In 2016, 74 million children lived in the United States. In that same year, 3.5 million children—1 in 22—experienced either an investigation or an alternative response from a state child welfare agency based on a report of suspected child maltreatment. Rates of child welfare involvement in US households increase year after year despite our best prevention efforts. Three-quarters of these cases involve child neglect, the form of maltreatment most resistant to targeted prevention and most vulnerable to repeated referrals to the child welfare system. 

According to the article by Brown et al, a promising reversal of this trend may be an unexpected benefit of recent Medicaid expansion. Brown and colleagues use the inconsistent adoption of the Affordable Care Act across states as a natural experiment to explore how policies that improve parental access to health care are associated with reduced rates of maltreatment among children younger than 6 years. The authors suggest that increased financial stability in households and improved mental health of adults, both of which have been described in association with Medicaid expansion, may contribute to an unintentional but welcome reduction in maltreatment of young children. In a thoughtfully constructed analysis, the authors found that, between 2013 and 2016, rates of child neglect decreased in the 31 states that expanded Medicaid on or after January 1, 2014, whereas rates of child neglect increased in the 19 states that did not expand Medicaid. By use of a model adjusted for social conditions and public policies associated with parental stress, financial hardship, and child maltreatment, Brown and colleagues report that, from a baseline of 3944 cases per 100,000 children, Medicaid expansion was associated with a relative reduction in child neglect of 422 cases per 100,000 children younger than 6 years. This could yield a potential reduction of more than 10% of child neglect cases in this population.

The study by Brown et al is not without limitations, and the findings may suggest promising paths for future research rather than more-immediate calls for political action. The authors did not observe a reduction in physical abuse and cannot describe contemporaneous shifts in child welfare policy and practice that might have influenced rates over this same period. Most important, the study does not identify the means by which Medicaid expansion might prevent child neglect. The authors explored 2 potential mediators for this association: Medicaid eligibility and Medicaid coverage of parents. Although the proportion of parents eligible for and covered by Medicaid increased in the states with Medicaid expansion, the authors were unable to demonstrate a linear association between this increase and the observed reduction in child neglect. The lack of a clearly articulated mechanism should limit wholesale acceptance of the findings.

Despite these limitations, the study by Brown et al adds to a small but growing stream of research in which the prevention of child maltreatment is the unanticipated bonus of a social policy rather than the primary objective of a prevention program. Improved access to affordable child care reduces household poverty and may also reduce child maltreatment. Paid parental leave reduces dependence on social welfare and may also prevent abusive head trauma. In contrast, increasing rates of child maltreatment have been described as the downstream consequence of political conflicts, natural disasters, and economic crises. Within this framework, child maltreatment serves as a proxy indicator for the overall well-being of a community. Promising findings from the study by Brown et al suggest that rates of child maltreatment may be rapidly responsive to policies intended to improve social determinants of health. Child abuse prevention might be a first bloom of success. 

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for expansive social programs that often promise a payoff in years and decades, rather than days and months.

For decades, many have hoped for a comprehensive approach to the primary prevention of child maltreatment. Over and over, we are presented with early evidence of program efficacy. Effectiveness may be established, followed by the challenges of replication, fidelity, and adaptation required for widespread implementation. Don't Shake, Healthy Start/Healthy Families, Nurse Family Partnership, Period of Purple Crying, Safe Environment for Every Kid, Triple P, and others are well known to professionals working within a bubble of pediatrics and child protection. Many of these programs provide meaningful and needed services to vulnerable families around the country and are sustained by local champions and variable funding streams. However, for state policy makers tasked with the almost impossible charge of balancing the needs of young and old, vulnerable and comfortable, and healthy and sick populations, this parade of child maltreatment prevention programs may appear to provide marginal benefits to a sliver of constituents, with a substantial upfront investment to be recovered only over the course of a generation.

What if the most effective, efficient, and sustained approach to preventing child maltreatment is the adoption of policies that broadly improve social equity and public health, rather than the implementation of programs that specifically target child maltreatment prevention? What if child maltreatment prevention is best achieved as a secondary, not a primary, outcome? Social policies that provide for paid family leave, universal home visitation, high-quality child care, and public prekindergarten are conceptually promising. Universal access to high-quality health care, including comprehensive family planning and mental health services, may improve the physical and mental health of parents and reduce the stressors that contribute to child maltreatment. More far-reaching proposals for a federal living wage or universal basic income might support not only financial security for households but also physical and emotional security for children.

No program or policy will eliminate social inequity. No program or policy will eliminate child maltreatment. In an ideal world, children at risk for maltreatment are best protected by intersecting and overlapping community resources that provide broad support to parents and effective protection for children when needed. In a world of limited public resources and even more limited public attention, however, it is worth considering whether those at highest risk of maltreatment are best supported and protected by broad social policies or through targeted prevention programs. The findings by Brown and colleagues3 add to growing evidence that prevention of and protection from child maltreatment may be best achieved through social policies that will support all members of our communities.

Placing child abuse prevention into the realm of broader social policies does not allow us to step away from this critical work in pediatrics. As health care professionals, we must encourage parents of our patients to enroll in the social programs that support child well-being. As researchers, we must critically evaluate how new social policies influence rates of child maltreatment and report these findings as meaningful indicators of the impact of these policies, whether good or bad. Finally, as advocates for children and families, we must raise our voices in support of policies and programs that demonstrate effectiveness in reducing child maltreatment and improving child well-being in our communities.
Conflict of Interest Disclosures: Dr Campbell reported that her institution receives financial compensation for expert witness testimony provided in cases of suspected child abuse for which she is subpoenaed to testify and reported receiving funding through the Interdisciplinary Research Leadership Program of the Robert Wood Johnson Foundation, the National Child Traumatic Stress Network, the Utah Department of Human Services, and the Primary Children's Hospital Foundation.

REFERENCES


