Association between Demographic Profile and Mental Health Needs of Children in Statutory Institutions of Care and Protection in Nairobi County, Kenya

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Abstract

Children bring into the justice system their past and current experiences both positive and negative. Despite this, studies show that child justice systems have limited mechanisms for screening and assessment of their psychosocial needs. This lack of internal audit mechanisms by agencies can contribute to worsening of the young person's mental status. This study screened children in need of care and protection residing in child protection units, remand homes and rescue centres in Nairobi County. Participants constituted 32 female and nine (9) male children recruited from these institutions. The Kiswahili version of strengths and difficulties questionnaire was used to determine their psychosocial needs. A brief questionnaire was developed for use in identifying their social and demographic profiles. The results showed that 64.41 % of respondents had prior contacts with the child protection system. The children had high scores in emotional (M=5.41, SD=1.78) and peer problems (M=3.24, SD=1.97). The study found an association between the nature of the statutory institution the child was residing and hyperactivity problems (p=.0.034), ethnicity and conduct problems (0.009), and between family type and prosocial behaviors (p=0.001). The study findings point to the need for in depth assessments for all children entering statutory institutions and development of evidence-based treatment programs to address their psychosocial wellbeing.

Key words: Mental health needs, Statutory institutions, Care, Protection, Strengths and difficulties questionnaire

Introduction

The Children Act 2022 defines a child in need of care and protection as one who lives in difficult circumstances and needs to be protected from all kinds of neglect, abuse or exploitation. Child abuse and neglect is a problem that affects children globally (Kobulsky et al., 2020). United Nations International Children's Emergency Fund (UNICEF) (2019) estimates that over 1 billion children worldwide experience abuse annually. It is widely acknowledged that these children have experienced psychological, emotional and social challenges (Hovey et al., 2017; Tolou-Shams et al., 2022). In the United States of America as at June 2022, there were approximately 391,098 children and youth in need of care and protection placed within the foster care system (US department of Human Services (2023). Most are rescued from abusive situations, poor parenting, and neglect hence mental and behaviors needs from the largest percentage of their health needs (American Academy of Pediatrics, 2021; Font & Gershoff, 2020; Kim et al., 2021; Suh et al., 2020). In Singapore, children and young people in out of home care have gone through adverse experiences and have been reported to have symptoms of post-traumatic stress disorders, depression, anxiety, and conduct problems (Peh et al., 2022).

Like most countries, Australia has its own share of children in need of care and protection

who present with varied mental health needs. In 2008, Osborn, Delfabbro and Barber studied the psychosocial functioning and underlying needs of 364 children in foster care in Australia. The findings were that most children had histories of domestic violence, physical abuse, parental substance abuse, sexual abuse and neglect. A national survey of the health needs of young people in custody by the government of North Southern Wales found out that 48% had been exposed to trauma, 17% had intellectual disabilities. Another 28% had gone through severe abuse and neglect. The children also had pre-existing physical illness and previous contacts with the law. They had been diagnosed with disorders such as traumatic brain injury, intellectual disabilities, autism spectrum disorders, foetal alcohol syndrome, among others (Cunneen et al., 2016).

Regionally many African countries grapple with large numbers of children institutionalized due to poverty, orphanhood, HIV/AIDS and other adversities (Desmond et al., 2020). In Rwanda for example, though foster and kinship care homes are common, there are children who end up in institutions. Studies in the Rwandan context show that these children have showed symptoms of depression, anxiety and irritability compared to their peers (Binagwaho et al., 2021; Nduwimana et al., 2017)

In Kenya, a 2019 survey on violence against children found that 45.9% females and 56.1% males aged 18-24 reported childhood violence. In the same survey, females who experienced childhood violence were more likely to experience mental problems in including suicidal ideation. National data from the 2022 economic survey revealed that between 2017-2021, 191,766 cases of children in need of care and protection had been reported to the directorate of children services.

Kenya is state party to the universally ratified United Nations convention on the rights of the child (UNCRC). Article 19 the UNCRC stipulates that state parties put in place measures to protect children from all forms of abuse including mental violence. One of the safeguards is placement in institutions for temporary care until an alternative placement with safe caregivers is found. The children Act 2022, has established three categories of places of safety. Charitable children institutions which managed by the non-state actors, statutory children's institutions which are under the jurisdiction of the Directorate of Children Services (rescue centers, remand homes) and child protection units are managed by National Police Service to serve as temporary non-threatening accommodations.

Statutory institutions in Kenya provide shelter, safety and basic needs. Conversely, provision of mental health services is said to be a challenge in many welfare serving systems (Neely-Barnes & Whitted, 2011). This shortfall can potentially make the justice system blind to the mental health needs of children and result in a child being placed in the wrong institution. Unidentified and unmet mental health needs can lead to emotional and behavioral problems and welfare seeking children crossing over to the juvenile justice system as a result of delinquent behaviour (Coggnis et al., 2021; Jäggi, et al., 2021). On the other hand, early identification ensures that children are connected with appropriate mental health services for continuum of care (Lehmann, 2018).

In order to increase the accuracy of detecting mental health needs, sociodemographic factors should be taken into consideration. In this study, sociodemographic factors were personal and family features that were common among the respondents and which have a bearing on their mental health needs. For example, ethnic and cultural issues are identified as influencing societal attitudes towards mental health and access to treatment (Shim & Compton, 2020). Gender and age are reported to be mediating variables as studies have demonstrated that boys

and girls have different needs (Martin & Hadwin, 2022). Research has shown that prior contact with the welfare system increases with age (Simmel, 2011) and dropping out of school is a risk factor for mental problems and contact with the justice system (Ramdsal et al., 2018). The purpose of this study was to determine the association between the demographic factors and mental health needs of children.

Methodology

To measure the mental health needs of children in statutory institutions, the study used the strengths and difficulties questionnaire (SDQ). The SDQ was developed by Robert Goodman (1997) and is an instrument that screens the psychological and social functioning of children and adolescents by pinpointing the difficulties and strengths in 5 domains namely; emotional symptoms, hyperactivity, conduct problems, peer problems, and a prosocial scale. The last part of the instrument is an impact supplement and is intended to find out the level of distress that the child is experiencing as a result of the difficulties as well as the level of impairment in emotional, concentration, behavioral and/or peer relationship aspects. Impact scores in these domains are computed to make an overall impact score, which ranges from 0 to 10. A total difficulties score is generated from the sum of the four sub-scales except prosocial behaviours which are reverse scored (Hall et al., 2019).

The SDQ is used with children aged 2-17 years (Collins & Grisso, 2019). The tool groups children into 3 age categories. There is a version for 2-4 year old's which can be filled by the parent or teacher, a version for those aged 4-17 years and a self-report version for 11-17 year old's. On each item, the child is required to indicate their degree of agreement with a statement on a three point scale, 0= not true, 1=somewhat true, 2=certainly true (Collins et al, 2015; Essex, 2019). Cutoff scores are banded into four levels and each given threshold. The SDQ scales and scoring format are demonstrated in Table 1.

Table 1. SDQ Scales and Scoring Profile

SDQ scores	Close to average	Slightly raised/slightly lowered	High/Low	Very High/Very Low
Total difficulties score	0-14	15-17	18-19	20-40
Emotional symptoms score	0-4	5	6	7-10
Conduct problems	0-3	4	5	6-10
Hyperactivity score	0-5	6	7	8-10
Peer problems score	0-2	3	4	5-10
Prosocial score	7-10	6	5	0-4
Impact score	0	1	2	3-10

Note: The prosocial scale is reverse scored

The Validity and reliability of SDQ as a screening tool for psychosocial needs has been established through various studies (Collins et al, 2015; Essex, 2019). Goodman set the Cronbach' s α coefficients for the scales at mean 0.73 and total difficulties score at 0.80. Retest validity for teacher report version was 0.73 and self -report 0.62. Baviskar et al. (2020) found an inter-correlation of 0.69 between all scales except conduct disorder which was 0.60. Test and retest reliability Pearson's correlations ranges from 0.72 to 0.81. Composite reliability of the five subscales among females ranges from 0.64–0.85 and 0.62– 0.86

(Baviskar et al., 2020). Although it has been used with various populations of children, the tool has limitations including inability to identify some disorders such as trauma, and also intellectual disabilities in children (Bryant et al., 2020). The SDQ emotional subscale may have some weaknesses in terms of its ability to detect specific disorders that are not the focus of the measure's attention such as specific phobias, panic disorders, separation anxiety, and eating disorders (Goodman et al., 2000).

This study used the 11-17 year's self-rating version of SDQ. The teacher version could not be used because during the piloting phase, the staff of the rescue centers, were unable to provide adequate/ reliable information for every child respondent since most had only been resident in the institutions for very short periods of time. The parent version could not be used because the parents were not available, traceable, and some were the perpetrators of abuse therefore could not participate in the study. There was no need to translate SDQ into Kiswahili as there was a Kiswahili version available. The Kiswahili version was found suitable as it was amenable to the reading abilities of most children in need of care and protection.

A separate questionnaire was developed to collect socio-demographic data. The questionnaire contained 10 items which included age, gender, ethnicity, parents' marital status, prior contact with the system, education status, sibling status and institution. Information regarding the reasons for being in need of care and protection was accessed from the respondents' files.

The study was carried out in Nairobi City County in Kenya. Nairobi County has one of the only two model children courts in Kenya. It is also the county with the largest number of statutory institutions that admit children in need of care and protection. The children were residing in child protection units, rescue centres, remand homes. Stratified sampling was used to create three strata for each of the three categories of statutory institutions. The study was conducted at the height of the Covid pandemic hence most institutions were reintegrating children back to the community. At the time of collecting the data there was a total of 53 children in the three statutory institutions. Since this was a small number, the researcher opted to use the census method. However, some children declined to participate. By the end of the data collection exercise, 41 children had been screened using SDQ.

The selected children were invited to sit in a pre-arranged hall where administration of SDQ took place. The tool and its purpose was explained to them in a language they could understand and they were allowed the opportunity to ask questions. The authors provided pencils, erasers and with the help of research assistants, questionnaires were administered to those children not able to read or write guiding and making the necessary clarifications.

Once the SDQ self-report version and the socio-demographic questionnaire were completed, each questionnaire was checked for errors. The clean questionnaires were entered into SPPSS version 29.0. Some variables such as age and ethnicity were collapsed into categories for ease of analysis. The SDQ scoring and interpretation instructions (seeTable 1) were used to compute SDQ profiles "Close to average", "slightly raised/slightly lowered" ," high/low" , "very high/ very low". Descriptive statics were used to compute mean scores. Chi-square test was used to determine the association between the social demographics and psychosocial needs.

The Study Results

Table 2. Socio-demographic Characteristics of Children in Need of Care and Protection

Socio-demographic characteristic	*f*	*%*
Age		
11-13 years	22	53.7
14-15 years	10	24.4
16-17 years	9	22.0
Sex		
Male	9	22
Female	32	78
Child's Family type (Marital status of parents)		
Married	16	39.0
Separated	13	31.7
Single	5	12.2
Both parents Deceased	4	9.8
Parents Unknown	3	7.3
Number of siblings		
1-3 siblings	21	51.2
4-6 siblings	17	41.5
7-9 siblings	3	7.3
Sibling position		
First born	12	29.3
Middle child	20	48.8
Last born	8	19.5
Only child	1	2.4

The mean age for children in need of care and protection was 13.5 years. Although most of the agencies handled cases of both boys and girls, female children were the highest number (78.0%), while males constituted (22%). The respondents came from different family types. Those from families with both parents were 39%. Those from separated or divorced families were 31.7%. Respondents from single parent families made up 12.2% of the total population. Orphaned children were 9.8%. Another 7.3% of children were those whose parents were unknown or could not be traced. In terms of siblings, the biggest population was respondents with 1-3 siblings. Middle born children were the most represented in this study as they constituted 48.8%.The education status ranged from grade 1 secondary school with majority of the children being in grade 3-4 (31.7%), followed by grades 5-6 (24.4%). Those in form one and two made up 17.1 %, while form three students were 4.9%. Children placed in vocational trainings were 9.8%, grades seven and eight 7.3%.

The children were at the time of the study admitted to various statutory institutions. This was also were they were screened using SDQ. Table 3 shows the sample distribution across the three categories of institutions.

Table 3. Distribution of Respondents across Statutory Institutions

Statutory institutions	Frequency	Percent
Remand homes	3	7.3
Rescue centers	33	80.5
Police stations (Child Protection Unit)	5	12.2
Total	41	100.0

Most respondents were placed in rescue centres (80.5%). Five children (12.2%) were screened at two different child protection units in police stations. The children had been resident in the child protection units for a period ranging between two days to one week. The least number of children were those in remand homes (7.3%).

The children were in contact with the justice system for abuse and neglect. The specific reason for seeking care and protection are illustrated in Figure 1.

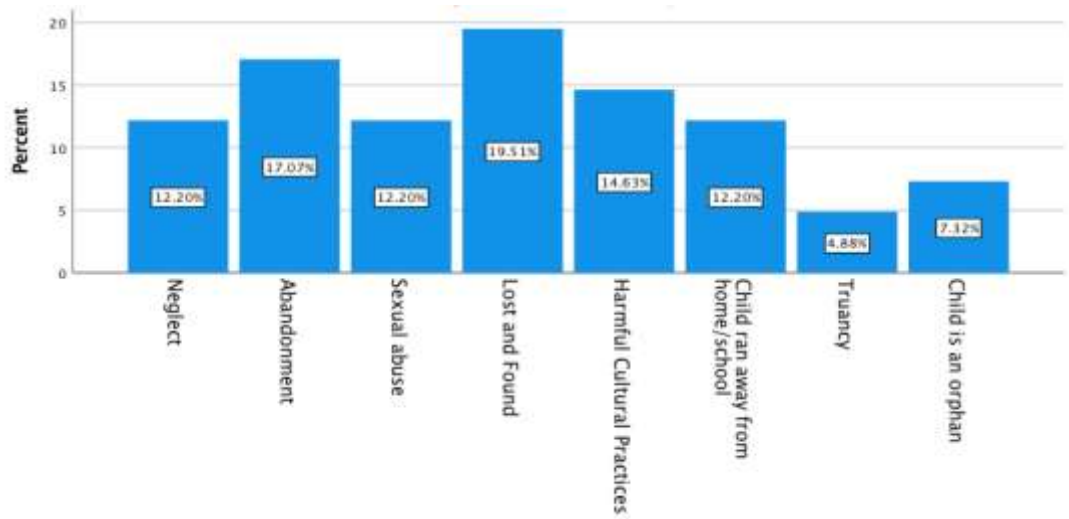

Figure 1. Reasons for Being in Need of Care and Protection

As shown in Figure 1, most of the respondents were "lost and found" children (19.51%). Some had been found by good Samaritans and taken to police stations or remand homes and committed to rescue centres. Another 17.07% had been abandoned by their parents or caregivers. There were those who were in the system as a result of having been sexually abused (12.20%). Those who had run away from home constituted 12.20% of the total population. Children rescued from harmful cultural and religious practices such as female genital mutilation, cultism, and child marriage made up 14.6%. Orphans were 7.3%, and truancy accounted for (4.88%) of the children.

The study sought to establish the contact history of the respondents. Figure 2, shows an analysis of their responses.

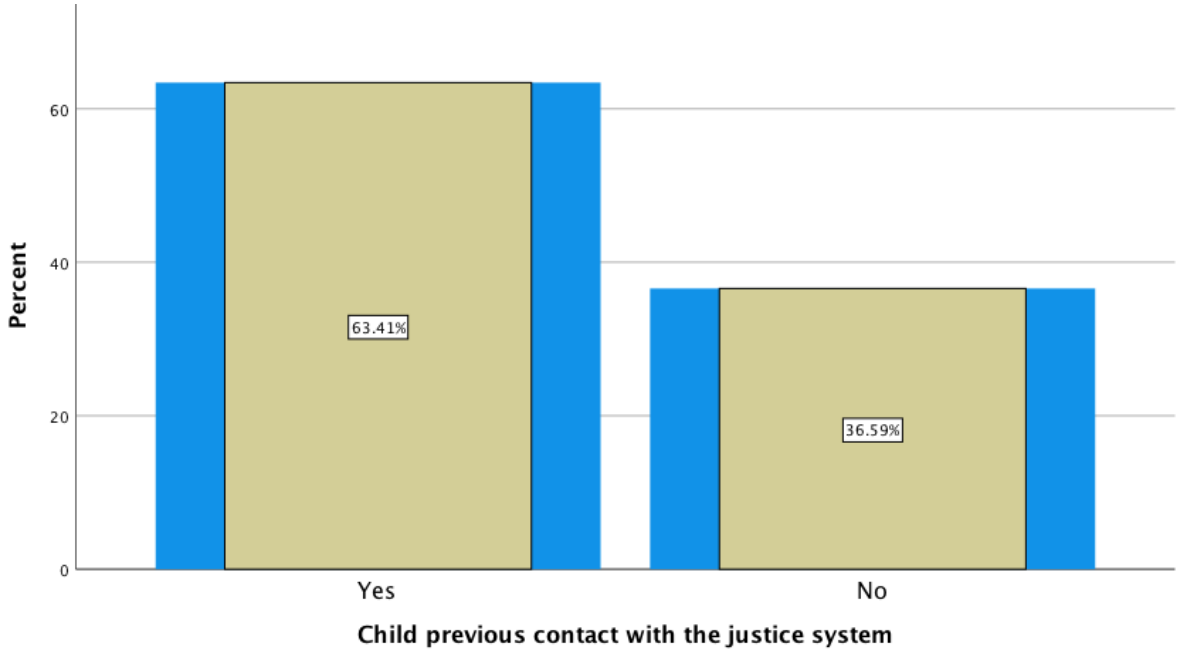

Figure 2. Previous Contact with the Child Justice System

Majority of the children had previous contacts (63.61%) with the Kenyan justice system. These contacts ranged from having been at the police station, diverted and repatriated or taken to court for protection orders. For all the children, the previous contact involved welfare related issues. Those passing through the justice system for the first time were 36.59% of the population.

Table 4. Mean scores and Standard Deviation on SDQ cutoffs

SDQ scales n (41)		SDQ Cutoffs		
	Close to average	Slightly raised/slightly lowered	High/Low	Very high/very low
Emotional symptoms	-	5.41(1.78)	-	-
Conduct problems	3.29 (2.10)	-	-	-
Hyperactivity disorders	2.88 (2.14)	-	-	-
Peer problems		3.24 (1.97)	-	-
*Prosocial behaviors	8.34 (3.70)	-	-	-
Total difficulties	14.83 (5.53)	-	-	-

As reported in Table 4, the population of children with emotional problems as indicated by a mean score of 5.41 and a standard deviation of 1.78 fell under the "slightly raised" indicating a clinical presence of emotional difficulties. Conduct problems which yielded (*M* =3.29, *SD*= 2.10) were banded under "close to average" revealing that most children did not have conduct problems. The mean scores for peer problems was (*M*=3.24, *SD* = 1.98) a score that was "slightly raised" hence a reflection of clinically significant peer problems. The mean score for

hyperactivity scale was (*M*= 2.88, *SD* =2.14). This score was within the 'close to average' band and meant that hyperactivity disorders in children in need of care and protection was not a significant problem. Most children scored close to average in prosocial skills (*M* = 8.34, *SD* =3.70). The total difficulties score was (M =14.83, SD =5.53) within the average range but almost near the 'slightly raised' threshold, an indication of the need for continued close monitoring. Overall, there were no children with very high or very low scores in all the scales.

Table 5 reports the distribution of SDQ cutoff scores for all the respondents across the four bands.

Table 5. **Distribution of SDQ Scales According to Cutoff scores**

SDQ scores	SDQ Scores Cut-offs			
	Close to average	Slightly raised/slightly lowered	High/Low	Very high/very low
Emotional symptoms	14 (34.1%)	5 (12.2%)	10 (24.4%)	12 (29.3%)
Conduct problems	25 (61.0%	4 (9.8%)	7 (17.1%)	5 (12.2%)
Hyperactivity disorders	36 (87.8%)	3 (7.3%)	1 (2.4%0	1(2.4%)
Peer problems	13 (31.7%	10 (24.4%)	6 (14.6%)	12 (29.3%
*Prosocial behaviors	31 (75.6%)	3 (7.3%)	2 (4.9%)	4 (9.8%)
Total difficulties	18 (43.9%)	9 (22.0%)	5 (12.2%)	9 (22.0%)

Note: Scores classified as slightly lowered, low & very low are only for prosocial behaviors

As portrayed in table 5, for emotional symptoms, most respondents (34%) were within close to average cut-off while 29% and 24% had ' high' and 'high' levels of emotional disturbance respectively. Among all children in need of care and protection, 61% fell under the close to average threshold for conduct problems, 17% scored "high" in conduct problems and 12.2 % were in the "very high" band for conduct problems. Hyperactivity disorders had 87.8% at close to average. Respondents with high scores in peer problems constituted 29.3%. Children endorsing prosocial behaviors formed the majority (75.6%) falling within the close to average threshold. Only about 21% of the respondents had lowered prosocial skills. Total difficulty score was within the average range at 43.9%. However, 54.2% of the children had their total difficult score falling between slightly raised and very high.

The association between socio-demographic profiles and mental health needs was measured by computation of Pearson's chi-square test of association. The results are illustrated in tables 6-11.

Table 6. **Association between family type and prosocial behaviors**

Family type	Very low *n*= 4	Low *n*=2	Slightly lowered *n*=3	Close to average *n*=31	X^2	*df*	*p*-value
Both parents deceased	1 (25%)	1 (50%)	1 (33%)	1 (3.2%)	28.7	12	0.001
Married	0 (0%)	0 (0%)	0 (0%)	15 (48%)			
Parents Unknown	0 (0%)	1 (50%)	0 (0%)	2 (6.5%)			
Separated	3 (75%)	0 (0%)	0 (0%)	10 (32%)			
Single parent	0 (0%)	0 (0%)	2 (67%)	3 (9.7%)			

According to Table 6, 75% of children in separated families had very low prosocial skills while orphaned children and those whose parents were untraceable were 50% respectively. Chi-square test revealed a statistical significance between prosocial behaviors and child's family type (p=0.001).

Table 7. Association between family type and total difficulties score

Family type	Close to Average, *n* = 18	Slightly raised, *n* = 9	High, N *n*= 5	Very high, *n* = 9	X^2	d.f	*p*-value
					19.5	12	0.044
Both parents deceased	1 (5.6%)	0 (0%)	2 (40%)	1 (11%)			
Married	7 (39%)	2 (22%)	0 (0%)	7 (78%)			
Parents Unknown	2 (11%)	1 (11%)	0 (0%)	0 (0%)			
Separated	6 (33%)	4 (44%)	3 (60%)	0 (0%)			
Single parent	2 (11%)	2 (22%)	0 (0%)	1 (11%)			

In Table 7, children whose parents were married formed the largest percent of those with very high total difficulty scores (78%). The findings also showed that 11% of those borne of single parents and those who were orphaned also had very high total difficult scores. Under the category of separated parents 60% scores high and 44% had slightly raised scores. A computation of the chi-square test yielded p=0.044 and this was an indication of an association between the type of family that the child was raised in and their total difficulties score.

Table 8. Association between ethnicity and total conduct problems

Ethnicity	Close to Average, *n* = 25	Slightly raised, *n* = 4	High, *n* = 7	Very high, *n* = 5	X^2	*df*	*p*-value
					44.14	27	0.009
Embu	1 (4.0%)	1 (25%)	0 (0%)	0 (0%)			
Foreigner	2 (8.0%)	0 (0%)	1 (14%)	0 (0%)			
Kamba	12 (48%)	0 (0%)	1 (14%)	0 (0%)			
Kikuyu	1 (4.0%)	0 (0%)	1 (14%)	3 (60%)			
Kisii	1 (4.0%)	2 (50%)	1 (14%)	1 (20%)			
Luhya	3 (12%)	0 (0%)	2 (29%)	0 (0%)			
Luo	3 (12%)	0 (0%)	0 (0%)	1 (20%)			
Masaai	0 (0%)	1 (25%)	0 (0%)	0 (0%)			
Rendille	1 (4.0%)	0 (0%)	0 (0%)	0 (0%)			
Samburu	1 (4.0%)	0 (0%)	1 (14%)	0 (0%)			

As portrayed in table 8, among children from the Kikuyu ethnic community, 60 % were rated very high in conduct problems. Another 20% from Luo, and Kisii ethnic groups were also placed at the very high cut-off scores. Respondents from the Luhya community had 29% of them and 14% from Kamba, Kikuyu, Kisii, Samburu and foreigners on the high range. Raised scores were reported in Kisii (50%), Embu (25%) and Maasai (25%) ethnic groups. Chi Square test revealed an association between ethnicity and conduct problem (p=0.009)

Table 9. Association between institution where child was screened and hyperactivity problems

Institution	Close to Average, *n* = 36	Slightly raised, *n* = 3	High, *n*= 1	Very high, *n* = 1	X^2	*d.f*	*p*-value
					20.2	27	0.034
Police Stations (CPU)	3 (8.3%)	1 (33%)	0 (0%)	1 (100%)			
Remand home	2 (5.6%)	0 (0%)	1 (100%)	0 (0%)			
Rescue Centers	31 (86%)	2 (67%)	0 (0%)	0 (0%)			

The institution were the child was admitted at the time of screening was deemed important as it was indicative of the stage of the child protection process. Table 9 shows that overall, most children were at close to average on hyperactivity disorders scores though there were a few who showed symptoms of the disorder. One was screened at a child protection unit and

scored "very high" and the other one was at a remand home who also scored high. Rescue centres had a larger percent of children with slightly raised scores (67%). Chi square *p* value was 0.034 indicating a significant relationship between the institution the child was receiving protection services and hyperactivity scores.

Table 10. **Association between institution where child was screened and conduct problems**

Institution	Close to average *n*=18	Slightly raised *n*=9	High *n*=9	Very high *n*=9	X^2	*d.f*	*p*-value
					12.31	6	0.018
Police Station (CPU)	0 (0%)	1 (25%)	3 (43%)	1 (20%)			
Remand home	2 (8.0%)	0 (0%)	0 (0%)	1 (20%)			
Rescue Centre	23 (92%)	3 (75%)	4 (57%)	3 (60%)			

Table 10 indicates that conduct problems were reported most by children in all three institutions with 75% in rescue centers having slightly raised scores and 60% with very high scores. All the five children screened at child protection units scored between slightly raised and very high scores. One child at the remand presented with symptoms conduct disorder.

Table 11. **Association between institution of residence and total difficulties score**

Institution	Close to average *n*=18	Slightly raised *n*=9	High *n*=9	Very high *n*=9	X^2 14	*df* 6	*p*= Value 0.012
Police Station (CPU)	0 (0%)	0 (0%)	1 (20%)	4 (44%)			
Remand home	1 (5.6%)	1 (11%)	0 (0%)	1 (11%)			
Rescue Centre	17 (94%)	8 (89%)	4 (80%)	4 (44%)			

Table 11 shows that ttotal difficulty cut-offs were normal in rescue centres (94%) albeit 89% with slightly raised scores, 80% with high and 44% very high. Child protection units received 20% with high total difficulties scores and 44% with very high scores. Remand homes housed 11% of children slightly raised and very high scores respectively. Pearson's Chi-Square test was *p*=0.012 indicating that an association existed between a child's total difficulties scores and the institution they were residing.

Discussion of Results

The study found that the most predominant needs after screening them using SDQ were emotional problems and peer problems. The high number of children with emotional problems could be linked to the traumatic experiences which had led to their contact and

subsequent placement by child protection services. These findings resonate with earlier studies on adverse experiences and their relationship with emotional and behavioral problems in children. One similar study carried out in Slovakia by Rebicova et al., 2019 found that children who had 1-3 adverse childhood experiences (ACE score) had more emotional and behavioral difficulties than those without. Zhu et al. (2023) also studied 874 children in Japan and found statistically significant differences between their negative experiences and emotional problems. In another study carried out in Singapore, Peh et al. (2022) found the prevalence of PTSD in out of home care children to be 23.1% and the prevalence of emotional problems to be 7.7%). Peer problems could be due to poor parenting and insecure attachments which are the basis for relationships with the world (Van et al., 2022).

Consistent with previous studies such as the one conducted by Osborn et al., 2008, in Australia, the current study also found that children with prior contact with the system had more mental health needs than those coming in for the first time. This may be due to failure of agencies to detect and provide interventions resulting in crossover from welfare to delinquency.

The study found an association between the institution that the child was receiving protection and care services and conduct and hyperactivity problems. This finding concurs with previous studies that have established that SDQ is a good predictor of emotional and behavioral problems (Engler, 2022; Hall et al., 2019).

Conclusion

Children admitted to statutory institutions for care and protection reported having problems in all of the five SDQ scales including the total difficulties score. The study also found an association between some socio-demographic factors and their mental health needs. Future studies could focus on screening of larger populations of children preferably in other regions in the country so at to gather a national profile. In addition to the provision of safe shelter and other basic needs, the directorate of children services in whose care the children are placed should institute mandatory standardized screening and assessment of children so that the appropriate referrals to psychosocial support services are made.

References

American Academy of Pediatrics (2021*). Mental and behavioral health needs of children in foster care.* https://www.aap.org/en/patient-care/foster-care/mental-and-behavioral-health-needs-of-children-in-foster-care/

Baviskar, S., Diop-Christensen, A., Ebsen, F. C., From, K. J., & Mackrill, T. (2020). Structural validity and reliability of the Danish self-report strengths and difficulties questionnaire among male and female students in vocational education and training. *Child & Adolescent Mental Health, 32* (2), 87-98.

Benner, G. J., Nelson, J. R., Stage, S. A., Laederich, M., & Ralston, N. C. (2010). Sex differences on MAYSI-2 mental health symptoms of juvenile detainees: Impact on status offenses and delinquency. *Behavior Analysis of Offender and Victim Treatment and Prevention, 2*(1), 37.

Binagwaho, A., Remera, E.,… & Bayingana, A.U. (2021). Addressing the mental health needs of children affected by HIV in Rwanda: validation of a rapid depression screening tool for children 7–14 years old. *BMC Pediatrics* (pp. 21- 59). https://doi.org/10.1186/s12887-020-02475-1

Bryant, A., Guy, J., Holmes, J., Astle, D., Baker, K., Gathercole, S.,... & CALM Team. (2020). The strengths and difficulties questionnaire predicts concurrent mental health difficulties in a transdiagnostic sample of struggling learners. *Frontiers in psychology*, *11*, Article 587821. https://doi.org/10.3389/fpsyg.2020.587821

Coggins, K., & Carnes-Holt, K. (2021). The efficacy of child–teacher relationship training as an early childhood mental health intervention in Head Start programs. *International Journal of Play Therapy*, 30(2), 112-124.

Colins, O. F., & Grisso, T. (2019). The relation between mental health problems and future violence among detained male juveniles. *Child and Adolescent Psychiatry and Mental health*, *13*(4), 1-11.

Colins, O. F., Grisso, T., Vahl, P., Guy, L., Mulder, E., Hornby, N., ...& Vermeiren, R. (2015). Standardized screening for mental health needs of detained youths from various ethnic origins: The Dutch Massachusetts Youth Screening Instrument-Second Version (MAYSI-2). *Psychopathology and Behavioral Assessment*, *37* (3), 481-492.

Cunneen, C., Goldson, B., & Russell, S. (2018). Human rights and youth justice reform in England and Wales: A systemic analysis. *Criminology & Criminal Justice*, *18*(4), 405-430.

Desmond, C., Watt, K., Saha, A., Huang, J., & Lu, C. (2020). Prevalence and number of children living in institutional care: global, regional, and country estimates. *Lancet Child Adolesc Health 4* 370–377.

Engler, A. D., Sarpong, K. O., Van Horne, B. S., Greeley, C. S., & Keefe, R. J. (2022). A systematic review of mental health disorders of children in foster care. *Trauma, Violence, & Abuse*, *23*(1), 255-264.

Essex, R. (2019). The psychometric properties of the strengths and difficulties questionnaire for children from refugee backgrounds in Australia. *Clinical Psychologist*, 23(3), 261-270.

Font, S. A., & Gershoff, E. T. (2020). Foster care: How we can, and should, do more for maltreated children. *Social policy report*, *33*(3), 1-40.

Goodman, R. (1997). The Strengths and difficulties questionnaire: A research note. Child Psychol Psychiatry. 38(5), 581-586.

Goodman, R., Ford, T., Richards, H., Gatward, R., & Meltzer, H. (2000). The development and well-being assessment: Description and initial validation of an integrated assessment of child and adolescent psychopathology. *Journal of child psychology and psychiatry*, *41*(5), 645-655.

Hall, C. L., Guo, B., Valentine, A. Z., Groom, M. J., Daley, D., Sayal, K., & Hollis, C. (2019). The validity of the Strengths and Difficulties Questionnaire (SDQ) for children with ADHD symptoms. *PloS one*, *14*(6), Article e0218518. https://doi.org/10.1371/journal

Hovey, K. A., Zolkoski, S. M., & Bullock, L. M. (2017). Mental health and the juvenile justice system: Issues related to treatment and rehabilitation. *World Journal of Education*, *7*(3), 1-13.

Jäggi, L., Schmid, M., Bürgin, D., Saladin, N., Grob, A., & Boonmann, C. (2021). Shared residential placement for child welfare and juvenile justice youth: Current treatment needs and risk of adult criminal conviction. *Child and Adolescent Psychiatry and Mental Health*, *15* (2), 1-13.

Kim, M., Barnhart, S., Garcia, A. R., Jung, N., & Wu, C. (2021). Changes in mental health service use

over a decade: Evidence from two cohorts of youth involved in the child welfare system. *Child and Adolescent Social Work Journal*, 1-15. https://doi.org/10.1007/s10560-021-00798-1

Kobulsky, J. M., Dubowitz, H., & Xu, Y. (2020). The global challenge of the neglect of children. *Child Abuse & Neglect, 110* (1), Article 104296. https://doi.org/10.1016/j.chiabu.2019.104296

Lehmann, S., & Kayed, N. S. (2018). Children placed in alternate care in Norway: A review of mental health needs and current official measures to meet them. *International Journal of Social Welfare*, *27*(4), 364-371.

Martin, J., & Hadwin, J. A. (2022). The roles of sex and gender in child and adolescent mental health. *JCPP advances*, *2*(1), Article e12059. https://doi.org/10.1002/jcv2.12059

Nduwimana, E., Mukunzi, S.. Ng, L.C., Kirk, C.M., Bizimana, J.I., & Betancourt, T.S. (2017). Mental health of children living in foster families in rural Rwanda: The Role of HIV and the family environment. *AIDS Behaviour, 21*(6):1518-1529.

Neely-Barnes, S., & Whitted, K. (2011). Examining the social, emotional and behavioral needs of youth involved in the child welfare and juvenile justice systems. *Health and Human Services Adminstration*, *34*(2), 206–238.

Osborn, A. L., Delfabbro, P., & Barber, J. G. (2008). The psychosocial functioning and family background of children experiencing significant placement instability in Australian out-of-home care. *Children and Youth Services Review*, *30* (8), 847-860.

Peh, C. X., Tan, J., Lei, T., Wong, E., & Henn-Haase, C. M. (2022). Evaluating the use of trauma-informed mental health assessment measures in care planning for children and adolescents in out-of-home residential care in Singapore. *Child Abuse Review*, *31*(2), 1-19.

Ramsdal, G. H., Bergvik, S., & Wynn, R. (2018). Long-term dropout from school and work and mental health in young adults in Norway: A qualitative interview-based study. *Cogent Psychology*, *5*(1), 1455365. https://doi.org/10.1080/23311908.2018.1455365

Rebicova, L, M., Dankulincova , Z., Husarova, D., Madarasova , A., van Dijk, J. P., & Reijneveld, S. A. (2019). The number of adverse childhood experiences is associated with emotional and behavioral problems among adolescents. *International journal of environmental research and public health*, *16*(13), 2446. https://doi.org/10.3390/ijerph16132446

Shim, R. S., & Compton, M. T. (2020). The social determinants of mental health: psychiatrists' roles in addressing discrimination and food insecurity. *Focus*, *18*(1), 25-30.

Simmel, C. (2011). Demographic profiles of children reported to the child welfare system. *Journal of Public Child Welfare*, *5*(1), 87-110.

Suh, B., & Luthar, S. S. (2020). Parental aggravation may tell more about a child's mental/behavioral health than adverse childhood experiences: Using the 2016 National Survey of Children's Health. *Child Abuse & Neglect*, *101*, 104330. https://doi.org/10.1016/j.chiabu.2019.104330

The Children Act of 2022. Act no.29 (2022). http://www.kenyalaw.org

Tolou-Shams, M., Holloway, E. D., Ordorica, C., Yonek, J., Folk, J. B., Dauria, E. F., ... & Wiley, H. M. F. (2022). Leveraging technology to increase behavioral health services access for youth

in the juvenile justice and child welfare systems: A cross-systems collaboration model. *The Journal of Behavioral Health Services & Research*. 49, 422–435.

UNICEF (2019). *Violence Against Children Report, 2019.* https://www.unicef.org/kenya/reports/The-2019-Violence-Against-Children-Survey#:~:text=The%202019%20VAC%20Survey%20report,and%20adult%20relatives%20also%20decreased.

US Department of Human Services (2022): *The adoption and foster care analysis and reporting system no.29.* https://www.acf.hhs.gov/cb

Van IJzendoorn, M. H., Bakermans-Kranenburg, M. J., Duschinsky, R., Fox, N. A., Goldman, P. S., Gunnar, M. R., ... & Sonuga-Barke, E. J. (2020). Institutionalisation and deinstitutionalisation of children: A systematic and integrative review of evidence regarding effects on development. *The Lancet Psychiatry, 7*(8), 703-720.

Zhu, Y., Zhang, G., & Anme, T. (2023). Adverse childhood experiences, resilience, and emotional problems in young Chinese children. *International journal of environmental research and public health, 20*(4), 3028. https://doi.org/10.3390/ ijerph20043028