who confuse judges and juries to the best of their abilities all over the world.
Some personal observations

• After the release of the 1990 report suggesting the US CPS system was “an emergency”, I planned to go to Europe to look at Health Based systems to see if they were a viable alternative.
  • Project was never begun because I became Dean of the CU medical school.

• In 2015, I stopped being Dean and returned to The Netherlands and Belgium to do the study I wanted to do 25 years earlier.

• But, as often happens, not much stays the same after 25 years.
  • The Confidential Doctor approach in both countries had been discontinued.
  • When I asked why, it appeared that scandal had driven policy change and there were no data that could be presented to preserve the approach.
Some personal observations

• This past year, my colleagues and I have begun a qualitative study on the child protection systems in The Netherlands, Belgium and the US.

• It is an effort to understand how the systems are designed, what the guiding principals are, what is going well and what isn’t going well.

• We have completed nearly 70 interviews with 14 more being translated from Dutch to English and another potential 12-20 interviews to take place in Belgium next month.
Two Preliminary Observations

• The Child Protection System in Colorado seems to be in better shape than it was in 1990.
  • Discussion in the US now focuses on “differential response” – an effort to be more helpful and less punitive.

• The European systems are different than they seemed to be in 1990 and with their approach now closer to that of the US and UK (responsibility to Child Welfare and Law Enforcement with the help of the courts).
  • Dissatisfaction with how the system is working seems similar to that in the US.
  • Discussion in Europe is now about whether there should be mandatory reporting.
Some personal observations

• What is consistent all over the world is that few if any Child Protection Systems have a culture of gathering data on quality or outcomes.

• When one asks (anywhere) “How do you know that the changes you have made in your system are better?”, the consistent answer is: “We don’t.”
  • The data that are collected are process data: how many calls received, how many calls responded to or triaged, how many families seen, for how long etc. etc.
  • There are no data published on mortality rates, complications in assessment or treatment (if any), outcomes for either children or families.
  • There are still few really reliable data on the incidence of abuse, the incidence of cases of Abusive Head Trauma.

• Privacy laws are universally cited as an obstacle.

• And health data and child welfare and court data are firewalled.
Meanwhile, over the last 20 years there has seen a sea change in how the Health Care Systems in the US and Europe function. It will be worth a short digression to understand this.
“Humans, in all lines of work, make errors. Errors can be prevented by designing systems that make it hard for people to do the wrong thing and easy for people to do the right thing.”

**Recommendations:**
- National focus on leadership, research, tools, and protocols to understand safety;
- Identify and learn from errors through *mandatory reporting* efforts;
- Raising standards and expectations through oversight organizations, group purchasers, professional groups;
- Create a safety system inside health care organizations.
1999

• More people died from medical errors in the US Health Care System than motor vehicle crashes, breast cancer, or AIDS.

• Medical errors resulted in $2 billion in annual costs.

• If errors were discussed, it was done in confidential committees, often with an attorney present to assert “privilege” should there be a lawsuit.
Six aims to reduce medical errors:

- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- Equitable
100,000 Lives Campaign
2004

• “SOME” IS NOT A NUMBER. “SOON” IS NOT A TIME.
  • Specific goals need to be specified with timelines.

• Six interventions selected to reduce medical injuries

• Estimated to save 122,342 lives from Jan 2005 to July 2006
Institute for Healthcare Improvement: Triple Aim
2009

Experience of Care

Population Health

Per Capita Cost
Number of Hospital Acquired Conditions and Deaths Averted since 2010

- Hospital Acquired Conditions Averted
- Deaths Averted

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<th>Year</th>
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<th>Deaths</th>
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<tr>
<td>2013</td>
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Challenges for the future

• All sectors of the child protection system should embrace the concepts embedded in “To Err is Human” and “Crossing the Quality Chasm”.

• We should not allow concerns about privacy and confidentiality to be an excuse for a clinical practice that cannot document its quality and its outcomes.

• Data, not scandal, should drive changes in child protection systems. That will require re-education of the media and elected officials.

• It will also require identification of new resources (or more likely the reallocation of existing ones) to support the research and workforce to transform the way our public child protection systems operate.
Challenges for the future

• And it may require that the child protection system as we know it (which deals with intrafamilial abuse) be moved organizationally into the health care system for the next decade or two.
  • Health care will increasingly focus on integrating primary health care services with behavioral health making it easier to identify and treat adverse childhood experiences, which affect later health, mental health and social ills.
  • The health care system is more likely to be able financially to absorb these services than public child welfare or mental health systems.
  • The infrastructure and culture are in place to begin looking at quality and outcomes for these families, all of whose records should be in one place.
Conclusion

• The time to begin this transformation is now.
Questions and/or comments:

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