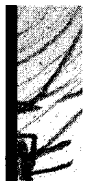

Mental health of children in institutional social care: Empirical findings from Greece

AGATHONOS-GEORGOPOULOU, H., SARAFIDOU, J., & STAVRIANAKI, M.

Abstract

Within the framework of a EU funded collaborative program against social exclusion, a study was carried out in Greece on the mental health of children living in institutional social care. The sample comprised 204 out of 2173 children 6-18 years, randomly selected, living in all (29) institutions of social care under the state and the Greek Orthodox Church. An additional 250 children in residential care provided by NGO's and voluntary organizations were not included in the study.

Findings revealed a steady decline in the population of children in institutions while an increasing need for fostering is being observed. At the time of the study (December 2002-March 2003), 2773 children 0-18 years were living under state care, 2173 in institutions and 600 in foster families, comprising 1:1000 of the total population of children in the country.

The instruments administered were: a) the Achenbach Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983), b) a questionnaire on the child and its family and c) a questionnaire on the institution, its policies and functions. All institutions responded with information on 95% of the children sample.

Results depict a high morbidity of mental health disorders as one in three children were clinically diagnosed with a mental health problem while differences in morbidity were observed among the three categories of institutions, reflecting the specific historical and cultural characteristics that have been influencing the evolution of child welfare policies in the country. As child protection in Greece manifests itself very differently to that of other countries in the EU, the re-orientation needed should bridge the gap between the organizational separation of child protection and mental health which is contributing in the violation of children's rights, as well as on the combination of cultural sensitivity and empirical evidence while being in accordance with the UN Convention on the Rights of the Child.

Key words: mental health, children, institutions, Greece

Introduction

The historical context

In Greece, historical, political, economic and cultural factors have been accounted as underlying the late development of mental health services. Nevertheless the last two decades, since

Greece's entry into the European Union in 1981, mental health services have been undergoing profound changes, moving from the traditional centralized institutional psychiatric care system to a decentralized community system based on extramural facilities, child guidance clinics and hospital outpatient departments (Madianos et al., 1999). Although the changes were introduced vertically, not by public demand as in the case of Italy, certain stereotypes and attitudes towards the mentally disabled – children and adults – are changing, while society is gradually becoming more tolerant by encouraging social reintegration of the mentally ill or disabled.

The same factors that hindered the development of mental health services, pertain more so in the case of children in care. In the Greek family, the child's invisibility as an individual in his own right, in conjunction with the protective net of the traditional extended family, have hindered the disclosure of a child's mental health problem outside the family, although the same factors have acted as buffers to the emergence of many of these problems. The state, in parallel, in an effort to cope with the numerous sociopolitical and economic turmoil which characterized the country's recent history, depended on the strength of the family to cope with its problems, especially those of its young ones. The present situation in regards to mental health services for children is definitely progressing but with major deficits and needs for improvement (Tsiantis, 1997).

In Greece, prevalence studies on mental health problems of children have been scarce. A number of studies on child psychopathology (Motti-Stefanidi et al. 1993 (a), Motti-Stefanidi et al., 1993 (b), Roussou et al., 2002) have applied the Achenbach Child Behaviour Checklist (Achenbach & Edelbrock, 1983, CBCL), to different child populations, while earlier studies used other tools to estimate the relationship of psychological disorders with other factors such as parental attitudes (Paraskevopoulos & Leoussi, 1970) and school performance (Papatheofilou et al., 1988).

The development of institutional care for children in Greece has followed a parallel route to that of mental health services, although more highly associated with the economic and geopolitical situation of the country. World war II and the Greek civil war that followed in the late 1940's, left the country in a state of acute poverty in which children were the most vulnerable group. Economic reasons, in conjunction with the geographical position of Greece bordering with communist countries, led in those times, to the political decision to create a large number of institutions for children along the northern border acting as "social fortification" (Agathonos-Georgopoulou, 1991, 1993). Today, more than fifty years later, a steady decline is being observed of the numbers of children requiring admission, especially among the under fives, followed by a corresponding closure of a number of institutions. Most of the remaining institutions in Greece are those in northern Greece, contrary to southern regions in some of which there are no provisions.

A new population of clients has emerged for the system since the early 1990's, when large numbers of economic migrants, mainly Albanian families, entered the country. As institutional upbringing was socially accepted in their countries, these parents have been requesting their children's admission to attain education and free boarding combined with a safe and steady place of residence. The institutional system has been responding positively to this request, for two reasons: firstly, because these children cover empty places thus raising their occupancy rate; secondly, because staff wish for the institutions to remain as they are fearing reforms for which they feel unprepared and, therefore threatened. Today, approximately 15% of children living in Greek institutions belong to the above category of the population.

The issue of mental health of Greek children living in institutional care can be approached through two main venues:

a) Mental health problems of children in care.

b) Children entering care because of their problematic behavior.

Since the early 1980's, a number of Greek studies have focused on the links between child protection and mental health of children living in institutional care. An early study (Panopoulou-Maratos et al., 1988), carried out in all residential care settings for normal children, children with physical or mental disabilities as well as hostels for children who lived there be-

cause of difficulties in accessing a high school from their remote villages, evaluated residential care and its effects on children's psycho-social development. The study findings suggested that many children of single parents or from broken homes caused by parental death or separation, were admitted for economic reasons. These findings have been confirmed in a later study (Agathonos-Georgopoulou, 1995), in which the main factors identified as predisposing to care entry for physically abused and neglected children in Greece were found to be associated with family disruption and its effects primarily on mothers and children such as single parenthood, social isolation, other family problems, life events in the last year prior to the child's admission into care and parents' mental health problems.

The adverse effects of institutional upbringing on children's psychosocial functioning have been a steady finding in consequent Greek studies (Panopoulou-Maratos et al., 1988, Vorria, 1995, 1998 (a) (b), Vorria et al., 1993, Vorria et al., 1998). Interventions into Greek institutions showed positive results in changing the overall climate of institutions, and through that reducing children's behavioral problems (Paritsis et al., 1985, Stavrianaki, 1996, Vassilias, 1994 Vassilias et al., 1993).

The association between abuse and institutional care of children was the subject of two studies in Greece. The first, a part of an an-going clinical study of physically abused and neglected children (Agathonos, 1983) focused on five children – four of them with disabilities – who suffered severe injuries by staff, in two cases fatal. The study suggested that as in the case of abusing families, for institutional abuse to occur, a special parent, a special child and a crisis situation, chronic and/or acute are needed. The second, a follow-up of 70 physically abused and neglected children two to twelve years after initial referral to a clinical team, evaluated children's behaviour in the two groups; one who stayed at home during intervention and a second group who were removed from home (Agathonos-Georgopoulou, 1995). On the basis of the Rutter Behavior Scale A 2 for parents (Rutter, 1967) as an outcome measure, it was found that children who were removed from home during intervention presented with higher rates of behaviour disorder compared to those who stayed at home.

The current context

In Greece, in comparison with other EU countries, a small number of children are under the care of the state (Agathonos-Georgopoulou, 1993). In 2003, 2173 children 0-18 years lived in institutional care and 600 in foster care, a total of 2773 children or 1‰ of the total population of children 0-18 years. The ratio of institutional vs. foster care is 4:1, a common finding among southern European countries in which family support systems seem to act as buffers to care entry. Nevertheless, this ratio is slowly changing, following the decline of requests for residential care and the growing need for fostering.

Children enter care through three venues:

a) The Peripheral Systems of Health and Welfare that, as of year 2003, function as decentralized services of the Ministry of Health and Welfare.
b) The Greek Orthodox Church and
c) Non-governmental Organizations and Voluntary Associations.

Children in social care

The Ministry of Health and Welfare through the Peripheral Systems of Health and Welfare operates:

a) 13 Centres for Child Care for separate sexes, 8 for boys and 4 for girls, with a number of children residents ranging from 23 to 97 children, a total of 570 children 6-18 years.
b) 7 Children's Towns (Pedopolis) of the National Welfare Organization, 6 for children 6-18 years and one for 3-12 years. All but one of these were of mixed sexes.
   A total of 234 children are under various programs of full residency (N: 192), home at night (N:8), at home on trial with support (N:34).

c) Babies' Centre METERA, a child protection and adoption organization for the under fives with turnover; 97 children awaiting rehabilitation were living there in April 2003.
d) PIKPA – A so-called "temporary shelter" which, because of children's social problems with legal implications, is actually a long – stay institution, with 40 children.
e) Church, NGO's and Voluntary Associations cover a total of 1200 children in, usually, average or small size care settings.

Table 1
Children in social care in Greece (year 2003)

A. Residential Care		Number of children
1. State Centres for Child Care		570
2. Children's Towns (Pedopolis) of the National Welfare Organization		266
Of these:		
2.1. – In full residency:	192	
2.2. – Home at night:	8	
2.3. – At home on trial with support:	34	
2.4. – In fostering:	32	
3. Babies' Centre MITERA		97
4. PIKPA – Temporary Shelter		40
5. Church and NGO's or Voluntary Associations		1.200
Total		2.173
B. Foster Care		600
Grand total		**2.733**

Reasons for entry

The most common reason given for a child's entry into care is "family difficulties". Abuse is rarely reported as such, while neglect may be disclosed as a reason, after discussion with staff. Family crisis, chronic or acute, may encompass mental and/or health problems in the family, neglect, family discordance with violence, a "dangerous" environment with risks for the child's moral upbringing and children's problematic behaviour which cannot be tolerated by the parents. Nevertheless, a significant underlying factor is poverty, a steady research finding since the early studies (Panopoulou-Maratos et al., 1988). Placements in institutions rarely break down but children may change care setting when they move, from primary to secondary school. Upon leaving care, usually at age 18, there is considerable support offered, especially for further education, training and employment.

The requirements for a child's entry into institutional social care of the three different schemes (Centres for Child Care, Children's Towns and Church settings) are in principle the same, with some variations. All require a medical certificate by a public hospital or Health Centre confirming that the child does not suffer from a contagious disease. Furthermore, state institutions require a medical certificate that the child is healthy and "fully bodied" (Children's Towns) or has sound physical and mental health (Centres for Child Care), while Church settings do not ask for physical health certificates. All types of settings require a mental health and learning difficulties assessment of the child in the case that a problem has been observed upon the initial contact with the child. It should also be noted that the two state schemes require a social worker's report for a child's referral into institutional care, while church settings do not. For urgency, the Prosecutor for Minors may bypass all or some of the

requirements for entry in the case of referral to an institution. The above requirements screen-out children with mental health problems, serving in essence, normal children needing social protection because of poverty and family breakdown. Nevertheless, once accepted into care, children who develop mental health problems or are diagnosed so later, tend to stay and receive help from community services.

Staffing

Unlike other countries, stability of employment of staff characterizes Greek institutions. On one hand it is positive for children, as there is no turnover in care giving, while on the other, the staff's identity as civil servants with tenure, in connection with a low profile job, limited or no continuous education, supervision and burn-out, may be risk factors in the system, harmful for the children, especially those who have little or no contact with their families. Staff qualifications vary among the different schemes. Child Care Centres have a majority of unqualified staff since emphasis is on "maternal" qualities. There are a few male care workers. Children's Towns have more qualified staff, have access to some in-service training but find difficulties in coping with children with behaviour or mental health problems. Lastly, staffing in Church and NGO care settings varies, with unqualified "maternal" figures being in preponderance.

General observation

The Greek social care system considerably differs from that in other countries in central and northern Europe, while it resembles that of other Mediterranean countries. The small number of children and the stability of staff may seem enviable, but research evidence has shown that the quality of institutions needs improvement while most need a re-orientation to meet the real needs of children.

The social exclusion issues characterizing Greek institutions are not associated with delinquency, crime or exclusion from school but with the admission and stay of children for long periods in care for economic reasons. Within the school system, children living in institutions are socially excluded because of the discriminatory attitudes of other children, their parents and of some educators. It is evident that within the Greek social context, solutions need to be found that would be culturally relevant but also child rights focused (Agathonos-Georgopoulou, 2003, Remsbery, 2003).

Objectives and research questions

European collaborative research projects offer a good opportunity for intra-country observations and comparisons that prove helpful to the development of policies at EU level as well as for the improvement of national policies. Furthermore, such projects promote understanding among countries by providing cultural sensitivity and cultural awareness.

The specific collaboration among the three EU countries, the United Kingdom, Belgium and Greece, offered a unique opportunity to pursue this general objective. Meanwhile, the methodology developed for the field study that was carried out in the two countries, Belgium and Greece, aimed at answering specific research questions. These were the following:

1. What is the prevalence of mental health problems in Greece and how are they compared to those in Belgium.
2. What are the characteristics of institutions as systems, of their staff and of the children.
3. What is the situation in regards to needs for mental health care.
4. How are children's rights guaranteed?

The Scientific Council and the Administrative Board of the Institute of Child Health, in Athens, a research center under the Ministry of Health and Welfare, approved the project proposal. The ethics committee accepted the Barnardo's Statement of Ethical Research Practice, which served as the ethical instrument of the overall project.

Methodology

Sample selection

Permission was obtained by the Ministry of Health and Welfare and the Greek Orthodox Church to contact all institutions under their jurisdiction. These comprise the total number (29) of institutions for social care in Greece for children 6-18 years, excluding a small number of settings operated by non-governmental organizations and voluntary associations. Following permission, all 29 institutions contacted by letter were the following: 13 Centres for Child Care, 7 Children's Towns and 9 Church settings. Geographically, they were distributed from the northern border with Albania and Bulgaria to the islands of Crete and Rhodes in the south. Children were selected with random sampling, using random numbers, on the basis of the number of children of both sexes living at each institution at the time. The original number of children upon initial selection was 252 but, at the time of the field study, 39 children had either left or were older than 18 years. The final sample comprised 204 children from 213 children or a response rate of 95%. The person in the institution who knew the child best completed the questionnaires with information about the child. Throughout the field study, probings by telephone were done to all institutions. This proved useful as in Greece, the unofficial communication network among professionals works better than the official one.

Instruments

For each child, a file was prepared containing two questionnaires:

a. The Achenbach questionnaire for parents (CBCL 4-18), in Greek (see Grietens & Hellinckx, this issue, for a description).
b. A questionnaire inquiring additional information for each child such as:

Age of admission and length of stay in care, schooling, information on the family, frequency of contacts with family, child's problems which are of concern for staff, help sought and found, child diagnosed as with mental health problems and how they were handled.

Managers were asked to complete an additional questionnaire with information on the institution and its function. Questions pertained to:

Places available and present occupancy, number of staff and distribution by discipline, part-time staff, activities of children in the community (i.e. foreign languages, computer lessons) and, if not, reasons were asked, access to health and mental health services, evaluation of access and use of above services in the last year, types of mental health help provided, degree of satisfaction, director's personal view on the types of problems children present.

Results

Description of the sample

Characteristics of institutions

Centres for Child Care comprise 13 institutions, 9 for boys and 4 for girls. There are 7 Children's Towns, five of which are for mixed sexes, one for girls and one for boys. Three of the Church institutions were for boys, 4 for girls and 2 were of mixed sexes.

The size of institutions varied according to type but also within each type. Centres for Child Care had from 23 to 97 children, with an average of 40 children in each. The larger are situated in northern Greece and across the border with Albania and Bulgaria. Children's Towns,

under the National Welfare Organization, are much smaller having 9 to 35 children (average size 23 children), while those of the Church presented with more variations in size, from 6 to 75 children (average 22 children).

Access to health and mental health services

All institutions were using the various community services according to needs. The most frequent use is that of hospitals' outpatient departments, while few use private mental health specialists. Access to services is considered by the manager to be "difficult" because of distance (14:29 institutions), heavy workload (8:29) and shortage of staff to accompany children (11:29). Easy access is reported in only 7:29 institutions.

The mental health services reported were the following: a) diagnostic assessment of the child (17 institutions) b) consultation to the institution (11 institutions), c) treatment for the child (12 institutions), d) diagnostic assessment of family (4 institutions), e) family counseling (2 institutions).

The degree of satisfaction from service use varied among the 14 institutions that responded to this question, from "very satisfied" (6 institutions) and "satisfied (3) to "average satisfaction" (4) and "little" or "none" (2).

Characteristics of staff

A total of 313 employees in the 29 institutions are distributed unevenly among the various positions. Auxiliary (cleaning) staff supercedes all other (42%), followed by administrative employees (22%), child-care workers (21%) and "other" staff (65:313) such as gardeners, night guardians, seamstresses and nurses. There are 17 (5%) social workers, most in Children's Towns (11), and only 5 psychologists, of which none in the 13 Child Care Centres.

In addition to the permanent staff, 13 out of the 29 institutions employ part time professionals, mostly teachers assisting children with their schoolwork. Furthermore, in 23 institutions, children take lessons of foreign language, computing, sports etc in the community, after school hours and on weekends.

Staff in 8 out of the 29 institutions commented on difficulties they face. These pertain to a) lack of professional staff for children (social workers, psychologists, child psychiatrists, speech therapists), b) absence of mental health services in the community to facilitate access, c) mental health services' requirement for parents' consent for a child's assessment or treatment, d) private mental health services are very expensive, e) children may be returned to their families with no family counseling provided, because of distance.

Socio-demographic characteristics of children

Data were collected for 204 children 6-18 years. The 6-11 age group comprised 28% of the children while 72% were in the 12 to 18 age group. One hundred and twenty one were boys (59%), of average age 13.8 years (SD = 2.8), and 83 were girls (41%), of average age 14.5 years (SD = 2.8). The difference in age was not significant (t = 1.52 on 202 df, p = .131)

Twenty-five of the children came from Albania and 2 from former USSR countries, 4 came from Africa or Latin America and 6 were Roma. For 77 of the children it was mentioned that they were of Greek nationality, while for the remaining 90 children their nationality was not mentioned. Assuming that the different ethnicity was always mentioned 85% of the children were Greek.

Almost half of the children (115 children, 56%) were living in Centers for Child Care, 40 children (20%) in Children's Towns and 49 children (24%) were living in institutions run by the Church.

Information from the children's questionnaire was obtained for 202 out of 204 children. The average age of children at entry in the institution was 11 years (SD = 4, range 0 to 17 years). The length of stay ranged from 0 to 15 years ($Median$ = 2 years). In regards to schooling, six children (3%) were not attending school, 7 children (3.5%) were in special education programs and another child was attending a preparatory class for immigrants (Table 2).

Table 2
Children's schooling

	Frequency	Percent
Primary school (grade 1-6)	52	25.7
Secondary school (grade 7-9)	72	35.7
High school (grade 10-12)	22	10.9
Vocational training	42	20.8
Special school	7	3.5
Preparatory class	1	.5
Not attending school	6	3.0
Total	202	100.0

Family status – Contact with parents

One in two children came from intact families with both natural parents living together. Parents were separated in 35% of the children while 14% were orphans, having lost one or both parents.

Children's contact with their parents varied, from regular or frequent with both parents (1:2 children or 53%), or with one parent only (29%) to occasional contact (8%) and to no contact at all in the case of 10% of the children in the sample. The latter group of children should be the subject of further investigation as they seem "lost" in the system. Almost all children coming from intact families have regular communication with both parents (94%) while most of the orphans (particularly those with a dead father), also have regular contacts with their surviving parent (64%). Out of the seventy children whose parents do not live together, very few (14%) have regular communication with both of their parents while almost half of them communicate regularly with either their mother or their father.

The association of children's contact with their parents was analyzed in relation to the type of institution to look into differences possibly attributed to factors such as policy of the institution, difficulties in access as well as social and family factors. Although percentages of children frequently communicating with both parents are similar among the three types of institutions, more children in Centers for Child Care compared to the other institutions have regular or frequent contacts with one parent while more children in Children's Towns have only occasional communication (chi-square = 14.908 on 6 *df*, $p = .021$). Although the difference in family status distribution between the different types of institutions does not attain significance (chi-square = 6.515 on 4 *df*, $p = .164$), Centers for Child Care seem to house more orphans and Children's Towns more children whose parents are separated.

Caregiver's perception about children in need for specialist's help

Most of the caregivers who completed the questionnaires and the Achenbach Child Behavior Checklist, were females (67%). The caregiver was female for 88% of girls in the sample, while only for 52% in the case of boys. The difference was statistically significant (chi-square = 31.85, on 1 *df*, $p < .001$), meaning that a bias may have been induced in the results by the fact that caregiver's gender was not balanced between boys and girls.

For 123 children out of the 202 children (61%), the caregivers reported the presence of problems calling for specialist's help. The percentage of children perceived by their caregivers to be in need for help significantly differs between the different types of institutions (chi-square = 10.274 on 2 *df*, $p = .006$). The percentage is higher in Children's Towns (77%) and lower in

institutions run by the Church (44%). The finding is in accordance with the differences in family status and contact with parents found.

Caregivers were further asked about specific areas of problems pertaining to the child as well as to the family and the social situation.

Table 3

Children's problems of different types according to caregiver's perception

	Frequency	Percent
Behavioural	43	21.3
Psychological	38	24.3
Delinquency	49	18.8
At least one of the above	80	39.6
Family	73	36.1
Social	95	47.0
Learning difficulties	58	28.7
Mental problems	7	3.5

It was found (Table 3), that social problems prevail (47%). Mental problems are reported in 3.5% of the children, which in connection with learning difficulties (28.7%), overlap with social problems to a large extent.

Official diagnosis and help offered

Caregivers were asked to report on those children who were officially diagnosed. One in three children (67 out of 202 children or 32%) were reported as officially diagnosed with mental health problems, other than mental retardation.

Table 4

Frequency of each type of problem for the 67 diagnosed children

Type of diagnosed problem	Frequency	Percent
Behavioral	29	43.3
Psychological	27	40.3
Delinquency	20	29.8
Learning	36	53.7
Other	3	4.5

More than one in two children with an official diagnosis were diagnosed as having learning difficulties. Behavioural and psychological problems were also frequent types of diagnoses (Table 4). It should be noted that many of these children (43%), presented more than one type of a diagnosed problem.

As in Greece most Child Guidance Centers offer clinical diagnosis, but fewer offer individual therapy, in 10 cases (15%), no further action was taken, while more than one type of help was offered in 47 cases (70%). Counseling for the Institution was given in almost all of the 57 cases (96%) and individual counseling session/s were also frequent (70%). Pharmaceutical

treatment and family counseling were not frequent (14% and 18%, respectively), while 21% of the cases were referred elsewhere. The finding is quite encouraging, taking into consideration the geographic location of most institutions and the access difficulties encountered.

Prevalence of mental health problems

In this study, 72% of children were in the 12-18 age group, while CBCL standardization data published in Greece are available only for 6-12 year old children. Therefore, Greek cut-off points for defining children in the clinical range were not used. Instead, percentiles for the various CBCL scales were calculated by the 2000 version of ADM (Assessment Data Manager for CBCL/4-18) software, that is, using cut-off points based on the USA community and clinical samples.

The prevalence of scores in the clinical range for the CBCL total problems scale as well as for the two broadband syndrome scales (Internalizing-Externalizing problems) is about two times higher than that of the community sample (Figure 1).

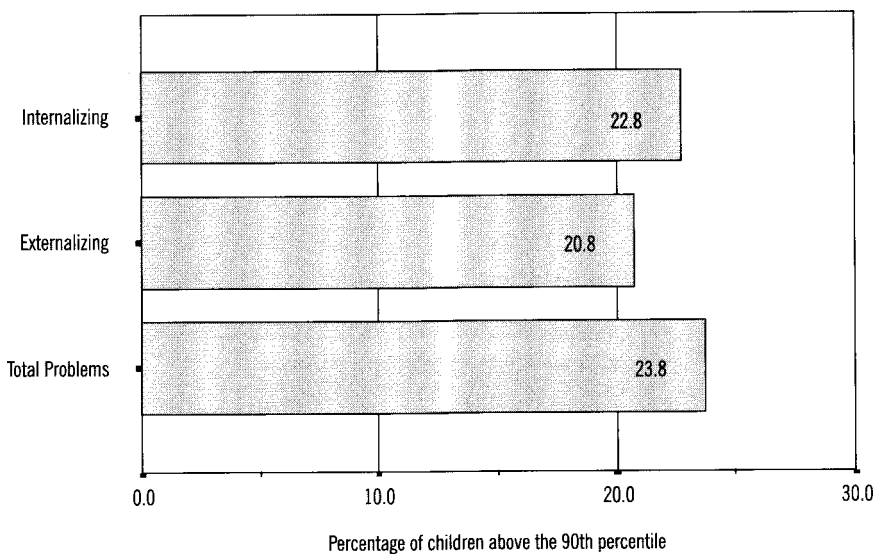

Figure 1
Prevalence (%) of scores in the clinical range on CBCL total scales

Regarding the sensitivity of caregivers in identifying children in the clinical range for CBCL total problems scale, it was found that 77% of these children were reported by their caregivers to need help by a specialist. Caregivers also perceive 56% of children in the non-clinical range as having problems, a fact indicating low specificity of caregivers' perceptions. It should also be noted that only 47% of children in the clinical range were officially diagnosed and 24% were neither officially diagnosed nor identified by the caregiver.

The prevalence of scores in the clinical range, for the CBCL eight narrow-band syndrome scales, was six times higher than that of the community sample for 'withdrawal/depression' and four times higher for 'rule breaking' and 'aggressive behaviour'. It was also more than

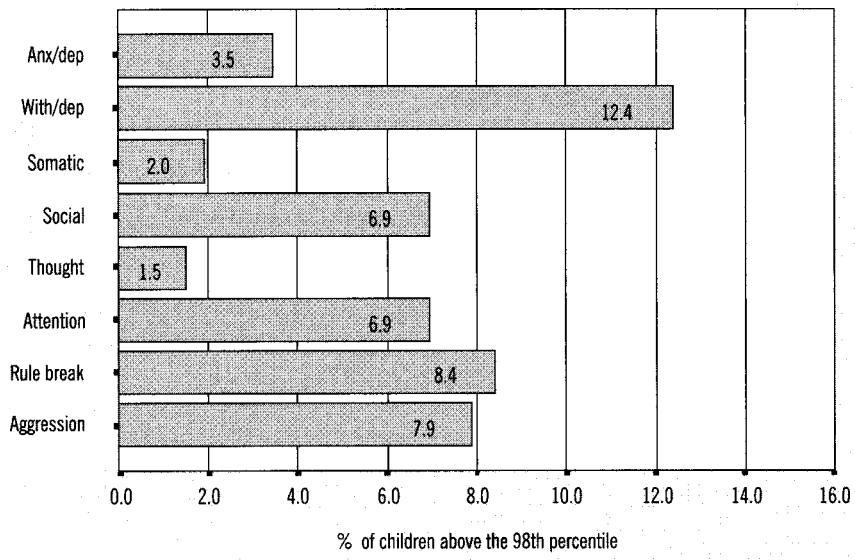

Figure 2
Prevalence (%) of scores in the clinical range on CBCL syndrome scales

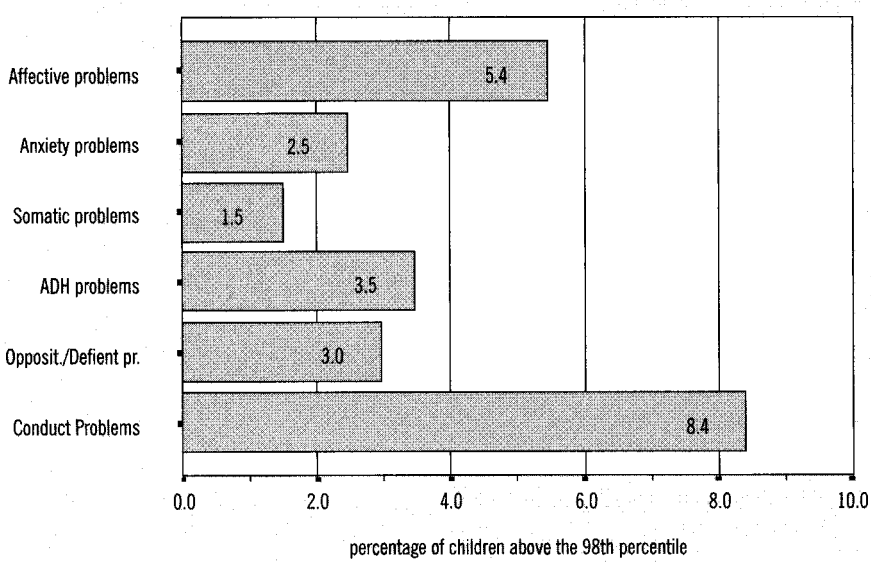

Figure 3
Prevalence (%) of scores in the clinical range on CBCL DSM oriented scales

three times higher for 'social' and ' attention' problems. The most frequent syndrome is that of Withdrawal/Depression (Figure 2).

Regarding DSM-oriented problem scales, conduct problems and affective problems prevail in children under state care (Figure 3).

Based on the clinical range of DSM oriented scales, the general co-morbidity rate, is 5% (or 4%, excluding overlap of OD and Conduct problems) while children scoring in the clinical range of only one of these scales are 11%.
Table 5 shows the prevalence of some CBCL key symptoms.

Table 5
Percentage of children with CBCL key symptoms

	Sometimes or often (%)	Sometimes (%)	Often (%)
Harms self	3.0	2.5	0.5
Hears things	3.5	2.5	1.0
Attacks	31.9	27.4	4.5
Runs away	10.9	8.9	2.0
Sees things	5.0	3.5	1.5
Sets fires	5.5	4.5	1.0
Thinks about suicide	4.0	3.5	0.5
Uses drugs	1.0	1.0	0

Correlates of mental health problems

Differences between boys and girls were found, showing that girls obtained on the average higher scores in CBCL total problems scale as well as in both the Internalizing and the Externalizing problems scale. Similar differences were found for almost all of the narrow-band syndrome scales with the exception of rule breaking where no gender differences were found. Gender differences are in the opposite direction of those known to exist in community samples in Greece and other countries. When gender differences were examined taking into account caregivers' gender, it was found that although female caregivers tend to see more problems than males, the higher scores of girls compared to boys persist even after adjustment for caregivers' gender.
Age was not correlated with CBCL total problems scale (r = -.104, p = .142) or the Internalizing problem scale (r = -.035, p = .619) but it had a small negative correlation with the Externalizing problems scale (r = -.172, p = .015). In fact, among all syndrome scales, only the aggressive behaviour scale was negatively correlated with age (r = -.210, p = .003). Similarly the conduct problems scale and the ADH scale were negatively correlated with age (r = -.212, p = .002 and r = -.197, p = .005).
Association between type of institution and T-scores in the CBCL total problems score was examined. The difference was significant (F = 6.75 on 2 and 199 df, p = .001) and post hoc testing showed that children in Centers for Child Care have on the average significantly lower scores (*Mean* = 51.0, *SD* = 10.6) than children in Children's Towns (*Mean* = 56.9, *SD* = 14.7) or Church Institutions (*Mean* = 57.1, *SD* = 10.5).

Discussion

This project offered a good opportunity to investigate the mental health of children 6 to 18 years living in institutional social care in Greece. Its added value has been twofold; it has allowed for the comparison of research results between two countries, Greece and Belgium (Flanders), with different systems of child protection, while its European perspective enriched the data with policy implications at EU level.

In Greece, few children are in public care, but placements may last long, sometimes throughout a child's life. The predominant child protection scheme is institutional care, while, due to cultural, historical and structural reasons, fostering has not developed adequately. In the last ten years, child protection undergoes re-organization, which seems to be more system oriented than child or family centered. The current de-centralization of welfare services and their merging with the health sector is a challenge entailing, though, serious difficulties and need for adjustments, as issues of adult «voters» may superimpose children's issues. Some of the results confirmed what has been known by clinical and research experience so far, while others have provided new knowledge based on which social policies at national level should be re-oriented.

Following the example of other European countries, the need for traditional institutional care in Greece decreases steadily while the residential tasks are changing. A few children enter care at an early age while most enter at the end of primary school. This may be attributed to the protective function of the Greek family, which, in spite of adversities, can pull in resources from the extended family to care for its young children. In early adolescence, children, are considered old enough to leave home for communal life, as in earlier years, before an extensive road network was built in the country, it was common for children to leave home at age 11-12 years. Institutions functioning as boarding houses or family boarding allowed them to attend high school that was not available in their home village.

Throughout the years, some of the reasons for children's entry into institutional care have been changing; being an "orphan" is not any more the main reason for care entry. In this study, 14% of children have lost one or both parents, while family breakdown and the economic and social consequences may lead to a child's admission into care. Most children come from intact or separated families that have difficulties in coping with life's adversities, of which poverty seems to be the major one. Another observable change is ethnic origin of children in state residential care, whose traditionally homogeneous population is incorporating a rising number of children from families of economic migrants. As regards the duration of children's stay in care, the socio-demographic characteristics of children in this study convey a population that has entered care at the average age of eleven years, living in the institution for two years on average with a prospect of stay up to fifteen years. Due to the limitations of the study, there is no record on prior care experience for these children, some of which may have been under state social care since their early years, while others enter after the end of primary school.

Some characteristics are shared among children in the three institutional groupings while others are differentiated on the basis of factors related to family composition, entry requirements, policies and level of staff training. In regards to schooling, most children are attending regular school in the community while, in spite of a high prevalence of learning difficulties found in the sample; only 3.5% of the children attend a special school. This may depict the absence of special schools in remote areas or small towns where most of the institutions are located, as well as the low expectations of educators in regards to the school performance of children living in care, a practice which reinforces their socially excluded status in the community. The low school drop out rate of 3% reflects the traditional function of Greek institutions offering boarding and education to children from poor families rather than protection from harm or therapy for their problems.

Differences in child-family contact were observed among the three categories of institutions that may be attributed to the recruitment of children from different types of families, the reasons for entry and the policies of the institution. Children in Children's Towns come from more problematic families, present with a high prevalence of behaviour problems that are de-

tected by the community service network of the National Welfare Organization whose staff has a higher level of training and a multidisciplinary composition. This also accounts for the differences observed in caregivers' perception of children in need for specialist help, with a higher percentage found in Children's Towns and a lower in those run by the Church. Of those children diagnosed with a mental health problem, most received some kind of help which was addressed either directly to them or in the form of counseling given to the institutions' staff on the management of the child and his needs. Although in 15% of the cases no action was taken in spite of the diagnosis of problems, the staff's mobilization to seek help for the child and the response of the service sector are quite encouraging.

The results of the CBCL depict that children in the 6 to 18 years age group living in institutional care in Greece, are two times more likely to score in the clinical range of the total problem scale as well as the two broadband syndrome scales. Regarding the eight narrow-band syndrome scales, children are more likely to score high on 'withdrawal/depression', on 'rule breaking' and 'aggressive behaviour' as well as on 'social' and 'attention' problems scales. It should be noted that, in view of the fact that scores on both Internalizing and Externalizing problems as well as Anxiety/Depression, Attention problems, Rule Breaking and Aggressive behaviour were found higher in Greece compared to USA community samples aged 6-12 years (Roussou et al., 2002), the prevalence of these problems among children in the present study may be somewhat overestimated for Greek standards. Nevertheless, one of the major findings of this study concerns the prevalence rate of Withdrawal/Depression that is six times higher than the corresponding rate for this age range in the general population. This rate is similar to that in the Belgian study (Grietens & Hellinckx, 2003), in spite of the fact that children in institutional care in Greece present with a much lower overall prevalence of mental health problems. These findings support those of other studies in Greece (Vorria, 1991; Vorria et al., 1998a; Vorria, 2003), which have suggested that a major characteristic of children living in institutional social care in Greece is their withdrawn behaviour. This finding was associated with their stigmatization by other children in the school, by school parents and by some educators.

Of those children with CBCL scores in the clinical range, 53% did not have an official diagnosis in their records and as a result they received no help. It should be noted that of the children classified by the CBCL to be in the clinical range, one in four are not perceived by their caregivers as having any kind of problem nor have they ever been diagnosed as such. These findings suggest two changes in policies; firstly, that existing care-giving staff are given more training so that they would be alerted by children's symptoms and overall behaviour and secondly, that professional staff such as social workers, psychologists and pedagogues be added to the system.

The DSM-oriented scales, suggest that, in the present study, most children with mental health problems have either conduct problems or affective disorders.

The most frequent symptom among the CBCL key symptoms is 'physically attacks others', 32% of the children having been described as showing this symptom at least "sometimes" and 4.5% "often". These rates are similar to those observed in Flanders in the Belgian study, while inter-country differences exist in the other key symptoms. In the light of the much lower overall prevalence rate of mental health problems in the Greek study, compared to that in Flanders, this finding needs further investigation.

The child's gender was found to be associated with the presence of mental health problems, girls obtaining on the average higher scores on the CBCL total problem scale as well as on both the Internalizing and Externalizing problems scales, even after adjustment for caregiver's gender. The finding may mean that institutional care in Greece has more adverse effects in girls, particularly if they are in their adolescence. Such an interpretation takes into account the fact that very few institutions house both girls and boys and also the different operation of institutions for separate sexes. Another reason may be that, in view of the well documented fact that more boys than girls are in residential care, girls that end up in institutions have more problems than boys.

Differences were also found among the types of institutions and children's mental health problems. Children in Children's Towns were more likely to have mental health problems followed by those in Child Care Centres and Church institutions. These seem to be associated with historical reasons which have determined the structure of each scheme, the population to which it is addressed and its recruitment policy, entry requirements, staff training, but mostly the overall ethos pertaining in the institution in conjunction with the personality of the director (Panopoulou-Maratos et al., 1988).

Most studies bear with limitations that need to be addressed. In this study, the limitations are associated with:

a) The use of American CBCL norms, since Greek standardization data were not available.
b) Lack of information on the child's previous history and possible traumatic life events as well as on the child's care trajectory.
c) The collection of information by only one caregiver. Although he/she was the one who knew the child best, crosschecking would have further validated the data.

Conclusions

Children's rights are nowadays an issue of public debate. Since the signing and endorsing of the Convention on the Rights of the Child (1989), all countries have incorporated its content into national law. The application of the CRC in everyday practice is the responsibility of the state in its role to safeguard and to promote the rights of all children. This role assumes great importance in the case of socially excluded children among which children living in care comprise a significant population. It is, therefore, of priority to consider the results of this study within a child rights perspective.

Children living in state social care in Greece do not enjoy equal rights with other children growing up in their families, while differences in the exercise of their rights exist among those in care, depending on characteristics of the judicial and child protection systems, the policies and "ethos" of each institutional scheme as well as "chance" factors in the absence of official guidelines for practice of institutional care for children. For example, the exercise of the rights of boys and girls living in institutional social care under the authority of the Greek state or the church, may depend upon the following: a) the venue of their original referral for care entry, b) their family's familiarity with and access to the appropriate service or personal contacts through the unofficial social networks, c) a prosecutor's or court's decision in the absence of Family Court, d) a social worker's own judgment in the absence of multidisciplinary child protection teams, e) geographical access, and f) adequacy of staff as well as staff's level of training which enables them to be alerted early enough about children's problems so that help is with their own perceptions. The underreporting of children's problems was found to be associated with caregivers' perceptions on the existence of problems. This may be also associated with the low expectations from children's behaviour and overall achievement level that contribute to a low threshold.

The implications of such studies are important at both practice and policy levels. The findings of the Greek study suggest that a re-orientation in practice is needed so that social care institutions address the real needs of children, within a changing society invoking new phenomena affecting the family. The changing residential task as a result of these changes, requires a multidisciplinary approach, with more professional staff on site, a higher caregiver: child ratio, within a shift from long-term social care to short-term therapeutic care. Children's emotional and behavioural problems are frequently their reactions to difficulties and "risks". Changes at practice level should reduce the difficulties and risks associated with factors related to the institution as a system. Guidelines for practice need to be issued by the Ministry of Health and Welfare so that all children entering care enjoy equal opportunities and equal rights to mental health, to non-discrimination, to equal opportunities and to treatment and rehabilitation. Staff

recruitment needs to be re-appraised, by shifting from civil service status and life long tenure to contracts on the basis of qualifications and evaluation. At organizational level, inspections need to be carried out periodically to cover primarily quality measures related to children and their rights in care and not only financial and administrative matters. Staff needs care themselves. The staff's fear of change and resentment to evolution and innovation reflect not only the lack of training but also of empowerment.

Lastly, the chasm between medical and social welfare language and conceptualization should be addressed, as it often leads to gaps in communication and understanding between mental health and child protection professionals, affecting the decision making process and the rights of children for a comprehensive evaluation of their situation and the taking of all appropriate measures safeguarding their best interest.

A number of fundamental changes are needed at policy level, of which the major one is ideological; namely, the prioritization of the needs of children in social care to those of the system. The decrease in demand for traditional social care should not be interpreted as a sign of the family's strength to cope with adversities but rather as new demands requiring alternative care schemes. Although fostering bears a long history in Greece since the late 1920's and in spite of a recent law establishing fostering as a child protection scheme, a limited number of foster parents are available. The reasons are associated with the cultural value on the family and the stigma felt by families whose children need protection and care away from their birth families. This leads natural parents to relinquish their children to institutional care in knowledge of the adversarial effects on the child, while resenting the "parenting" of their child by others. The impersonality and rigidity of the "state as a parent" seems less threatening to that of strange to them "good-enough" parents. A parent participation philosophy and practice in child welfare and protection would contribute to the surpassing of these cultural boundaries and human resistances. The increase of foster care allowances, the professionalization of the scheme within cultural awareness and sensitivity, the recruitment of foster parents from all social classes and the promotion of fostering through public awareness campaigns, are measures that need to be taken at policy level, to buffer the entry of children into institutions by providing alternative family care and family support. Financial assistance to poor families should be encouraged to act as another buffer to care entry. Poverty should not any more be the reason for separating children from their families for long periods of time. This is more pertinent in the light of research findings since the 1980's until today, depicting the negative effects of institutional upbringing on children's mental health and overall functioning. Issues of abuse and neglect should be openly discussed in child protection work. The stigma attached to failure in parenting in conjunction with the realization that diagnosis is of no use, while often proves negative if no therapy is provided, has led professionals to under-diagnose. Improvements at policy level will certainly help in this domain.

This study on the mental health of children in institutional social care in Greece, offered a wealth of empirical data related not only to the mental health of children of the sample but to the characteristics of caregivers and of institutions and their function as systems. The comparison of children's mental health status between the Greek and the Belgian studies identified a significant difference in prevalence rates, with rates in the Flemish sample three to five time higher. These findings are attributed to historical reasons, to cultural differences in regards to family composition and the support of unofficial social networks, the nature of institutional social care and the priority attributed to child protection in each country.

Collaborative studies at European level are building conscience and are fortifying knowledge among professionals, which are much needed elements in the fight against social exclusion within the EU.

References

ACHENBACH, T.M., & EDELBROCK, C. (1983). *Manual for the Child Behavior Checklist and Revised Child Behavior Profile*. Burlington: University of Vermont, Department of Psychiatry.

AGATHONOS, H. (1983). Institutional child abuse in Greece: Some preliminary findings. *Child Abuse and Neglect*, 7, 71-74.

AGATHONOS-GEORGOPOULOU, H. (1991). The state as a parent. Crises and innovations in residential care for abused and neglected children in Greece. In W. HELLINCKX, E. BROEKAERT, A. VANDEN BERGE, & M. COLTON (Eds.), *Innovations in Residential Care* (pp. 71-78). Leuven/ Amersfoort: Acco.

AGATHONOS-GEORGOPOULOU, H. (1993). Greece. In M.J. COLTON, & W. HELLINCKX (Eds.), *Child Care in the EC – A country-specific guide to foster and residential care* (pp. 96-117). Ashgate: Arena.

AGATHONOS-GEORGOPOULOU, H. (1995). *A comparison of child abusing and non-abusing families in Greece: Identification of predictive characteristics for screening and intervention*. PhD Thesis, University of Birmingham.

AGATHONOS-GEORGOPOULOU, H. (1997). Child abuse and neglect in Greece: A review of research. *Child Abuse and Neglect*, 6, 257-271.

AGATHONOS-GEORGOPOULOU, H. (2003). Child maltreatment in socio-cultural context: From a syndrome to the Convention on the Rights of the Child. *International Journal of Child and Family Welfare*, 6, 18-26.

Convention on the Rights of the Child (1989). New York: United Nations.

GRIETENS, H., & HELLINCKX, W. (2003). Mental health problems in 6 to 18 year-old children in residential care in Flanders (Belgium): A prevalence study. Paper presented at the Conference on The mental health of children in state care: European perspectives, London, 19-20 September.

MADIANOS, M.G., TSIANTIS, J., & ZACHARIAS, C. (1999). Changing patterns of mental health care in Greece (1984-1996). *European Psychiatry*, 14, 462-467.

MOTTI-STEFANIDI, F., RICHARDSON, C., & TSIANTIS, J. (1993a). Epidemiology of behavioural and emotional problems of primary schoolchildren in Greece. *European Journal of Child and Adolescent Psychiatry*, *2*, 111-118.

MOTTI-STEFANIDI, F., RICHARDSON, C., & TSIANTIS, J. (1993b). The relationship between parental child rearing practices and various psychosocial factors. *Eklogi*, July-August-September, 159-169 (in Greek).

PANOPOULOU-MARATOS, O., STANGOU, L., GEORGAS, D., LAMBIDI, A., & DOXIADIS, S. (1988). Schemes of residential care for children in Greece. Institutional function and its effects on children's mental health. In T. CALLINICAKI (Ed.), *Growing up in residential care*. Athens, Hellenic Society for Mental Health and Child Neuropsychiatry (in Greek).

PAPATHEOPHILOU, R., SOKOU-BADA, K., MICHELOGIANNIS, J., & PANTELAKIS, S. (1988). School performance, social, psychological and physical parameters; psychiatric disturbance and school achievement. *Psychologica Themata, 1*, 211-229 (in Greek).

PARASKEVOPOULOS, J.N., & LEOUSSI, C. (1970). Diagnosis of problematic behavior in children. *School Hygiene*, 31, 3-8 (in Greek).

PARITSIS, N., LAMBIDI, A., TODOULOU, M., & DEDOULI, M. (1989). Reducing behavioural problems in residential care: An experiment based on system's approach. Paper presented at the First European Conference on Residential Care, De Haan, Belgium.

REMSBERY, N. (2003). *Education of Children in Public Care – European perspectives*. Report, National Children's Bureau, London.

ROUSSOU, A., KIPRIANOS, S., KARAGIANNIS, D., KARADANOS, G., LAZARATOU, E., MAHERA, D., ZOUBOU, B., TASSI, M., RICHARDSON, C., & HARTMAN, K. (2002). Standardization of the Achenbach questionnaire for parents (CBCL) in a representative sample of school children ages 6-12 years: Comparison of a community with a clinical sample. In A. ROUSSOU (Ed.), *Issues of Psychometrics in Clinical Practice and Research*, Ellinika Grammata, Athens (in Greek).

RUTTER, M. (1967). A Children's Behaviour Questionnaire for completion by teachers: Preliminary findings. *Journal of Child Psychology and Psychiatry*, 8, 1-11.
STAVRIANAKI, M. (1996). The experience of an intervention for the reorganization of a residential care institution for children. *Koinoniki Ergasia*, 44, 265-273 (in Greek).
TSIANTIS, J. (1997). The psychiatric reform of mental health services for children in Greece: A concise view. *Tetradia Psychiatrikis*, 57, 72-76 (in Greek).
VASSILIAS, A. (1995). Centre for Child Care for Boys, Lamia, 1991-1993. Unpublished Report to the Ministry of Health and Social Services (in Greek).
VASSILIAS, A., GEORGOUDI, N., & STAVRIANAKI, M. (1996). Thesmos-Idrima-Idrimatismos. *Tetradia Psychiatrikis*, 54, 39-50 (in Greek).
VORRIA, P. (1988). The effect of long-term institutionalization on children's social behaviour. In *Growing up in an institution*. Greek Society of Mental Hygiene and Child Neuropsychiatry, Athens (in Greek).
VORRIA, P. (1991). *Children growing up in Greek institutions: Their behaviour and relationships at school and in the institution*. Unpublished PhD Thesis. University of London.
VORRIA, P., PAPALIGOURA, Z., DUNN, J., VAN IJZENDOORN, M., STEELE, H., KONTOPOULOU, A., & SARAFIDOU, J. (2003). Early experiences and attachment relationships of Greek infants raised in residential group care. *Journal of Child Psychology and Psychiatry*, 44, 1208-1220.
VORRIA, P. (1995). The changing social profile of mothers whose children are admitted into institutional care in Greece. *Scandinavian Journal of Social Welfare*, 4, 36-43.
VORRIA, P. (1998). Behaviour problems of adolescents with long-term experiences in an institution: A follow-up study. *Psychology*, 5, 213-223 (in Greek).
VORRIA, P., RUTTER, M., PICKLES, A., WOLKIND, S., & HOBSBAUM, A. (1998a). A comparative study of Greek children in long-term residential group care and in two-parent families: I. Social, emotional and behavioural differences. *Journal of Child Psychology and Psychiatry, 39*, 225-236.
VORRIA, P. (2003). *Attachment and children in state care*. Paper presented at the Conference on The mental health of children in state care: European perspectives, London, 19-20 September.

Authors notes

Helen Agathonos-Georgopoulou, PhD
3 Pandoras, Ekali
Athens 145 78
Greece
agathonos@hotmail.com

Jasmina Sarafidou, PhD
Institute of Child Health
7 Fokidos Street
11526 Athens
Greece

Metaxia Stavrianaki, PhD
Institute of Child Health
7 Fokidos Street
11526 Athens
Greece