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A DETAILED LOOK AT THE FAMILIAL, SOCIAL, AND CLINICAL CONTEXTS FOR CHILDREN AFTER THE IDENTIFICATION OF MALTREATMENT

by

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A DETAILED LOOK AT THE FAMILIAL, SOCIAL, AND CLINICAL CONTEXTS FOR CHILDREN AFTER THE IDENTIFICATION OF MALTREATMENT

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PSYCHOLOGY

ABSTRACT

In 2007, Child Protective Services received 3.2 million child abuse and neglect referrals that involved 5.8 million children. According to Health and Human Services, these reports resulted in nearly 796,000 cases of confirmed maltreatment, requiring 271,000 children to enter foster care. Research indicates children in care have a higher prevalence of medical, emotional, behavioral, and developmental disorders or concerns. Despite this increased prevalence, foster care children have a heightened risk for their mental health needs going unmet. By review of CPS records, this paper intends to examine the mental health assessments, service utilization, provider characteristics, and placement decisions for a sample of maltreated children. This history is then compared to findings and recommendations resulting from a multidisciplinary mental health evaluation. Results indicate that 50% of children were diagnosed with AD/HD prior to the interdisciplinary evaluation and those evaluations performed by medical practitioners resulted in AD/HD in 70% of cases. Inventory and assessment methods were unknown or not given in the records from every MD evaluation and the resultant recommendation always included medication. Psychologists and Masters-level professionals used 4.5 diagnostic inventories on average to determine clinical impairments and offered therapy, skills training, and academic considerations as recommendations. They diagnosed fewer cases of AD/HD and more mood disorders and developmental delays. In contrast, the interdisciplinary evaluation used 9 inventories on average, recommended a form of

therapy for every child, and more often included recommendations specific to the home, school, and social environments of each child. Diagnoses included fewer behavioral disorders and highlighted more emotional and developmental concerns. The decline in AD/HD diagnoses from previous evaluations is a significant finding due to the use of stimulant medication as the primary means for mediating symptoms. In addition, discrepant diagnostic findings, especially in regards to learning disorders and developmental delays, may have kept some children from receiving educational interventions permitted to them by law. Given the vulnerability of maltreated children, it is paramount that evaluations incorporate valid means of identifying familial, social, emotional, and behavioral concerns in order to guide effective service decisions, which can only result from the highest clinical accuracy in determining diagnoses.

Keywords: professional credentials, mental health assessments, clinical methods, diagnoses, child maltreatment

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INTRODUCTION

A report recently published by the Office of Juvenile Justice and Delinquency Prevention found that nearly half of the children surveyed were physically assaulted at least once in the previous year and approximately 1 in 10 were sexually victimized (2009). In 2007, 3.2 million investigated child maltreatment reports resulted in 794,000 confirmed victims of abuse or neglect (Department of Health and Human Services [DHHS], 2009). In the United States, a new case of child maltreatment is reported every ten seconds and nearly 5 children will die each day at the hands of an abuser (DHHS, 2009). Since 1988, child abuse and maltreatment research has explored the complex path leading up to abuse and its complicated aftermath. Best stated by Cicchetti and Toth (2005), "child maltreatment exemplifies a toxic relational environment that poses considerable risk for mal-adaptation across diverse biological and psychological domains of development." While current research has made major strides at informing theories of potential development redefined by this toxic setting, it must also aid in guiding clinical implications, assessment refinement, as well as service delivery and utilization. To date, researchers have examined the risk factors associated with maltreatment and the medical, mental, academic, and social consequences of this kind of suffering; however, little research examines how diagnoses are determined in this population, who is making the decisions, and the appropriateness of services utilized as a result. Furthermore, after maltreatment is identified, little research examines what happens next and how the child's life changes in terms of out-of-home placements and school transfers due to decisions made based on the results of these evaluations. As researchers, we are familiar

with the rates of abuse and even familiar with the rates of incarceration for the perpetration of such abuse, but do we really have a concrete grasp on what it means to be identified as a maltreated child? Do we really know how state agencies respond to such identification, if sibling pairs are being placed together, or what disorders tend to be co-morbid in this vulnerable population? The current paper attempts to offer this insight. Results will highlight the need for quality mental health interventions on behalf of these children in order to combat the impact of this violence epidemic.

General Population Prevalence

In 2005, it was estimated that nearly 899,000 American children suffered some form of maltreatment; however, nearly 3.6 million children were the subject of some kind of investigation into alleged maltreatment (DHHS, 2007). While 2007 evidenced nearly 100,000 fewer child victims of abuse or neglect, the rate of fatality from maltreatment increased during this same time frame from 1.96 to 2.35 children per 100,000 (DHHS, 2009).

The most recent national estimates indicate a majority, or 59%, of children were found to have endured neglect (DHHS, 2009). Approximately 10.8% of these children were physically assaulted, while 7.6% were sexually abused. In addition, these surveys consistently find that the youngest cohort of children is maltreated at rates significantly higher than older children. In 2005, children ages birth to 3 years were victimized at a rate of 16.5 per 1,000 children and were most often found to be neglected. This remained stable; however, in DHHS's report entitled Child Maltreatment 2007, this youngest cohort was further dissected and identified the highest risk for maltreatment in infants

less than a year old. Specifically, they experienced the highest rate of medical neglect when compared to other age groups. The report also indicated that girls and boys are victimized at similar rates of 51.5 per 1,000 for females and 48.2 for males; however, this relationship varied by type of maltreatment. For instance, girls experienced slightly higher rates of sexual abuse, while boys suffered physical abuse at increased rates (DHHS, 2009). This was most apparent as females approached adolescence. African American and American Indian or Alaskan Native children continued to experience the highest rates of substantiated child maltreatment, at 16.7 and 14.2 incidents per 1,000 children. Children of multiple races, Hispanic, White, and Asian children had rates of 14.0, 10.3, 9.1, and 2.4 cases per 1,000 children, respectively (DHHS, 2009).

Prevalence in Children with Disabilities

While gender, race, and age are associated with rates of maltreatment, it is prudent to consider other child characteristics that have been indicated to increase risk for abuse or neglect. Researchers have investigated the role developmental delays and other disorders play in the presence of abuse and additionally as the result of abuse. Results indicate that children with disabilities are maltreated at a rate 1.6 to 3.88 times higher than children without disabilities, depending on maltreatment type considered (Sullivan & Knutson, 2000; Jaudes & Shapiro, 1999; Boys Town, 1996; Crosse et al, 1993). More specifically, it has been theorized that children with mild disabilities, such as speech/language, hearing impairments, and even behavioral issues, are at a higher risk of maltreatment than those children with severe physical and cognitive disabilities, including mental retardation or an autism spectrum disorder (Jaudes & Shapiro, 1999;

Sullivan et al, 1991). The rate of neglect has consistently been found to be higher in children with disabilities than those without (Hibbard et al., 2007). While research only speculates the reason for this distinction, there is agreement that children with any form of disability are at a higher risk for maltreatment.

While certain factors may increase the risk for child maltreatment, child abuse, and neglect is also a risk factor for subsequent developmental, psychological, and behavioral consequences as well. These will be the focus of the next section.

THE NEED FOR MENTAL HEALTH SERVICES

Confirming whether developmental delays or emotional and behavior problems were present before abuse or neglect occurred remains difficult for researchers. Given circumstances involving inaccurate or incomplete records or little to no baseline data, a causal link from maltreatment to potential consequences cannot readily be established. Even with this controversial link, researchers have shown diagnostic and developmental trends worthy of consideration for a correlative link between abuse and neglect and child outcomes. Following this, the inclusion of a discussion on the requirement of out-of-home placement for some of these children is presented. An agency's role in decision making for a child is considered as well as the possible impacts these decisions have on child outcomes.

The issue of foster care placement is brought to the forefront, since some research does not delineate whether or not children were removed from their homes due to maltreatment, but instead focuses on the presence or absence of abuse and neglect. Therefore, the following subsections will include research that may involve both groups

of children. It is essential to consider that the consequences of maltreatment may also be intertwined with parental or sibling separation. Since children ages 5 and younger are found to be at the greatest risk for maltreatment, experience removal from the home at a rate higher than other age groups, and also tend to remain out of the home longer, this section will begin with a brief review of early developmental considerations. The proceeding sections will review general as well as specific implications of child maltreatment evidenced in the research. Finally, a review of foster care placement and placement stability will close this section.

Early Developmental Implications

Researchers, policy makers, and professionals can all agree that the best way to promote and enhance healthy child development is to prevent abuse, neglect, and state agency involvement (Bass et al, 2004). Given the heightened risk for maltreatment, removal, and longevity in a system of care, it seems appropriate to start with the effects of maltreatment on the youngest cohorts. In this age range, researchers and clinicians do not solely focus on diagnostic criteria, but instead on the developmental processes that may be influenced by a maltreatment experience. These developmental domains typically include attachment, affect regulation, identity formation and self-concept, self control of behavior, social interactions, cognition, and even dissociation (Cook et al, 2005).

In regards to attachment, researchers tend to find that neglected and abused infants are more likely to be unable to form secure attachments to caregivers. For example, Barnett and associates (1999) compared 12-, 18-, and 24-month old maltreated

and non-maltreated infants in a longitudinal design and found that maltreated infants exhibited more disorganized or disoriented types of attachments. Moreover, the researchers observed seeming insecure attachments in 86%, 61%, and 75%, respectively, of the maltreated sample. Uncertainty as to whether they will receive a soft touch or a stinging slap, in addition to uncertainty surrounding the receipt of comfort in their times of need may cause distress and discomfort for the child. The result may be interpersonal boundary issues, indiscriminate sociability, and inappropriate relationships resulting from the child trying to have their emotional and physical needs met. In some cases, maltreated children will try to hug or touch strangers, walk up to them, or even go along with them, potentially placing them at risk for further maltreatment. Maltreatment serves to interfere with the parent-child relationship in that children who have suffered maltreatment may lack a normative model of social exchange and behavior, thereby potentially stunting their social interaction skills. Establishing normal attachment and developing boundaries is a vital step in the development of distress tolerance, communication, agency, and curiosity (Cook et al, 2005). Therefore, disruption of this process due to maltreatment is reason for concern.

Most research in the area of affect regulation finds evidence that maltreated children struggle with excessive amounts of negative affect or have stunted or flat affect. Deficits have been noted in the ability of a maltreated child to recognize and understand emotions due to their inability to correctly recognize and interpret their personal emotional states. Without this ability, maltreated children have a decreased capacity for self-soothing and self-regulation (Cook et al, 2005). Exposure to adult violence was found to cause more distress for abused boys than for non-abused boys in a study

examining affect regulation. Additionally, the abused boys endorsed more fear to the hostile interactions than the non-abused comparison group (Hennesey et al, 1994). It appears as if witnessing abuse or being the victim has profound effects on how a child interprets interactions with others. The child assesses the situation from a perspective of fear or anger and is on guard to protect themselves from potential threats. In this case, the exhibition of more distress seems like a preparatory step for self-preservation.

In addition, these children may experience rapidly escalating reactions to what others may see as trivial (Cook et al, 2005). Maughan and Cicchetti (2002) found deficits in affect regulation and observed that maltreated children exhibited less controlled and even ambivalent regulation of emotions. Other research showed maltreated children, especially those that have been physically abused, have heightened sensitivity for anger and hostility and may interpret seemingly mundane situations as aggressive in nature (Dodge et al, 1995; Pollack & Kistler, 2002). Accordingly, affect deregulation can lend itself to behavior problems, social isolation, avoidance of situations including those that may be positive in nature, dysfunctional coping strategies, and an abnormal view of the self and the world; therefore, a disruption like this can have detrimental effects on social and interpersonal functioning as well as personal identity and self-esteem.

To move beyond recognition of personal affective states, some research examined the emotional processing skills of maltreated children. Beeghley and Cicchetti (1996) reported a noticeable deficit in emotion identification in maltreated children as early as 30 months of age. However, some research clarifies that this deficit does not include the expression of anger. Sroufe (1979) noted that in normal development infants as young as 7 to 9 months show the earliest signs of facial displays of anger. However, in another

study, researchers noted that maltreated children as young as 3 and 4 months exhibited negative facial displays (Gaensbauer & Hiatt, 1984). As a maltreated child ages, research tends to note a response bias for angry stimuli or anger inducing events for these children (Pollack et al, 2000; Pollack et al, 1998). This may be an adaptive mechanism for maltreated children to prepare for potential threats or to identify threatening situations before escalation. Pollack and Sinha (2002) attribute this bias for anger to the interruption in the development of mental representations of emotion categories due to maltreatment. Their interpretation is based on evidence that maltreated children could detect anger at very low intensities in pictures when compared to non-maltreated children. This skill may be adaptive in an environment stricken with violence, where detecting happiness and joy may not be as beneficial to survival or situational avoidance.

Research along these lines also posits that children who have been abused or neglected have anger representations primed in their minds and therefore have facilitated access to them. Dodge et al (1995) did in fact find that children who had been physically abused interpreted neutral stimuli as aggressive or hostile more often than controls, as well as utilized more physical responses to potential threats. This means that maltreated children are focusing more intently on potentially hostile threats or even seeking them out; however, this over-exaggerated focus then leaves them little mental capacity to take note of other social, emotional, and environmental cues (Cicchetti & Toth, 2005).

Evidence from the research mentioned above may point to lend support to a learning model in the formation of these developmental deficits. As they are being abused, they are learning methods for coping with situations. When faced with anger or hostility, potential physical reactions are what maltreated children may rely on from their

coping repertoire. They may be hypervigilant about the potential for hostility in order to protect themselves. Their behavioral responses then become adaptive for that protection. However, this anger bias is maladaptive for creating and maintaining social interactions, especially in the case where neutral or mundane situations are interpreted as hostile. With an emotional negative lens constantly in place, maltreated children may have a very different view of the world around them- one that may presuppose pessimism, doubt, impassivity, or more importantly distrust. Even in settings where the child's best interests may be served (i.e., foster care or hospital), the lack of trust potentially makes any attempt at recovery very challenging. Furthermore, if a child only sees displays of anger, they are then potentially learning about the expression of this emotion over other emotional expressions. How to effectively recognize an emotion as well as how to express that same emotion both have an imitative element, a piece that must be learned from others around the child. It may be the case that a maltreated child simply does not attend to other emotions like happiness, joy, confidence, and security hence why they may be unable to replicate or recognize it. This may speak directly to the higher rate of internalizing and externalizing disorders seen for this group.

Taken together, the lack of emotion regulation and insecure attachments may interfere with the development of the self as distinct from others, which speaks directly to displays of indiscriminate sociability, and with later development of a child's theory of mind (Cicchetti et al, 2003). "Maltreated toddlers […] have been found to exhibit fewer internal-state words, to show less differentiation in their attributional focus, and to be more context-bound in their use of internal-state language than were their non-maltreated peers," (Beeghley & Cicchetti, 1996). These researchers hypothesized that the emotional

environment in addition to the maltreatment may create a situation where there is limited acceptance to discuss feeling. Due to the potential threat they may create, the child may learn not to talk about feelings, especially negative affective states. This omission and constant inhibition may consequently diminish their capacity to understand themselves or others in terms of emotions. Furthermore, maltreated children may experience and express emotions differently than non-maltreated children, thus making it difficult for abused and neglected children to recognize and interpret feelings in others. This line of research lends itself to inquiries about the development of empathy and moral reasoning. It may be the absence or retardation of the empathetic response or the delayed development of moral judgment and decision making that precedes the possibility of increased delinquency, violence, and general noncompliance to societal or community norms in maltreated children. However, this research also lends support to the idea that context and the maltreatment environment may be just as important as the act itself.

To close, the developmental processes in early infancy and toddlerhood serve to equip the child with a healthy self-image, constructive coping mechanisms, and appropriate social roles. Disruption of the normal advancement of these processes by maltreatment may severely dampen healthy development. Concerns over personal boundaries, distrust of others, stunted empathy, communication difficulties, depersonalization, body image disturbances, poor impulse control, and learning problems may all arise given a child suffers maltreatment (Cook et al, 2005). Since developmental issues have been addressed, we now consider how these disruptions have the potential to morph into diagnostic significance.

General Medical and Mental Health Implications

Halfon et al (1995) estimated that nearly 80% of 213 maltreated children seen for a comprehensive assessment had at least one developmental delay or emotional disturbance. Specifically, more than 50% of children had disorders in both categories and fewer than 30% had 3 or more conditions. Amster (1999) found that 52-73% of maltreated children have a speech and language deficit. Other studies indicated expressive language disorders for between 55-63% of children 60 months or younger in addition to receptive language disorders and fine motor deficits ranging from 38-44% and 27-33% for this young cohort, respectively (Halfon et al, 1995).

The National Survey of Child and Adolescent Well Being started in 1997 reported that 33% of children subject to a maltreatment investigation were identified as having a learning problem, a developmental disability, or some other special need (No. 1). In addition, maltreated children aged 2 and older exhibited 3 to 4 times as many behavior problems than their non-maltreated comparison group. Elevated risk for neurodevelopmental delays as well as deficits in daily living and social skills were also noted in the maltreated groups (ACF, NSCAW-No. 1). This same study found learning disabilities, emotional disturbances, and speech impairments to be the most common conditions identified, at 21%, 14%, and 12%, respectively for the total sample. Moreover mental retardation or hearing impairments were seen in 2% of the total sample and a vision impairment or autism was noted in 1% of the children (ACF, NSCAW-No. 7).

While any form of maltreatment is associated with elevated risks for internalizing and externalizing issues, some forms have been linked to specific outcomes. In general, research indicates that physically abused children manifest more behavior problems,

cognitive delays, peer problems, and aggression. Sexually abused children engage in more sexualized externalizing behaviors, depression, and even dissociation. Children who experience neglect most often evidence potential increases in learning, cognitive, and language impairments (Cicchetti & Toth, 1997).

Specific Clinical and Diagnostic Implications

Maltreated children have been found to have more depressive and anxious symptoms when compared to their non-maltreated counterparts, as well as be more hostile and aggressive (Teicher et al, 2006; Kaplan et al, 1999a; Kaplan et al, 1999b; Shields & Cicchetti, 1998). Regarding specific disorders and diagnoses, research in this area has traditionally taken two forms. In one way, researchers have examined a specific disorder (i.e., AD/HD) and determined its prevalence in a maltreated sample. For instance, Posttraumatic Stress Disorder (PTSD) has been examined and found to occur more frequently in child victims of sexual abuse when compared to children suffering other forms of maltreatment (Pelcovitz et al, 1994; Deblinger et al, 1989).

Alternatively, other researchers have broadly classified disorders and examined symptomology in a maltreated sample or limited their scope of investigation by assessing for just a few disorders (i.e. Dysthymia and Major Depression tend to be grouped into a "Depression" classification or research designs include simply administering Depression and Anxiety inventories). After determining abuse type, Teicher et al (2006) administered the Dissociative Experience Scale and Kellner's Symptom Questionnaire to 554 18- to 22-year olds who self-reported an "unhappy childhood" and found robust effects of abuse type on dissociative experiences, anxiety symptoms, depression

symptoms, and anger-hostility symptoms. Effect sizes ranged from 0.1 to 3.7 and varied for type of maltreatment. While both approaches have laid a substantial groundwork in maltreatment research, more detail and richer insight is needed to better inform clinical applications and assessment procedures.

Even with the divergent paths of researching the psychological outcomes of maltreatment, some research proves to be more informative in depicting the internal environment of an abused child. For instance, Pelcovitz et al (2000) found that adolescents who had been exposed both to intrafamilial violence as well as physical abuse had significantly higher rates of Separation Anxiety Disorder (SAD) and PTSD than those children without such traumatic experiences. Moreover, adolescents in the study exposed to one or both of the traumatic experiences were at a higher risk for Major Depression, Conduct Disorder, Oppositional Defiant Disorder, and Substance Abuse. Specifically, adolescents in the double-exposure category were 5 times more likely to currently be depressed and have a history of SAD, were 4 times as likely to receive a diagnosis of ODD, and were 376 times more likely to receive a lifetime diagnoses of PTSD when compared just to the single-exposure group (Pelcovitz et al, 2000). This research not only assessed for a range of potential outcomes, but also considered the familial impact on those outcomes by assessing for the violence occurring in the home in conjunction with the maltreatment experiences of the adolescents. Overall, research converges in this area and consistently finds that prevalence rates for depression and anxiety disorders as well as behavioral and other developmental disorders are several times higher in maltreated children and adolescents than there non-maltreated counterparts.

However, as researchers, we must determine if we are limiting our interpretations of the consequences of maltreatment by asking if our results are mere artifacts of the specific inventories we administered. Additionally, are we gaining a factual picture of reality if we expect comparable results evidenced in past research? To address this, the current paper uses data collected from an interdisciplinary team of professionals, where bias may have been optimally minimized by the influence of the expertise offered by multiple disciplines. While case histories certainly guided assessment preparation for each child, the interdisciplinary nature of the assessment counter-balances any one professional's bias in their field, personal preference for select inventories or methods, and their expectations of the findings.

Again, before closing on a section that reviews the mental health outcomes for maltreated children, it is essential to consider the impact of the involvement of state protection agencies and the actual and potential influences they have on child functioning.

Out-of-home Placement Implications

On any given day in the United States, there are over half a million children in foster care (DHHS, 2006). For protection from immediate physical danger or continued emotional harm, children can be placed in a foster care setting until further investigations are conducted and appropriate resources are identified. Therefore, a review of maltreatment is not complete without a review of research conducted with foster care children. Moreover, it is essential that research consider the impact of any state

intervention or involvement on the lives of maltreated children. The following discussion leads with a review of state involvement and ends with a look at children in foster care.

The involvement of state agencies in the lives of families and children is best captured by the following statement: “Two essential ingredients justify intervention in the lives of families: a child is in need of protection, and the parents or caretakers are unwilling or unable to provide that protection,” (Schene, 1998). However, the mission of most state agencies is to protect the children, while also safeguarding the privacy of the family. With such juxtaposed ideals, state involvement is either criticized as an ‘unwarranted intrusion’ into a family’s private life or charged with ‘negligent inaction’ (Weber, 1997). Other descriptions of child welfare systems seen in numerous special reports and newspaper articles include adjectives like mismanaged, incompetent, ill-informed, confused, understaffed, and untrained. Historically, these charges stem from isolated, albeit tragic, events of child death or severe maltreatment that have served to highlight the failings of the system. In turn, the system has become one that is reactive and reflexive, instead of one that is proactive and calculated, to make amends for those singular incidents. The current paper aims to challenge the current belief of system imprudence by taking a practical step in understanding a child’s involvement with a protection agency. While not all children will be removed from a home, an agency may still remain involved with a family to monitor the support and wellbeing of the children as a preventive measure. Therefore, a review of their mandates and subsequent procedures seems relevant to start.

Any child protection service or system (CPS) exists to investigate reports of maltreatment, conduct family risk and safety assessments, aggregate and offer services,

provide means of alternate care (in cases where children are removed from their homes), and determine progress through extensive follow-ups. However, the first step begins with caseworkers and their investigation into an alleged incident of abuse or neglect. It is here that the determination is made to either proceed with intervention services or move to close the case. Common resources utilized by caseworkers after involvement is deemed necessary are emergency medical services, domestic violence shelters, substance abuse treatment facilities, urgent housing refuges, mental health evaluations, child care centers, and continuing counseling services both for individuals and families (Schene, 1998). While this appears to be an extensive list of resources, it must be noted that not all communities will have access to them, either due to funding constraints or because they simply do not exist in some areas. Moreover, "the spread of substance abuse among parents, rates of family breakups, deepening pockets of poverty, and cuts in government services have intensified family problems and reduced options for helping," (Larner et al, 1998). One study found that that children were 2.7 times more likely to be abused and 4.2 times more likely to be neglected when they had a drug-abusing parent (Kelleher et al, 1994). Substance abuse is also known to be associated other harmful experiences for children including exposure to domestic violence and neglect.

Caseworkers are then given the task of evaluating the family, determining the safety of the child, and providing the family with the appropriate resources. However, from this we can see that CPS is an agency that is interdependent on other agencies and organizations. "Other agencies and community members play critical roles in protecting children from abuse and neglect, and responding to maltreatment once it occurs,"

(Schene, 1998). The current paper seeks to examine the role of mental health professionals and the use of these services once maltreatment has been identified.

For the current sample, CPS was notified of possible maltreatment and determined some form of intervention was necessary for these families and in some cases, maltreatment was substantiated. Therefore, the current paper relies on the mental health evaluations conducted to help identify the potential deficits in the child after the identification of maltreatment. Additionally, other supporting documentation provided for such an assessment becomes a valuable resource for examining the social and familial environments for these same children. To increase efficiency and effectiveness, state agencies should require the fullest understanding of these changing contexts and how state involvement alternately influences these changes. Through the examination of this dynamic and interrelated system, it is thought that decisions regarding the safety and welfare of the child can be better informed. Moreover, a closer look may also serve to provide the groundwork necessary to develop appropriate service provisions and intervention options that may ameliorate the negative effects of maltreatment on children and potentially even prevent them.

Nevertheless, the current study is not only examining the use of such services, but the service providers themselves. Critics charge that services offered to children are cookie-cutter or "out-of-the-box" and may not always be appropriate given the developmental stage of the child. Child advocates posit that services and clinical recommendations should look very different for infants and toddlers than they do for adolescents. More is offered on this topic below.

Children in Foster Care

Foster care was initially intended to serve as a temporary shelter for children found to have suffered abuse or neglect and whose safety and well-being were in jeopardy if they remained in the home. Even with family preservation serving as a main tenet for most child protection agencies, the number of children entering foster care annually increases. In 2005, of the nearly 311,000 children entering foster care, 148,646 were maltreatment victims and an additional 84,518 non-victims were removed due to the heightened risk for maltreatment given another child victim had been identified in the home (DHHS, 2006). In 2006, this overall number of children entering care was just over 300,000 as well. The mean age remained relatively stable at around 10 years old and the average length of their stay was just under 30 months (DHHS, 2008)

Neglect and parental incapacity (i.e., due to substance addiction) are the most common reasons children are placed in foster care, followed by physical abuse, abandonment, and sexual abuse (Silver et al, 1999). The maltreatment experience and the trauma of being removed from one's parents can impact the developmental, mental, and physical health of a child, thus making these children a vulnerable population (Vig et al, 2005). Rosenfeld et al (1997) estimated that children in foster care have 3 to 7 times as many acute and chronic health conditions, developmental delays, and emotional adjustment problems when compared to children in a low socioeconomic category. Specifically, Haflon et al (1995) looked at the presence of developmental delays or emotional problems in 213 foster care children and found that 76% of children ages birth to 12 months, 83% of the children 13 to 36 months, and 92% of the children 37 to 60 months evidenced one or some variation of them both. Additionally, these researchers

found that over 80% of the children had at least 1 medical problem requiring continuing treatment, while almost 30% had 3 or more chronic conditions. This is coupled with the fact that nearly 40% of them were born prematurely or born with low birth weight. To add to this, the U.S. General Accounting Office (1994) estimated that nearly 80% of children in foster care were exposed to drugs or alcohol in utero, which may contribute to some of the disorders or delays present at birth. It becomes apparent from the numbers then that children in foster care are at high risk for potential dysfunction and may require multiple needs being met simultaneously in order to prevent any further developmental interruptions.

At this point, it is worth noting the difficulty in parsing out the effects of prenatal influences (i.e., prenatal care, potential substance use, domestic violence during pregnancy, adequate nutrition, and medical care for existing conditions in the mother) and potential influences occurring after the birth of the child (i.e., abuse, neglect, adequate nutrition, parents mental illnesses). Even reviewing records offers incomplete details and often times details conflicting or unsupported facts regarding the experiences of maltreated children. The current paper will include such information where it is available and allow it to serve as supplemental details that may better capture the reality of a maltreated child. Due to the inconsistent availability of client history and incomplete records, drawing any firm conclusions from histories will be difficult. However, relying on data and records collected since state involvement seems to afford more reliable and accurate depictions of the children.

Foster Care Placements

To speak directly about what is known about removal from the home, most children in foster care evidence feelings of confusion, distrust, fear, apprehension, loss or bereavement, anxiety, sadness, and general distress. These feelings may surface in the child's behavior as hostility, defiance, and aggressiveness on the one hand or may appear as excessive crying, isolation, trouble eating and sleeping, and even developmental regression like bed-wetting, baby-talking, or complete disuse of spoken language. Hyperarousal, hypervigilance, intrusive memories, or dissociative experiences are just a few of the potential consequences of maltreatment seen in foster care placements. These behaviors lend themselves to diagnoses like PTSD, Reactive Attachment Disorder, Oppositional Defiant Disorder, Depression or Dysthymia, Adjustment Disorder, and regulatory disorders.

Still, the experience of these symptoms may be directly related to the type of placement and the number of placement disruptions the child endures. Kinship care, or placement with relatives, has received a lot of attention recently due to researchers identifying its disproportional use in African American children (Harris & Skyles, 2008). Some may argue that placement with relatives has psychological benefits for the children in regards to knowing familial roots and promoting family identity (American Academy of Pediatrics [AAP], 2000). However, the Committee on Early Childhood, Adoption, and Dependent Care also warns that kinship care can lead to an unanticipated return of the child to their parents given supervision is usually less intense with this placement (AAP, 2000). While research is mixed on the effects of kinship care or non-relative foster placement on developmental outcomes (Taussig et al, 2002; Wilson & Stukes Chipungu,

1996), research does suggest that placement instability is associated with more negative developmental outcomes for these same children (Staff & Fein, 1995; Smith et al., 2001; Redding et al, 2000). As stated by the American Academy of Pediatrics, "[m]ultiple moves while in foster care (with the attendant disruption and uncertainty) can be deleterious to the young child's brain growth, mental development, and psychological adjustment" (2000).

While most children only experience one to two placements while in foster care, a majority of these placements are disrupted within the first two years (Staff & Fein, 1995). In a report by the Future of Children organization, they state, "[s]tability of care appears to be more consistently related to social and emotional well-being than in quality or type of care" (Huston, 2002). Studies on number of placements vary greatly by region. For example, 77% of youth in a California study experienced 3 or more placements, while 63% of youth in a Washington study had only 1 or 2 placements (James, 2004; Wilson, 2000). Additionally, the longer a child remains in foster care, the more likely they are to experience multiple placements. Therefore, variations in the number of placements experienced by children may be a function of time spent in care. This is sometimes difficult to establish when records are incomplete and kinship care is not consistently counted as removal from the home. For this reason, this paper will focus on the number of recorded placements as documented by the protection agency.

Like other concerns in the maltreatment literature, it becomes difficult in determining whether multiple placements exacerbate child outcomes or whether developmental difficulties or even difficult child behavior results in multiple placements. However, research is not mixed on the potential for negative outcomes and intellectual

deficits when children are deprived of physical and material resources, attention from a loving and warm caregiver, and subject to low quality care settings (English, 1998). Therefore, including variables related to placement type and stability is useful for the current examination. Additionally, information on school transfers involved with placement changes and sibling placements may serve to better inform our understanding as well.

To summarize, a review of some of the research conducted with foster care children is essential to any review of child maltreatment; however, it should be noted that foster care children represent a mere 10% of those children for whom abuse or neglect has been substantiated (Simms et al, 2000). Moreover, it is difficult to disentangle how the foster care system or any state involvement as well as other factors influence the developmental outcomes of these children. Those individuals who contacted the proper authorities when they suspected maltreatment most likely did so with the feeling that they their actions were helping the child (Schene, 1998; Bass et al, 2004). Allegations then needed to be investigated and substantiated by state personnel, or caseworkers. Approximately one-third of all reports of maltreatment are typically confirmed and some families may receive services at this point. For a smaller fraction, children are removed from the home to ensure their safety, while their family has an opportunity to benefit from services (Schene, 1998). A clearer picture as to what the child experiences in terms of placements, sibling removals, and related factors like school transfer and the original reasons for agency involvement are then necessary to understanding contexts after the identification of maltreatment.

With a better understanding of the mental health needs anticipated with abused and neglected children, we now turn our focus to the use of services that may attend to and ameliorate these needs.

THE USE OF MENTAL HEALTH SERVICES

Child protection agencies and government's involvement in a family life can be considered highly invasive and intrusive; however, this same intrusion has undoubtedly saved many children lives and spared many more from additional suffering. When a state decides to take custody of or intervene on behalf of a child, they are in effect saying they can do a better job at protecting and providing for this child than its birth parents have done (Bass et al, 2004). Therefore, it is reasonable to expect that these agencies recognize the potential conditions that may have already interfered with healthy development and must be prepared to respond accordingly.

Child maltreatment does not typically happen in isolation of other circumstances, including poverty, possible parental substance use, domestic violence, and exposure to environmental toxins. We have already reviewed the spectrum of diagnoses and conditions that a majority of children will bring with them into care. It goes without saying that medical concerns should be addressed at the point of contact with a family to ensure a child's physical health. This includes necessary immunizations, a health screening, and even disease testing, given some children's high exposure rate to HIV and other communicable diseases. However, it would be a misstep in their involvement with a child to stop intervention after addressing their medical needs. The proceeding sections will review the literature on mental health service utilization for this population.

Use of Services

Given the heightened risk for emotional, behavioral, and developmental disorders for maltreated children and the associated need for services, it still remains difficult to accurately determine service utilization in this population. Some researchers argue that a families involved with state agencies receive care over and above the rates at which non-maltreated children receive them (Leslie et al, 2005). However, most would agree that a maltreated child's need for these services may far surpass the need of a child exempt from such treatment. The following discussion then will present available research.

Using national longitudinal data collected on children 3 years or younger, researchers found that 35% of this group qualified for early invention services and 34% of them were eligible due to a developmental delay (ACF, NSCAW-No. 8). While further findings from this study showed increased likelihood for receipt of services as this young cohort aged, many children who showed need due to a developmental delay, and therefore likely eligible for services, did not receive them (ACF, NSCAW-No. 8). Only 1 in 8 children (birth to 2 years) were tested for special education eligibility and only 3% received some form of early intervention services. Also, despite their elevated risks for delays, only 1% received some mental health service (ACF, NSCAW-No. 4). With preschool-age children, nearly half of the sample showed signs of developmental risks and 1 in 10 showed evidence of language deficits. Even so, only 12 - 13% of preschoolers were receiving special education services (ACF, NSCAW-No. 3). Even fewer preschoolers, or approximately 3%, were receiving mental health services. Overall, infants and toddlers were the least likely cohort to receive needed mental health services.

A follow-up of the infants (birth to 12 months) in the study 5 to 6 years later showed 16.7% received more than 1 outpatient mental health service; 12% used a specialty mental health intervention; 7% relied on a family physician; 10.8% utilized a school-based service; and 6.4% were taking psychotropic medication (ACF, NSCAW-No. 10). In addition, 22.6% had an Individualized Education Plan (IEP) and were currently receiving special education services.

Using additional data from the NSCAW study, Burns and associates (2004) determined a strong relationship between clinical need for services and mental health service use across all age cohorts (OR = 2.7 – 3.5). They also found that children aged 2 to 5 years that suffered sexual abuse (compared to neglect) showed increased use of services and older African American children still living at home used fewer services. Similar results were also found by Leslie and colleagues (2004) in that they too found that race/ethnicity ($p < .01$), placement type ($p < .001$), physical maltreatment ($p < .05$), and sexual abuse ($p < .001$) as significant predictors of service use. Specifically, they found children who suffered sexual abuse were 5 times more likely to receive services (compared to sexual abuse history); children in group care were 6.07 times more likely to receive services than those in non-relative foster care placements; and African American children were 0.34 times more likely to received services compared to White children.

Service use for school age children in this sample indicated that 18% received outpatient mental health services even though between 36% and 45% exhibited borderline to clinical levels of behavior problems and 15% of the sample aged 7 years or older manifested symptoms indicative of depression (ACF, NSCAW-No. 3). Twenty-one percent of children in this age cohort were receiving special education services and 27%

had an IEP or Individualized Family Service Plan (IFSP) documenting a learning disability. While children in out-of-home placements had higher behavioral risks than those children still at home, children living away from home showed increased probabilities of receiving mental health services than those remaining in the home (ACF, NSCAW-No. 8).

Besides longitudinal data, other researchers have used Medicaid claims data to determine service use for children involved with state agencies, both in and out of foster care. One study that looked at paid claims for children under 18 years of age in California found that foster care children had a mental health age-adjusted service use rate that 15 times the total Medicaid dependent youth population that served as the comparison group (Halfon et al, 1992a, 1992b). Additionally, foster care children accounted for 53% of all psychologist visits, 47% of psychiatry visits, and 27% of all inpatient psychiatric hospitalizations. Another study in San Diego County found that 56% of children used mental health services within 5 to 8 month of entering foster care and this rate of use increased with age (Blumberg et al, 1996). Specifically, 21% of children aged 2 to 3 years using services and over 70% of children 7 years or older using them. Finally, when researchers compared service use of foster care children and children qualified for Supplemental Security Income (SSI) due to moderate to severe functional limitations resulting from a medically defined physical or mental disability, they found comparable rates of service use and prevalence of psychiatric disorders between children in care and those with the disabilities (Harman et al, 2000). This is significant in that children who have suffered maltreatment require care similar to those children who have a medical basis for their disability. Over and above treating the

physical consequences of abuse, these children require care that attempts to heal the psychological, emotional, cognitive, and social scars left behind. The functional impairments caused by these factors create a significant need for services that can address these issues.

In sum, these findings offer a picture of service use rates that clearly surpass service utilization for the normal population and is comparable to or higher than other children involved with state agencies. Even with such high rates, there is still a gaping unmet need of mental health service use for maltreated children. The variation of service use by these children may involve multiple factors, but the elevated risk of negative outcomes demands the attention necessary to develop procedures to meet these needs. Not only is it important that we examine what services are being used by this population, it is also paramount to determine how mental health assessments are being conducted and who is doing them. This is the topic of the proceeding section.

Mental Health Assessments and Professional Qualifications

The service rates examined above clearly indicated the use of mental health care by maltreated children. However, it is unclear what exactly researchers mean by mental health care, who is a mental health professional, and what exactly a mental health or psychological assessments involves when it comes to this population. For example, the national longitudinal study discussed above distinguishes between “Specialty” and “Nonspecialty” mental health services. Moreover, we know that when they tested the children in the sample they used the Child Behavior Checklist (Achenbach, 1991) to determine behavioral concerns and the Battelle Developmental Inventory (BDI), the

Kaufman Brief Intelligence Test (K-BIT), and the Preschool Language Scale to determine special education and speech/language needs (NSCAW Research Group, 2002). In addition, they used both the parent and teacher forms for evaluating behavior problems in children. This use of empirically valid and reliable inventories seemed appropriate for the goals of the project. However, other studies have used single behavior rating scales to determine clinical significance for their samples, including the San Diego County study mentioned above. Instead of comparing multiple resources of information, this study used responses from a single-rater to decide which children had clinically significant behavior problems. While conducting research certainly has its constraints (i.e., time, money), these examples serve to highlight the range of input utilized by professionals to draw conclusions about their samples. This use of inputs is even more important in the clinical setting, where the participants are not numbers in a database, but are patients with a unique set of personal needs. In our case, these are children with a complex history of physical and psychological suffering. However, it is in this mental health setting that we know the least about the process informing clinical significance and diagnostic decisions.

Mental health professionals are one piece of an extended network that collaborates to protect children from abuse and neglect. Psychological evaluations are key determinants in placement decisions and service provisions, especially when state agencies are involved. Even with this, the professional qualifications of those conducting assessments have not been examined to date. While psychological research seems primarily to be conducted by PhD's, MD's, and supervised support staff (i.e., interns, graduate assistants), it cannot be said that these same professionals are the only ones

diagnosing psychological and psychiatric disorders in maltreated children. Research to date has not examined the credentials of practitioners making such diagnoses, nor has it examined what assessment measures and inventories are being utilized to make them. While researchers typically make known the instruments and inventories utilized in their studies, it is not obvious if these same measures are being employed in clinical practice. Current research cannot identify how practitioners in a community setting evaluate maltreated children and arrive at diagnoses. More importantly, research cannot say whether the assessment procedures were developmentally appropriate. The developmental needs of children change dramatically as they enter adolescence and will again change as they progress into adulthood. To account for differential needs, inventories and assessments undertaken with these children need to be precise enough to capture their diagnostic presentation given it controls for their developmental stage.

Finally, the determination of a diagnosis informs what interventions, services, and resources are offered to a maltreated child. It is not always obvious what options are made available to maltreated children in order to aid recovery and guide coping. Additionally, critics argue that when maltreated children are provided with interventions, they are all afforded similar service provisions, regardless of their age-appropriateness. Again, developmental needs change significantly as children age, making service provisions appropriate for toddlers inappropriate for adolescents. Ensuring developmental needs are met requires very different strategies for the different age cohorts given they each have unique challenges. By examining the recommendations made and services utilized, the current study can examine this trend further. The existing lack of research in this area highlights the need for the current paper.

STATEMENT OF THE PROBLEM

This study intends to examine the mental health of maltreated children by observing the evaluative support system that surrounds them. A more substantial breakdown of delays and disorders following maltreatment is necessary in order to facilitate interventions and appropriate services. Research in this area would benefit from knowing which ones exist specifically. We will also benefit from knowing exactly which ones are diagnosed more frequently. To this effect, the current paper intends to provide a very detailed look at the psychological consequences of maltreatment as diagnosed by mental health professionals and other specialists.

In order to evaluate the current mental health status of children identified as maltreated, a team of various professionals representing developmental psychology, neuropsychology, social work, and counseling met weekly to scrutinize each child's case and decide on the best method for psychological assessment. Formation of an interdisciplinary team allows expectations before assessments to be minimized, thus allowing for an unbiased and extensive evaluation. Additionally, multiple specialties allow for different training and knowledge to enter into the assessment. The use of multiple inventories from varying disciplines, information gathered from several sources, as well as clinical interviews and lengthy reviews of records ensured a more complete depiction of a child in the wake of maltreatment. By achieving a better grasp on current functioning, recommendations and services offered are better informed and may be more customized for the specific circumstances of the child. This paper intends to examine what services were being utilized at the time of the assessment as well as review the types of assessments the child had previously. These will then be compared to what

recommendations are offered after an interdisciplinary assessment. With this kind of assessment, it is ensured that qualified professionals are evaluating these children and that these same practitioners are using empirically validated and reliable measures. To speak directly to this effect, this paper will also review past diagnoses of the children, the credentials of the practitioner who diagnosed the child, as well as the methods used to derive the diagnoses. Little research has examined this process; therefore, a comparison between past evaluations and a current psychological assessment is intended to offer insight into this area.

In addition to examining the mental health interactions with maltreated children, this paper also seeks to examine the impact of other decisions made by state agencies or caseworkers on the maltreated child. To this effect, placement characteristics, sibling separation, and school transfers will also be examined in parallel to the developmental delays and diagnoses seen in this sample of maltreated children. The aims for this descriptive study are outlined below.

Research Aims

One goal for this research is to analyze prior emotional and behavioral diagnoses resulting from previous evaluations and compare these with the procedures and diagnoses determined by an interdisciplinary team. Therefore, frequency distributions will be used to identify past and present diagnoses.

Another goal of this study is to examine placement stability following abuse or neglect. Specifically, the number of out-of-home placements, type of placement (i.e. residential treatment, regular foster care, therapeutic foster care, family/relative

placement), sibling removals (placed together or not), and number of school transfers will be examined.

The fourth goal of this study is to examine the professional credentials of the practitioner who diagnosed the children prior to an interdisciplinary assessment as well as identify what measures were utilized to confer the diagnoses. Again, frequency data will be tabulated to address this goal.

Finally, the last goal of this paper is to examine what intervention strategies were recommended for this sample and how these recommendations compare to what services may have been already recommended by other practitioners. Using frequency data, this paper will examine what services are currently being used by the child and examine their developmental appropriateness.

METHOD

In order to achieve these aims, this paper utilized data collected from children aged 2 to 18 that were referred by Child Protective Services (CPS) to an interdisciplinary team of mental health professionals. This team met weekly to discuss the referred children and prepare individualized assessments that would accurately capture the current functioning of the child. Team members performed extensive psychological evaluations and psychoeducational assessments at a community mental health care clinic located at a state university. The data used for this paper, including background information as well as evaluation results, were stored in a de-identified database and were made accessible to the researcher after obtaining the appropriate permissions.

Procedure

The researcher obtained consent from CPS, the authorizing agent, to review the psychological, familial, and medical records of the above-mentioned sample as recorded in the de-identified database. Additionally, this descriptive study was formally submitted to the University's Institutional Review Board and was subsequently approved before proceeding.

The variables of interest in the dataset were the following:

- *Demographics*: gender; race/ethnicity; number of siblings; chronic medical issues
- *Assessment History*: first date of CPS involvement; date of most recent removal from the home; previous diagnoses; professional credentials of evaluators from previous assessments; psychological, behavioral, or educational assessment inventories; recommendations for intervention; service utilization; identified abuse or neglect type; initial reason for CPS involvement; number of foster placements; number of school transfers; placement of siblings
- *Interdisciplinary assessment*: diagnoses; recommendations for intervention; professional credentials; psychological, behavioral, or educational assessment inventories

Sample

To obtain a random sample of the children seen through the community clinic, a list of 100 identification numbers was created utilizing a random number generator in

SPSS 14.0. The selected numbers then corresponded to an associated record in the database and that data was extracted for use.

Given the difficulty in obtaining complete historical and medical records for this sample, the variables listed above typically did not have information available in every record. Therefore, the sample sizes involved in the description of these cases are reported when appropriate. The descriptive nature of this paper prescribes the use of counts, proportions, and percentages in accurately examining this sample. The final sample used consisted of records from 98 of the 100 records extracted from the database.

RESULTS

The current sample consisted of 56 boys. Of the 98 cases randomly selected for use, 58 were African American and 35 were White race/ethnicity. They ranged in age from 2 years, 9 months to 18 years, 6 months. On average, girls seen were 9 years, 6 months, while boys were approximately 1 year younger than this. Nearly one-half (n = 47) of these children had a chronic health condition including asthma, allergies, and skin conditions like eczema that required consistent physician follow-up and/or daily medication. Four children experienced a sexually transmitted disease. Neurological impairments seen in the group included 3 children with significant head injuries or skull fractures, 3 children who experienced seizures, and 1 child with microcephaly. Physical disabilities were reported in slightly more than 10% of the sample and included legal blindness (n = 3), significant hearing loss (n=4), or a physical disability (n = 3). Records also indicated that 10 children in the sample were born prematurely and another 5 children had highly specific medical conditions that were not indicated, as to protect the

Table 1: Demographic Information by Number of Placements

Number of Previous Placements:	N	0-1 (%)	2-3 (%)	4+ (%)	Sum	Mean	Range
Total	98	19.4	43.0	37.8	~	~	~
Sex							
Boys	56	17.9	46.4	35.7	174	3.1	0 - 7
Girls	42	21.4	38.1	40.5	144	3.4	0 - 9
Race/ethnicity							
White	35	14.3	45.7	40.0	127	3.6	1 - 8
Black	58	24.2	37.9	37.9	176	3.0	0 - 9
Other	5	0.0	80.0	20.0	15	3.0	1 - 8
Age at SEBD Evaluation							
2 - 5 years	27	18.5	55.5	26.0	81	3.0	1 - 7
6 - 9 years	38	21.1	50.0	28.9	110	2.9	0 - 7
10 - 13 years	16	12.5	37.5	50.0	58	3.6	0 - 7
14+ years	17	23.5	17.6	59.0	69	4.0	0 - 9
Medical Problems							
Chronic health condition	47	23.5	31.4	45.1	~	~	~
Physical Disability	10	0.0	60.0	40.0	~	~	~
Neurological Impairment	7	14.3	42.8	42.8	~	~	~
Failure to Thrive	2	0.0	100.0	0.0			

identity of the child. Table 1 displays basic demographic information of the sample by the number of placements experienced by the children. Placement stability is discussed in the following sections.

In regards to custody, two-thirds of the children were in the legal custody of CPS (n=66), while approximately 20% in the custody of a relative (n = 20) and another 12% children remained in the custody of a parent (n = 12). At the time of the evaluation, it was reported that 55 children, or nearly 60%, were residing with foster parents, with slightly less than one-third of these placements considered therapeutic settings (n = 21). Just under two-thirds of the children had been removed from a parent's home only once (n = 64), one-fifth were removed twice (n = 18), and one-tenth were removed from their parent's home 3 or more times (n = 10). Only 6 children evaluated had not been removed from parental care. Together, this sample experienced 131 separations from their primary caregivers and on average was removed 1.34 times. Moreover, among the 92 children

Table 2: Maltreatment and Concerns

Maltreatment Types (%)	
Neglect	49.0
Educational	5.1
Medical	1.0
Physical Abuse	37.8
Sexual Abuse	25.5
Emotional Abuse	6.1
Other Identified Concerns (%)	
Parental Substance Use	37.8
Unstable Housing/Resources	34.7
Exposure to DV	19.4
Lack of Supervision	13.3
Prevention/Safety[a]	10.2
Parent in Jail/Prison	6.1
Abandonment	5.1
Other Parental Incapacity[b]	3.1

[a] Removal due to CPS involvement with a sibling
[b] Includes Death, Physical/Mental Illnesses

removed, each child experienced an average of 3.5 placements, with the group totaling 318 placements in all. The maximum number experienced by any one child was 9, with 16 children in the removal group experiencing 6 or more placements.

The maltreatment experienced by this group included 55% (n = 54) children who experienced some form of neglect, with educational neglect in 5% of the cases (n = 5) and medical neglect determined for one child. Approximately 38% experienced physical abuse (n = 37), one-quarter had potentially been sexually abused (n=25), and 6% of children suffered emotional abuse (n = 6). These estimates are presented in Table 2 and include 'indicated' as well as 'substantiated' cases of maltreatment.

Since evidentiary support for maltreatment can be difficult to attain, especially in the case of neglect, emotional abuse, and in some cases of sexual abuse, even suspected maltreatment was included in these estimations. More on that point, research consistently finds that children rarely endure one single type of maltreatment. Therefore, including suspected types of maltreatment seems appropriate to gain a better understanding of the

experiences of the child from their perspective, in addition to what a state agency could prove occurred to these children. Specifically, there were 17 cases where only one form of maltreatment was included in the records. However, preventive measures or concern for child safety was indicated for many of these children as the reason for CPS involvement and/or subsequent removal. In addition, sexual abuse accounted for several instances of singular abuse reports. We may suppose in these cases that after sexual abuse was confirmed, the state did not need to find additional evidence of maltreatment in another form and simply listed the immediate and primary form of maltreatment.

In addition to maltreatment, CPS identified several other concerns for these children, as noted in Table 2. For these additional reasons, children were potentially removed from the home and child welfare became involved with these families. It is significant to note that approximately one-third of cases included reports of parental substance use. In addition, a significant lack of available resources to care for the children, including stable housing, was indicated in a comparable proportion. While exposure to domestic violence is not universally accepted as a formal type of maltreatment, it is worth noting that one-fifth of these children were reported to have witnessed this aggression in their homes. Parental imprisonment, abandonment, and other parental incapacitation including their own mental illness were also reported as concerns.

In the children with multiple placements, it appears that previous placements more often included settings with relatives. When these placements became no longer appropriate, children then seemed to be placed in non-relative homes. This trend seems consistent with the goal of family preservation strived for by most child welfare agencies.

Table 3: Previous and Current Placements

Placement Type	Current (%)	Prior (%)	Prior #2 (%)
Foster Care	34.7	39.5	36.9
Therapeutic Foster Care	21.4	6.2	4.6
Relative	21.4	30.9	38.5
Parent	11.2	9.9	6.2
Group Home/Residential	7.1	6.2	4.6
Other/Unknown	4.1	7.4	9.2
Totals (N)	98	81	65

The percentage of children in particular placements is presented in Table 3. Please note that the current placement presented in the table may in fact be the child's one and only placement at the date of the multidisciplinary assessment. To speak more directly on placement changes, it is important to consider trends in placement type as children were relocated. Of the 27 children whose Prior #2 placement was with a relative, 11 were moved into a foster home, 7 were sent to live in another relative's home, and another 5 were returned home to a parent. If a child was in a foster care setting, 15 children were moved to another foster care home (with one designated as a therapeutic foster care setting, or TFC), 6 were sent to a relative's home and 1 was returned to their parent. Of the 8 children who were placed into care and experienced a relative placement as their Prior #1, half of them went on to reside in a foster care setting, while the other half returned to a parent or a family member.

There were also 7 children in the sample who entered care and were placed into a foster home as their Prior #1. Consistent with the relative placements, about half of these children then moved into a relative or parental placement, while the other half continued onto another foster care home. None of these children were returned to their primary parent. There were only 2 instances where children's last 3 placements had all been family members and only 5 who experienced relative placements as their previous and

current homes. On the other hand, there were 11 children who experienced foster care settings as their last three placements and 13 who experienced foster placements as their previous placement and current home.

It is also worth making special mention of those children who moved from foster care homes into therapeutic settings. Ten children were noted to have transferred from a normal foster care home into a therapeutic setting and an additional 7 children were placed in TFC after being removed from a kinship or parental residence. A stable pattern does not necessarily emerge when reviewing these placement changes; however, it is clear that when a stable relative placement is available it is sought as a temporary haven for these children. Those without relative resources find refuge in the home of foster care parents and must learn to cope amidst strangers.

Coupled with placement changes, children also may have experienced a school transfer. There were 77 school-age children in the group. Approximately 31% of these children did not have to transfer schools (n = 24), while the other children removed from the home experienced anywhere from 1 to 6 school disruptions. Slightly less than half, or 48% of this group, who did transfer experienced 1 or 2 school changes (n = 26), while the rest experienced 3 or more different schools once maltreatment was identified. In general, the number of placements and the number of school transfers had a positive linear relationship, meaning as one increased, so did the other. There were a few cases where the transfers were low even with 5 or 6 placements. In these 2 cases, the children appeared to move between relatives and back to their parent with little disruptions in school attendance.

To better understand the circumstances surrounding out-of-home placements, it is also worth considering how siblings are involved in the process. Only 9 children seen for the multidisciplinary assessment had no siblings, while the 89 other children had 242 full, half-, and step-siblings. The sibling average was 2.7 per child. The maximum number of siblings was 8. Of those with siblings, 57% had only 1 or 2 (n = 50), while 43% had 3 or more brothers and sisters. In over 80% of these cases (n = 72), siblings were also removed and approximately 57% of children were placed with at least one of their siblings. For approximately one-third of all the children seen at the clinic (n = 35), a placement was determined where all children removed from the home could reside together in their new setting.

Previous Evaluations and Services Utilized

One-third of the children in the sample had no prior evaluations before being seen at the community clinic. Less than one-fifth of the children received one previous evaluation, 18% had 2 prior evaluations, and about 24% had three or more assessments in the past. Twenty-one children had been tested for special education eligibility through their school system and 7 children were reported to have undergone inpatient psychiatric hospitalization at some point prior to the interdisciplinary assessment.

. In consideration of current services being utilized by these children, it was found that of those with no formal evaluation documented in the records, 13 were undergoing some form of therapy. There were a few children also undergoing social skills training, involved with family counseling, in receipt of in-home services, or enrolled in speech therapy. It is unclear if the records were simply incomplete or these

services were initiated without professional guidance. Taking this into consideration, nearly 42% of all the children were undergoing some form of individual counseling or play therapy, 23% were taking medication prescribed for a psychiatric disorder, 20% were receiving in-home services, 14% were receiving Special Education Accommodations, including classroom interventions, behavioral aides, early intervention services, or an Individualized Education Plan. In addition, 7 children were undergoing Speech Therapy.

In regards to the professionals performing the previous assessments, records indicate that mental health assessments were primarily conducted by MD's and PhD's, while Masters-level professionals predominantly performed specialized testing including school special education eligibility and speech/language evaluations. Of the 107 prior evaluations reviewed for this sample, Masters-level completed 27 assessments and in 7 cases the credentials of the evaluator were unknown. Since Licensed Professional Counselors (LPC) and Social Workers made up only 6 of these assessments, it seems worthwhile to focus more intently on the mental assessments conducted by doctoral practitioners.

While very few records indicated whether the doctor was a psychiatrist or a pediatrician, MD's still accounted for 44 of the 107 previous evaluations that were reviewed, while PhD's accounted for 30 prior assessments. The inventories or measures used by MD's were unknown or not listed in every case of an assessment. The instruments were identified in almost every other assessment conducted by clinical psychologists. In fact, prior evaluations conducted by PhD's involved the use of 4.5

Table 4: Indicated Concerns for an Evaluation or Assessment

Referral Reason	Current (%)	Prior #1 (%)	Prior #2 (%)
General Behavior Problems	65.3%	16.9%	4.2%
Violent/Aggressive Behavior	35.7%	4.6%	6.3%
Academic/School Concerns	25.5%	21.5%	12.5%
Potential Developmental Delay	22.4%	15.4%	16.7%
Potential Mood/Personality Disturbance	18.4%	7.7%	8.3%
Sexualized Behavior	14.3%	4.6%	2.1%
Case Management	14.3%	13.8%	6.3%
Odd/Eccentric Behavior	7.1%	0.0%	0.0%
Regressive Behavior	6.1%	1.5%	0.0%
Other	0.0%	12.3%	14.6%
Unknown/Not Given	0.0%	23.1%	29.2%
Totals (N)	98	65	42

inventories or methods on average, including intelligence, behavioral, and specific personality or emotional measures.

The referral reasons for this group prior to the interdisciplinary assessment are presented in Table 4. It is worth noting that the primary concerns for this group were reported as academic concerns or developmental delays, when the reasons for the evaluation were known. Without the knowledge of assessment procedures, it is not clear as to how developmental concerns or other diagnoses were considered and subsequently supported or ruled out.

In looking at diagnostic results, MD's diagnosed Attention Deficit/Hyperactivity Disorder (AD/HD) in 30 of their 43 previous assessments, compared to 12 cases diagnosed when PhD's preformed the assessment. This was the most widely diagnosed disorder among children evaluated prior to the multidisciplinary assessment. In every case of AD/HD diagnosed by an MD, the recommendation offered was stimulant medication. While MD's did diagnose a few mood disorders including Major Depressive Disorder (MDD) and PTSD, they tended to diagnose an externalizing behavior disorder

most frequently, like Oppositional Defiant (ODD), Disruptive Behavior (DBD), and Intermittent Explosive Disorder (IED). While PhD's also conferred similar disorders, they also tended to diagnose Generalized Anxiety (GAD), Reactive Attachment (RAD) and Adjustment Disorders with as great or greater frequency. Developmental delays captured in this group prior to the evaluation included 1 child with Autism and 5 with mild or moderate Mental Retardation. The additional diagnoses in this category included receptive and expressive language disorders as well as learning disorders.

While MD's and PhD's predominantly conducted the mental health evaluations, it is important to consider how the findings of every assessment have influenced the decision making on behalf of this child. It is from the diagnoses derived from these evaluations, including the learning disorders and speech impairments in addition to the mental health concerns that a system of care has responded to the needs of these children. Therefore, another goal of the multidisciplinary assessment then was to potentially determine why services rendered have been ineffective at minimizing the emotional and behavioral symptoms of this sample given the previous diagnoses.

Multidisciplinary Evaluation

Even with prior assessments and service utilization, children still appeared to experience significant behavioral problems and exhibit other concerns. Referral reasons for the current evaluation in addition to those recorded for previous assessments are presented in Table 4. General behavior problems were recorded as reasons for the evaluation in approximately two-thirds of children, while violent and aggressive acts were reported in one-third of cases. About one-quarter were referred in relation to

Table 5: Assessment Outcomes and Diagnostic Findings by Professional

Evaluation and Credentials	Current (%)	Previous (Total %)	MD (%)	PhD (%)	Masters (%)
Diagnoses					
Adjustment Disorder	36.7	12.3	0.0	100.0	0.0
Attn Deficit/Hyperactivity Disorder	27.5	52.3	70.6	29.4	0.0
Depression (MDD, Dysthymia)	20.4	13.8	44.4	55.6	0.0
Developmental Disorder (ASD, MR, LD)	19.4	18.5	16.7	50.0	16.7
Anxiety (PTSD, GAD, SAD)	15.3	12.3	62.5	37.5	0.0
Borderline Intellectual Functioing	13.2	4.6	33.3	66.7	0.0
Behavior Disorder (Disrupt, ODD, CD)	12.2	24.6	37.5	50.0	12.5
No Diagnoses	9.2	12.3	25.0	12.5	62.5
Total (N)	98	65	~	~	~

academic or learning concerns. This is contrasted to unknown reasons indicated in previous evaluations. For those that were given in the records, reasons for previous evaluations included academic and developmental concerns as well.

Every evaluation conducted at the community clinic was performed by a licensed clinical Psychologist. In addition, 38% of all evaluations were conducted with additional assistance, including postdoctoral residents, Master's level interns and graduate psychology trainees. Twenty-six children also received a psychoeducational evaluation to evaluate academic performance and special education eligibility conducted by an EdS level professional. The average evaluation included 9 diagnostic assessment inventories with a range of 2 to15 (mode=10). With two-thirds of the children, projective measures were also used during the evaluation. This is compared to the 4.5 average number utilized in community clinical settings and none indicated as used by MD's.

Table 5 provides the clinical diagnoses of the children as a result of the multidisciplinary evaluation. The table also displays the previous findings as determined by the appropriate professional. For previous diagnoses, the table provides the total in the sample with the diagnoses and then provides the estimates for the professional conferring the diagnosis. For example, 52% of the children were previously diagnosed

with AD/HD and nearly 71% of these children received this diagnoses from a physician or psychiatrist. Please note that when a child underwent multiple assessments, the clinical diagnoses were counted only once in the case of comparable or equivalent diagnoses in order to reduce inflated estimations.

Slightly fewer cases of AD/HD were determined after the interdisciplinary assessment, while more instances of anxiety and depression disorders were noted. However, 9 new cases of AD/HD were diagnosed; meaning only 18 cases diagnosed previously were also determined by the interdisciplinary evaluators. This may have lasting implications for these children, given the most widely offered recommendation to an AD/HD diagnoses was stimulant medication. In addition, significantly more cases of Adjustment Disorder were identified in this group, while other behavioral disorders sharply declined. Mental Retardation (MR) was identified in 6 children, while Developmental delays were seen in 4 children and Autism in 1 child. Other general Learning Disorders accounted for the rest of the diagnoses in this category. Previous evaluations indicated more non-specific learning delays with fewer MR specifications or Developmental delays identified. It is worth noting that PhD's captured half of all these diagnoses as well. This may have resulted from the use of more inventories and methods, as well as multiple rater perspectives. Also, those children determined to have Borderline Intellectual Functioning increased markedly from previous evaluations. Three times as many children were identified as a result of the interdisciplinary evaluation. These findings have a significant impact in terms of the school services children become eligible to acquire for additional academic support.

To determine these diagnoses, parents, teachers, and other caregivers completed multiple inventories, including behavioral checklists, sexualized behavior inventories, and trauma symptom checklists. Just at 130 behavioral inventories like these were completed by the appropriate adults in the child's life in order to assist evaluators in determining diagnoses. The average caregiver inventory was 1.5 for each child, indicating that at least one person familiar with the child was consulted as part of the evaluation. These results coupled with the results from a multitude of other inventories aimed to measure reasoning, perception, motor coordination and integration, memory, attention span, and parent-child dysfunction all served to inform the clinical diagnoses for these children. Again, in many cases of previous evaluations, inventories were not mentioned or listed in the report or found in the records. Moreover, projective measures were utilized in over 60 assessments as an additional means of capturing the current functioning of each child. This is especially relevant given this paper aims to understand their experiences and projectives allowed the evaluators to gain this understanding in the child's own words. While the use of projective measures may vary greatly by professional training or orientation, they were mentioned in only 5 prior evaluations.

Given past and current diagnoses, the interdisciplinary evaluators determined comparable diagnoses in 34 children, or approximately half of the sample who had previous evaluations. In these cases, only one diagnosis may have been supported, while in other cases, all prior diagnoses were supported after the interdisciplinary evaluation. Even in these duplicate diagnostic cases, it is important to note that some children came into the evaluation with upwards of 8 or even 10 previous diagnoses. The interdisciplinary assessment may have determined the same findings; however, it might

have only been 2 diagnoses total that they offered. In these cases, it is hard to pinpoint an exact concordance rate. In addition, it was difficult to determine if prior diagnoses were inaccurate or time and development has impacted the child, resulting in a diagnostic picture that has dramatically changed. In these instances, intensive case studies would help clarify discrepancies.

There is also an interpretive caution presented with offering a concordance estimate. If we consider verbatim diagnoses, this number decreases; however, this count includes diagnoses that are clinically similar. For example, one professional may have diagnosed an unspecified Mood Disorder, while another may have diagnosed this same child with Dysthymic Disorder. In this case, it may be reasonable to infer that they both were attempting to describe the same impairment in the child. Or in other cases, Major Depressive Disorder and Dysthymic Disorder were treated as comparable for these estimations. Therefore, to count these types of discrepancies as true dissimilarities may not be accurate. While time between evaluations was not considered in this paper, its inclusion in future reviews may better inform the inconsistencies between clinical diagnoses (i.e., did the disorder become more or less severe over time).

In regards to recommendations made on behalf of these children, in 22 of the cases, 504 Plans or Individualized Service Plans were indicated as either needing to be pursued or revised given the recent evaluation. Some form of Individual therapy or play therapy was recommended for every child seen. For those seen previously, therapy was recommended in approximately 1 in 3 children. Given their trauma histories, placement changes, or CPS involvement, every child was referred for counseling services as a result of the interdisciplinary evaluation. Other recommendations made most frequently

Table 6: Additional Evaluations (N)

Speech/Language	29
Psychiatric	26
Occupational/Physical Therapy	23
Psychoeducational/School test	21
Medical/Health	19
Vision	9
Hearing	8
Neurology	8
Sexual Abuse	8
Nutrition	1
Total	152

included behavioral parenting skills, social skills training/modeling for children, the establishment of behavior management plans at both home and school, and increased home-school communication via a daily report card or other note. Behavior management plans was also noted frequently in previous evaluations; however it was only recommended in 15% of cases.

Finally, additional evaluations were recommended for many of the children and are presented in Table 6. The multidisciplinary evaluation highlighted the need for several other assessments that totaled 152 in all for these children. Additional evaluations were rarely referred to in previous evaluations, except in the case where medication use needed a follow-up consultation. Records revealed only 2 cases where the multidisciplinary evaluators recommended a consultation for pharmacological intervention. In both cases, the adolescents were suffering from major depression and medication was recommended as part of a multi-pronged approach that included therapy and other recovery strategies.

To summarize, the multidisciplinary assessment offered a unique opportunity to evaluate past assessments conducted with maltreated children. Evaluations utilized the professional skills from a variety of practitioners and sought input from numerous

sources to achieve the best understanding of the child seen. Over 9 different measures were used on average and in many cases, several evaluators had the chance to interact with the child and attempt to recognize the true clinical concerns present. These evaluators did not always confer the same diagnoses seen in the past, but instead evidenced new clinical pictures of these children that may better inform service utilization in the future.

DISCUSSION

This paper aimed to gain a better understanding of children identified as maltreated. To do this, these children were identified by CPS to have suffered some form of maltreatment or neglect or be in serous harm of experiencing a similar situation. Given the unique set of circumstances intrinsic to each one of these children, it was difficult to adequately capture the individuality of each family in the variables contained in this dataset. However, it has proven useful in highlighting areas of improvement in the professional community's response to maltreated children.

The preponderance of AD/HD is this sample prior to the multidisciplinary evaluation is reason for concern. While this disorder is traditionally higher in this population than other groups, it was interesting to discover that MD's were primarily diagnosing it and the lack of transparency in how they arrived at that diagnosis. Without this knowledge, it is only conjecture that they may rely more on caregiver reports and interviews than formal, objective measures. Further, it was not clear whether pediatricians or psychiatrists were prescribing the stimulant medication. While these children most likely required a medical evaluation upon CPS involvement with their

family, the transition from potential "check-up" to AD/HD remains unclear. Moreover, it is unclear how competent and confident pediatricians may feel when examining the psychological aftermath of a child who has been abused or neglected. In one study that specifically asked these questions to primary care physicians, Lane and Dubowitz (2009) found that of 147 completed questionnaires, the majority of physicians indicated little experience in evaluating suspected child maltreatment. In fact, most indicated they would want to seek an expert consultation and acknowledged their limitations in providing care to these children. These same pediatricians surveyed also indicated support for creating a subspecialty of Child Abuse Pediatrics in the field specifically for these reasons.

To move a step further, the over-reliance on an AD/HD diagnoses has other consequences. This is a disorder that is primarily treated through the use of stimulant medication. An inaccurate diagnosis can subject a child to unnecessary prescription drugs. The same is true for any inaccuracy in clinical decision-making. Based on the diagnoses afforded by clinicians, services and interventions are assigned to assist these children in recovery. Without an accurate diagnostic picture, children are either getting services they really do not need, and may not benefit from, or they are not receiving the services they so desperately need in order to make sense of their experiences. Finally, this diagnosis could not always be conferred in these same children after a thorough assessment was conducted. For clinical practitioners, researchers, and certainly welfare systems that are charged with upholding the well-being of these children, a new set of questions emerge as to how and why these diagnostic discrepancies exist.

If we are a community that believes in doing no harm, then we should also be a community committed to getting it right the first time. This is essential, especially for a population that is already vulnerable. Committing to focus on the whole child by incorporating the context of their family and school life offers the details necessary to produce valid clinical decisions that then can serve to guide effective service delivery. The team of evaluators at the community clinic appeared to have a valid algorithm that allowed them to capture the small details of each child while also realizing the broad picture of their circumstances. Seeking multiple responders both at home and in other settings allowed these practitioners to estimate behaviors across settings. Using numerous, developmentally appropriate measures and inventories also allowed them to identify patterns in emotional and behavioral responding that could only have been seen by allotting sufficient time for them to manifest. It seems difficult to believe that an informal interview with a parent or child can produce valid diagnostic decisions. The multidisciplinary team spent several hours prepping for each child's assessment and then spent several additional hours with the child and caregivers when they arrived at the clinic. This kind of one-on-one attention coupled with the use of empirical measures served to inform better estimations of diagnoses. Better informed diagnoses can serve to inform appropriate interventions and targeted recommendations specific to each child. The multidisciplinary evaluation aimed to accomplish this in an effort to minimize anymore unnecessary suffering for the child, especially if their suffering was exacerbated by an undiagnosed disability or mood disorder.

Although this paper was merely descriptive by design, it is not without limitations. As stated previously, the records and files associated with the children in the

database were not always complete. Additionally, the accuracy of previous information cannot be determined. When it was appropriate, the interviews conducted during the multidisciplinary evaluation attempted to clarify any inconsistencies; however, given the lack of stability for some of the children, it was difficult to remediate every disjointed fact in a child's history. It is possible that records and case notes were missing from the file; however, it is improbable that every case would be devoid of notes from one practitioner in particular.

In end, this paper may serve to assist professionals, policy makers, and community resources in gaining a better understanding of a child's life after the identification of maltreatment. It is hoped that this effort will continue and we will become better able to effectively address the needs of this vulnerable population.

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APPENDIX

THE UNIVERSITY OF ALABAMA AT BIRMINGHAM

Institutional Review Board for Human Use

Form 4: IRB Approval Form
Identification and Certification of Research
Projects Involving Human Subjects

UAB's Institutional Review Boards for Human Use (IRBs) have an approved Federalwide Assurance with the Office for Human Research Protections (OHRP). The UAB IRBs are also in compliance with 21 CFR Parts 50 and 56 and ICH GCP Guidelines. The Assurance became effective on November 24, 2003 and expires on January 23, 2012. The Assurance number is FWA00005960.

Principal Investigator:	DUTY, LINDSAY M
Co-Investigator(s):	MARULLO, DANIEL S PERUMEAN-CHANEY, SUZANNE E
Protocol Number:	**X090210007**
Protocol Title:	*A Detailed Look at the Familial, Social and Clinical Contexts for Children after the Identification of Maltreatment*

The IRB reviewed and approved the above named project on 3/30/09. The review was conducted in accordance with UAB's Assurance of Compliance approved by the Department of Health and Human Services. This Project will be subject to Annual continuing review as provided in that Assurance.

This project received EXPEDITED review.

IRB Approval Date: 3-30-09

Date IRB Approval Issued: 3/30/09

Marilyn Doss

Marilyn Doss, M.A.
Vice Chair of the Institutional Review
Board for Human Use (IRB)

Investigators please note:

The IRB approved consent form used in the study must contain the IRB approval date and expiration date.

IRB approval is given for one year unless otherwise noted. For projects subject to annual review research activities may not continue past the one year anniversary of the IRB approval date.

Any modifications in the study methodology, protocol and/or consent form must be submitted for review and approval to the IRB prior to implementation.

Adverse Events and/or unanticipated risks to subjects or others at UAB or other participating institutions must be reported promptly to the IRB.

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