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Mental health referral and services for maltreated children and child protection evaluations of children with special needs: A national survey of hospital- and community-based medically oriented teams☆

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ABSTRACT

Objective: To survey the self-perceived capability of medically oriented child maltreatment teams in the US to provide mental health referrals and services when needed and to evaluate children with special health care needs (CSHCN).
Methods: Mailed questionnaire with 5 items related to mental health, 12 items on services for CSHCN, and 28 items on financial issues previously reported.
Results: Responses were received from 320 of 472 organizations (67.8%); 153 respondents had at least 1 physician or nurse practitioner and were included in the analysis; 91 were hospital-based teams (HBTs); and 62 were community-based teams (CBTs). CBTs were significantly more likely to offer mental health treatment (65.0% vs 35.6%). When mental health services were needed in another language, only half (50.7%) indicated that services were available in Spanish, less than a third (29.3%) could find services in sign language, and only 20.3% expected to find services for patients who used other languages. Of all children evaluated, 31.2% had special health care needs. CBTs reported seeing significantly more CSHCN than HBTs (38.3% vs 26.5%). Over two-thirds (67.7%) did not have a special program or specialized staff to serve CSHCN. Overall, teams had some training and experience with CSHCN. Children who were deaf were evaluated by 84.5% of teams, while only 50.5% reported using professionally trained sign language interpreters. Most teams (82.2%) indicated that more time was needed to evaluate CSHCN, and 69.1% found arranging for mental health treatment for CSHCN more difficult than children without special needs.
Conclusions: Medically oriented child maltreatment teams are generally able to arrange for mental health services for the children served, and most feel capable of serving CSHCN. Significantly more mental health service providers are needed for children and families who communicate in languages other than English (e.g., Spanish, American Sign Language [ASL]).
Practice implications: Our results suggest that medically oriented child maltreatment teams and mental health services for maltreated children would improve gaps in services by: (1) recruiting and training bilingual professionals, (2) ensuring that children or family members who are deaf receive professional ASL services, and (3) ensuring that training is provided related to the needs of CSHCN.

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Introduction

Mental health needs are uniformly recognized as an important component of the care and treatment of children who have been maltreated (Landsverk, Garland, & Leslie, 2002; Widom & Maxfield, 2001). However, even before the current economic downturn, children's mental health services have been widely recognized as being limited in availability, difficult to access and poorly funded and reimbursed (US Department of Health and Human Services [DHHS], 1999). The mental health needs of American children, in general, continue to be relatively unmet. The delivery system is fragmented, difficult for families and providers to navigate and described as a "patchwork" that is complex, "sometimes to the point of inscrutability" (US Department of Health and Human Services [DHHS], 1999, p 179). Children who are victimized by maltreatment face the same fractured system of providers, agencies and payers, perhaps at their most vulnerable time of need (Burns et al., 2004; Staudt, 2003). Additionally, with the increasing prominence of managed care approaches to health care reimbursement, authorization and payment for these essential mental health services may be difficult to arrange (Ratiner, 2000).

With regard to maltreated children with special health care needs (CSHCN), there is a growing body of clinical and epidemiologic information that recognizes these children's increased risk of maltreatment when compared to routinely developing children (Hibbard & Desch, 2007). For example, Sullivan and Knutson (1998) found that disabilities were twice as prevalent among maltreated hospitalized children compared with non-maltreated hospital controls. According to the investigators, this finding was consistent with either of two hypotheses, namely that (1) disabilities increase the risk of maltreatment or that (2) maltreatment contributes to the development of disabilities. The hospital-based methodology prevented definitively determining which hypothesis should be accepted. A later study by these investigators using a broader, school-based population found that children with disabilities were 3.4 times more likely to be maltreated than their non-disabled peers (31% vs 9%) (Sullivan & Knutson, 2000). This work built on an earlier study mandated by the US Congress, which, using a nationally representative sample, had demonstrated that children with developmental disabilities were on average nearly at twice the risk of all forms of child maltreatment (Westat Inc., 1993). Despite this increasingly recognized risk of child maltreatment among CSHCN, child abuse teams may be unprepared for the clinical requirements for appropriately evaluating children with various special health care needs (Giardino, Hudson, & Marsh, 2003; Hibbard & Desch, 2007). In response, medical professionals have issued calls for additional research and training related to the connection between child maltreatment and disabilities or special health care needs (Hibbard & Desch, 2007; Kendall-Tackett, Lyon, Taliaferro, & Little, 2005). The readiness and capability of established medically oriented teams to evaluate CSHCN and to provide mental health referrals, treatment, and follow-up to all children seen by these teams are largely unknown. The purpose of this study, therefore, was to explore challenges faced by hospital- and community-based medically oriented child abuse teams, when: (1) arranging for mental health services for all children evaluated for suspected maltreatment and (2) serving CSHCN.

Method

Description of survey

In 1999, a self-report survey utilizing a 45-item questionnaire was conducted. Twenty-eight items focused on staffing and financial characteristics and were previously reported (Giardino, Montoya, & Leventhal, 2004). This article describes the responses to the remaining 17 items focusing on: (1) mental health referral and treatment of all children evaluated for suspected child maltreatment and (2) evaluation, referral and treatment of children with special health care needs. The survey provided respondents with the following American Academy of Pediatrics' definition of children with special health care needs: "*Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally*" (McPherson et al., 1998, p. 138). The specific questions for the present study are listed in Table 1

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Five items focused on mental health treatment, referral and follow-up and elicited information such as the percentage of maltreated children referred to mental health services, whether these service were provided by the team, and the availability of these services financially, geographically, in a timely manner, and in languages other than English. Ten items addressed the medically oriented team's self-perceived readiness and capability to evaluate CSHCN. One question specifically asked about the team's evaluation practices of children and families who are deaf and communicate via sign language. The final question had teams compare the evaluation of CSHCN and planning for the mental health needs of these children. Of the 17 items, 13 required discrete or dichotomous responses, and 2 required respondents to indicate all responses that applied in their case. One item required a rating from 1 to 10 on a Likert scale to rate the experience and competence in evaluating or treating CSHCN where 1 indicated no training or experience and not competent to evaluate or treat, 5 indicated some training or experience and may require some outside consultation or assistance, and 10 indicated the team specializes in working with the specific special needs child, possessing extensive training and experience in the area. One item invited respondents to describe any special staff or programs they have to serve children with special needs and to comment on differences they experienced between serving children with and without special needs. The survey protocol was reviewed and approved by the Institutional Review Board of The Children's Hospital of Philadelphia.