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# A Health-Based Child Protection System: Studying a Change in Paradigm

*Richard D. Krugman, Stephanie Stronks-Knapp, Mischa Haroutunian, and Jessica M. Yeatermeyer*

**Richard D. Krugman, MD,** is Vice Chancellor for Health Affairs and Dean at the University of Colorado Denver School of Medicine, Anschutz Medical Campus, *Richard.Krugman@ucdenver.edu.*
**Stephanie Stronks-Knapp** is a Staff Member at the Federal Bureau of Investigation, Denver Regional Office.
**Mischa Haroutunian** is a Fourth-Year Medical Student at the University of Colorado Denver School of Medicine.
**Jessica M. Yeatermeyer** is a Fourth-Year Medical Student at the University of Colorado Denver School of Medicine.


## INTRODUCTION

The child protection system in the United States is struggling: 18 years after a federal advisory board called the situation "a national emergency," there are still problems in many parts of the U.S.[1] For historic reasons, the responsibility for protecting children from intra-familial abuse has been given to departments of Child Welfare. These agencies, which years ago had a tradition of supporting and helping families, are now primarily involved in the investigation and substantiation of abuse and neglect, and there are relatively few resources available for treatment. The situation has been quite different in parts of Europe. When Belgium and the Netherlands designed their child protection systems in the 1970s, they put the responsibility for protection of children from intra-familial abuse and neglect within the Health System.[2] This system has been passionately proposed by Catherine Marneffe, MD, formerly a physician at a Confidential Doctor Center in Brussels, as the better way to approach this problem,[3] but there are no published data to support that view. Given the lack of outcome data for any large approach to child protection, it seems reasonable to test these two approaches prospectively and see which has better outcomes for children and families.

Relocating the child protection system represents a radical departure for addressing child abuse and neglect. This article reports on the rationales for a proposal to test the feasibility of a health-based child protection system in Denver, Colorado. It was supported by a grant from the Hasbro Children's Foundation. While the testing is not yet completed, we want to report our experience to see if others would be interested and whether there is broader support for the concept. If successful, such an approach could mark intra-family violence as much a medical problem as a social one, alter societal approaches to the issue, and serve as a model for addressing other types of family violence.

Denver was selected for several reasons. First, the awareness of child abuse and neglect in the health professional community there is very high. Denver generated the cases for the classic article by C. Henry Kempe and colleagues, "The Battered Child Syndrome."[4] Since 1958, generations of physicians, nurses, physicians' assistants, and other health professionals in Denver have had the benefit of decades of training

and 24-hour-a-day, 365-day-a-year consultation services available through a physician-social worker child protection service at the University of Colorado School of Medicine. Second, the Denver Department of Social Services was a willing participant in the feasibility study. In fact, the department had been concerned for several years about its inability to provide enough services to families reported and substantiated for abuse and neglect. Third, Denver Health is an integrated public health, mental health, and physical health system that reaches into all neighborhoods in Denver to provide services to the Denver population. Fourth, the professionals who could support and staff such a health-based child protection approach were readily available at the Kempe National Center for Prevention and Treatment of Child Abuse and Neglect.

## OUR APPROACH

We proposed to recruit and train a team of professionals to recognize and treat children and families for whom there were concerns about physical abuse and child neglect, using protocols similar to those used by the Confidential Doctor Centers in Europe. To assure that the legal responsibility for child protection remained with Denver Child Protection Services, we proposed that one or two members of the team of professionals we would assemble would be social work staff who are employed by Denver Child Protection Services. We further proposed that the team of professionals would be randomly assigned to every fifth or tenth call received by the Denver Child Protection Services hotline, and outcomes would be compared between the Denver Child Protection Services agency and the proposed team of professionals.

Conversations were held with the professionals at Denver Child Protection Services, the Denver County Attorney's Office, Juvenile Court, and the Denver Health System. Several were in favor of the experiment; others wanted to see the details. To gather more information on the health-based model in Europe, two of the study personnel visited Confidential Doctor Centers in Belgium and the Netherlands, and Community Centers in Berlin in the spring of 2005. Much had changed there since Dr. Catherine Marneffe's earlier description of a program that was supportive and therapeutic to all members of the family, including the abuser, while still protecting children from further harm.[5] In both Belgium and the Netherlands, public reaction to mismanaged child abuse cases had led to replacement of the previous "compassionate" approach with a more law-enforcement-based "control" approach. In fact, nine of the 10 Confidential Doctor Centers in Belgium had been closed, and cases were referred directly to the police and the family courts. The Dutch Confidential Doctor Centers were also closed, and the pediatricians who had been involved in family intervention were now doing forensic analysis to assist the police and courts. Ironically, the two cases that helped to trigger these changes did not involve intra-familial abuse (which was the focus of the health-based Confidential Doctor Center approach). Rather, one case, in Brussels, involved the kidnapping, sexual abuse, starvation, and murder of girls by unrelated pedophile sex offenders. The other concerned the sexual abuse of children in a day care center in the Netherlands. Nevertheless, public backlash against the failure to protect these children led to a more punitive, coercive approach to child protection generally.

In light of this change in policy and our inability to study outcomes of the previous European approach, a "hybrid" approach combining the health-based approach previously used in Europe and our own child welfare-based approach was suggested as the best one to test in the U.S. Such an approach would include the training of a multidisciplinary team (including pediatricians, social workers, psychologists, and/or psychiatrists) to assess and treat the behavioral dysfunctions of families who came for care. Because child protective services agencies are legally required to be involved with all families when abuse or neglect has been substantiated, it was not possible to conduct a randomized control trial of the original Confidential Doctor Center approach with our proposed health-based team.

As a first step to demonstrate the feasibility of a health-based approach, we proposed to contact families who had been reported to Denver Child Protection Services, but who had been triaged over the telephone as "not being a case to investigate." We believed that a significant number of these families were at risk of being abusive or neglectful. The European experience suggested that these families would be amenable to help — particularly if there was no formal involvement by Child Protection Services or law enforcement agencies.

Offering these families supportive social services, parenting classes, day care, or other forms of assistance would provide a trial-run for the health-based team, and, should the approach prove to be efficacious, could provide the data needed to obtain the legal waivers necessary to then do a randomized trial of all cases coming into the Denver Child Protection Services hotlines. We assumed that among the "triaged cases" would be collectible data to measure "recidivism," that is, another call to the hotline, this time confirmed. The rate of this "recidivism" could be compared to the cohort of "triaged" families who received the social and mental health services from the health-based team.

This approach was supported by the Denver County Attorney's Office. Because Denver Child Protection Services will have triaged all of the families over the telephone, it would no longer be responsible for providing care to those families. We are in discussions with judges of the Juvenile Court to learn whether they would be comfortable with this experiment. If so, we would look for grant funding to implement the team within the Denver Health System.

## REASONS FOR TESTING A HEALTH-BASED APPROACH

A health-based approach to intra-familial violence could provide a number of benefits. Clearly, the health system has little to offer in the investigation or treatment of abusers who harm children outside the family. The commission of physical and/or sexual abuse on an unrelated child is clearly a crime, and needs to be addressed as such by law enforcement and the criminal justice system. Intra-familial abuse may be a different matter, however, in part because the incarceration of a parent or major caretaker is enormously disruptive to a family and inevitably leads to the coercion of the child-victim to recant. Most children who are abused inside the family want two things: they want to be believed that the abuse is happening, and they want it to stop. However, most also wish that the family can be kept together. Early reports by Kempe and Helfer[6] in the late 1960s and 1970s suggest that multidisciplinary treatment was possible for physically abusive families, and work by Giaretto[7] extended the multidisciplinary approach pioneered by Kempe and Helfer to families with first-time incestuous fathers in Santa Clara County, California. To the extent that the reports suggest non-punitive approaches may be successful, we believe that they should be tried and evaluated in the context of the child protective services system in place today. We believe providing treatment in a health system context is less threatening to families.

Further, recent articles and work by different groups of investigators in mouse, primate, and human studies suggest that there may be a genetic basis for abusive and neglectful behavior.[8] If there is a biologic basis for the behavior, or a biologic basis that underlies whether a child survives the trauma or "repeats the cycle" as an adult, then increased involvement by the health system in the recognition, treatment, and prevention of abuse and neglect seems appropriate. Approaches to alcoholism and substance abuse have taken a similar path: 50 years ago, these addictive disorders were considered to be social problems and were dealt with primarily by law enforcement. Now the biologic basis of these disorders is recognized. And while biology is not an excuse for criminal behavior — and criminal prosecution is appropriate for the injuring and/or murder or sexual assault of another person or child — understanding the basic biology of addictive disorders has led to better treatment. The same approach could be successful for child abuse and neglect, and, if proven, would be good cause for having health system involvement in the treatment and prevention of these problems.

Another reason for engaging the health system in the treatment of child abuse and neglect is a financial one. The public child welfare systems in the U.S. are struggling financially. They only have enough resources to investigate 60 percent of the calls that come into their hotlines, and finding resources for treating the more than 800,000 substantiated abuse cases in the U.S. annually is unusual. The health system in the U.S. is incredibly rich by comparison. While physicians and hospitals complain about "cuts" in federal Medicare and Medicaid programs, these "cuts" are *reductions in the rate of increase* of annual spending for these programs. There has been no year, since the inception of these federal health programs, that their annual budgets did not actually increase. Public child protection agencies would have loved to live through

these types of "cuts" through the years. In Colorado, state agencies lost 42 percent of their state funding between 2001 and 2005. The healthcare system could probably absorb the costs of treatment for abused and neglected children and their families by hiring the therapists and coordinating the care of these families. There are data documenting the significant hospital costs for seriously abused children.[9] Preventing and treating these cases is well within the realm of the health system.

Finally, the health system can have a huge role in prevention. Physical abuse is preventable. Randomized controlled trials by Olds found strong evidence that public health nurse home visitors can prevent the physical abuse of children.[10] The weight of this evidence-based approach suggests that it is, in fact, unethical to not implement this program as a basic benefit of public and private health plans in the U.S.

## CONCLUSION

In the 45 years since our recognition of child abuse and neglect, the public child welfare system in the U.S. has found it increasingly difficult to protect children from abuse and to treat them and their families. State and federal law require that this approach — which has no base in evidence — continue, in spite of many calls for change. Although there is also no evidence to support previous health system-based child protection systems in Europe, history supports the need to design new approaches to the protection of children and the treatment of them and their families. The healthcare system offers a promising locus of responsibility for enhanced child protection services. Studying approaches such as the one described may indicate how best to address child abuse and neglect.

## NOTES

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4. C.H. Kempe et al., "The Battered Child Syndrome," *Journal of the American Medical Association* 181 (1962): 17-24.

5. See note 3 above.

6. C.H. Kempe and R.E. Helfer, *Helping the Battered Child and His Family* (New York: Lippincott, 1972); R.E. Helfer and C.H. Kempe, *The Battered Child,* 3rd ed. (Chicago: University of Chicago Press, 1980).

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