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Struggling to Stem the Tide of Child Maltreatment

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Many *JAMA* readers understand that child maltreatment is a pervasive public health and costly societal problem with devastating consequences to the long-term physical health, mental health, and well-being of surviors.[1–3] But few have witnessed what we see on a regular basis: the lost futures of chronically neglected children who have never experienced the stability and safety of a nurturing family; the mental health challenges of adolescents who have been sexually abused and assaulted for years by their caregivers; the permanent neurologic injuries of infants who have survived abusive head trauma; and the battered bodies of murdered toddlers in our local morgues. As primary care pediatricians, hospitalists, and child abuse experts, these neglected, abused, beaten, and battered children are our patients, and it has been an uphill battle to stem the tide.

We were therefore disheartened, but not surprised, to read the conclusions from the US Preventive Services Task Force (USP-STF) commissioned systematic review of the evidence on primary care–feasible or referable behavioral counseling interventions to prevent child maltreatment: the evidence is largely insufficient to make a recommendation for or against, and where it exists, it is inconclusive.[4,5] Every day we see our patients' caregivers doing their best with the resources available to them. We also see that those resources—food security, housing stability, accessible treatment for substance use and mental health disorders, effective and developmentally appropriate strategies to manage typical child

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behavior, and affordable childcare—too often fall short. We would like to think there is something we as pediatrician scan do help our patients and their families to strengthen their resources and reduce the risk of maltreatment. So, what does this USPSTF recommendation mean? Is the only available response a referral to Child Protective Services (CPS)? Should we abandon the prevention strategies available to us as physicians?

The bottom line is no, prevention efforts should continue. We contextualize this clear bottom line with 3 considerations. First, complicated multifactorial societal problems such as child maltreatment require societal investment in strategic solutions that target multiple contributing factors. No single prevention intervention will tip the balance. Second, the inability to accurately measure the outcome of child maltreatment makes it challenging to determine prevention effectiveness; for this reason, proximal measures of maltreatment (which may be more accurate) should be embraced. And last, a lack of evidence to support the benefit of primary care–based child maltreatment prevention efforts does not mean that they are in effective—only that the evidence is lacking, as it is for many pediatric primary prevention strategies.

The effectiveness of select pediatric prevention interventions such as vaccinations and fluoride varnish has been clearly demonstrated.[6,7] And although these prevention breakthroughs took ground breaking scientific discovery, the problems they addressed were primarily biological, with clearly defined and measurable outcomes. Child abuse and neglect, on the other hand, is a complex, multifactorial, widespread societal problem, which no single person, intervention, institution, policy, or program can solve. Multifactorial problems require multifactorial solutions; in the absence of societal investment in programs to support families and mitigate the risk factors that increase a child's vulnerability to maltreatment, a primary care–based intervention studied in isolation is unlikely to register on existing blunt and inadequate measurement tools. Large societal factors influencing child maltreatment include the health, economic, educational, and social policies that perpetuate economic and social inequalities in the US. Thus, prevention requires policy intervention at the societal level. For example, policies addressing Medicaid expansion, paid family leave, earned income tax credit, and lack of waitlists to access subsidized childcare have each been associated with a decrease in child maltreatment.[8–15]

To assess the effectiveness of primary care–based child maltreatment prevention programs, one must be able to measure maltreatment as an outcome. Multiple prevention studies were excluded from the USPSTF review because they did not report on either a direct measure of abuse or neglect (report to CPS or removal of child from the home) or a few specified proxies for abuse or neglect (injury, emergency department encounter, or hospitalization). While CPS outcomes and medical encounters are important to measure, they do not fully capture cases of maltreatment, even those that are fatal.[16] CPS reports both underestimate the problem and are racially biased, falsely suggesting that child maltreatment is more common in non-White families.[17] Medical outcomes also capture only a portion of cases. Examining multiple outcomes on the causal path way of child maltreatment might provide a framework for evaluating how primary care interventions are contributing to prevention. For example, a primary care–based positive parenting intervention that reduces child behavior problems and harsh, punitive parenting may help

prevent physical abuse. A primary care–based partnership with mental health clinicians to address postpartumdepressionmayreducetheriskofabusiveheadtrauma.Primarycare–basedmedical legal partnerships that prevent family evictions and care management programs that increase family enrollment in SNAP benefits may reduce the risk of child neglect. Proximal outcomes along a causal pathway have been used to evaluate the effectiveness of other prevention interventions and should be considered for child maltreatment. For example, based on Evidence that counseling about minimizing exposure to UV radiation is associated with a moderate increase in use of sun-screen protection, the USPSTF recommends that counseling be provided to certain populations. The USPSTF did not require direct evidence that counseling decreases skin cancer.[18]

In addition to research using more proximal outcomes, evidence from studies that apply rigorous methods other than randomization at the individual level should be considered. Research on some primary care interventions, such as Safe Environment for Every Kid (SEEK) and the Positive Parenting Program (Triple P), was not included in the USPSTF review, at least in part because randomization did not occur at the level of the child or caregiver. Individual randomization requires large sample sizes and long follow-uptimes to detect changes in the relatively rare outcomes of CPS reports and maltreatment related hospitalizations. Such studies are expensive, logistically difficult, and potentially unethical. The feasibility of conducting studies using randomization at the individual level becomes increasingly challenging when assessing the efficacy of maltreatment interventions for older children. The rate of substantiated reports of child maltreatment decreases by half after a child's first birthday but remains unacceptably high. Not surprisingly, all but 2 studies in the USPSTF review were home-visiting interventions, and 60% of included studies enrolled participants in the prenatal or neonatal period. Quality research is needed to evaluate the benefits and harms of interventions other than home visiting and those delivered beyond in fancy and early childhood.

The insufficient evidence on which to base a recommendation found by the USPSTF does not mean that primary care child maltreatment prevention efforts are ineffective, only that the evidence is lacking. More high-quality research is needed, as is called for by the USPSTF. Given the inadequacy of the current gold standard measures of child maltreatment, proximal outcomes on the complex, multifactorial, causal pathway to child abuse and neglect should be considered. Consequential prevention is not possible in the absence of sustained societal investment in policies and programs that provide tangible support to families, reduce childhood poverty, and target relevant risk factors. But it is not yet time to wave the white flag of surrender and abandon primary care–based efforts to mitigate risks for child abuse and neglect. To all our primary care colleagues, know this: while additional evidence is amassed, do not stop your ongoing efforts to protect vulnerable children. You are an important component of child maltreatment prevention, although your actions and support cannot be delivered (or measured) in isolation.

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