

The Role of Primary Healthcare Providers in Preventing Child Maltreatment

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Healthcare providers who care for children have long realized that to be effective, medical care must include consideration of the child in the context of the family, school, and community, but the concept of a broadly defined “medical home” has gained increasing emphasis in recent years. The American Academy of Pediatrics defines the medical home as “primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.”¹

By providing a medical home for children and their families, primary care providers have the potential of playing a significant role in the prevention of child maltreatment. The strategies inherent in the medical home principles closely mirror child maltreatment prevention strategies. Realizing the full potential of these prevention strategies, however, will require an increased awareness of protective and risk factors for maltreatment among primary care providers. Most primary care providers are trained to recognize abuse or neglect once it has already occurred, but strategies for early prevention have not been a focus of their training. With the recent promotion of a medical home becoming the standard of practice, now is the time to focus on prevention.

The Longitudinal Relationship with the Family

An essential component of providing a medical home is the establishment of a longitudinal relationship with the child and

her/his family. This is a dynamic relationship that engages parents as partners in the care of their child. It begins early, eliciting family strengths and weaknesses and screening for risk factors

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and supports. This relationship communicates an openness to discussion of concerns or issues as they arise. From the beginning of well-child care, interactions with the medical care home are built on communication about the whole child—in the family and in the community (child care, school, etc.). The primary care provider utilizes screening for:

(1) psychosocial risks and strengths and (2) the child’s developmental and social-emotional skills. Screening is not a one-time event, but is done periodically over the course of the relationship (surveillance), building on the communication exchange. Research has given us good information about the 40 assets (internal and external) for children that optimize success and about factors that put children and families at risk.² Awareness and early recognition of these factors allows for early intervention and prevention of unwanted outcomes.

New Visions for Well-Child Care

Both national and state initiatives are directed at this approach to practice.^a In addition, Bright Futures^b is currently being revised with an emphasis on screening and preventive care, being family-centered, and addressing development and

a Both the American Academy of Pediatrics and the American Academy of Family Practice have adopted and encouraged the medical home concept for several years now.

b Bright Futures is an approach dedicated to the principle that “every child deserves to be healthy, and that optimal health involves a trusting relationship between the health professional, the child, the family, and the community.” For more information visit: <http://brightfutures.aap.org/web/>.

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behavior. There is great interest on the part of the AAP, the American Board of Pediatrics, the Commonwealth Fund, and others in redefining and redesigning well-child care and the periodicity schedule to be more reflective of children's developmental needs.³ The Substance Abuse Mental Health Services Administration, the National Institute of Mental Health, the Centers for Disease Control and Prevention (CDC), and Children and Adults with Attention-Deficit/Hyperactivity Disorder co-sponsored a national conference in April of 2005 to call for early screening and identification of social-emotional problems among children in primary care practices. The CDC has a national campaign, "Learn the Signs, Act Early," encouraging primary care providers and parents to screen for developmental and social-emotional issues.

In North Carolina, the Assuring Better Child Health and Development (ABCD) project is in its fifth year. Originally funded by the Commonwealth Fund, it has resulted in a state-wide Medicaid policy of using a validated, standardized screening tool for development and behavior periodically at specific well-child visits from birth to five years. Anticipatory guidance materials for parents have been developed in the project, and local and state-level networking has been established for referrals and interventions. Social-emotional screening and maternal depression screening has been incorporated in many counties.

Early Screening for Assets and Risk Factors

The primary care provider has the role of recognizing a family's assets and risks and supporting them in optimizing success. Family assets include support from other adult family members, shared family activities and values, connections in the community, parent involvement in child care or school, living in a safe neighborhood, and opportunities for stable employment. Knowledge of risk factors is also key. These are common to several important outcomes. Poverty, maternal depression, domestic violence, and familial substance abuse are all risk factors for developmental delays, social-emotional disorders, and for maltreatment. The primary provider is generally a trusted professional, who by virtue of the well-child visit schedule, comes into contact with the child and family with some frequency. The medical home then, is a very likely and appropriate place for screenings to take place. The primary care provider, who sees the family on a regular basis with the child, is in a unique position to facilitate limiting the impact of risk factors.

Discussing assets and promoting connections for support should be part of early conversations with families, along with open discussion regarding risk factors. When psychosocial screenings reveal risk, the office is the source for initial discussion and referral to community resources. This assumes previous networking by the practice with community partners and a working knowledge and connection to community providers, such as counselors, agencies, Early Intervention, child care, schools, etc.

Psychosocial screening includes asking about family relationships, maternal depression, domestic violence, and substance abuse.⁴ There are brief screening tools regarding these individual issues and general tools that address all of these topics. Other

questions regarding stable housing, financial resources, and insurance coverage are also pertinent. The practice can assist families with contacting community agencies and with applying for Health Choice or Medicaid. In a family-centered practice, financial issues need to be considered for each family in order for a plan of care to be realistic and possible (e.g., for covering the cost of medication, transportation, or a referral).

Developmental and behavioral screening, completed by parents and reviewed by the provider, allow early identification of potential problems or delays. Of equal importance, screening also reviews appropriate expectations at a given developmental age, facilitating understanding regarding the child's behavior and potentially facilitating appropriate use of discipline strategies by parents. A conversation about the screening identifies the child's strengths and weaknesses, gives a template for anticipatory guidance, and elicits and respects parental concerns. In this way, parental self-efficacy and confidence are promoted. Encouraging parents to share age-appropriate books with their children from an early age has benefits for their relationship and helps develop language skills and success for early reading skills.

Children found to be at risk through screening can be referred to to Early Intervention (the Children's Developmental Services Agency). For a parent whose child has a medical condition or developmental problem, a connection to the Family Support Network can provide parent-to-parent support. Parents surveyed in the the North Carolina ABCD project indicated that participating in developmental screening allowed them to learn about typical development and to understand their own child's behavior better. The potential here for reducing abuse and neglect is obvious.

Opportunities for Intervention in the Medical Home

Maternal depression may have many ominous consequences for a child, which make screening and assistance for this disorder an important role for the child's primary care provider. The most significant of these is attachment disorder, which has dire prognoses for the child, including social problems and conduct disorder. Attachment problems have a major impact on social-emotional development in the child. In infancy, problems with social relatedness can contribute to feeding problems, which can compound the problems of attachment with a mother who has depression and can reduce her interest in feeding time with the baby. Failure to Thrive can be the result of this cycle, adversely affecting the infant's brain development and adversely impacting later learning and development.

Colic in an infant can also exacerbate attachment issues and/or can create significant parental stress. There is a typical peak of increased crying and fussiness in most babies at about six weeks of age, which finally resolves at about three-to-five months of age. For some babies, this is more prominent, and in an already stressful social situation, the risk for maltreatment is increased. The outcome of colic can be increased family interaction problems and depression. Indeed, there is a peak incidence of

shaken baby syndrome associated with the age at which colic occurs.

Parents bringing home a premature infant who has had a complex neonatal intensive care unit course, may initially be faced with caring for an infant who is easily overstimulated and has poor state control. The infant may be difficult to feed and may not have predictable responses to affection or stimulation. While this is generally temporary, its duration can vary, presenting a challenge for parenting and often leading parents to question their own capability.

Anticipatory guidance that addresses these issues in a timely fashion and an atmosphere of openness to parental concerns are tools that a primary care provider can use to prevent child maltreatment. Utilizing well-child care to focus on the child in the family, employing screening tools, and making the discussion of sometimes uncomfortable topics a routine matter, establish the practice as a resource for information, support, referral, and connection to other community providers.

Early empowerment for parenting has implications for long-term outcomes, including readiness to learn, school success, and social success. The primary care home supports parenting by sharing information about appropriate expectations and discipline, facilitation of developmental skills, and promotion of the developing child-parent relationship. Early identification of risk and coordination of interventions must be timely, if prevention of maltreatment is the desired result. "Wait and see" is not only ineffective, but is actually detrimental. For example, in the case of maternal depression and attachment disorder, waiting to intervene until the child is 18 months-to-two-years old may be too late. Treatment needs to be for the dyad: therapy and/or medication for the mother and intervention for the mother-infant relationship. Referral to the Children's Developmental Services Agency for Early Intervention services will provide modeling for interaction with the child and for appropriate developmental stimulation. In North Carolina there are now

community-based mental health providers who are directly enrolled with Medicaid and receive referrals from primary care providers. In many instances they are co-located with primary care practices. Availability of such referrals reduces the stigma families often associate with mental healthcare.

The Medical Home and Networking with the Community

The critical value of a medical home to a child and family is its connectedness in the community and other sources of care. The primary care home itself is not sufficient without community partners. The characteristics of a medical home described thus far are focused on partnership with the family, include periodic psychosocial screening, and utilize specific screening for maternal depression, child development and behavior, substance abuse, and domestic violence. When concerns arise or screens indicate a child is at risk, primary care providers cannot be experts in all areas. They can be a resource for referrals for further assessment and interventions, a partner in finding information, a sounding board, and a facilitator to negotiate the system. To this end, activities for the practice to network with other community providers, establish actual contacts rather than just a phone list, and have staff designated to communicate with these contacts, make the process of referral more likely to be successful. The process is more family-centered and more satisfactory to both the provider and the family.

Measures to prevent child maltreatment are an inherent part of the medical home concept, in that the prevention and risk-screening activities are consistent with maltreatment prevention strategies. The task now is to realize the characteristics of the medical home in all primary care practices by improving office processes and by informing and encouraging families to seek medical home characteristics and processes. **NCMedJ**

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