

CHILD PROTECTION AROUND THE WORLD

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Girl with Balloon. Banksy

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This chapter reviews child protection. Child neglect and abuse and their sequelae are discussed in other chapters of the textbook (e.g., [Chapter B.1](#)). Although child protection is often thought to belong to social work, with variable connections to mental health, the healthy development of children and youth is so shaped by the ways that we protect them—a central responsibility of every human society—that child protection belongs to child and adolescent mental health as well. This chapter reviews how that responsibility has evolved and the forms it has taken around the world, specifically:

- How responsibility for the child, once belonging solely to parents, has come to be shared with the larger society
- The forms that child protection takes around the world for prevention, detection, and intervention
- How public knowledge and political processes interact to determine what society does to protect children, and
- Current opportunities to enhance child protection, especially by addressing the child's context, not just the child.

CHILD PROTECTION – NOT LONG AGO, UNDISCUSSSED

How children and their development are seen has changed through history (see [Chapter J.9](#)). The story of those changes has itself been changing. Ariès (1960) argued that child development was not written about, much less a field of study, until the last century or so. More recent historians (Orme, 2001) have cited earlier writings on child development going back at least to medieval times.

As to responsibility for children, until modern times, parents, with support from extended family, enjoyed unchallenged oversight of their children, who were seen as property, an economic asset (if they could work or be sold) or a liability (if ill or developmentally delayed). Children gradually acquired the features of adults and were respected to the degree that they became like an adult. Responsibility for “bringing up” the child rested squarely with the parent. Gradually, in the last two centuries, with urbanization and other social changes, a different view of the child emerged. Disadvantaged children, especially orphans, began to be sympathetically portrayed, as in the work of Dickens.

In addition, increasingly objective descriptions of developing children (as by Binet, in describing cognition) launched child development as a field of study. Newspaper reporting of abandoned or abused children aroused public concern. In response, community responsibility for children grew, extending beyond what parents alone could provide. Informal community support, especially from religious organizations, was supplemented in the US and elsewhere by the creation of agencies like the Society for the Prevention of Cruelty to Children (founded a few years after the creation of the Society for the Prevention of Cruelty to Animals).

A culture's understanding that a child has needs, thoughts, and feelings and is not just a blank slate (either evil, according to the doctrine of original sin; or good, like Rousseau's noble savage), resembles what, in individuals, is called mentalization. That is, people gradually have come to see children as having their own legitimate experience, which could be understood by others.

In the 20th century, this sympathetic view of the child has been extended, gradually and incompletely, to children from disempowered and stigmatized



“Please sir, may I have some more?” Oliver Twist, Dickens



New York Society for the Prevention of Cruelty to Children (1875)

groups, including racial and ethnic minorities, the economically disadvantaged, and those with stigmatizing conditions, like developmental differences, homelessness, criminal history, or substance use.

Institutions for orphans and abandoned children gradually replaced “indenture” programs—under which orphan children were hired out to intact families—and “orphan trains”, that carried such children to be raised by and to work for pioneer families on the United States frontier. Orphanages, in turn, were replaced by individual placement in foster homes. Laws gradually made neglect and abuse punishable offenses. Support for child welfare came about despite opposition, often moralistic, blaming the “undeserving” poor for their own poverty, or expressing a fear that public support would decrease parents’ motivation to work. Advocates of children’s rights often had to contend with advocates of parents’ rights who resented what they saw as state intrusion in their lives (Bartholet, 2020). In effect, entire systems of child protection were established (see Gordon, 2011; Myers, 2008).

In the 20th century, children’s rights were defined and codified in declarations of the rights of the child, by the League of Nations in 1924 and by the United Nations in 1959 (see [Chapter J.7, The United Nations Convention on the Rights of the Child and Implications for Clinical Practice, Policy, and Research](#)).

The recognition of child abuse in the 19th century was not just the result of increased public awareness of children’s lives. It was also a response to increased child vulnerability, when isolated nuclear families could not provide on their own the support that traditionally came from extended families. The modern assumption that biological parents will meet all a child’s needs misses the traditional role of community, especially extended families, in supplementing what parents provide. Some argue that modern societies overestimate the extent to which biological parents by themselves can meet all of their children’s needs, and that child protection systems are a necessary result.

CHILD WELL-BEING AND HEALTHY DEVELOPMENT

Since the mid-19th century, healthy development has been seen to depend on:

- Economic well-being
- Physical health, including nutrition
- Education
- Safety from neglect and abuse
- Positive parenting
- Support for self-care and advocacy
- Special support for those with developmental differences.

As the definition of child well-being has expanded, so has the list of adversities that threaten the child, namely:

- Abandonment and lesser forms of neglect
- Poverty and malnutrition
- Child labor
- Exclusion from school



Advocating for children's rights, Bulgaria, 1924



- Physical abuse
- Corporal punishment
- Emotional abuse, including neglect, exposure to violence, harassment and bullying
- Sexual abuse
- Child marriage
- Ritual mutilation, especially female genital mutilation
- Factitious illness imposed on another, also known as Munchausen by Proxy or medical child abuse
- Online abuse – bullying, sexting
- Discrimination against members of a disempowered or minority group.

Not everything listed here is universally acknowledged as a threat to the child. Attitudes to some practices, like corporal punishment, differ over time and between countries. Other practices, like child marriage, are even more controversial and seen differently by different groups within the same country. For instance, some groups hold that some rites of passage, like female genital mutilation, are positive experiences, enhancing connection to the group and to culture-specific traditions.

The resulting debate puts on one side some who see “children’s rights” as a new form of Western colonialism (Shweder, 2000). Others, including advocates from within the communities where such practices have been traditional, have strongly condemned such practices. This debate resonates both with the world-wide debate about women’s rights and their right to control their bodies and with critiques of societies’ supporting or eroding social connection in general.

Such views have influenced the establishment of child protection laws. Other cultural differences such as, in the US, fear of government control, have slowed the implementation of protective services. For instance, nearly universal child care was established in the US during World War II to allow women to join the workforce, but with benefit for the children. Once the war was over, the program, seen as a government takeover of a family responsibility, was stopped, leaving stressed families without that support.

Important in countering such fear of social supports were studies showing the effects, short- and long-term, of adverse childhood experiences, including neglect and abuse. Research like the [Adverse Child Experiences Studies](#) from the US Centers for Disease Control and Prevention have demonstrated that experiences like neglect and abuse, over decades, impair health and shorten lifespan.

Positive childhood experiences also make a difference. Along with the [Adverse Childhood Experiences](#), ACES, some have developed a metric to assess using Resilience Childhood Experiences, RCEs. And recent work shows the long-term protective effects of positive childhood experiences (Bethell et al, 2019). RCEs and ACES together comprise ICEs, Influential Childhood Experiences.

There are networks now devoted to informing the public of such knowledge and of using it to guide policy (for example, [Harvard’s Center on the Developing Child](#)). Newer research links early abuse to details of later health, like the features of adults’ hallucinations (Rosen et al, 2020).



Children working in factory.
United States, 1920s



The advocate Bogaletch Gebre, whose sister died after female genital mutilation, was herself a survivor of female genital mutilation (NYTimes, 17 November 2019).

The role of the environment of child and family is even more important in child protection than in other areas of child mental health. The importance lies both in causation – the higher rates of abuse and neglect associated with socio-economic status and with ethnicity, for example – and in mediating prevention and recovery interventions (as discussed below). Higher rates of abuse and neglect are not intrinsic features of the affected groups, but reflect adversities, historical and current.

CHILD PROTECTION: PREVENTION, DETECTION, ASSESSMENT, PLANNING, RECOVERY

These terms echo those used in public health. Primary prevention refers to measures directed at an entire population; secondary prevention to measures directed to a subpopulation deemed at risk; and tertiary prevention helps those who already have a condition, to support recovery and adaptation.

Prevention

Child protection starts with *promotion of healthy development*. Promotive measures may be universal—applied to all children in a population—like universal education or healthcare, a kind of *primary prevention*. In this line, for example, Sweden, like other Scandinavian countries, has a “family service” child welfare approach, as opposed to a narrower “child protection” approach that is common in English-speaking countries. These two approaches are contrasted in Table B.3.1.

In the US, the swings of the pendulum between these two poles have been traced by the historian Lepore in response to the discovery of the body of an abused child in Boston Harbor in 2015, known only as “Baby Doe” for weeks before she was identified (Lepore, 2016).

For all children, measures used to promote healthy development include income support, prenatal and postnatal care, parental leave, preschool education, and measures to prevent and respond to domestic violence.

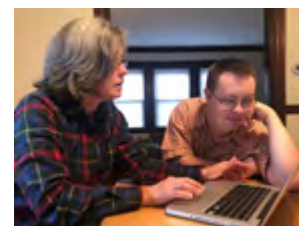
Schoolteachers are often the first to recognize the signs of abuse or neglect and to report them. Some systems have curricula devoted to child protection, to inform children about mental health, and the possibilities of neglect, abuse, or molestation.

Detection

For children suspected or recognized to be at risk, *detection* may take the form of mandated reporting, one of the most widely enacted forms of protection. Detecting and reporting child abuse became a responsibility of physicians (and other professionals) in the US in the 1960s. A pediatrician, Kempe, and colleagues (1962), drawing on clinical experience, including radiologists’ recognition that children with repeated fractures might have inflicted injuries, reported their findings under the provocative title, “The Battered Child Syndrome.” Within a decade, nearly all US States enacted laws requiring professionals (medical and others) to report to protective services any child whom they even *suspected* might be at risk of abuse or neglect. While mandated reporting was accepted decades ago in North America, it became a requirement of medical practice much later in other countries, for example, in Germany.



“Baby Doe” on a milk carton, part of an effort to identify a child whose body was found in Boston Harbor in 2015



To protect children with differences, a school-based program in the US, “Understanding our Differences,” promotes acceptance. Brian Heffernan, a guest speaker, reviews his school presentation with his mother. Boston Sunday Globe, 17 November 2019

Table B.3.1. Orientations to child protection*		
Characteristic	Child protection	Family support
Goal	Protecting children from harm	Supporting families with social, economic and psychological difficulties
Entry to services	Single entry point; report or notification by third party	Range of entry points and services
Basis of government intervention and services provided	Legalistic, investigatory, in order to formulate child safety plans	Supportive or therapeutic responses to meeting the needs of children and families or resolving problems
Place of services	Separated from family support services	Embedded within and normalised by broad child welfare or public health services
Coverage	Concentrates on families at risk	Universal
Service approach	Standardised procedures; rigid timelines	Flexible to meet clients' needs
State-parent relationship	Often adversarial	Partnership, relationship-based
Role of the legal system	Often adversarial	Last resort; informal
Out-of-home care	Mainly involuntary	Mainly voluntary

*Adapted from Price-Robertson et al (2014)

Assessment

Reporting is followed by *investigative assessment*, in which child protection workers may have authority to access information, including health information, otherwise considered private. How such assessment is done varies greatly, ranging from the use of standard clinical assessments borrowed from other clinical fields to the use of formats specially designed for assessing risk. Investigation may include review of police response to homes, contact with clinical providers, school personnel, extended family, and other state agencies. Systematic review of assessment has shown predictable cognitive errors based on overly simple assumptions, recognition of which can decrease these errors (Munro, 1999).

Assessment is challenging, starting with the child. Whatever the basis for a protective report, the child may show (or feel, but not show) a variety of responses, including confusion and emotional distress at intruders' entry into family life, on the one hand, and relief that a desperate situation has been recognized, on the other.

Regardless of how the child understands the situation, they may show various symptoms, largely post-traumatic:

- Emotional dyscontrol to the point of tantrums
- Meanness to others
- Failure to care for self or protect oneself
- Self-injury or suicidal threats or behavior
- School failure, with possible changes in language processing or learning profile
- Emergent depression or other mood disorder
- Emergent psychotic disorder

The assessment of the child considers several mental health possibilities:

- A reaction to trauma and removal, needing understanding and support from foster parents and protective workers, and likely to subside with time
- A similar reaction, but less likely to subside, needing mental health support
- A major developmental or mental health condition, needing consultation and referral.

This assessment is addressed in a Practice Parameter developed by the American Academy of Child and Adolescent Psychiatry (Lee et al, 2015).

Hearing the child is an essential, but challenging, part of the assessment. Without talking with the child, serious injuries or death can occur when the adult's report is taken as the basis for dismissing a protective report (as shown in the documentary "The Trials of Gabriel Fernandez"). Abused children, like adult victims of domestic violence (Snyder, 2019), may have difficulty finding their voice, masked by:

- Fear for their own safety, especially if they fear they will be identified as the reporter or the one confirming the abuse
- An ambivalent relationship with the perpetrator (for example, needing as well as fearing); or
- Feelings of guilt – blaming themselves for what has happened.

The effect of a clear statement of what has happened is powerful. Such a statement gives the child the sense of being heard and affirms that abuse is not the child's fault. As one youth posted in response to the video "ReMoved", "It's quite amazing, because usually I feel like no one gets what happened."

Hearing the child's voice is facilitated, using developmentally appropriate language, by:

- Interviewing the child in a safe place
- Taking time
- Acknowledging a problem ("We're here because some things have not gone well...")
- Reinforcing the feeling of safety and value with statements like, "We're interested in hearing your experience, which sometimes is difficult, even scary. But our first goal is keeping you safe. You deserve that"

- Considering the use, at least at the start, of impersonal language (“Often, people have trouble...” or, “Sometimes, children are confused about...”), rather than personal language (“You...” or, “Your mother or father...”)
- Acknowledging the possibility of guilt, and offering relief (“When things go badly, children often blame themselves, feel that the trouble is their fault. We don’t see it that way.”)
- Acknowledging ambivalent relationships (“Parents sometimes care a lot about their children, but things get in the way of taking good care... We want to help kids stay in touch with parents, maybe even stay with them, while we help with those problems.”)
- Speaking respectfully but candidly about parents (“While a mother/father may care a lot about a child, sometimes they have troubles with...”)
- Acknowledging partnership in working toward a goal (“We want to work together with your mother/father to make things better. We’ll see how that goes. Meanwhile, the plan for right now...”)

Assessing the parents and family is also challenging. Attitudes to parents vary. At one time, parents were often seen as offenders, not as people needing support (Bourne & Newberger, 1979). Today, most protective services aim to provide a sympathetic and supportive relationship, in which *shared* planning for the child can occur. Moving beyond the era when professionals spoke and families listened, many now encourage the family to start the planning process by stating their needs. Family-friendly language is used, as opposed to professional jargon.

This approach is used by in-home therapy services in the US like Intensive In-Home Child & Psychiatric Service (IICAPS) in Connecticut (Woolston et al, 2007). This approach is also described in Allen (2018). The team, as it develops a plan for each family, can also gather data showing how differences in attachment and mentalizing mediate the transmission of trauma across generations (Stob et al, 2019).

Planning

Assessment leads to a decision: either to rule out that abuse or serious risk of abuse is occurring or to substantiate (support) the report. If the report is supported, the next decision is whether the child can remain with parent(s) or needs to be relocated to a safe setting.

Here the protective pendulum has swung widely. It was once assumed that the abused or neglected child needed, first of all, to be separated from the family. More recently, the negative consequences of such automatic relocation have been recognized. These include loss of connection with birth relatives, relationships that for many protected children remain important, and repeated broken attachments sustained when living in a series of foster or group homes. In addition, evidence for lasting benefit from treatment away from parents has been weak (Lewis et al, 1980). A contemporary approach is reflected in the document *Foster Care – a Path to Re-unification*, from the US Children’s Bureau (2019).

Recognizing the child’s need to sustain a relationship with the biological parents has led others to develop ways to find previously unrecognized family

IICAPS illustrates that family-driven care can give voice to families as well as professionals. As professionals listen to the family’s needs and plans, they have in mind a model of how problems are transmitted across generations, a model in which attunement, attachment, and mentalization play a part. Thinking this way, they both support the family and have a way of understanding mechanisms that contribute to problems and that, mobilized appropriately, can promote recovery.

resources in order to support children's ties to the family and keep them out of substitute—and often, temporary—care with strangers. Such efforts include the “Family Finding and Permanency” work started by Kevin Campbell in Australia (see box) and, in the US, “the Urgency of Permanency” started at the Walker Program in Massachusetts.

The variety of forms that protection can take is summarized in Table B.3.2. Striking the balance between these two goals – effective protection and supporting and using ties with primary family – remains a challenge for child protection. When risk to the child is acute and severe, protective services may seek custody. Protective custody may be obtained immediately but will usually entail court proceedings at some stage.

When data are ambiguous, neither confirming risk nor allowing dismissal of protective concerns, the ambiguity may be managed by developing a *provisional plan*, starting with acknowledgement of uncertainty and stipulating criteria to be used, after a period of observation, to further define or rule out the need for intervention (Harper, 2016a). Although support may start with change of parenting or of residence, it often includes mental health treatment and special education services as well.

“In-home support” takes many forms:

- Economic support
- Education
- Peer support
- Treatment
- Jointly developed “safety plan”

Providers – biological kin or foster parents – must demonstrate:

- Trauma awareness
- Mature impulse control and
- The ability both to understand the child's experience and to help the child understand what has happened, including the effects of relocation.

All of these should provide safety and nurturance for the child recovering from abuse or neglect. They should also provide what children need for long-term recovery and growth. For the child removed from the family home, out-of-home care may take the form of:

- “Kinship care”, foster care, residential care (see Table B.3.2)
- Relationship support—with the family of origin, with relatives, with peers, with co-survivors in recovery
- Mental health care, which may include psychotherapy and psychoactive medication—psychoactive medications are more often prescribed for children in protective custody than for their peers (see below; overprescribing is also addressed in a [guideline from the American Academy of Child & Adolescent Psychiatry](#)).

A substitute caregiver must be screened for criminal or legal history and risk of domestic violence, physical or emotional. Kinship care has the advantage of family connection, but must provide safety not available with the child's original family. Prospective foster parents (possibly a person known to the child but not

Family Finding and Permanency: Current Projects

The Path Out of Foster Care Crisis Runs Through Family

By Kevin Campbell and Jill Borgeson.

An article on the language of family finding evolving in response to years of learning from practice and research.

Family Finders Helping Vulnerable WA Kids

By Kate Campbell.

An article on Kevin's work in Western Australia.

Good Business, Real Results: Time for Radical Change in Child Protection

By Kevin Campbell.

Table B.3.2. Recovering from Abuse or Neglect

WHERE IS THE CHILD?	IN-HOME SUPPORT	KINSHIP CARE	FOSTER CARE	RESIDENTIAL CARE
LOCATION	In familiar home, with parents	In home with relatives	In a new home, with new (foster) parents	In a group setting, designed both to house and to heal
ALONG WITH	Often, usual family members	Relatives, family members, maybe siblings	Foster parents and their children, maybe other foster children	Professional staff and other children
RELATIONSHIP WITH PARENTS	Continues, but hopefully with change	Usually kept up by visits	May or may not continue	May or may not continue
RELATIONSHIP WITH SIBLINGS	Continues	Usually kept up, by visits if not living together	May or may not continue	May or may not continue
THE CHILD IS PROTECTED THROUGH	Intensive in-home supports: parent aides, behavioral coaching, indicated medical care	Change of caretakers	Change of caretakers	Change of caretakers
ADVANTAGES OF THIS MODE OF CARE	Maintains key attachment relationships	Maintains family relationships, even if not living with parents	Fresh start with new family, relationships	Sometimes, only care available
DRAWBACKS OF THIS MODE OF CARE	No guarantee of change	Not always available or acceptable	Risk of frequent changes; loss of new attachments	“Institutional” care; no close relationships replacing parents; weak evidence of lasting effectiveness

related, like a teacher, friend of the family, child’s friend’s family, boy or girl scout leader etc.) must be screened as well. As stated above, re-unification with the family of origin may or may not be a goal – the challenge is to balance the contrasting goals of “rescue through separation” and of “supporting connections”.

Talking Recovery

Wherever the child lives, various kinds of support aid recovery. Support starts by informing the child of what is happening, a difficult but important conversation. In a developmentally appropriate way, one aims to:

- Respect the child’s view of their needs (which may or may not include recognizing that they need protection)
- Let the child know that they are not to blame for what has happened, and
- Give concrete information about the next steps.

One must affirm the child’s need for protection – that the current parent (biological or not), despite strengths and some degree of devotion to the child, has not been meeting the child’s needs – and outline what will happen.

Immediate protection

The need for immediate protection arises, for example, when a mother two weeks post-partum has a depression with command hallucinations to kill the baby. The protective team, with mental health consultation, makes an emergency assessment (the child is at acute, immediate risk) and plan to ensure the child’s safety.



Girls Educational & Mentoring. GEMS' unique Victim, Survivor, Leader™ program model is the gold standard for organizations serving trafficking victims and survivors across the country and GEMS trains thousands of professionals every year on its best practices.

Recovery must also take a longer view of outcomes. A short term view focused on “stabilization” or absence of repeat injuries in the short term is not enough. For example, serial foster placements, as noted above, fail to provide the child with lasting connections. In this way, outcomes in child protection, as in other areas of child mental health, go beyond the framework called the “Triple Aim” (patient experience, population health, per capita cost), that is widely used in evaluating health care. In child mental health, the goals are broader: health (physical, developmental, relationship) over the longer term of the child’s development; patient experience that includes both child and parent; and costs beyond healthcare to include costs in mental health, education and special education, juvenile justice, and social services.

Recovery communities

For all children, but especially for those recovering from conditions that have included social isolation and shame, finding and growing with a recovery community is a key part of recovery. These recovery communities may be generic (youth associations) or specifically aimed at recovering groups. Two examples of organizations that support recovery in adolescent girls and young women who have suffered commercial sexual exploitation are “[My Life, My Choice](#)” and “[Girls Educational & Mentoring Services](#)” (GEMS).

In many countries, child protection is made more difficult by the existence of “silos”: locating protection services in parallel agencies not responsible to each other and sometimes not even communicating. For instance, in most States in the US, children’s services are divided between education, health, mental health, social service, and juvenile justice. Isolation from other agencies may be more prevalent in child protection services than in other public services. Such isolation was one of the system failures identified in the documentary “The Trials of Gabriel Fernandez,” about the death of a child in Los Angeles who had been reported as needing protective supervision. For families who already have to deal with fragmented lives, separation of services in this way makes recovery more difficult.

IMPLEMENTING SERVICES: KNOWLEDGE TO PRACTICE

As discussed in the child and adolescent mental health policy chapter of this Textbook (J.6), public programs result from the interaction of knowledge base, political will, and political strategy. In healthcare, the term “implementation

science” is now used for translating knowledge of what *can* be done into widespread *practice* (Bauer et al, 2015). Child protection—at the intersection of media reporting (sometimes inflammatory), public opinion (sometimes sympathetic and sometimes stigmatizing), and the political process—illustrates this interaction.

In the US, for example, increasing publicity about abandoned and abused children, coinciding with a political administration determined to act on long-recognized social problems, led in the first decade of the 20th century to the founding of the Federal Children’s Bureau, the passage of the “first State laws” to prevent abuse and neglect, and the convening of the first national conference on the needs of children. But a generation elapsed before federal support to the States’ children’s services included money, in response to economic depression and an administration committed to social support. This support became known as “Aid to Families with Dependent Children” (Murray & Gesiriech).

The vulnerability of those services to public opinion and political pressure was shown again in the 1990s in the US, when an administration largely seen as progressive, responding to negative characterization of welfare payments as encouraging dependency, terminated the “Aid to Families with Dependent Children Program”, replacing it with “Temporary Assistance to Needy Families,” which included work requirements for mothers. Consequences of this more restrictive support program were often negative.

The effect of political change has also been evident in support of research on child abuse and neglect by the US National Academy of Sciences. After a report in 1993 called for new research, a follow up report two decades later reviewed the costs of child abuse and neglect and made ambitious recommendations regarding the research base (“New Directions in Child Abuse and Neglect Research”). But with a change in administration two years later, not only have those recommendations faded from view, but research on child abuse and neglect no longer appears on the agenda of the National Academy of Sciences.

Public knowledge about child protection is also informed by investigative journalism. Exposés appear both in print and screen media. For instance, in the US, an investigative report in a newspaper documented the story of a child who sustained many changes in foster and pre-adoptive placements, as reunification with biological parent was endorsed and then discarded as a goal (Lazar, 2019b). A television documentary, “The Trials of Gabriel Fernandez,” mentioned above, recounted not only the torture and abuse that led to the death of an 8-year-old, but the failed processes in the protective system. These resulted in indictments of social workers as well as of the child’s mother and her partner.

Shortcomings identified in such investigative reporting illustrate the path that leads from *knowledge* of abuse and neglect, through detection and reporting, to protective *intervention*. Obstacles on this path include:

Problems in program design:

- Failures in striking a balance in *mission* between protection through separation and family reunification
- Conflicts of interest, for instance when providers contracted to provide services are incentivized not to take protective actions that will increase

In 1960, an incident illustrated the relationship between publicity and policy change. A State in the US terminated welfare payments to families when a child was born out of wedlock, breaking a State rule. Resulting publicity and public outrage led to an administrative decision, later supported by legislation and the courts, that the States could not simply cease services for needy families for breaking such a rule – the State had to develop other services.

expenses and would “fail the mission”—i.e., decrease the rate of family re-unification, if that is the (cost-saving) goal

- Other conflicts of interest, for instance between contractors and government officials responsible for contracting
- Administrative pressures to meet quantitative goals, like the use of expensive out-of-home placements, resulting in failure to provide protection
- Failure to acknowledge and counteract social, economic, and ethnic disparities.

Problems in implementing programs:

- Inadequate *human resources*, such as understaffing (in the US, agencies have been sued for having caseloads greater than 30 cases per worker), and the assigning of less trained workers to challenging positions without adequate support (as in “The Trials of Gabriel Fernandez”)
- Failure to follow established policies, like documenting sites of repeated injuries, or monitoring the activities of frontline staff
- Failure to monitor policy consequences, for instance, when family reunification is promoted for clinical and budgetary reasons but without tracking the outcomes needed to assess the effects of such policy
- Failure to help child-serving agencies work together by countering the frequent isolation of those involved in child protection.

A challenge needing emphasis in protective services is stress on workers, which needs acknowledgement and special support. Workers in other fields are often protected from physical hazards, like exposure to harmful chemicals. Among healthcare workers, the psychological burden of stress and unreasonable work schedules are recognized. But for workers in protective services, acknowledgement of the stresses they routinely encounter, starting with secondary trauma, is much less common. This challenge, identified historically (Copans et al, 1979) and recently (Rakoczy, 2009; [Child Welfare Information Gateway](#)), is still missing effective, systems-wide response.

For this and other challenges, one solution offered is to establish an independent oversight body (Lazar, 2019a). In Los Angeles, after the tragedy reported in “The Trials of Gabriel Fernandez” documentary, an independent Child Protection Board was established, but without the recommended authority or funds.

Another remedy would be to create in child protection the culture that has contributed to quality and safety in healthcare and in other industries. For instance, in the US, while the Federal government supports children’s services in dozens of States, outcomes are examined and analyzed in only a handful. Evaluations track numbers participating and access to services, but give less attention to functional outcomes, let alone what can be learned from such reviews. This difference seems to arise from the isolation of child protection from other areas of healthcare, from underfunding of services for people from ethnic minorities and backgrounds of poverty, and especially for evaluation of such services, and from political reluctance to examine too closely a politically sensitive area of practice (Harper, 2018).

Implementation of a culture of quality improvement in child protection entails:

- A commitment to review adverse events from a systems point of view, not a personalized approach that strives to find a person to blame
- After adverse events, regular review conferences for teaching and learning, protected—like medical reviews—from “discovery” and
- Support structures for vulnerable front-line workers.

Some of these activities are carried out by organizations like “[Zero Abuse Project](#)”, which, through consultation and training to child-serving agencies, aim to enhance protection by engaging people and resources through a trauma-informed approach of education, research, advocacy, and technologies that strengthen investigations, expose abusers, and provide survivors with pathways to recovery.

MOVING AHEAD: CHILD PROTECTION MEANS LOOKING AT THE CONTEXT, NOT JUST THE CHILD AND PARENTS

Easily overlooked when the child has acute needs, the child’s *context* (beyond the family) must be addressed to decrease risk, both to the index child and to children in general. Some aspects of context bear on the situation of the child and family:

- Socio-economic status, especially poverty, powerfully influences child outcome. Although higher rates of abuse and neglect are well known to be associated with poverty, income disparities and the legacy of racial and ethnic discrimination are often omitted from discussions of child protection. An exception is [The Harlem Children’s Zone](#), a project that provides economic, nutritional, and educational support to an at-risk population of children, starting in early childhood. While reducing educational disadvantage, not abuse or neglect, is the primary goal, child safety is enhanced as well
- Historical and current discrimination, especially against ethnic and sexual minorities, enhances risk. Dedicated advocacy groups, like those found at www.twloha.com, www.strongfamilyalliance.org, and www.ncai.org, provide support for such youth
- Generational context. As mentioned above, transgenerational transmission of trauma is addressed by programs like IICAPS.

Aspects of Context that Bear on the Ways We Provide Services

How are our services organized?

The isolation of many child protection services from other child-serving agencies has been mentioned above. Long-term child well-being, as well as morale among child protection workers and cost efficiency, argues for bringing these services together. Some States have reorganized child-serving agencies into a single agency to promote that goal.

Medication – can we prescribe in context?

In the US, prescription to children in public custody of more psychoactive medications and in higher doses than those prescribed to their peers has prompted

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Federal oversight, in particular a requirement that States implement oversight and management programs for such practice. This is a striking example of *context*: it is not a feature of the children themselves, but of the lack of coordination of medication prescription with other aspects of child service and the lack of State oversight of prescribing that result in such high levels of prescription.

In a simplified model, central nervous dysfunction produces symptoms that lead (usually) a medical practitioner to make categorical diagnoses and then to prescribe agents aimed at the central nervous system. A comprehensive model would include more of the context. For instance, in the child:

- The developmental stage
- Intrapsychic factors
- The child's self-understanding
- Understanding of their symptoms and alliance with treatment.

In the doctor, factors are relevant like:

- Experience level
- Role in the treatment system
- Relationships and coordination with other therapists
- Scope of "evidence" to be considered
- Relationship with the child and
- Relationship with parent/guardian.

Such a larger, contextual view is advocated in the Recommendations from the American Academy of Child and Adolescent Psychiatry (2015); see also Harper (2016b).

Beyond Talk – How Can We Use Non-Verbal Media?

In child mental health, it is always worth looking for opportunities to use play, music, theater, and social connections. But this is especially true when dealing with a population for whom language may not be a strength, like children recovering from abuse and neglect. That difference may be constitutional or an acquired liability – related to the abuse and neglect and to trauma, or interrupted connection with those with whom children first use language.

Relevant here are domains not often considered, like art, play, and the media. A silent and guarded child may come alive when a silent and guarded child hears a song or a story, or watches a movie that make a connection where words did not suffice. A striking example was the use of a popular movie—"Antwone Fisher," featuring a famous African-American actor, about a soldier with a traumatic background—shown in a fancy downtown theater full of children in State custody. Such an event, in a high-prestige setting, sharing openly a narrative otherwise hidden by shame, uses play and story-telling to open up the path to recovery.



A creative use of recovery narratives presented a popular movie, "Antwone Fisher," about a soldier, survivor of early abuse and neglect, getting help for a breakdown while in the service. He later meets his long-lost mother, still struggling with addiction. The movie was shown in a fancy theatre to an audience of children in public custody, most of whom had never seen adverse experiences like theirs told as a recovery story and presented in such a celebrated setting.

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