Therapeutic residential care in Spain. Population treated and therapeutic coverage

Eduardo Martín, PhD[1]
edmartin@ull.edu.es
Carla González-García[2]
carla.gonzalez.garcia@gmail.com
Jorge F. del Valle, PhD[2]
jvalle@uniovi.es
Amaia Bravo, PhD[2]
amaiabravo@uniovi.es

[1] Universidad de La Laguna, España
[2] Universidad de Oviedo, España

Corresponding autor: Eduardo Martín, Facultad de Psicología, Universidad de La Laguna, Campus de Guajara s/n, 38071,Tenerife, Spain. Email: edmartin@ull.edu.es

Acknowledgements: This research has been supported by the Ministry of Economy and Competitiveness of Spain through the National Plan of I+D+i (Ref. PSI2012-33185)

No potential conflict of interest was reported by the authors

Therapeutic residential care in Spain. Population treated and therapeutic coverage

Running head: Therapeutic residential care in Spain

Abstract

Therapeutic residential care (TRC) is the name given to specialized children's homes for treating cases with severe emotional and behavioral problems that have been placed in residential care. A recent international review has revealed great diversity in the referral criteria of cases and in the models of intervention carried out. The goal of this study is to describe the population treated in this type of facilities in Spain and the therapeutic coverage given. The sample is made up of 215 young people in children's homes, of whom 93 are in TRC. The cases referred to TRC have been in residential care for less time but have gone through a greater number of placements. These young people also exhibit more problems of drug use, and there is a larger percentage of clinical-range cases in the Child Behavior Checklist (CBCL) scales of Attention Problems and Aggressive Behavior. Nevertheless, the results of logistic regression indicate that the only variables that significantly increase the probability of being referred to TRC are drug use and changes of care placements. With regard to therapeutic care there is a higher percentage in the TRC group receiving psychiatric care, and the sessions are also more frequent.

Keywords: Child therapy; Mental Health; Residential care; Therapeutic social work

Therapeutic residential care in Spain. Population treated and therapeutic coverage

Introduction

Residential care is a resource for children and adolescents in a situation of neglect, for whom foster care is not possible. Although the percentage of cases with a family separation measure in these facilities varies considerably in studies comparing different countries (Del Valle & Bravo, 2013), these facilities usually respond to those cases with more complex welfare measures, many of which need some kind of intervention that is not possible to implement in a family or community context (Dozier et al., 2014). These children and adolescents have suffered various forms of maltreatment, growing up in very unfavorable circumstances, in family environments with many problems such as adverse economic situations, gender violence, mental health problems, and drug addiction (Raviv, Taussig, Culhane, & Garrido, 2010; Tarren-Sweeney & Vetere, 2014).

This situation usually has a negative impact on the development of children and young people and can lead to mental health problems. Various studies show that the prevalence of emotional and behavioral problems in this population is particularly high (Bronsard et al., 2011; Burns et al., 2004; Greger, Myhre, Lydersen, & Jozefiak, 2015; Jozefiak 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), proportions ranging from 60% to 89% have been found. However, although there is a consensus about the high prevalence of mental health problems in the population of children and adolescents in residential care, it is noteworthy that the percentage receiving some kind of intervention is much lower (Sainero, Bravo, & Del Valle, 2014; Tarren-Sweeney, 2010). Given the high frequency of these problems, it is not surprising that there are many cases to which the regular network of homes and residences cannot respond adequately, so there is a need for specialized

resources to meet the treatment demands of more complex cases. This type of specialized facility is called therapeutic residential care (TRC).

Therapeutic residential care as a specialized resource

There is an international consensus that acknowledges the need for this type of specialized center to adequately address those cases that require specialized therapeutic intervention that cannot be undertaken from a family context (Whittaker, Del Valle, & Holmes, 2015; Whittaker et al., 2016). What is not so clear is how to design these resources or the intervention provided. For instance, there is the problem of finding a way to overcome the young people' great reticence to being treated for the emotional and behavioral problems that have led them to these placements, possibly due to previous therapeutic failures and to fear of being stigmatized (Aventin, Houston, & Mcdonald, 2014; Lambert, Hurley, Tomlinson, & Stevens, 2013). In addition, the most appropriate way of dealing with situations of crisis and conflict that frequently occur in these types of facilities has not yet been solved (Soenen, Volckaert, D'Oosterlinck, & Broekaert, 2014).

Moreover, from a technical standpoint, there is growing interest in developing evidence-based intervention programs (James, 2011; James, Alemi, & Zepeda, 2013; Pecora, & English, 2016). Although it is very difficult to carry out efficacy studies— because they tend to be performed with very small samples, amongst other reasons—, results indicate some factors associated with the efficacy of the intervention, such as being based on a defined theoretical model, with defined phases that include the family, and relatively short placements, among other aspects (Whittaker et al., 2015, 2016).

A last aspect that should be clearly defined is the profile of the population that is treated in these centers. It seems that the lack of clear criteria, as well as the limited use of rigorous detection instruments to refer cases to TRC facilities, is fairly widespread (Chor,

McClelland, Weiner, Jordan, & Lyons, 2012; Pecora & English, 2016; Whittaker et al., 2015). This is a serious problem because, as the profile of the population to be treated is not defined, it is practically impossible to clearly define the components that determine the success of the intervention because of the mix of different profiles. Moreover, there is a risk of referring false positives, that is, cases that should not enter TRC, but that are referred because of insufficiently objective criteria (Chor et al., 2012).

Therapeutic residential care in Spain

According to the official statistics, in Spain in 2014 there were 32,682 children separated from their family due to a situation of severe vulnerability, of whom 13,563 were in foster homes (Observatorio de la Infancia [Child Observatory], 2016). Traditionally, Spain has been a country in which residential care has been very important in dealing with cases of child abuse and neglect (Del Valle & Bravo, 2013; Del Valle, Canali, Bravo, & Vecchiato 2013), although in recent years considerable efforts have been made to promote foster care (Del Valle, López, Montserrat, & Bravo, 2009), which is producing good results, especially at earlier ages. This, in turn, is causing residential care to become more specialized, dealing with specific profiles and problems more closely associated with adolescence (Bravo & Del Valle, 2009). The mean age of the population in residential care has increased, as 43% of the children placed are over 15 (Observatorio de la Infancia, 2016). With this age profile, the number of cases with emotional and behavioral problems that require therapeutic care begins to rise. Such care is currently regulated by the Organic Law 8/2015, of July 22, regarding the modification of the system of childhood and adolescent welfare. This law places special emphasis on the regulation of the use of measures of restraint and on safeguarding the minor's rights, possibly due to the conclusions from the Ombudsman's report some years previously (Defensor del Pueblo [Ombudsman], 2009). In addition to these aspects, this law states that

these centers are to deal exclusively with children in care of the state whose admittance should be under judicial authorization.

In some autonomous communities (Spain has a decentralized the child welfare system) these facilities are called therapeutic centers, in others, socialization centers, although they are practically the same, and currently represent almost 8% of centers and 7% of residential places nationwide (Del Valle, Sainero, & Bravo, 2015).

Nevertheless, in spite of efforts to regulate and provide these centers with resources, the situation of TRC in Spain is still confusing, mainly due to the lack of research (Del Valle et al., 2015), as in other countries (Whittaker et al., 2015).

In view of the above, this research aims to shed some light on this aspect and therefore we propose two goals. Firstly, we shall define the profile of cases referred to TRC in Spain, and secondly we shall analyze, both quantitatively and qualitatively, the therapeutic care these young people receive.

Method

Participants

The sample was made up of 215 young people in residential care in the 6 participating regions, who had resided for at least 3 months in these centers. Out of the total population in residential care in these communities, the 93 adolescents that were in TRC were selected. As a comparison sample, the 122 young people in homes with autonomy programs for adolescents (APA), were selected as the group that was most similar to the TRC group. Other types of residential care programs in Spain (Bravo & Del Valle, 2009)—unaccompanied migrant children's homes, homes for children with disabilities, and family children's homes—were not examined.

Instruments

The variables analyzed in the study were collected with two instruments. A questionnaire was designed, based on the "Sistema de Evaluación y Registro en Acogimiento Residencial" (SERAR [Evaluation and recording system in residential child care services]; Bravo, Del Valle, & Santos, 2015; Del Valle & Bravo, 2007) to collect relevant information in each case: (a) intervention process (time in foster care, length of stay, reason for care, number of previous care placements); (b) characteristics and family history; and (c) the youngster's problems, therapeutic care received, and type of mental health treatment (psychiatric, psychological and/or pharmacological).

To examine the presence of behavioral or emotional problems the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001) was used. This is a screening technique which is widely used with children and young people in care (Burns et al., 2004; Greger et al., 2015; Jozefiak et al., 2016). The CBCL has eight specific clinical subscales: Anxiety-Depression, Isolation, Somatic complaints, Social problems, Thought problems, Attention problems, Disruptive behavior and Aggressive behavior. From these, three second-order scales are obtained: Internalizing, Externalizing and Total. The *t*-scores allow the classification of cases in three ranges: normal, borderline, and clinical. Only cases in the clinical range (excluding the borderline ranges) will be considered as clinical cases. The CBCL has demonstrated good reliability and validity, with a Cronbach alpha coefficient of .92 and test-retest reliability of .92 for the second-order scales (Achenbach et al., 2008).

Procedure

After obtaining permission from the regional administrations, the managers of the homes were contacted in order to explain the goals of the investigation and distribute the questionnaires to the youngsters' tutors. The following criteria were used: the questionnaires

were completed by youngster's tutors but only in the cases where they had known the child for at least 3 months.

Data analysis

Bivariate analysis by means of χ^2 and the Student's *t*-test was carried out along with logistic regression analysis to study the predictive capacity of variables over admittance to TRC. The variables included in the model were those for which significant differences in the bivariate analyses were found. In the case of the CBCL scales, only the first-order scales were included. For the numeric variables, the interpretation of the odds ratio (OD) was that they would increase by a constant multiplicative factor for each unit of increase of the independent variable. To analyze group differences in the therapeutic care received, $|^2$ and the standardized corrected residuals were analyzed. A value of $p \leq .05$ was established as the degree of significance in all analyses, except for the case of the standardized corrected residuals, for which values lower than -1.95 or higher than 1.95 were set.

Results

Table 1 gives the results of the analyses. It can be seen that there were no significant group differences, either in distribution by sex or mean age. However, there were differences in the time spent in residential care, with the APA group spending an average of almost one year more in residential care than the TRC group. Significant differences in the opposite direction were found in the variable number of changes of placement: the TRC group had almost double the number of the APA group, with a mean of almost 2 changes, which would indicate that they had been in three different centers. Only one significant difference was found in the scores of variables about the reason for being in care: in the TRC group, there was a higher percentage of parents who could not meet their parental obligations—for being in prison, disease…—, compared with the APA group. No significant group differences were found in

the variables related to family problems, although there were in problems associated with the child, as the TRC group presented a significantly greater percentage of cases of substance abuse than the APA group. Finally, percentages that were within clinical range according to CBCL were compared. In the first-order scales, the TRC group had significantly higher percentages within the clinical range than the APA group in two scales, specifically in the Attention Problems Scale and the Aggressive Behavior Scale. On examining possible differences in the second-order scales, the TRC group had a significantly higher percentage than the APA group in the Externalizing Scale but there were no group differences in the Internalizing Scale.

Insert Table 1 about here

Subsequently, logistic regression was carried out using the Introduce method, using only the variables in which significant differences had been found in the bivariate analyses. A significant function was obtained ($\chi^2(6) = 44.099$, $p < .001$; Negelkerke $R^2 = .316$) which correctly classified 70.3% of the cases. The OD values are given in Table 2.

Insert Table 2 about here

The variable months spent in foster care had an OD value very close to one, although with an associated probability of < .01, so the probability of being referred to a TRC was not increased. However, the variable number of care placements almost doubled the probability of referral, and the variable substance abuse multiplied the probability by almost four.

In Figure 1, the percentages of cases receiving any kind of mental health treatment are shown. No significant group differences were found in the percentage of cases receiving some kind of mental health treatment, $\chi^2(1) = .394$, $p > .05$. If only receiving psychological care is considered there are still no differences, $\chi^2(1)=1.765$, $p > .05$. Although there were no significant statistically differences, it is notable that the percentage receiving care in both

these cases is slightly higher in the APA group. In contrast, we found significant group differences when comparing the cases that receiving psychiatric, $\chi^2(1)=16.752$, $p < .001$, and pharmacological treatment, $\chi^2(1)=13.732$, $p < .001$. In both of those treatments, the percentage of cases in the TRC group was much higher than in the APA group.

Insert Figure 1 about here

Table 3 presents the differences between the cases in the TRC and APA groups that were receiving psychological and/or psychiatric care, in terms of the type of resource providing therapeutic care and the frequency of the sessions. In the case of the young people receiving psychological treatment, there were only significant differences in the fact that the therapists from child welfare service programs treat more cases in APA centers than in TRC facilities.

On examining differences in psychiatric care, it was seen that a staff therapist (belonging to the center) treated almost half the cases in the TRC group receiving this kind of care, whereas this kind of staff therapist does not exist in APA homes. Therapists from the public mental health network treat almost all recipients of psychiatric care in APA homes.. There are also significant differences in the frequency of the sessions, with a high percentage of TRC cases—almost half— receiving weekly sessions, a frequency that does not occur in any APA case. For the latter group, the percentage of cases receiving psychiatric care every two months is significantly higher than in the TRC group.

Insert Table 3 about here

Discussion

This study had two goals: to define the profile of the cases referred to TRC in Spain; and to analyze the therapeutic coverage provided in this kind of residential center. In terms of the

first goal, the results of the bivariate analyses, in which a group of adolescents in TRC centers was compared with another similar aged group indicate some differences. Firstly, although the TRC cases had spent less time in residential care, they had been through more placement changes, almost twice that of the comparison group. This outcome may indicate that cases which end up being referred to TRC centers already have problems that hinder their placement in the regular network of residential care. This difficulty could be due to the inability of the regular network to provide a therapeutic response but, on another hand, it could be because these cases can generate a lot of disruption in the centers, hampering their general functioning (Soenen et al., 2014). The rest of the differences identified seem to point in this direction. The TRC group has significantly higher percentages of drug use than the comparison group, and more scores within the clinical range in the CBCL scales of Attention Problems, Aggressive Behavior and in the second-order scale of Externalizing Problems.

However when these variables are used logistic regression model to attempt to measure their influence on the referral of cases to TRC, only two variables significantly increase the probability of being referred to TRC. They are: the number of changes of center, which doubles the probability of referral; and drug abuse, which almost the quadruples it. No CBCL scale significantly increases the probability of being referred to TRC. This seems to indicate that the criteria behind referral to this program are adaptation problems in other homes in the general network and drug abuse. Referral was not found to be caused by the detection of certain clinical problems or by their severity.

This may be because the prevalence of emotional and behavioral problems in the population in the regular network of residential care is so high (Bronsard et al., 2011; Burns et al., 2004; Greger et al., 2015; Jozefiak et al., 2016; McMillen et al., 2005) that the number of TRC places available in Spain (Del Valle et al., 2015) is patently insufficient to provide therapeutic coverage to all of them. Therefore, the regular network is dealing with these

problems, leaving TRC to the cases that overwhelm their resources, such as problems with drug use. This would mean that TRC is being used for purposes it was not designed for. The lack of clear technical referral criteria (Chor et al., 2012; Galán, 2013; Pecora & English, 2016; Whittaker et al., 2015) may be enabling this. The second goal of this study, the analysis of interventions in TRC, may help understand the results found.

Comparing the percentage of the two groups receiving some kind of mental health treatment, we see that there are no significant differences. In fact, the percentage of cases is somewhat higher in the comparison group. The fact that around 30% of the cases referred to TRC do not receive any kind therapeutic care is surprising, to say the at least. A possible explanation could be that many of the cases referred to these specialized centers arrive with a prior history of therapeutic failures, which leads them to refuse any intervention of this type (Aventin et al., 2014; Lambert et al., 2013). However, also taking into account the variables that increase the probability of being referred to TRC (placement changes and drug abuse), these centers may be being used as tools for restraint and control, at least initially, with the intention of achieving stabilization so as to be able to start therapeutic intervention (Soenen et al., 2014).

The comparison between the two groups regarding the variable receiving psychological treatment is similar, as there are no significant differences, and the comparison group has a somewhat higher percentage in receiving treatment. In contrast, when looking at the numbers receiving psychiatric and psychopharmacological treatment, the percentage in the TRC group is twice that of the comparison group. It might be better to comment on these results in conjunction with the analysis of resources used and frequency of sessions.

If we compare cases in the two groups who are receiving psychological treatment, we see that the control group uses therapists from specific child welfare service programs to a

greater extent. The purpose of these services, which exist in most autonomous communities, is to provide psychological treatment to all those in the regular child protection network that require it because, in contrast to TRC, most regular centers do not have therapists on their staff. This may explain, at least in part, why the comparison group receives more psychological intervention.

In terms of resources used and frequency of psychiatric treatment sessions, TRC stands out because these facilities have staff therapists, which weekly therapeutic sessions possible, a TRC strength we highlight. This is practically impossible in the regular network, which, without staff psychiatrists, must resort to the public mental health network, with a stark lack of professionals, at least in Spain (Del Valle et al., 2015; Galán, 2013). This leads to an inadequate frequency of sessions. It would be desirable to explore the extent to which the choice of treatment type depends on the problem diagnosed or the availability of resources.

A number of conclusions may be drawn from this study. Firstly, the fact that more than 70% of cases in both groups are receiving some kind of mental health treatment should be considered positive. Given the high percentage of cases in residential care with emotional and behavioral problems (Bronsard et al., 2011; Burns et al., 2004; González-García et al, 2017; Greger et al., 2015; Jozefiak et al., 2016; McMillen et al., 2005) and considering that several voices have called attention to the scarce therapeutic coverage for these problems (Sainero et al., 2014; Tarren-Sweeney, 2010), it seems that in Spain, we have become aware of the problem and are making an effort to treat this population.

A less positive conclusion comes from the fact that nearly 30% of the population referred to TRC do not receive any kind of mental health treatment. If we add this to the fact that the variables associated with an increased possibility of referral to TRC have nothing to

do with the screening test but rather with variables that the regular network is not prepared to deal with, such as drug abuse, it would confirm the warnings of many researchers: the evident lack of rigorous criteria and failure to use detection instruments for referral of cases to TRC (Chor et al., 2012; Pecora & English, 2016; Whittaker et al., 2015). In Spain, the thoroughness with which the legislation has developed the legal details— especially related to physical restraint and the safeguarding of children's rights—has not been reflected in the development of technical aspects, in which the criteria and techniques for referring cases to TRC are specified and developed. The Organic Law 8/2015 states that these centers, which it calls specific centers of protection of youths with behavioral problems, "are intended to treat cases diagnosed with behavioral problems, that present recurrent disruptive or antisocial behaviors that transgress social norms and the rights of third parties, and when justified due to their protection requirements and determined by a specialist psychosocial assessment". It seems to be a sufficiently broad definition to include any event that causes problems in the regular network of residential care, which goes against the specific and specialized character that these centers should have (Chor et al., 2012). Moreover, the lack of a clearer definition of the profile to treat hinders both the design of intervention programs and the assessment of their efficacy (James, 2011; James et al., 2013; Pecora & English, 2016). It seems clear that further research is needed to define the profile of cases that should be referred to TRC. It seems to be an issue that must be resolved before we can deal with other issues, such as which interventions work.

We do not want finish without commenting on some of this study's main limitations. This study is essentially descriptive in nature—which is justified due to the lack of research on these topics—, the subject needs to be addressed in greater depth, analyzing aspects such as the technical reports the referrals are based on, the components of the interventions, and so on. Subsequent research should also look at why a significant percentage of youngsters in

TRC receive no treatment. The non-referral to treatment in this group may be due to the fact is that the program itself is considered sufficient to address their therapeutic needs, or that the educators do not consider treatment necessary, or that the youngsters refuse to go to therapy (Aventin et al., 2014; Lambert et al., 2013).

References

Achenbach, T. M., & Rescorla, L. (2001). *Manual for the ASEBA school-age forms and profiles*. Burlington, VT: University of Vermont, Research Center for Children Youths & Families.

Achenbach, T. M., Becker, A., Dopfner, M., Heiervang, E., Roessner, V., Steinhausen, H. C., & Rothenberger, A. (2008). Multicultural assessment of child and adolescent psychopathology with ASEBA and SDQ instruments: Research findings, applications, and future directions. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, *49*, 251-275. doi:10.1111/j.1469-7610.2007.01867.x

Aventin, A., Houston, S., & Macdonald, G. (2014). Utilising a computer game as a therapeutic intervention for youth in residential care: Some preliminary findings on use and acceptability. *Children and Youth Services Review, 47*, 362-369. doi:10.1016/j.childyouth.2014.10.012

Bravo, A., & Del Valle, J. F. (2009). Crisis y revisión del acogimiento residencial. Su papel en la protección infantil [Crisis and review of residential child care. Its role in child protection]. *Papeles del Psicólogo*, *30*, 42-52.

Bravo, A., Del Valle, J.F., & Santos, I. (2015). Helping staff to connect quality, practice and evaluation in therapeutic residential care. In J.K. Whittaker, J.F. Del Valle, & L. Holmes (Eds.), *Therapeutic residential care for children and youth*. *Developing*

evidence-based international practice (pp. 275-285). London: Jessica Kingsley Publishers.

Bronsard, G., Lançon, C., Loundou, A., Auquier, P., Rufo, M., & Siméoni, M.C. (2011). Prevalence rate of DSM mental disorders among adolescents living in residential group homes of the French Child Welfare System. *Children and Youth Services Review*, *33*, 1886-1890. doi:10.1016/j.childyouth.2011.05.014

Burns, B. J., Phillips, S. D., Wagner, H. R., Barth, R. P., Kolko, D. J., Campbell, Y., & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child and Adolescent Psychiatry*, *43*, 960-970. doi:10.1097/01.chi.0000127590.95585.65

Chor, K. H. B, McClelland, G. M., Weiner, D. A., Jordan, N., & Lyons, J. S. (2012). Predicting outcomes of children in residential treatment: A comparison of a decision support algorithm and multidisciplinary team decision model. *Children and Youth Services Review, 34*, 2345-2352. doi:10.1016/j.childyouth.2012.08.016

Defensor del Pueblo (2009). *Centros de protección de menores con trastornos de conducta y en situación de dificultad social* [Residential child care for children with behavioral diseases and social difficulties]. Madrid: Oficina del Defensor del Pueblo.

Del Valle, J. F., & Bravo, A. (2013). Current trends, figures and challenges in out of home child care: An international comparative analysis. *Psychosocial Intervention, 22*, 251-257. doi:10.5093/in2013a28

Del Valle, J. F., & Bravo, A. (2007). *SERAR. Sistema de evaluación y registro en acogimiento residencial* [SERAR. Evaluation and recording system in residential child care services]. Oviedo, Spain: Nieru.

Del Valle, J. F., Canali, C., Bravo, A., & Vecchiato, T. (2013). Child protection in Italy and Spain: Influence of the family-supported society. *Psychosocial Intervention, 22*, 227-237. doi:10.5093/in2013a286

Del Valle, J. F., López, M., Montserrat, C., & Bravo, A. (2009). Twenty years of foster care in Spain: Profiles, patterns and outcomes. *Children and Youth Services Review, 31*, 847–853. doi: 10.1016/j.childyouth.2009.03.007

Del Valle, J. F., Sainero, A., & Bravo, A. (2015). Needs and characteristics of high-resource using children and youth: Spain. In J. K. Whittaker, J. F. Del Valle, & L. Homes (Eds), *Therapeutic residential care for children and youth. Developing evidence-based international practice* (pp. 49-59). London: Jessica Kingsley.

Dozier, M., Kaufman, J., Kobak, R., O'Connor, T. G., Sagi-Schartz, A., Scott, S.,…Zeanah, C. H. (2014). Consensus statement on group care for children and adolescents: A statement of policy of the American Orthopsychiatric Association. *American Journal of Orthopsychiatry, 84*, 219-225. doi:10.1037/ort0000005

Ford, T., Vostanis, P., Meltzer, H., & Goodman, R. (2007). Psychiatric disorder among British children looked after by local authorities: Comparison with children living in private households. *British Journal of Psychiatry*, *190*, 319-325. doi:10.1192/bjp.bp.106.025023

Galán, A. (2013). Residential treatment for severity disruptive minors: Technical contributions to a social and institutional debate. *Papeles del Psicólogo, 34*, 23-31.

González-García, C., Bravo, A., Arruabarrena, M.I., Martín, E., Santos, I. & Del Valle, J.F. (2017). Emotional and behavioral problems of children in residential care: Screening detection and referrals to mental health services. *Children and Youth Services Review, 73*, 100-106. doi: 10.1016/j.childyouth.2016.12.011.

Greger, H. K., Myhre, A. K., Lydersen, S., & Jozefiak, T. (2015). Previous maltreatment and present mental health in a high-risk adolescent population. *Child Abuse & Neglect*, *45*, 122-134. doi:10.1016/j.chiabu.2015.05.003

James, S. (2011). What works in group care? A structured review of treatment modelos for group homes and residential care. *Children and Youth Services Review, 33*, 308-321. doi:10.1016/j.childyouth.2010.09.014

James, S., Alemi, Q., & Zepeda, V. (2013). Effectiveness and implementation of evidence-based practices in residential care settings. *Children and Youth Services Review, 35*, 1455-1462. doi: 10.1016/j.childyouth.2013.01.007

Jozefiak, T., Kayed, N. S., Rimehaug, T., Wormdal, A. K., Brubakk, A. M., & Wichstrøm, L. (2016). Prevalence and comorbidity of mental disorders among adolescents living in residential youth care. *European Child and Adolescent Psychiatry*, *25*, 33-47. doi:10.1007/s00787-015-0700-x

Lambert, M. C., Hurley, K. D., Tomlinson, M. M. A., & Stevens, A. L. (2013). Measurement properties of the Motivation for Youth Treatment Scale with a reidential group home population. *Child and Youth Care Forum, 42*, 555-570. doi:10.1007/s10566-013-9217-y

McMillen, J. C., Zima, B. T., Scott, L. D., Auslander, W. F., Munson, M. R., Ollie, M. T., & Spitznagel, E. L. (2005). Prevalence of psychiatric disorders among older youths in the foster care system. *Journal of the American Academy of Child and Adolescent Psychiatry*, *44*, 88-95. doi:10.1097/01.chi.0000145806.24274.d2

Observatorio de la Infancia (2016). *Estadística básica de protección a la infancia* [Spanish Child Protection Figures]. Madrid: Ministerio de Sanidad, Servicios Sociales e Igualdad.

Pecora, P., & English, D. J. (2016). *Elements of effective practice for children and youth served by therapeutic residential care*. Accessed on May 5, 2016, at http://www.casey.org/media/Group-Care-complete.pdf

Raviv, T., Taussig, H. N., Culhane, S. E., & Garrido, E. F. (2010). Cumulative risk exposure and mental health symptoms among maltreated youth placed in out-of-home care. *Child Abuse & Neglect*, *34*, 742-751. doi:10.1016/j.chiabu.2010.02.011

Sainero, A., Bravo, A., & Del Valle, J. F. (2014). Examining needs and referrals to mental health services for children in residential care in Spain: An empirical study in an autonomous community. *Journal of Emotional and Behavioral Disorders*, *22*, 16-26. doi:10.1177/1063426612470517

Sempik, J., Ward, H., & Darker, I. (2008). Emotional and behavioural difficulties of children and young people at entry into care. *Clinical Child Psychology and Psychiatry*, *13*, 221-233. doi:10.1177/1359104507088344

Soenen, B., Volckaert, A., D'Oosterlinck, F., & Broekaert, E. (2014). The implementation of life space crisis intervention in residential care and special education for children and adolescents with EBD: An effect study. *Psychiatry Quaterly, 85*, 267-284. doi:10.1007/s11126-014-9288-4

Tarren-Sweeney, M. (2010). Concordance of mental health impairment and service utilization among children in care. *Clinical Child Psychology and Psychiatry*, *15*, 481-495. doi:10.1177/1359104510376130

Tarren-Sweeney, M., & Vetere, A. (2014). *Mental health services for vulnerable children and young people*. New York: Routledge.

Whittaker, J. K., Del Valle, J. F., & Homes, L. (2015). *Therapeutic residential care for children and youth. Developing evidence-based international practice*. London: Jessica Kingsley.

Whittaker, J. K., Holmes, L, Del Valle, J. F., Ainsworth, F., Andreassen, T., Anglin, J. ..., Zeira, A. (2016). Therapeutic residential care for children and youth: A consensus statement of the international work group on therapeutic residential care. *Residential Treatment for Children and Youth, 33*, 89-106. doi:10.1080/0886571X.2016.1215755

Table 1 Comparative analysis of the case variables and mental health problems in the children treated in therapeutic programs and autonomy programs

	(TRC)	**(APA)**
	% Yes or *M* (*SD*)	**% Yes or *M* (*SD*)**
Sex		
Male	64.5	54.9
Female	35.5	45.1
Age	15.5 (1.2)	15.7 (1.4)
Time in residential care (months)	27.1 (30.2)*	38.9 (45.3)*
Number of placement changes	1.8 (1.5)***	1 (1)***
Break-up adoption or foster care	10.5	18.2
Reason for protection		
Child abuse	45.6	65
Child-to parent violence	12.1	7.5
Inability to exert parental control	70.3	59.2
Impossibility to meet parental obligations	23.1**	9.2**
Family background		
Mental health problems	22.6	32.8
Intellectual disability	5.4	9.8
Suicidal behavior	4.3	11.5

Criminal behavior	19.6	12.3
Poverty	23.9	28.7
Gender violence	25	20.5
Substance abuse	41.9	33.6
Young person's problems and mental health		
Intellectual disability	14	10.3
Suicidal behavior (threats or attempts)	20	16
Alcohol consumption	8.6	3.3
Substance consumption	66.3***	37.2***
CBCL Clinical range		
Anxiety-depression	28.3	22.5
Withdrawal-depression	25	21.7
Somatic Complaints	19.4	19.2
Social Problems	29.3	23.1
Thought Problems	20.4	12.5
Attention Problems	32.6*	19.8*
Disruptive Behavior	51.1	40
Aggressive Behavior	47.8**	28.9**
Internalizing Scale	48.9	48.3
Externalizing Scale	84.8***	59.2***

TRC = therapeutic residential care ; APA = program of autonomy for adolescents.

*$p \leq .05$. **$p \leq .01$. ***$p \leq .001$.

Table 2 Logistic regression model of referral to therapeutic residential care

Selected variables	**OR**	**95% CI**
Months in foster care	.982*	.969, .996
Number of placement changes	1.765**	1.249, 2.496
Care due to parents' impossibility to meet obligations	1.670	.581, 4.8
Substance consumption	3.808**	1.842, 7.872
Clinical range in CBCL-Attention Problems	1.454	.582, 3.634
Clinical range in CBCL-Aggressive Behavior	1.338	.582, 3.076

*$p \leq .01$. **$p \leq .001$.

Table 3 Comparative analysis of the young people who receive mental health treatment depending on whether they are in therapeutic or autonomy programs

	In treatment psychological		**In psychiatric treatment**	
	TRC (N = 60)	**APA (N = 89)**	**TRC (N = 48)**	**APA (N = 29)**
	% Yes	**% Yes**	**% Yes**	**% Yes**
Type of resource providing treatment				
Public mental health service therapist	18.3	11.4	55.3*	96.4*
Private therapist	6.7	5.7	0	3.6
Therapist from specific child welfare service program	33.3*	52.3*	0	0
Staff therapist from the center	48.3	37.5	44.7*	0*
Therapist from some other resource	5	6.8	0	0
Frequency of sessions				
Weekly	76.3	69.8	43.8*	0*
Bi-weekly	13.6	19.8	8.3	3.6
Monthly	6.8	10.5	31.3*	64.3*
Every two months	3.4	0	14.6	21.4
Every three months	0	0	0	7.1

< Every three months	0	0	2.1	3.6

TRC = therapeutic residential care; APA = program of autonomy for adolescents.

* Corrected standardized residuals < -1.95 or > 1.95.

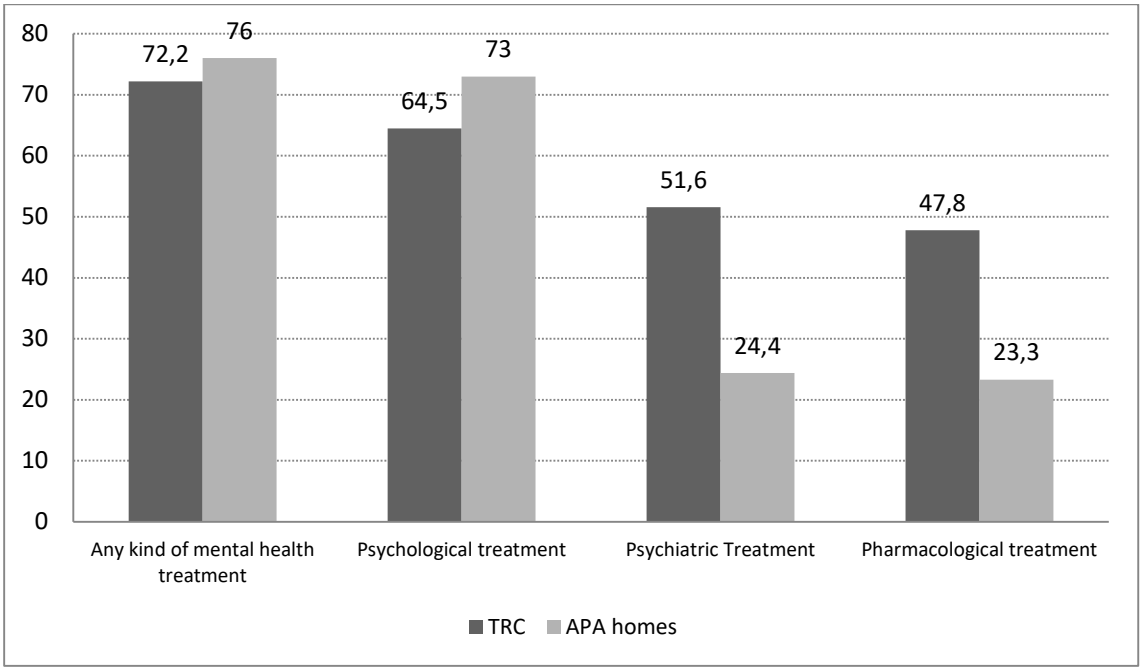

Figure 1. Therapeutic coverage. Percentages of cases receiving mental health treatment