

Special Health Care Needs Across the School and Family Contexts: Implications for Service Utilization



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ABSTRACT

OBJECTIVE: A fifth of children enter school with special health care needs (SHCN), many of whom have difficulties that are milder or not yet formally diagnosed (emerging SHCN). This study aimed to investigate how differing perceptions of children's emerging SHCN across the family and school contexts relates to service utilization.

METHODS: Sample: The nationally representative birth cohort of the Longitudinal Study of Australian Children, which includes parent reports on the abbreviated Children with Special Health Care Needs Screener. For a subsample of 2459 children teachers also completed the Australian Early Development Census, a measure of early childhood development at school entry that includes SHCN. Analysis: Logistic regression analyses were conducted adjusting for severity of condition, gender, language background, and disadvantage.

RESULTS: Overall 24.1% of children were identified by their parent and/or teacher as experiencing emerging SHCN. Compared with those with consistent reports, children with

parent-only identified needs had lower odds of accessing school services (odds ratio [OR], 0.29; 95% confidence interval [CI], 0.10–0.81). Similarly, children with parent-only (OR, 0.39; 95% CI, 0.20–0.75) and teacher-only (OR, 0.25; 95% CI, 0.14–0.46) identified needs had significantly lower odds of accessing services in the community.

CONCLUSIONS: When parent and teacher perceptions of children's emerging SHCN were inconsistent, service use was lower at school and in the community. Further efforts are needed by health and education providers to ensure that common understandings about a child's needs at school are established early in children's educational careers.

KEYWORDS: chronic health condition; disability; emerging special health care needs; home school partnerships; school functioning; special health care needs

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WHAT'S NEW

Inconsistencies in parent and teacher perceptions of children's needs are related to lower use of services in the school and community settings. Health and education providers should direct greater attention to fostering a shared understanding of children's needs at school between all relevant stakeholders.

CHILDREN WITH SPECIAL health care needs (SHCN) have or are at increased risk of having a chronic physical, developmental, behavioral, or emotional condition that requires more medical, allied health, education, or related services than their peers.¹ This definition of SHCN shifts focus away from diagnostic categories toward children's individual needs for additional support, and is purposefully inclusive of children considered "at increased risk" for

being diagnosed with a chronic condition, in recognition of the important potential benefits of early intervention.²

In Australia, the provision of special education funding from the state government to support a child at school requires the presence of a formally identified disability meeting strict eligibility criteria.³ Whereas 4% of children have established SHCN that meet this threshold, many more (18%) experience emerging SHCN in their first year of school and do not qualify.⁴ Instead, children with emerging SHCN are expected to be supported through the school budget, although general services like counseling or behavior management programs are constrained in most schools.³ This leaves children with emerging SHCN at high risk of experiencing unmet service needs,^{3,5} creating a significant missed opportunity for more cost-effective early intervention.⁶

Despite having less severe difficulties compared with those with established SHCN, children with emerging SHCN nevertheless begin school with poorer academic

and social/emotional skills compared with their non-SHCN peers,⁴ and these early differences persist or increase during elementary school.⁷ Even conditions with no direct effect on cognitive or neurological functioning—like allergies or asthma—can influence academic performance.^{8,9} This is because health can affect learning through many other pathways; for example, school absenteeism, difficulties accessing the curriculum because of factors like fatigue or irritability, poorer child-teacher relationships, and restricted involvement in social activities with peers.¹⁰ A key factor shown to buffer against this risk of school failure is when the different stakeholders involved in a child's care, including parents, teachers, pediatricians, and allied health practitioners, develop a coordinated approach that can flexibly respond to the child's individual needs.¹⁰ Medical practitioners such as pediatricians have a critical role to play in achieving this by helping to coordinate supports over the health, education, and home contexts, through platforms such as the medical home.¹¹

The task of developing a common understanding of a child's difficulties can be challenging, especially because SHCN can be expressed differently across settings. At school, teacher's perceptions of SHCN might be primarily driven by the child's need for more educational supports, such as assistance in accessing the curriculum. In contrast, parents' perceptions of SHCN in the family setting might be more strongly influenced by the need to ensure adherence to medication regimes, or parent experiences of accessing supports in the community setting. Children's behavior can also differ markedly across these contexts.¹² The increased social and cognitive demands of the classroom environment often highlight children's need for greater support, whereas parenting practices can influence children's behavior in the home setting.

Parent and teacher perspectives on children's SHCN are therefore often different. In an Australian sample of children starting school who were identified as having emerging SHCN, only 16% had their SHCN reported by their parent as well as their teacher.¹³ Children whose emerging SHCN were only identified by their teacher (and not their parent) appeared particularly vulnerable. These teacher-only identified children were at risk on all domains of early development examined (physical health and well-being, social competence, emotional maturity, language and cognitive development, communication skills, and general knowledge), and additionally came from the most disadvantaged families.

The lack of a shared understanding about a child's needs between parents and teachers is understandable because of their different vantage points, but is also concerning because it might interfere with appropriate service provision and drive inequity gaps. Teachers are instrumental in identifying and making referrals to school services and providing information about community based health services.¹⁴ In addition, parents are increasingly expected to advocate for their child to receive additional supports and services at school and in the community.¹⁵ Pragmatic problems might arise when there is a lack of coordination between these important stakeholders. For example,

teachers in the United States reported that when they made suggestions and gave contact details for parents to follow-up with mental health services in the community, their recommendations were often ignored if parents did not share their concerns.¹⁴ They also reported difficulties in obtaining parental consent for the child to access school-based services.¹⁴

How best to support children with SHCN so that they are able to succeed at school is a topical issue in many countries, particularly for the numerous but often overlooked group of children with emerging SHCN.^{2,10} Parents as well as teachers have important roles to play in linking these children with appropriate services, but they do not always perceive children's needs for additional support in the same way.¹³ The aim of this study was to determine whether alignment in parent and teacher perceptions of children's emerging SHCN related to the use of additional services in the school as well as the community settings, in a sample of Australian children starting school.

METHODS

DATA SOURCES AND SAMPLE SELECTION

Growing Up in Australia: the Longitudinal Study of Australian Children (LSAC) is a nationally representative sample of 2 cohorts of Australian children—the birth cohort (B-cohort) of 5107 infants and the kindergarten cohort of 4983 four-year-old children—which commenced in May 2004.¹⁶ To date, 6 waves of data have been collected every 2 years. At each wave, families were visited by an interviewer who conducted a parent interview, completed direct child assessments and observational measures, and left behind a self-report questionnaire for parents to return via mail. Teacher report was collected via a mail-out survey. Approval for this methodology was given by the Australian Institute of Family Studies human ethics review board.

The current report is focused on the 2461 children in the LSAC B-cohort who started school in 2009 and therefore also had data on SHCN collected through the Australian Early Development Census (AEDC).¹⁷ The AEDC is an Australian adaptation of the Canadian Early Development Instrument, and is a population measure of young children's development completed by teachers.¹⁷ The AEDC was conducted across Australia for all children who began school in 2009, and has subsequently been linked to the LSAC data with parental consent. Preliminary analyses found this subset to have near identical rates of parent-reported SHCN as the full LSAC B-cohort (14.8% and 14.5%, respectively). All measures explored in the current analyses were assessed when children were 4 to 5 years of age and in their first year of compulsory schooling.

MEASURES

SERVICE USE IN THE SCHOOL SETTING

Teachers reported whether the child received additional services at school to support their learning, including speech therapy, psychological assessment, learning

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