



Research article

Effectiveness of manualized case management on utilization of evidence-based treatments for children and adolescents after maltreatment: A randomized controlled trial



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ABSTRACT

The objective of this study was to compare structured case management (CM) to usual care (UC) for helping victims of child abuse and neglect (CAN) with mental disorders access evidence-based treatment (EBT). $N = 121$ children and adolescents aged 4–17 with a history of CAN and a current mental disorder were recruited in three German states in a multi-center parallel group trial. They were randomly assigned, stratified by study site and level of psychosocial functioning, to receive CM additionally to UC or only UC. CM was delivered by trained professionals and volunteers, most of them affiliated to local child welfare agencies or NGOs. UC comprised child welfare services typically delivered in Germany. The primary outcome was EBT utilization after 6 months. Secondary outcome was the time until commencement of EBT. Outcomes were determined by semi-structured clinical interviews with assessors blinded to group allocation. Predictors of access to EBT and barriers to utilization of treatment were analyzed. The intent to treat analysis showed that after 6 months 23 of 60 participants recruited to CM (38%) and 19 of 61 participants recruited to UC (31%) were using EBT, $\chi^2(1, N = 121) = 0.689, p = .261$. Female gender, out-of-home placement, and home state were significant predictors of access to EBT. Less than 40% of participants across both groups were successfully referred to EBT. Access to EBT seems to be in part due to system-level barriers, namely lack of implementation of EBT in community settings.

Trial Registration: DRKS00003979 German Clinical Trials Register

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1. Introduction

Children and adolescents with a history of child abuse and neglect (CAN) are among the most vulnerable populations to develop mental disorders (Buckingham & Daniolos, 2013; Maniglio, 2009; Norman et al., 2012). At the same time there is reason to believe that they are less likely to receive evidence-based treatments (EBT) than children without a maltreatment history (Fegert, Ziegenhain, & Goldbeck, 2013; Rassenhofer, Spröber, Schneider, & Fegert, 2013). Untreated emotional and

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behavioral problems often sustain into adulthood resulting in disadvantages for the individual maltreatment survivor as well as society as a whole (Gilbert et al., 2009). Survivors suffer from more and more severe mental health problems (Fergusson, Boden, & Horwood, 2008; Tanaka, Afifi, Wathen, Boyle, & Macmillan, 2014), lower income, less employment (Zielinski, 2009), lower quality of life (Corso, Edwards, Fang, & Mercy, 2008) and more somatic morbidity such as diabetes, obesity and cardiovascular diseases (Felitti et al., 1998; Nygren, Carstensen, Koch, Ludvigsson, & Frostell, 2015; Romans, Belaise, Martin, Morris, & Raffi, 2002; Springer, Sheridan, Kuo, & Carnes, 2007; Su et al., 2014). Society is faced with the high costs of treatment and support for these victims (Brown, Fang, & Florence, 2011; Habetha, Bleich, Weidenhammer, & Fegert, 2012). With prevalence rates for child abuse and neglect in Germany ranging between 10 and 14.5% (Häuser, Schmutzer, Brähler, & Glaesmer, 2011; Iffland, Brahler, Neuner, Hauser, & Glaesmer, 2013; Pillhofer, Ziegenhain, Nandi, Fegert, & Goldbeck, 2011), facilitating timely access to EBT for children and adolescents with mental disorders after child abuse and neglect is of vital importance.

Among barriers to treatment faced by victims of CAN and their caregivers are a lack of knowledge about appropriate treatments, such as their benefits and how to access them, negative assumptions about treatment and associated fears of stigmatization. Furthermore, there are practical barriers such as caregivers' lack of financial resources or time, as well as out of home placement and other frequent changes in caregivers and living arrangements (Kazdin, Holland, & Crowley, 1997; Young & Rabiner, 2015). Previous research on services used by maltreated children and their caregivers showed that a close cooperation between the child welfare system, where maltreatment is often discovered, and the mental health service system is beneficial for victims of CAN's access to appropriate treatment (Bai, Wells, & Hillemeier, 2009; Hurlburt et al., 2004).

There are very few studies investigating victims of CAN access to treatment. Gender, out of home placement, age and severity of emotional and behavioral problems as predictors of successful access are controversially discussed in the service use literature. Case management approaches can be useful in overcoming barriers to treatment in adolescents (Bender, Kapp, & Hahn, 2011; Bunge, Chuang, & McBeath, 2012; Burns, Farmer, Angold, Costello, & Behar, 1996) and families that were subjects of child abuse or neglect investigations (Bunger et al., 2012). While Dorsey, Kerns, Trupin, Conover, & Berliner, (2012) successfully increased child welfare workers' knowledge about EBTs, they were not able to show an increase in actual referral rates in a small intervention study involving four child welfare agencies. In an earlier study we were able to show that the implementation of a case manager was beneficial to identifying children's possible need for treatment and treatment planning (Goldbeck, Laib-Koehnemund & Fegert, 2007). To our knowledge, so far no study has evaluated the implementation of a manualized referral process delivered by child welfare case managers. Placed at the interface between the child welfare system and the mental health service system in Germany, we designed a community based case management protocol. It offers direction and support to those working with maltreated children in helping these children and their families to find and engage them in appropriate treatment. Research on the effectiveness of mental healthcare interventions underlines the superiority of evidence-based treatments to unspecified approaches often delivered in usual care (Weisz, Jensen-Doss, & Hawley, 2006). Therefore, we aimed at a referral to providers who offer EBT. Our main hypothesis is, that 6 months after the implementation of the case management intervention significantly more children and adolescents with a history of CAN in the intervention group are receiving EBT than children receiving child welfare services as usual. Our secondary hypothesis is that the time until commencement of EBT is shorter in the intervention condition than in the usual care condition. Additionally, access to EBT at 12 months after baseline, predictors of a successful referral to EBT within both study groups as well as reported barriers to treatment are analyzed.

2. Methods

Within a multicenter, stratified parallel-group design conducted in three German states we compared a newly developed structured case management to usual care. IRB approval was obtained at all study sites. The study was registered in the German Clinical Trials Register (DRKS00003979).

2.1. Participants

Participants were 121 children and adolescents aged between 4 and 17 years who had experienced physical abuse, emotional abuse, neglect, sexual abuse and/or domestic violence. Further inclusion criteria were a safe living environment at the time of recruitment, meeting the criteria of a mental disorder according to ICD-10 and the willingness of a non-offending or no longer offending caregiver to participate in the study. Exclusion criteria were the use of EBT at the time of recruitment and a sibling participating in the trial to prevent crossover between groups in the case of siblings randomized to different conditions. For details on reasons for exclusion of participants and number of participants per study site, see participant flow diagram (see Fig. 1). Informed consent was obtained from all legal guardians as well as informed assent from the participating children and adolescents. The eligibility criteria were adapted with respect to participants' age after trial commencement. Throughout the first year of recruitment several participants older than 14 were referred to the study and had to be turned down. Since there is no reason to believe that adolescents aged 15–18 would benefit less from case management than younger children as well as due to a low recruitment rate the age limit was raised from 14 to 16 one year after trial commencement and from 16 to 17 another year later.

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