

Addressing the most damaged adolescents in the child protection system: An analysis of the profiles of young people in therapeutic residential care

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HIGHLIGHTS

- 1) The manuscript analyses in detail the characteristics and needs of a especially vulnerable group inside the child welfare system: adolescents in therapeutic residential care.
- 2) Adolescents showed a huge range of risk behaviours, closely related with an inestable protection process (such as placements changes and breakdowns).
- 3) At the same time, 70% of young people scored as clinical in YSR.
- 4) Girls in TRC showed a higher vulnerability, with more mental health problems and specific risk behaviours, suggesting the necessity of gender perspective in the interventions with this population.
- 5) The majority of the sample had had a previous mental health treatment, and had been in other protective measures before being referred to TRC. For this reason, is important to create a therapeutic environment in residential care.

AUTHORS STATEMENT:

Águila-Otero, A.: conceptualization; methodology, formal analysis, investigation, resources, writing-original draft, writing – review & editing, visualization

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ABSTRACT

In many countries, adolescents in the child protection system present with serious emotional and behavioral problems. In order to address their specific needs, therapeutic residential care (TRC) programs have been created. The goal of this study is to analyze the profile of adolescents in TRC in Spain. Data on family history, high-risk behaviors and their process of intervention in the child welfare system were collected, as well as the clinical profile through the Youth Self- Report (YSR). Results showed a high frequency of high-risk behaviours, especially violent behaviours, substance abuse, running away and suicidal behaviors. About 90% of the sample had a history of continuous mental health treatments starting at an average of 10 years old. About 70% of the sample scored above the clinical threshold of the YSR. Girls exhibited a specific pattern of risk behaviors and mental health needs, showing greater psychological distress and a more complex profile.

KEYWORDS: *Therapeutic residential care; mental health problems; gender differences; adolescents; child welfare system.*

INTRODUCTION

Adverse experiences during childhood, particularly abuse and neglect, lead to significant problems in child development. As a consequence, children and adolescents in child care present with high prevalence of high-risk behaviors (delinquent behaviour, substance abuse, autolytic behaviour, etc.) and mental health problems. The connection between experiences of abuse and neglect in childhood and later developmental problems has been demonstrated extensively by research (Cicchetti & Valentino, 2006). Consequently, researchers from different countries (Farmer et al., 2001; González-García et al., 2017; Hukkanen, Sourander, Bergroth, & Piha, 1999; Vostanis, 2010) have

emphasized the need to provide therapeutic support to children and youth in residential care who have been exposed to adverse conditions in their own families.

With respect to high-risk behaviors, Ryan, Marshall, Hertz and Hernández (2008) found that young people in residential care were more likely to exhibit delinquent behavior, particularly if they were male, or had had placement changes because they had run away. Malvaso and Delfabbro (2015) also found that 50% of young people in out-of-home care showed delinquent behavior, which was more likely from adolescents in residential care than those in family foster care, and was related to behavioral problems, as well as alcohol and substance abuse. Problems of substance abuse are also often found in adolescents in child care: Aarons et al. (2008) found substance abuse in 13.5% of these young people and dependency in 4.8%. The greater prevalence of consumption in children and adolescents in care was also found by Traube, Yarnell and Schragger (2016), who studied polyconsumption in a large sample of adolescents in care using a longitudinal design. They highlighted that the consumption of cannabis or other drugs such as cocaine or amphetamines were predictors of future polyconsumption. One particularly serious topic is the frequency with which children and young people in care show autolytic behaviors. Evans et al. (2017) performed a review of suicide in children and adolescents in child care and found that they were twice as likely than the general population to have suicidal ideation, and had almost four times as many suicide attempts. Tavares-Rodrigues, González-García, Bravo and Del Valle (2019) found that 13.3% of the adolescents in residential care in Portugal had attempted suicide. Along similar lines, Lüdtke et al. (2017) analysed non-suicidal self-injury (NSSI) in a sample of 397 adolescents in care and found that 21.9% had presented NSSI at some point in their lives, and 18.4% had done so on multiple occasions.

Regarding mental health, children and adolescents in residential care have shown rates of mental health problems between 46 and 76%, predominantly externalising disorders (González-García et al., 2017; James, Roesch, & Zhang, 2012; Jozefiak et al., 2015; Keil & Price, 2006; Lehmann, Havik, Havik, & Heiervang, 2013; Pecora, Jensen, Romanelli, Jackson, & Ortiz, 2009). In Spain, research into mental health problems in children and young people in residential child care is still limited, but studies from González-García et al. (2017) and Sainero, Bravo, and Del Valle (2014) give figures of 44–60% with a clinical range in the CBCL, and referral rates to mental health services

between 26% and 49% (“the differences are due to the different regions in the country”).

All of these problems lead to greater referral of these children and adolescents to mental health treatment (Burns et al., 2004; Farmer et al., 2001; González-García et al., 2017; Pecora et al., 2009). It is remarkable in this population the high frequency of pharmacological treatments (Breland-Noble, Wagner, Farmer & Burns, 2004; Brenner, Southerland, Burns, Wagner, & Farmer, 2013; Desjardins, Lafortune, & Cyr, 2017; Raghavan et al., 2005). In particular, the use of antipsychotics for the reduction of behavioral problems, and psychostimulants for attention problems (Zito et al., 2008), as well as the use of various types of medication at the same time (Brenner et al., 2013; Desjardins et al., 2017; Zito et al., 2008).

The need for therapeutic residential care

All of the aforementioned problems mean that residential child care resources have been often overwhelmed and unable to adequately respond, which has led to the development of highly specialised resources, usually referred to as therapeutic residential care (TRC). TRC has been defined as that which involves the planful use of a purposefully constructed, multi-dimensional living environment designed to enhance or provide treatment, education, socialization, support, and protection to children and youth with identified mental health or behavioural needs in partnership with their families and in collaboration with a full spectrum of community-based formal and informal helping resources (Whittaker & Del Valle, 2015, p. 24).

Some studies have reported on the profile of social, educational and behavioral problems of the young people treated in TRC. This includes high rates of high-risk behaviors such as drug use, criminal behavior, suicidal behavior, inappropriate sexual behavior, or a history of running away and prolonged absences; multiple residential/fostering placement; high levels of disruptive behavior, habitual physically and verbally violent behavior; mental health problems or developmental delays or disabilities (Davidson, Dumigan, Ferguson, & Nugent, 2011; McLean, Price-Robertson, & Robinson, 2011; Robst, Armstrong, Dollard, & Rohrer, 2013). These are serious emotional and behavioral problems that make living in residential care or family contexts significantly harder.

Such disruptive behaviors might contribute to these children and adolescents experiencing one or more placement changes before they are admitted to TRC. In Australia, young people have between four and ten placement changes on average, depending on the region examined, before admittance to a TRC centre (Ainsworth & Hansen, 2015). Robst et al. (2013) also saw a high incidence of breakdowns, and in their sample most of those young people had been in prior treatment, either in hospital (30%), another TRC centre (19.5%) or Treatment Foster Care (TFC) (6.6%). Attar-Schwartz (2013) analysed runaway behavior in adolescents in TRC and found that 44.2% of them had attempted or managed to run away after they were admitted.

In Spain, specific TRC programs appeared in the 1990s with the designation of socialisation centres. Various regional governments later created resources of this kind, turning to a diversity of labels (high intensity educational programs, special regime centres, etc.). In 2009, the report of the Spanish Ombudsman (Defensor del pueblo, 2009) warned that this type of residential care was being used in a very heterogeneous way by the different regional authorities, with some practices being clearly inadequate. The report considered a priority to thoroughly study the profiles of the young people referred to TRC in Spain, in order to better understand and address their needs.

In Spain, the need to standardize these services while guaranteeing their quality, triggered the publication of quality standards in specialised residential care by the Spanish government (Del Valle, Bravo Martínez, & Santos, 2012; Pérez-García, Águila-Otero, González-García, Santos, & Del Valle, 2019). Spanish national statistics indicate that 47,493 children and adolescents were in out-of-home care in 2017. Over a third (35.54%, $n = 16,878$) were in residential child care. This same year, there were 1,104 residential care facilities in Spain, of which 81 were TRCs, with a total of 846 places for young people with serious behavioral problems (Observatorio de Infancia, 2018).

Despite the significant needs of these children and adolescents in TRC, there is scarce research carried out in Spain, and only two studies to date have presented data on the profile of young people in TRC (Martín, González-García, Del Valle, & Bravo, 2017; Sabaté Tomàs, 2017). This data allow us to conclude that the majority of this population are male, with a mean age of 15 years old, with more residential placements than the adolescents in other types of residential care and, as expected, a greater incidence of mental health problems, substance use, and running away from the therapeutic home.

The main objective of this study is to carry out an in-depth analysis of the profile of young people in TRC in a large sample with regard to various essential aspects: variables related to family background and the care process, health and medical history, high-risk behaviors, and emotional and behavioral problems, including the analysis of differences between boys and girls.

METHOD

Participants

A total of 353 young people (120 girls and 233 boys) aged between 11 and 18 years old ($M = 15.61$; $SD = 1.31$) in TRC participated in this study. The sample came from 36 TRC facilities in Galicia, Asturias, Cantabria, Basque Country, Catalonia, Castile & Leon, Madrid and Tenerife. All of the young people in this age range placed in TRC as a child protection measure were selected (cases placed due to a juvenile court order were excluded). Most of the young people were Spanish but 4.2% were unaccompanied migrant minors (UMM) and 22.7% came from families of immigrants. In terms of ethnicity, 11.9% were Roma.

Instruments

Information about the profiles of these young people in TRC was obtained using an ad hoc questionnaire, based on the *System of Evaluation and Registration in Residential Care* (SERAR) (Bravo, Del Valle, & Santos, 2015) which collects the following variables: (1) information related to the child care intervention (reasons for care, time in residential care, changes of children's home placement, history of breakdown in care or adoption, and reasons for admission to TRC), (2) family background and characteristics, analysing the significant family units for the adolescents, whether biological, foster or adoptive, (3) high-risk behaviors exhibited before admittance to the current centre, (4) general medical and mental health history.

The Youth Self-Report (YSR) (Achenbach & Rescorla, 2001) was used to analyse the young people's emotional and behavioral problems. The YSR is an instrument with proven guarantees with regard to indicators of reliability and validity, with a Cronbach Alpha coefficient of 0.90 and test-retest reliability of 0.85 for the broadband scales (Achenbach et al., 2008). It has been widely used internationally, frequently in the field of child protection (Campos et al., 2019; Heneghan et al., 2013; Kleinrahm, Keller,

Lutz, Kölch, & Fegert, 2013; Nowacki & Schoelmerich, 2010). The YSR is composed of 112 items giving 8 specific clinical subscales (anxiety-depression, withdrawal-depression, somatic complaints, attention problems, thought problems, social problems, aggressive behavior and rule-breaking behavior) and three broadband scales (internalizing, externalizing and total).

Procedure

Information about the background and protection processes of the young people in TRC was gathered from a review of their files in child protection services by the research team. Before collecting data, express permission was sought from the legal guardians of the minors (in some cases the family of origin, in others the responsible authority). For the evaluation with the YSR, the test was applied in the residential facilities under the supervision of the research team, following an explanation of the research and obtaining informed consent to participate in the study.

Throughout the study, a protocol was followed to ensure data protection and confidentiality. The study complied with all of the ethical criteria required by the 1964 Declaration of Helsinki for research with human beings, and was authorised by the Ethics Committee of the University La Laguna (Tenerife).

Data analysis

The following bivariate analysis were used for comparative analysis between sex groups. For nominal variables, the Chi-squared was used and an analysis of corrected standardised residuals was performed; for quantitative variables, the Student t test was used.

The level of significance was set at $p \leq 0.05$ in all analyses. For the analysis and interpretation of corrected standardised residuals, significance was set at less than -1.95 or greater than 1.95 . All analyses were performed using the statistics program SPSS v24.0.

RESULTS

Sociodemographic and family background

Most of the sample (80.7%) was over 15 years old, indicating that TRC programs are mostly aimed at this group of older adolescents and very few are under 13 (*Table 1*).

In addition, there were almost twice as many boys as girls, just under a quarter (22.7%) were from immigrant families, but cases of young unaccompanied immigrants only represented 4.2% of the total sample.

In terms of family background, 80.5% of the young people had some high risk family background, with a mean of a little more than two factors per family. The most common were a precarious economic situation, mental health problems in some member of the family unit, gender violence, and substance abuse. About a third of the young people had a sibling in care, and a similar proportion of the families had participated in a family preservation program before the young person entered TRC,

Risk behaviors

Practically all of the young people (97.7%) presented one or more of the serious risk behaviors covered in the study (*Table 2*), with a mean of 3.32 ($SD = 1.47$). Significant differences were found by sex, with girls reporting more risk behaviors [$t(351) = 3.45, p = 0.001$], with a mean of 3.69 ($SD = 1.47$) compared to the boys' mean of 3.13 ($SD = 1.44$). The frequency of histories which included suicide attempts stood out, having been found in 22.1% of cases, with significant differences by sex [$\chi^2(1, N = 353) = 22.42, p = \leq 0.001$]. Almost one in three girls presented with such history, doubling the frequency in boys. In 87.2% of these episodes, young people caused injury to themselves.

More than half of the sample consumed some kind of drug, particularly cannabis and cocaine, along with problematic alcohol drinking. Significant differences were found between sexes in cocaine consumption, which was present in 14.1% of the girls and 6% of the boys [$\chi^2(1, N = 353) = 6.58, p = 0.010$].

Most of the young people had exhibited violent behaviors prior to entering TRC. This reached 88.4% in boys and 73.3% in girls [$\chi^2(1, N = 353) = 12.94, p = \leq 0.001$]. More than half of the adolescents (64.3%) had exhibited physically and verbally violent behaviors, followed by 19.4% had exhibited verbally violent behaviors, 11.2% had exhibited physically violent behavior and 5.1% without specifying the type. As *Table 2* shows, these behaviors predominated in the residential and family contexts. Violent behavior was more prevalent in the boys in school [$\chi^2(1, N = 294) = 5.21, p = 0.022$] and community contexts [$\chi^2(1, N = 294) = 4.17, p = 0.041$], with significant differences between the groups.

Running away was also relatively common, and more so from prior residential placements than family homes. Running away from family homes was more common in the girls' group with a rate of 38.8%, compared to 18.5% for boys [$\chi^2 (1, N = 353) = 15.59, p = \leq 0.001$]. A third of the sample had a court record for some kind of delinquent behavior and the numbers increase if we consider delinquent behavior reported by educators or families without going to court, reaching 58.4% in the total sample. This behavior was present in 20% of girls and 40% of boys, with significant difference between the groups [$\chi^2 (1, N = 353) = 14.73, p = \leq 0.001$].

High-risk sexual behaviors (prostitution, unprotected sex, sexual relations with adults and/or strangers, unplanned pregnancy) were found in a quarter of the sample and were more prevalent in girls [$\chi^2 (1, N = 353) = 36.41, p = \leq 0.001$]. It is worth highlighting that 5.8% of the girls had had an unplanned pregnancy. All types of sexual risk behavior were more frequent in girls, including hypersexualized sexual behavior [$\chi^2 (1, N = 353) = 8.585, p = 0.003$], unprotected sex [$\chi^2 (1, N = 353) = 39.264, p = \leq 0.001$], sex with adults [$\chi^2 (1, N = 353) = 19.370, p = \leq 0.001$], prostitution [$\chi^2 (1, N = 353) = 7.591, p = 0.006$], as well as unspecified sexual risk behaviors [$\chi^2 (1, N = 353) = 18.414, p = \leq 0.001$].

The child care intervention

As *Table 3* shows, the most common reasons for protection were child abuse and neglect, followed by incapability of parental control and child-to-parent violence. In particular, the most common types of maltreatment were neglect (emotional, physical and educational, via school absence), along with emotional maltreatment. There were significant differences between the group of boys and girls with respect to negligence of educational needs [$\chi^2 (1, N = 351) = 6.65, p = 0.010$] and sexual abuse [$\chi^2 (1, N = 351) = 7.5, p \leq 0.001$], with both being more common in the girls' group.

The vast majority (78.8%) of the young people had experienced some breakdown in their care placements before entering TRC, ranging from 0 to 9 breakdowns. Most of the young people had suffered a breakdown of residential care, and a smaller proportion in family Foster care and adoption. These breakdowns of foster care and adoption were mostly caused (87.7%) by some kind of behavioral problem. In adoption breakdowns, 5.9% of them were definitive, with no more contact between the family and the

adolescent. An appreciable number of failures of family reunification (17%) were found, meaning re-entering into residential care once more.

Most of the young people had been previously in residential care (87.5%), with a mean of almost two changes, and between 0 and 9 facilities, excluding stays in primary reception or emergency centres. It was relatively common for them to have been in another TRC centre previously. The mean cumulative time in residential care in these young people's lives varied between 0 and 209 months. There was varied data with respect to stays in the current centres, ranging between 0 and 48 months, with significant differences between groups, the longest stays being boys [$t(351) = -3.25, p = 0.001$], who had spent a mean of 10.71 months ($SD = 11.04$) in their current centre while girls had a mean stay of 7.5 months ($SD = 7.34$).

The majority of the young people in TRC centres came from another residential care facility, followed by another TRC centre or a family home. Table 3 shows that the most common reasons for referral to TRC were behavioral problems, repeated running away, the presence of severe mental disorders and delinquent behavior. Significant differences were found between sexes, being more frequent among boys the admission to TRC due to severe behavioral problems [$\chi^2(1, N = 352) = 4.24, p = 0.039$] and criminal behavior [$\chi^2(1, N = 352) = 30.950, p \leq 0.001$]. Girls were more frequently referred due to behaviors related to runaway [$\chi^2(1, N = 352) = 4.32, p = 0.038$], suicide [$\chi^2(1, N = 352) = 13.95, p \leq 0.001$] and sexual risk [$\chi^2(1, N = 352) = 15.69, p \leq 0.001$].

Mental health problems and interventions

Around a fifth (21%) of the young people presented some kind of disability (officially diagnosed by health services), predominantly mental disability due to mental health disorders and intellectual disability. In this latter subgroup, the majority (80%) presented a moderate level, followed by severe (12.7%) and mild (7.9%).

The majority of the young people (89%) had had or were having some kind of mental health treatment prior to entering TRC, whether psychological, psychiatric or psychopharmacological (Table 4). The mean age of first contact with mental health services was 10.14 years old ($SD = 3.71$) and 96.2% of those who had had treatment had been receiving continuous intervention over time, compared to 3.8% with occasional consultations. More than half of those receiving treatment (61.5%) had experienced

changes of professional within the same type of treatment (psychiatric or psychological).

In the psychotropic medication that two thirds of the young people were receiving, what stands out is the prescription of antipsychotics, mostly atypical or second generation (for the control of aggressive behaviors) and psychostimulants (for attention problems). There was a high frequency (45% of those receiving medication) of simultaneous consumption of various types of psychopharmaceuticals, a mean of 2.21 medicines per person ($SD = 1.04$), ranging from 1 to 6 different types. Significant differences were found between boys and girls in the pattern of medication, with the girls having consuming more antidepressants [$\chi^2 (1, N = 219) = 14.05, p = \leq 0.001$] and anxiolytics [$\chi^2 (1, N = 219) = 9.04, N = 219, p = 0.003$], and fewer psychostimulants [$\chi^2 (1, N = 219) = 5.38, p = 0.020$]. About two-thirds (65.5%) of the young people on medication had experienced significant changes in medication and in the vast majority (80.3%), that meant increasing the number of medications or the change to a stronger drug.

In terms of diagnosis, only half of the young people had an explicit diagnosis, and the high frequency of comorbidity is notable, with a mean of 1.71 disorders ($SD = 0.94$), ranging from 0 to 5. The most common diagnoses were behavior disorder and attention deficit hyperactivity disorder (ADHD). ADHD was more prevalent in boys [$\chi^2 (1, N = 180) = 4.28, p = 0.039$], while personality disorders were more common in girls [$\chi^2 (1, N = 180) = 7.04, p = 0.005$].

A third of the sample had been admitted to a psychiatric unit, in almost all cases (97.2%), repeatedly. These psychiatric hospitalizations were significantly more common in girls [$\chi^2 (1, N = 180) = 13.21, p \leq 0.001$].

Finally, *Table 5* shows the assessment of emotional and behavioral problems with the YSR questionnaire. More than half of the sample were in the clinical range in one or more broadband scales, with a notably greater frequency of cases in the externalizing clinical range than internalizing. In almost all of the first order scales, more girls than boys scored in the clinical range, with significant differences in the scales of anxiety-depression [$\chi^2 (1, N = 325) = 13.72, p \leq 0.001$], social problems [$\chi^2 (1, N = 325) = 10.47, p = 0.001$], and internalizing problems [$\chi^2 (1, N = 325) = 10.92, p = 0.001$].

DISCUSSION

This is the first study in Spain which describes the adolescent population in TRC with a large and representative sample from various regions, looking at the socio-family profile, the type of care intervention and their mental health issues. Most of these young people were referred to TRC because of serious behavioral issues, and most likely because of the enormous difficulties adults had controlling and educating them, both in the family unit and in other residential placements. These difficulties are explained by the high incidence of backgrounds of risk behaviors that characterize this group: violent behaviors, substance abuse, running away from home or other residential placements, as well as criminal behavior. At the same time, the high frequency of severe family risk factors, such as gender violence or substance abuse by parents, points out the serious adverse family contexts of these young people.

Among the broad range of risk behaviors found in these young peoples' histories, suicide attempts stand out because of their seriousness and because they represent a different problem to the more common externalizing disorders. Almost a quarter of the young people had an episode of this type, and in girls it was twice as common as in boys. The importance of this problem means it needs further research, not only as something to address in TCR treatment, but also to address and prevent it in residential child care placements. As other authors have indicated (Sainero et al., 2014; Tavares-Rodrigues et al., 2019), there is little research on this topic in residential care despite the potentially serious consequences, and the particular incidence in girls (Heneghan et al., 2013).

The results of the YSR, together with these young people's risk behaviors, highlight the importance of carrying out interventions with a gender perspective, adapting both preventive and treatment interventions to the individual characteristics of each adolescent, bearing in mind the possible gender differences in the symptomatology and the therapeutic approach. A gender perspective is needed in the broader sense, for intervention in child protection, as already noted by Daniel, Featherstone, Hooper, and Scourfield (2005). The range of severe problems affecting our sample in TRC is very broad, and to everything noted above, it is worth emphasising the 11% incidence of intellectual disability. The overrepresentation of this problem in child care has been noted by other authors (Hill, 2012; Lightfoot, Hill, & LaLiberte, 2011). In Spain, our percentage in TRC is lower than in general residential child care (Águila-Otero, González-García, Bravo, Lázaro-Visa, & del Valle, 2018; Sainero, del Valle, López, &

Bravo, 2013) where the number is around 17%, but when mental health disorders are added to intellectual disability, the resulting profile may be particularly severe and make it extremely difficult to achieve effective treatment (Sainero et al., 2013). Almost 90% of our sample had already been receiving mental health treatment, starting in an early age and having a background of continuous treatment. Without doubt there has been a failure of previous treatment that should lead to a review of the interventions taken when children and young people need these treatments.

We have found very high rates of pharmacological treatment, affecting two thirds of the young people in our sample, a very similar figure to those found previously by Desjardins et al. (2017) and Brenner et al. (2013). Various studies have found greater prescribing of psychostimulants followed by antipsychotic medication (Desjardins et al., 2017; Zito et al., 2008), however in our study the most prescribed psychotropic drugs were antipsychotics. Atypical antipsychotics are used for behavioural symptoms in general population (Pappadopulos et al., 2003), because their short term efficacy (Loy, Merry, Hetrick, & Stasiak, 2017), which would indicate the need for the simultaneous, continued use of other types of intensive, prolonged psychosocial therapies. In addition, just under half of our sample were being prescribed more than one psychopharmaceutical, which agrees with results from Brenner et al. (2013) who found that 60.6% of adolescents in TFC had been prescribed more than one psychotropic drug at a time.

The question of gender is also worth highlighting from the results. There are twice as many boys as girls in TRC, but analysing the differences in background risks shows very different profiles. While the boys present more violent and criminal behavior, the girls present more suicide attempts, hospital admissions, cocaine use, high-risk sexual behavior, and running away from family homes. Pharmaceutical treatments in TRC show that girls are prescribed more anxiolytics and antidepressants and less psychostimulants (associated with ADHD treatments, more common in boys). Finally, the results of the YSR confirm a profile of more internalizing problems in girls, with particularly large differences in the anxiety-depression scale and more clinical scores in social problems. Although the boys had more clinical externalizing problems, the difference was not statistically significant. Epidemiological research in the general population has found sex-related differences in mental pathologies in adolescents. Boys commonly present more externalizing problems than girls (Costello, Mustillo, Erkanli,

Keeler, & Angold, 2003; Polanczyk & Jensen, 2008; Wagner et al., 2017), and girls commonly present more internalizing problems (Merikangas, Nakamura, & Kessler, 2009; Wagner et al., 2017). Some longitudinal epidemiological studies have found that over time girls' mental health problems increase, but boys' problems diminish (Fink et al., 2015; Van Droogenbroeck, Spruyt, & Keppens, 2018). However, in samples of adolescents in care these differences are less apparent and both sexes usually exhibit similar rates of externalizing problems (Sempik, Ward, & Darker, 2008), as in our study.

educators in children's homes cannot deal with them, these situations trigger a demand for referrals to TRC. This difficulty of control and failure to achieve an appropriate educational relationship is manifested in the large number of previous changes or breakdowns, something which is in line with previous research (Perry & Price, 2017; Rubin, O'Reilly, Luan, & Localio, 2015; Vanschoonlandt, Vanderfaeillie, Van Hoken, De Maeyer & Robberechts, 2013). It is important to note that placement breakdowns and placement changes not only affect residential care but also family foster care and, more worryingly, adoptions. The violent behavior of these adolescents is a precipitant factor in these adoption breakdowns, as research has shown (Paniagua, Palacios, & Jiménez-Morago, 2019).

This work does have some limitations. The data referring to the profiles of the adolescents (care history, family background, risk behaviors and mental health treatments) came from child protection services reports. In Spain we do not have a homogeneous system of information collection in the different regional governments, so in some areas detailed information on some aspects, particularly family backgrounds, was not available or complete. Another potential limitation is that the information about mental health needs was obtained via the application of a self-report from the adolescents themselves, so these needs may be underestimated due to a lack of awareness of the problem or social desirability. The use of multi-informant assessment tools has been recommended for residential child care research and practice (Martín, González-García, Del Valle, & Bravo, 2019).

CONCLUSIONS

As expected with such a specialised program as TRC, our sample showed extremely severe profiles. The predominant problem in these types of resources is externalizing in nature, associated with risk behaviors such as physical and verbal

aggression, drug use and criminal behavior. This behavioral symptomatology leads to a less stable care process, with out-of-home placement and adoption breakdowns, and changes of residential facilities. The girls in TRC show greater psychological upset or damage, manifesting in greater frequency suicidal behavior, risky sexual behaviors, running away from the family home, and consumption of certain drugs such as cocaine, in addition to greater mental health problems. For this reason, we believe that it is essential for interventions in these types of resources to be carried out from a gender perspective that would allow suitable work to be done beforehand in any prior residential or foster family care placement.

The particular severity of the profiles of this group of young people comes from a long history of serious risk-behaviors which combine substance abuse, criminal behavior, breakdowns in both co-living in residential care and family foster care, and even adoption, along with suicide attempts. These are cases with a long history of mental health treatment that have not managed to improve their emotional well-being despite having been treated over long periods in care, something which should lead to a rethinking of mental health treatments in child care. Over many years, the most effective programs have been those based on evidence which work with the adolescent, the family, the educational context and community to significantly, transversally reduce the behavioral symptomatology, achieving significant, long-term changes. It is essential to achieve a therapeutic environment in the residential care facility itself, so that the links between the adolescents and the educational and clinical teams promote learning and reduce the problem, just as Whittaker et al. (2016) indicated. This must be the aim of TRC programs, but residential child care resources in general must also adopt this perspective, albeit not with the same therapeutic intensity.

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(3), 251–275.

<http://doi.org/10.1111/j.1469-7610.2007.01867.x>

Águila-Otero, A., González-García, C., Bravo, A., Lázaro-Visa, S., & del Valle, J. F. (2018). Children and young people with intellectual disability in residential childcare: Prevalence of mental health disorders and therapeutic interventions. *International Journal of Social Welfare*, 27(4), 337–347.
<https://doi.org/10.1111/ijsw.12351>

Ainsworth, F., & Hansen, P. (2015). Therapeutic Residential Care: Different Population, Different Purpose, Different Costs. *Children Australia*, 40(4), 342-347.
<http://doi.org/10.1017/cha.2015.47>

Aarons, G. A., Monn, A. R., Hazen, A. L., Connelly, C. D., Leslie, L. K., Landsverk, J. A., ... Brown, S. A. (2008). Substance involvement among youths in child welfare: The role of common and unique risk factors. *American Journal of Orthopsychiatry*, 78(3), 340–349. <http://doi.org/10.1037/a0014215>

Attar-Schwartz, S. (2013). Runaway behavior among adolescents in residential care. The role of personal characteristics, victimization experiences while in care, social climate and institutional factors. *Child and Youth Services Review*, 35(2), 258-267. <http://doi.org/10.1016/j.childyouth.2012.11.005>

Bravo, A., Del Valle, J. F., & Santos, I. (2015). Helping staff to connect quality, practice and evaluation in therapeutic residential care: The SERAR Model in Spain. In J. Whittaker, J. F. Del Valle, & L. Holmes (Eds.). *Therapeutic residential care for children and youth. Exploring evidence-informed international practice* (pp. 275–287). London: Jessica Kingsley.

Breland-Noble, A. M., Elbogen, E. B., Farmer, E. M. Z., Dubs, M. S., Wagner, H. R., & Burns, B. J. (2004). Use of Psychotropic Medications by Youths in Therapeutic Foster Care and Group Homes. *Psychiatric Services*, 55(6), 706–708.
<http://doi.org/10.1176/appi.ps.55.6.706>

Brenner, S. L., Southerland, D. G., Burns, B. J., Wagner, H. R., & Farmer, E. M. Z. (2013). Use of Psychotropic Medications Among Youth in Treatment Foster Care. *Journal of Child and Family Studies*, 23(4), 666–674.
<http://doi.org/10.1007/s10826-013-9882-3>

- 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(8), 960–970.
- Campos, J., Barbosa-Ducharne, M., Dias, P., Rodrigues, S., Martins, A. C., & Leal, M. (2019). Emotional and Behavioral Problems and Psychosocial Skills in Adolescents in Residential Care. *Child and Adolescent Social Work Journal*, 19(2), 113-124. <http://doi.org/10.1007/s10560-018-0594-9>
- Costello, E. J., Mustillo, S., Erkanli, A., Keeler, G., & Angold, A. (2003). Prevalence and Development of Psychiatric Disorders in Childhood and Adolescence. *Archives of General Psychiatry*, 60(8), 837-844. <http://doi.org/10.1001/archpsyc.60.8.837>
- Daniel, B., Featherstone, B., Hooper, C. A., & Scourfield, J. (2005). Why gender matters for Evert Child Matters. *British Journal of Social Work*, 35(8), 1343-1355. <http://doi.org/10.1093/bjsw/bch225>
- Davidson, C., Dumigan, L., Ferguson, C., & Nugent, P. (2011). Effective Therapeutic Approaches withing Specialist Residential Childcare Settings. *Child care in practice*, 17(1), 17-35. <http://doi.org/10.1080/13575279.2011.528968>
- Defensor del pueblo (2009). *Informes, estudios y documentos. Centros de protección de menores con trastornos de conducta y en situación de dificultad social. [Residential child care for children with behavioural diseases and social difficulties]*. Madrid: Oficina del Defensor del Pueblo.
- Del Valle, Bravo, A., Martínez, M., & Santos, I. (2012). *Estándares de calidad en acogimiento residencial especializado. EQUAR-E. [Quality standars in specialized residential child care. EQUAR-E.]* Ministerio de Sanidad. Servicios Sociales e Igualdad.
- Desjardins, J., Lafortune, D., & Cyr, F. (2017). Psychopharmacotherapy in children placed in group homes and residential centres in Canada: Psychopathological portrait of children receiving psychotropic medications and educators' perception of treatment. *Children and Youth Services Review*, 81, 197–206. <http://doi.org/10.1016/j.childyouth.2017.08.001>

- Evans, R., White, J., Turley, R., Slater, T., Morgan, H., Strange, H., & Scourfield, J. (2017). Comparison of suicidal ideation, suicide attempt and suicide in children and young people in care and non-care populations: Systematic review and meta-analysis of prevalence. *Children and Youth Services Review*, 82, 122–129. <http://doi.org/10.1016/j.childyouth.2017.09.020>
- Farmer, E., Burns, B., Chapman, M., Phillips, S., Angold, A., & Costello, E. J. (2001). Use of Mental Health Services by Youth in Contact with Social Services. *Social Service Review*, 75(4), 605-624. <http://doi.org/10.1086/323165>
- Fink, E., Patalay, P., Sharpe, H., Holley, S., Deighton, J., & Wolpert, M. (2015). Mental Health Difficulties in Early Adolescence: A Comparison of Two Cross-Sectional Studies in England From 2009 to 2014. *Journal of Adolescent Health*, 56(5), 502–507. <http://oi.org/10.1016/j.jadohealth.2015.01.023>
- González-García, C., Bravo, A., Arruabarrena, 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. <https://doi.org/10.1016/j.childyouth.2016.12.011>.
- Hill, K. M. (2012). Permanency and placement planning for older youth with disabilities in out-of-home placement. *Children and Youth Services*, 34(8), 1418–1424. <http://doi.org/10.1016/j.childyouth.2012.03.012>
- James, S., Roesch, S., & Zhang, J. J. (2012). Characteristics and Behavioral Outcomes for Youth in Group Care and Family-Based Care: A Propensity Score Matching Approach Using National Data. *Journal of Emotional and Behavioral Disorders*, 20(3), 144–156. <http://doi.org/10.1177/1063426611409041>
- Jozefiak, T., Kayed, N. S., Rimehaug, T., Wormdal, A. K., Brubakk, A. M., & Wichstrøm, L. (2015). Prevalence and comorbidity of mental disorders among adolescents living in residential youth care. *European Child & Adolescent Psychiatry*, 25(1), 33–47. <http://doi.org/10.1007/s00787-015-0700-x>
- Keil, V., & Price, J. M. (2006). Externalizing behavior disorders in child welfare settings: Definition, prevalence, and implications for assessment and treatment. *Children and Youth Services Review*, 28(7), 761–779. <http://dx.doi.org/10.1016/j.childyouth.2005.08.006>

- Kleinrahm, R., Keller, F., Lutz, K., Kölch, M., & Fegert, J. M. (2013). Assessing change in the behavior of children and adolescents in youth welfare institutions using goal attainment scaling. *Child and Adolescent Psychiatry and Mental Health*, 7(1), 33. <http://doi.org/10.1186/1753-2000-7-33>
- Lehmann, S., Havik, O. E., Havik, T., & Heiervang, E. R. (2013). Mental disorders in foster children: a study of prevalence, comorbidity and risk factors. *Child and Adolescent Psychiatry and Mental Health*, 7(1), 39. <http://doi.org/10.1186/1753-2000-7-39>
- Ley Orgánica 8/2015, de 22 de julio, de modificación del sistema de protección a la infancia y a la adolescencia.
- Lightfoot, E., Hill, K., & LaLiberte, T. (2011). Prevalence of children with disabilities in the child welfare system and out of home placement: An examination of administrative records. *Children and Youth Services Review*, 33(11), 2069–2075. <http://doi.org/10.1016/j.chilyouth.2011.02.019>
- Loy, J. H., Merry, S. N., Hetrick, S. E., & Stasiak, K. (2017). Atypical antipsychotics for disruptive behaviour disorders in children and youths. *Cochrane Database of Systematic Reviews*. <http://doi.org/10.1002/14651858.cd008559.pub3>
- Lüdtke, J., In-Albon, T., Schmeck, K., Plener, P. L., Fegert, J. M., & Schmid, M. (2017). Nonsuicidal Self-Injury in Adolescents Placed in Youth Welfare and Juvenile Justice Group Homes: Associations with Mental Disorders and Suicidality. *Journal of Abnormal Child Psychology*, 46(2), 343–354. <http://doi.org/10.1007/s10802-017-0291-8>
- Malvaso, C. G., & Delfabbro, P. (2015). Offending Behaviour Among Young People with Complex Needs in the Australian Out-of-Home Care System. *Journal of Child and Family Studies*, 24(12), 3561–3569. <http://doi.org/10.1007/s10826-015-0157-z>
- McLean, S., Price-Robertson, R., & Robinson, E. (2011). *Therapeutic Residential Care in Australia: Taking Stock and Looking Forward*. (National Child Protection Clearinghouse Issues Paper No. 35). Melbourne: Australian Institute of Family Studies, Government of Australia.

- Merikangas, K., Nakamura, E. F., & Kessler, R. (2009). Epidemiology of mental disorders in children and adolescents. *Dialogues in Clinical Neuroscience, 11*(1), 7-20.
- Nowacki, K., & Schoelmerich, A. (2010). Growing up in foster families or institutions: Attachment representation and psychological adjustment of young adults. *Attachment & Human Development, 12*(6), 551–566.
<http://doi.org/10.1080/14616734.2010.504547>
- Observatorio de la Infancia (2018). *Estadística básica de medidas de protección a la infancia [Basic statistics of child welfare]*. Vol. 20. Madrid: Ministerio de Sanidad y Servicios Sociales e Igualdad.
- Paniagua, C., Palacios, J., & Jiménez-Morago, J. M. (2019). Adoption breakdown and adolescence. *Child & Family Social Work, 1*-7. <http://doi.org/10.1111/cfs.12631>
- Pappadopulos, E., Macintyre, J. C., Crismon, M. L., Findling, R. L., Malone, R. P., Derivan, A., ... Jensen, P. S. (2003). Treatment Recommendations for the Use of Antipsychotics for Aggressive Youth (TRAAAY). Part II. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*(2), 145–161.
<http://doi.org/10.1097/00004583-200302000-00008>
- Pecora, P. J., Jensen, P. S., Romanelli, L. H., Jackson, L. J., & Ortiz, A. (2009). Mental health services for children placed in foster care: An overview of current challenges. *Child Welfare, 88*(1), 5–26.
- Pérez-García, S., Águila-Otero, A., González-García, C., Santos, I., & Del Valle, J. F. (2019). No one ever asked us. Young people's evaluation of their residential child care facilities in three different programs. *Psicothema, 31*(3), 319–326.
<https://doi.org/10.7334/psicothema2019.129>.
- Perry, K. J., & Price, J. M. (2018). Concurrent child history and contextual predictors of children's internalizing and externalizing behavior problems in foster care. *Children and Youth Services Review, 84*, 125–136.
<http://doi.org/10.1016/j.chilyouth.2017.11.016>
- Phillips, E. L., Phillips, E. A., Fixsen, D. L., & Wolf, M. M. (1971). Achievement place: modification of the behaviors of pre-delinquent boys within a token economy. *Journal of Applied Behavior Analysis, 4*(1) 45–59.

- Polanczyk G., & Jensen, P. (2008). Epidemiologic considerations in attention deficit hyperactivity disorder: a review and update. *Child and Adolescent Psychiatric Clinics of North America*, 17(2), 245-260.
<http://doi.org/10.1016/j.chc.2007.11.006>
- Raghavan, R., Zima, B. T., Andersen, R. M., Leibowitz, A. A., Schuster, M. A., & Landsverk, J. (2005). Psychotropic Medication Use in a National Probability Sample of Children in the Child Welfare System. *Journal of Child and Adolescent Psychopharmacology*, 15(1), 97–106.
<http://doi.org/10.1089/cap.2005.15.97>
- Robst, J., Armstrong, M., Dollard, N., & Rohrer, L. (2013). Arrests among youth after out-of-home mental health treatment: Comparisons across community and residential treatment settings. *Criminal Behaviour and Mental Health*, 23(3), 162-176. <http://doi.org/0.1002/cbm.1871>
- Rubin, D. M., O'Reilly, A. L. R., Luan, X., & Localio, A. R. (2007). The Impact of Placement Stability on Behavioral Well-being for Children in Foster Care. *Pediatrics*, 119(2), 336–344. <http://doi.org/10.1542/peds.2006-1995>
- Ryan, J. P., Marshall, J. M., Herz, D., & Hernandez, P. M. (2008). Juvenile delinquency in child welfare: Investigating group home effects. *Children and Youth Services Review*, 30(9), 1088–1099. <http://doi.org/10.1016/j.chidyouth.2008.02.004>
- Sabaté Tomàs, M. (2017). *Els CREI en Catalunya. Intercenió, perfil y evolució dels joves ates atesos. [CREI en Catalonia. Intervention, profile and evolution of youth looked after]*. Doctorado. Universidad Aurtónoma de Barcelona.
- 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(1), 16–26. <https://doi.org/10.1177/1063426612470517>.
- Sainero, A., del Valle, López, M., & Bravo, A. (2013). Exploring the specific needs of an understudied group: Children with intellectual disability in residential child care. *Children and Youth Services Review*, 35(9), 1393–1399.
<https://doi.org/10.1016/j.chidyouth.2013.04.026>.

Sempik, J., Ward, H., & Darker, I. T., (2008). Emotional and behavioural difficulties of children and young people at entry into care. *Clinical Child Psychology and psychiatry*, 13(2), pp. 221 - 233. <http://doi.org/10.1177/1359104507088344>

Tavares-Rodrigues, A., González-García, C., Bravo, A., & Del Valle, J. F. (2019). Needs assessment of youths in residential child care in Portugal / Evaluación de necesidades de jóvenes en acogimiento residencial en Portugal / Evaluación de necesidades de jóvenes en acogimiento residencial en Portugal. *Revista de Psicología Social*, 34(2), 354–382. <https://doi.org/10.1080/02134748.2019.1576325>.

Traube, D. E., Yarnell, L. M., & Schragger, S. M. (2016). Differences in polysubstance use among youth in the child welfare system: Toward a better understanding of the highest-risk teens. *Child Abuse & Neglect*, 52, 146–157. <http://doi.org/10.1016/j.chiabu.2015.11.020>

Van Droogenbroeck, F., Spruyt, B., & Keppens, G. (2018). Gender differences in mental health problems among adolescents and the role of social support: results from the Belgian health interview surveys 2008 and 2013. *BMC Psychiatry*, 18(1). <http://doi.org/10.1186/s12888-018-1591-4>

Vanschoonlandt, F., Vanderfaeillie, J., Van Holen, F., De Maeyer, S., & Robberechts, M. (2013). Externalizing problems in young foster children: Prevalence rates, predictors and service use. *European Psychiatry*, 35(4), 716–724. [http://doi.org/10.1016/S0924-9338\(13\)77107-4](http://doi.org/10.1016/S0924-9338(13)77107-4)

Wagner, G., Zeiler, M., Waldherr, K., Philipp, J., Truttmann, S., Dür, W., Treasure, J. L., & Karwautz, A. F. K. (2017). Mental health problems in Austrian adolescents: a nationwide, two-stage epidemiological study applying DSM-5 criteria. *European Child and Adolescent Psychiatry*, 26(12), 1483-1499. <http://doi.org/10.1007/s00787-017-0999-6>

Whittaker, J. K., Holmes, L., Del Valle, 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 & Youth*, 33, 89–106. <https://doi.org/10.1080/0886571X.2016.1215755>.

Whittaker, J. W., & Del Valle (2015). In L. Holmes (Ed.). *Therapeutic residential care with children and youth: Developing evidence-based international practice*. London and Philadelphia: Jessica Kingsley Publishers.

Yarnell, L. M., Traube, D. E., & Schrager, S. M. (2016). Brief report: Growth in polysubstance use among youth in the child welfare system. *Journal of Adolescence*, *48*, 82–86. <http://doi.org/10.1016/j.adolescence.2016.02.001>

Zito, J. M., Safer, D. J., Sai, D., Gardner, J. F., Thomas, D., Coombes, P., ... Mendez-Lewis, M. (2008). Psychotropic Medication Patterns Among Youth in Foster Care. *Pediatrics*, *121*(1), e157–e163. <http://doi.org/10.1542/peds.2007-0212>

Table 1. Sociodemographic and family background

Variable	<i>N</i> (<i>n</i> = 353)	% or <i>M</i> (SD)
Sexo		
Male	233	66
Female	120	34
Age		15.61 (1.30)
11-12 years old	7	2
13-14 years old	61	17,3
15-16 years old	184	52,1
17-18 years old	101	28,6
Roma children	42	11.9
Immigrant Family	80	22.7
Unaccompanied migrant minor	15	4.2
Family risk factors (<i>n</i> =349) ^a		
Poverty	158	45.3
Mental health disorder	151	43.3
Gender violence	137	39.3
Substance abuse abuse	125	35.8
Criminal behavior	83	23.8
Intrafamilial violence	47	13.5
Intellectual disability	33	9.5
Suicidal behavior	18	5.2
Mean risk factors		2.15 (1.67)
Number of children in family (<i>n</i> =350)		2.8 (1.59)
Siblings in protection	102	29.1
Number of siblings in protection		1.88 (1.17)
Family Preservation Program (FPP)	112	31.7
Duration FPP		17.58 (13.63)

^a More than one category per case is possible

All the percentages were calculated over the total sample (*N*=353)

Table 2. Risk behaviors previous to TRC placement

Variable	Total (n=353) n (%)	Boys (n=233) n (%)	Girls (n=120) n (%)
Suicide behavior ^a	105 (29.7)	48 (20.6)	57 (47.5)***
Threat	37 (10.5)	17 (7.3)	20 (16.7)**
Attempt	78 (22.1)	34 (14.6)	44 (36.7)***
Non-suicidal self-injury	25 (7.1)	14 (6)	11 (9.2)
Problematic alcohol consumption	93 (26.3)	54 (23.2)	39 (32.5)
Drug abuse ^a	215 (60.9)	138 (59.2)	77 (64.2)
Cannabis	204 (57.8)	131 (56.2)	73 (60.8)
Cocaine	31 (8.8)	14 (6)	17 (14.1)*
Other psychostimulants	20 (5.7)	11 (4.7)	9 (7.5)
Psychiatric drugs	6 (1.7)	5 (2.1)	1 (0.8)
Inhalants or solvents	10 (2.8)	7 (3)	3 (2.5)
Other drugs	15 (4.2)	10 (4.3)	5 (4.2)
Non-specified	9 (2.5)	5 (2.1)	4 (3.3)
Violent behavior ^a	294 (83.3)	206 (88.4)	88 (73.3)***
Previous residential care	204 (57.8)	146 (62.7)	58 (48.3)*
Family home	144 (40.8)	94 (40.3)	50 (41.7)
School	102 (28.9)	80 (34.3)	22 (18.3)**
Community	77 (21.8)	61 (26.2)	16 (13.3)**
Family home runaway	89 (25.2)	43 (18.5)	46 (38.3)***
Residential care runaway	187 (53)	115 (49.4)	72 (60)
Criminal behavior	118 (33.4)	94 (40.3)	24 (20)***
Against persons	62 (17.6)	47 (20.2)	15 (12.5)
Against property	24 (6.8)	20 (8.6)	4 (3.3)
Against persons and property	27 (7.6)	26 (11.2)	1 (0.8)
Juvenile justice unit	15 (4.2)	12 (5.2)	3 (2.5)
Sexual risk behavior	90 (25.5)	36 (15.4)	54 (45)***

^a More than one category per case is possible

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

Table 3. Characteristics of protection process

Variable	<i>N</i> (<i>n</i> =353)	% or <i>M</i> (SD)
Reason for admission (<i>n</i> =351) ^a		
Child abuse or neglect	262	74.6
Out of parental control	221	63
Child-to-parent violence	83	28.4
Impossibility to meet parental obligations	40	11.4
Abandonment	39	11.1
Unaccompanied migrant minor	15	4.3
Child abuse or neglect (<i>n</i> =351) ^a		
Physical abuse	99	28.2
Emotional abuse	151	43
Physical neglect	149	42.5
Emotional neglect	183	52.1
Security needs neglect	105	29.9
School attendance neglect	113	32.2
Sexual abuse	15	4.3
Break-down experiences ^a		
Residential child care breakdown	241	68.3
Foster care breakdown	72	20.4
Adoption breakdown	34	9.6
Family reunification breakdown	60	17
Number of breakdowns		1.65 (1.41)
Number of placement changes		1.78 (1.56)
Mean time spent at residential child care		33.17 (32.40)
Mean time spent at current TRC		9.62 (10.43)
Referred from		
Residential child care	218	61.8
Other TRC	66	18.7
Origin family	60	17
Family foster care	5	1.4
Other facilities/placements	4	1.1
Reason for TRC (<i>n</i> =352) ^a		
Severe behavior problems	318	90.3
Severe mental health disorder	158	44.9
Runaway	199	56.5
Child-to-parent violence	100	28.4
Delinquency	115	32.7
Drug consumption	69	19.5
Suicide behavior	21	5.9
Sexual risk behavior	32	9.1

^a More than one category per case is possible

All the percentages were calculated over the total sample (*N*=353)

Table 4. Mental health variables

	Total (<i>n</i> =353)	Boys (<i>n</i> =233)	Girls (<i>n</i> =120)
Variables	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)
Disability ^a	74 (21)	55 (23.6)	19 (15.8)
Mental disability	60 (17)	46 (19.7)	14 (11.7)
Intellectual disability	40 (11.3)	29 (12.4)	11 (9.2)
Physical disability	5 (1.4)	2 (0.9)	3 (2.5)
Sensorial disability	1 (0.3)	1 (0.4)	0
Mental health treatment ^a	314 (89)	208 (89.3)	106 (88.3)
Psychological treatment	257 (72.8)	175 (75.1)	82 (68.3)
Psychiatric treatment	235 (66.8)	153 (65.6)	82 (68.3)
Psychopharmacological treatment	232 (65.7)	157 (67.4)	75 (62.5)
Type of psychotropic drugs ^a			
Psychostimulant	93 (26.3)	70 (30)	23 (19.2)*
Antidepressant	64 (18.7)	30 (13.7)	34 (28.3)**
Anxiolytic	67 (19)	35 (15)	32 (26.7)**
Antipsychotic	171 (49)	117 (51.1)	54 (45)
Antiepileptic	61 (17.3)	36 (15.5)	25 (20.8)
Hypnotic	17 (5.1)	12 (5.6)	5 (4.2)
Other psychotropic drugs	5 (1.4)	3 (1.3)	2 (1.7)
Psychodiagnostic ^a	180 (51)	118 (56.7)	62 (58.5)
Attention deficit hyperactivity disorder	80 (22.7)	59 (25.3)	21 (17.5)
Other neurodevelopmental disorders	30 (8.5)	19 (8.2)	11 (9.2)
Depressive disorder	9 (2.5)	6 (2.6)	3 (2.5)
Stress disorder	32 (9.1)	19 (8.2)	13 (10.8)
Attachment disorder	30 (8.5)	19 (8.2)	11 (9.2)
Behavior disorder	80 (22.7)	55 (23.6)	25 (20.8)
Personality disorder	21 (5.9)	8 (3.4)	13 (10.8)**
Squizophrenia or psychotic disorder	5 (1.4)	3 (1.3)	2 (1.7)
Drug abuse disorder	13 (3.7)	6 (2.6)	7 (5.8)
Other psychodiagnostics	17 (4.8)	11 (4.7)	6 (5)
Comorbidity	86 (24.4)	57 (24.5)	29 (24.2)
Psychiatric hospitalization	109 (30.9)	57 (24.5)	52 (43.3)***

^a More than one category per case is possible

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

Table 5. Percentage of cases in clinical range in YSR and gender differences

	Total	Boys	Girls
	(<i>n</i> =325)	(<i>n</i> =216)	(<i>n</i> =109)
Variable	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)
Anxiety-depression	42 (16)	23 (10.6)	29 (26.6)***
Withdrawal-depression	39 (12)	23 (10.6)	16 (14.7)
Somatic complaints	37 (11.4)	28 (13)	9 (8.3)
Social problems	58 (17.8)	28 (13)	30 (27.5)**
Thought problems	40 (12.3)	23 (10.6)	17 (15.6)
Attentional problems	72 (22.2)	42 (19.4)	30 (27.5)
Disruptive behavior	138 (42.5)	92 (42.6)	46 (42.2)
Aggressive behavior	86 (26.5)	53 (24.5)	33 (30.3)
Internalizing	104 (32)	56 (25.9)	48 (44)**
Externalizing	198 (60.9)	124 (57.4)	74 (67.9)
Total	155 (47.7)	95 (44)	60 (55)
Any scale	222 (67.7)	138 (63.9)	82 (75.2)*

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