Emotional and behavioral problems of children in residential care: Screening detection and referrals to mental health services

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ABSTRACT

Adverse family conditions, abuse and neglect during childhood present important risk factors for the appearance of emotional and behavioral problems. The main aim of this paper is to describe the presence of these kinds of disorders in children in residential child care and to explore individual, socio-family and care process factors associated with the use of mental health services. The sample consisted of 1216 children 6–18 years old in residential care in several Spanish regions. Information about emotional and behavioral problems was gathered according to two criteria: receiving some kind of treatment services and/or being identified as within the clinical range in the Child Behavior Checklist (CBCL). Results showed that 49% of cases were receiving some kind of mental health treatment and 61% were identified as within the clinical range in some of the broad band scales of the CBCL. In terms of agreement between referral to treatment and CBCL scores, results showed that four out of ten cases identified as within the clinical range were not receiving any kind of treatment. Several factors related to the type of problems detected in the CBCL, personal variables, and child care arrangements are associated with greater use of mental health services.

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1. Introduction

National child welfare statistics show that in Spain 35,682 children and adolescents were in an out-of-home placement due to severe situations of abuse or neglect at the end of 2014, of that number 13,563 were in residential care (Observatorio de la Infancia [Child Observatory], 2016). These children have experienced very unfavorable circumstances, living in family environments with many problems such as adverse economic situations, gender violence, mental health problems, and drug addiction (Sainero, Bravo, & Del Valle, 2014). Research has shown clear evidence of the way in which these adverse conditions jeopardize psychological functioning, encourage the appearance of emotional and behavioral disorders (D’Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; Greger, Myhre, Lydersen, & Jozeak, 2015; McLaughlin et al., 2012; Segura, Pereda, Guilera, & Abad, 2016) and can lead to maladaptation, not only in childhood, but adulthood as well (Jonson-Reid, Kohl, & Drake, 2012; Ramiro, Madrid, & Brown, 2010).

Research by Raviv, Taussig, Culhane, and Garrido (2010), demonstrated the cumulative effect of adverse experiences; the more risk factors that are present, the more probable the presence of mental health problems. Other studies identified factors like exposure to violence, presence of severe neglect, age at first placement and number of placements as predictors of various psychiatric disorders (Lehmann, Havik, Havik, & Heiervang, 2013). Instability of care placement (foster and residential) has been shown to be a factor with a significant impact on the mental health of children and adolescents. Several changes of foster family and residential placement have been associated with the presence of externalizing and internalizing emotional and behavioral problems (Del Valle, Bravo, Álvarez, & Fernanz, 2008; Newton, Litrownik, & Landsverk, 2000; Rubin, O'Reilly, Luan, & Localio, 2007).

Consequently, these children present varied mental health problems, with externalizing disorders being particularly significant (Schmid, Goldbeck, Nuetzel, & Fegert, 2008; Vanschoonbeek, Vanderfaellie, Van Holen, De Maeyer, & Robberechts, 2013). Keil and Price (2006), analyzing a wide range of studies, estimated that an average of 42% of these children have this type of disorder. Other diagnoses, such as depression (Jozeak et al., 2016) and post-traumatic stress...
disorder are also frequent (Keller, Salazar, & Courtney, 2010), as is the presence of comorbidity (Bronsard et al., 2011; Lehmann et al., 2013). Other studies have noted the incidence of serious problems such as consumption of addictive substances (Leslie et al., 2010; Traube, James, Zhang, & Landsverk, 2012) and suicidal behaviors (Bronsard et al., 2011; Heneghan et al., 2013; Taussig, Harpin, & Maguire, 2014).

Thus, the prevalence of mental health problems in this population is particularly high ranging from 40% to 88% (Burns et al., 2004; Garland et al., 2001; Jozeilik et al., 2016; McMillen et al., 2005) and clearly higher than estimates in the general population (Ford, Vostanis, Meltzer, & Goodman, 2007; Sempik, Ward, & Darker, 2008). Even though research confirms the increased presence of clinical problems, the ratio of prevalence varies from study to study. This variation is likely due to different factors such as the sample type (age, residential or family foster care), differences between the child welfare systems in each country or the methodology used.

Tellingly, a significant proportion of children with mental disorders are not receiving mental health treatment (Burns et al., 2004; Sainero et al., 2014; Tarren-Sweeney, 2010). Factors that have been associated with higher probability of referral to these services include: a history of sexual abuse (Leslie, Hurlbut, Landsverk, Barth, & Sylmen, 2004), older children (Raghavan, Inoue, Ettner, Hamilton, & Landsverk, 2010), ethnic origin (Horwitz et al., 2012) and intellectual disability or mental disorders in the parents (Farmer et al., 2010).

Given the importance of mental health disorders of children in care and the lack of a nationwide study in Spain, this study has two goals: (a) to describe the emotional and behavioral problems in children in residential care using the CBCL; and (b) to examine the therapeutic coverage they are receiving and determine which factors are associated with referral to treatment and which may be hindering detection and impeding the referral decision.

2. Method

2.1. Participants

The sample comprised 1216 children, 524 girls (43.1%) and 692 boys (56.9%) between 6 and 18 years old (M = 13.43, SD = 2.97) who had been living in residential facilities for at least 3 months. The sample included all children of this age who were in residential care in the regions of Asturias, Cantabria, Extremadura, Murcia, Guipúzcoa, Tenerife and seven SOS Children’s Villages located in various parts of Spain. Most of the sample was Spanish, but there were also 153 children of immigrant families (12.6%) and 94 unaccompanied asylum seeking children (UASC) (7.7%).

2.2. Instruments and procedure

The following variables were collected through a questionnaire that was designed for this research: (a) intervention process (length of stay, number of changes of residential facility, reason for admission, type of maltreatment); (b) family characteristics and background; and (c) existence of a diagnosis of intellectual disability, suicidal behavior, detection of emotional and behavioral problems, therapeutic attention, and type of mental health treatment (psychiatric, psychological and/or pharmacological).

In order to objectively assess the need for clinical attention, the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001) was used as a screening tool. It has broad assurance of reliability and validity with a Cronbach alpha coefficient of 0.92, test-retest reliability of 0.92 for broad band scales (Achenbach et al., 2008) and has been widely used with children in residential care. The CBCL provides eight specific clinical subscales and three broad band scales: internalizing, externalizing, and total score. The T-scores from the broad band scales allow classification of cases into three ranges: normal, borderline, and clinical. Cases are considered clinical only if scores are in the clinical range (excluding the borderline range) in any of the broad band scales (internalizing, externalizing, and/or total). The number of cases with CBCL assessment was reduced to 1182 as 34 questionnaires were discarded for not meeting validity criteria.

The data were collected during the year 2013 with the cooperation of key residential workers (in Spain they are social educators) to complete the questionnaires about intervention process, family background and therapeutic services. CBCL assessments were carried out by psychologists of the research team visiting all the residential facilities in the sample. The study design was approved by the Ethics Committee of the Faculty of Psychology of the University of Oviedo.

Bivariate analysis with chi-square and Student’s t-test was carried out. Logistic regression analysis was done to study the predictive capacity of the case variables for referral to mental health treatment. The variables included in the model were those that had been shown to have a significant association with the variable “being in treatment”. The degree of significance was established at p ≤ 0.05 in all analyses.

3. Results

3.1. Characteristics and risk factors in children, young people, and families

The mean stay in residential care was 42.6 months. The reason for residential care in 61.8% of the cases was abuse or neglect experiences when living with their families. Others were referred to care for abandonment or due to the child’s behavioral problems. 43.7% of those who were victims of abuse and neglect suffered various types of maltreatment. Physical and emotional neglect were the most frequent types of maltreatment (43.9% and 36.7% of children in this sample). Emotional abuse was suffered by one in four children, physical abuse by one in five and 4.5% of the sample presented a history of sexual abuse. Near 80% of the children had at least one family risk factor or background of psychosocial problems. The most common risk factors were an adverse economic situation (41.3%), and alcohol and other substance abuse (40.3%). In addition, a third of the sample had a family history mental health issues (30.3%).

3.2. Mental health problems and associated factors

Almost half of the children, 48.7% had been referred for some kind of mental health treatment (of those, 48.4% received only psychological treatment, 13% only psychiatric treatment, and 34% received both treatments simultaneously). 43.2% of the children being treated were receiving psychotropic medication, in 3% of the cases this was the only treatment received, with no associated psychiatric or psychological treatment. 16.5% had a diagnosis of intellectual disability, of whom 71.9% received mental health treatment and 50.3% received psychotropic medication. Furthermore, 7.5% of the children had displayed suicidal behaviors in the form of threats (6%) or attempts (2.4%).

In the CBCL, 61.1% of the cases were in the clinical range in some broad band scale (51.1% on the externalizing scale and 30.7% on the internalizing scale). Table 1 shows detailed results of the rest of the subscales.

Table 2 shows the relationship between scoring in the clinical range of the CBCL and personal, family, or care process variables; the following values were found to be positively significant: changes of residential facility (t = −2.209, p = 0.027), intellectual disability (χ² = 4.828, p = 0.028), receiving pharmacological (psychotropic) treatment (χ² = 44.119, p < 0.001), suicidal behaviors (threats or attempts) (χ² = 32.660, p < 0.001), and parental incapability of controlling the child's behavior as the reason for care (χ² = 27.505, p < 0.001). The following variables were associated with a lower probability of being in the clinical range: age between 6 and 8 (χ² = 8.446, p = 0.038), good academic performance (χ² = 23.098, p < 0.001), and being an unaccompanied asylum seeking child (χ² = 13.213, p < 0.001).
دریافت فوق

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