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# Study of Status, Issues and Challenges Influencing the Effectiveness of Mental Health Services and Interventions Provided within Child Care and Protection Centers in Kingston Jamaica

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## Abstract

This study explores the status, challenges, and effectiveness of mental health services in Child Care and Protection Centers in Kingston, Jamaica. With the growing number of at-risk children, adolescents, and youths (CAY), concerns about their mental well-being have intensified. The research surveyed 30 individuals 20 wards of the state and 10 caregivers to assess their experiences in state care facilities and the impact on mental health. Findings indicate a strong link between mental health challenges and childcare facilities, driven by stigmatization, cultural barriers, limited resources (such as trained professionals and funding), lack of community involvement, and inadequate monitoring and evaluation. The study emphasizes the need for comprehensive needs assessments, increased funding, awareness campaigns to reduce stigma, enhanced collaboration, improved infrastructure, and stronger policies. Addressing these issues will help improve mental health support and overall well-being for CAY in state care.

**Keywords:** Stigma; Cultural Barriers; Community; Mental Health; Childcare; Resources; Monitoring; Evaluation

## Introduction

The foundational status and the cry for help with mental health challenges echo from the heard and unheard voices of the children who are placed in state care in Kingston, Jamaica. Did you know that Mental Health is often one of the lowest health priorities in low-income post-colonial countries? According to Abrahams K, et al. [1] former Secretary-General of the United Nations – Kofi Annan quoted, "There's no trust more sacred than the one the world holds with children. This can be dissected to mean that no duty is more important than ensuring that the rights of children and young people are respected, welfare is protected, lives are free from fear, and they can grow up healthy and peaceful" (Noble Prize 2001). We have a moral obligation to care for and protect children, who are the most vulnerable and innocent members of society. Children have rights and they should be respected and fulfilled, such as the right to proper healthcare; which includes their mental health. According to UNICEF, the Convention on the Rights of the Child outlined the basic human rights, specifying that every child under age 18 has the right to survival; the right to develop to the fullest; the right to protection from harmful influences, abuse and exploitation; and the right to participate fully

in family, cultural and social life (Do Good Jamaica, 2018). However, without the necessary platforms and resources to combat deficits such as mental health challenges in state-run facilities, there is an infringement of these basic rights.

Research in this field for Jamaica and the Caribbean is limited but there are a few researchers whose data indicated that children in state care experience high levels of trauma, which can cause them to feel sad, and lonely, cry, have low self-esteem, display anger, and frustration. These symptoms are further linked to mental health conditions such as anorexia nervosa, depression, anxiety, schizophrenia, bipolar disorder, and psychosis, just to name a few (American Psychological Association (APA), 2013, pp. 87-329). These mental illnesses and a plethora of others are conditions that many of the children living in state care may be diagnosed with as their tenure in the facility progresses. For example, children might begin to exhibit signs of behavioural issues, while other behaviours may be deemed unusual or abnormal. Mayo Clinic [2] explained that mental disease and mental health problems encompass a broad spectrum of ailments and disorders that impact an individual's mood, thought process, and behaviour. Therefore, the very displacement of a known surrounding for a child who's placed in state care is a traumatic experience and without the proper interventions, that child is at risk of developing mental health challenges. Robinson in his report published in the Gleaner on February 23, 2020, lamented that there are about 5,000 children in state care who have severe mental illnesses. He further explained that these conditions frequently got worse after the children were taken from their homes or other unsafe environments. It's easy to identify why this may be possible when these children frequently ask: Why am I here? Because some honestly don't know why they are there and they are not allowed to know until they attain the age of 18. Did I do something wrong?, is another question children - especially the younger ones ask when they can't understand what's happening to their little worlds. "Why don't my parents want me?" is another frequently asked question by even those who are older and more settled. After many years, some never got over the separation and some even refused to forgive their parents. They just can't get over the fact that their parents never wanted them and Huntington C [3] noted that basic issues like parental stress, substance abuse, social isolation, and poverty have not been sufficiently addressed, which is one of the main reasons children frequently end up in state care. Huntington C [4] discussed changes that were meant to increase determinacy and argued that the system needs more realistic objectives and a fundamental reorientation toward preventing child separation from family. Additionally, employees of childcare institutions have stated that state-adopted children who got into legal trouble were not given enough support and were housed in unsuitable conditions that compromised their mental and physical well-being. The fact that, there is not enough room in state-run facilities affects privacy and makes it difficult for traumatised children to find peace or alone space for reflective moments. In these centres, children with disabilities are placed among children without impairments to foster inclusivity. However, staff members who typically lack the necessary expertise and resources to attend to their medical and developmental needs are challenged to care for them effectively. Several studies have been done regarding the variables that may have impacted the mental health of children in Jamaican childcare facilities. Some of the contributing factors are the violations of their rights to health, education, and protection from all forms of violence, the socioeconomic conditions of their families and communities, and the accessibility and availability of resources to assist with mental health. Children who are placed in institutional care frequently experience "structural neglect," which may include inadequate physical resources, unfavourable and inconsistent staffing patterns, and insufficient social-emotional caregiver-child interactions (van IJzendoorn MH et al.).

Childhood Central [5], reported that 34% of people have an onset of a mental disorder before the age of 14, while 48.4% have an onset before age 18. This data corroborate with Corr L, et al. [6] idea that there's a strong correlation between childcare providers and mental health. If the providers are overworked and underpaid, then this could lead to burnout, creating mental unsteadiness for caregivers and ripple effect on the children in their care. Conformation also came from Nelson D, et al. [7]; they believe that it's important to understand the interplay between mental health of care providers and the quality of care provided, as the outcome from poor mental health among providers can lead to suboptimal care for children. There's also a strong connection between child adversities and life expectancy. Historically, children would outlive adults. However, younger persons are dying prematurely from diseases previously known to affect older people. Chan and Colleagues (2023) postulated that people with a mental disorder have a decreased life expectancy of 10-15 years when compared to the general population, and some risk factors for child mental ill-healthiness. CAPRI's situational analysis of child and adolescent mental health in Jamaica also revealed that 45% of children have experienced anxiety symptoms, 60% of children in State care have exhibited psychological problems, with 76% exhibiting maladjusted behaviours Morrison M [5]. The evidence indicates that children who are exposed to traumas such as loss - removal from their family of origin, substandard care - inexperienced caregivers, and lack of appropriate interventions are more likely to develop mental health challenges. Following this discovery, a group of researchers from the University of the Commonwealth Caribbean (UCC) studied the accessibility, efficacy, and obstacles of mental health services offered in Kingston,

Jamaica's Child Care and Protection Facilities.

## Research Aim

This research aims to examine the contributing factors to the mental health challenges of children living in state care in Kingston, Jamaica.

### Research Objectives

1. To assess the availability of mental health services within state care facilities.
2. To explore the accessibility of mental health services in state-run facilities.
3. To investigate the effectiveness of mental health intervention approaches used in state care.
4. To identify barriers individuals in state care facilities face in accessing and receiving the appropriate mental health care.

## Review of Literature

Jamaica has a high rate of violence against children, which has an impact on their mental health and general well-being (UNICEF, n.d). There is a paucity of information and evidence about child abuse and neglect, as well as poor and disorganized child protection systems. The primary government organization tasked with providing assistance and protection to children in Jamaica is the Child Protection and Family Services Agency (CPFSA). However, it encounters difficulties such as constrained resources, staff capability, coordination, and monitoring. The provision of mental health services in childcare in Kingston, Jamaica, faces many challenges. There are significant research gaps and certain populations have been examined more thoroughly than others. Most of the existing studies identify population characteristics, needs, and consequences of a lack of systemic services to promote family-like care. Fluke JD, et al. [8] reported the findings of a focal group convened by the U.S. Government Evidence Summit whose core focus was Protecting Children Outside of Family Care and reviewing the literature on systems, strategies, and interventions for sustainable long-term care and protection of children with a history of living outside of family care in low- and middle-income country contexts like Jamaica and the Caribbean. To put it another way, countries like Jamaica have major economic constraints, which means that focusing on matters such as the mental health of children in childcare facilities would not be a priority for policy makers; although it should be. A system must be in place to protect our children's needs, identify programs, and establish eligibility requirements so that children placed in childcare facilities can receive better rehabilitation, despite the obstacles. In return, they'll be more rounded individuals to carry on the legacy of past generations. In Jamaica there are several issues and challenges that affect children who are placed in childcare facilities, which sometimes cause serious mental health issues. Our research revealed that some of the main problems include ineffective staff members - those lacking childcare training, failing to show them love, or acknowledge their needs; lack of funds, infrastructure, and professional resources to combat the needs when they arise; appropriate needs assessment to identify possible challenges ahead of time. Maslow's Hierarchy of Needs as reported by McLeod (2024), outlined needs such as physiological, safety, love and belongingness, esteem and self-actualization needs. These needs as explained by Maslow are arranged in levels and to reach the peak, which is the ultimate goal for every individual, one must first satisfy the previous levels. If this is not achieved, persons will be stuck trying to reach their full potential. However, they can't because something is missing. That missing link may very well be connected to the lack of safety needs, which is the second tier of the needs pyramid and includes their health and that's lacking in our childcare settings. Consequently, children are incapable of developing any meaningful emotional relationships, high self-esteem, of live up to their full potential. Similarly, in 2006, Glisson and Green conducted a study that focused on examining access to mental health care between children served by one state's child welfare and juvenile justice systems as a function of several child and service system characteristics. The duo made discoveries that suggested that efforts to improve access to mental health care for children should include the development of constructive organizational cultures in case management units responsible for the children's care. This approach could be useful to reduce stigmas, remove barriers in access to mental health care, thus providing high quality mental health care. When children who are placed in childcare facilities show signs of mental health issues there's a frequent justification for the length of time it takes them to see a psychiatrist - there's no resources. This delay often leads to incorrect diagnoses and some even turn to self-harm as a coping mechanism. Garland et al. explained that the majority of children in state care who needs mental health interventions do not receive the type that is most likely to have the greatest impact on them. Mind the Gap [9] further explains that 60% of children living in childcare settings develop psychological issues and this further cement the hypothesis that children in childcare facilities are at a disadvantage when it comes to their mental health. Not only are they not properly diagnosed, but some are left untreated throughout their tenure in the system causing not just further mental detriments but also possible physical harm.

The system is faced with so many deficits that when the signs and symptoms of mental health challenges become evident, the illness has progressed and requires extensive treatment and the resources for such treatment is unavailable. Timonen-Kallio, Hämäläinen, and Laukkanen (2017) also contributed their knowledge to the body of literature and proposed that

many children who are taken into care frequently require both child protection services and psychiatric care, and that, as a result, professionals of both systems must be coordinated in their care. Nonetheless, it is well recognized in many nations, particularly those with low and middle incomes, that there is little cohabitation between the partnership of child protection services and mental health care, and that the results are subpar. Inter-professional collaboration between mental health practitioners and residential workers is not well studied, despite a critical need for this information. Nelson D, et al. [7] suggested implementing an innovative community engagement model, which may create a possible solution that can not only help to reduce stigmas surrounding mental health treatment but also enhance the effectiveness of the interventions provided in the local context. The literature posit that creating a correlation between stakeholders and integrating training programs geared towards caregivers will help to create a more cohesive framework that not only addresses the immediate mental health needs of the children but also fosters resilience and attachment, essential for their long-term well-being Nelson D, et al. [7].

John Bowlby theorized that children are innately preprogrammed to form attachments with others as a means of survival (McLeod, 2024). Bowlby theory suggested that children form attachments in their earlier years and if this is not done, then they will not be able to form that internal working model, which comprises of the cognitive framework and the mental representation for understanding the world, self, and others Karbowa-Płowens M [10]. Although Bowlby attachment theory is generalized, it's quite applicable in childcare facilities in Kingston Jamaica. What we must remember is that some children enter the system very young and because of the lack of stability they are incapable of forming any meaningful attachments. Children in state care, Adoption and Fostering (2013) explained, lacks acknowledgement that attachment issues fall within the remit of mental health services. Some facilities have high staff turn overs; others have two to three shifts, which mean that there's no guarantee that the caregiver that works in a particular unit one day will be working there the subsequent days. As a result, the children see a constant rotation of staff and none have the time to give them the quality care that they deserve. Subsequently, no attachment is formed and as stated in Bowlby theory, when that happens, the children grow up with a deficit and this can also contribute to some of their mental health challenges.

Children and young people living in state care often report experiencing poorer levels of mental health and well-being, and it's for this reason that government policy encourages a holistic approach to the assessment of all aspects of the health and well-being of these children and young people (McCrystal & McAloney, 2010). The duo further lamented that a mental health screening was done with a sample of children living in and one living out of state care using the Strength and Difficulty Questionnaire (SDQ) tool to garner a better understanding of the level of mental well-being. The results indicated that the children living in state care have a higher propensity for behavioural problems. Mental illness has historically received little attention in Jamaica, and those who suffer from it are frequently disregarded by their families or ostracized by the community (Morgan, Barrett, and Silvera). In Jamaica, people who are experiencing a crisis typically receive little to no support. Boys especially, their emotional needs are frequently neglected. This is due largely to the historical stigma surrounding male sense of weakness if they display anything outside that manly tone. What we fail to understand is that the mind is the chief powerhouse of our emotions, which determines our behaviors. A lack of support for victims of abuse and other traumas can cause the unconscious minds to become unsettled and often result in mental health issues. The Lancet (2021) reported that further research confirmed these conclusions, and also suggests that there have been insufficient resources and preparations for mental health in Jamaica. The recent pandemic has caused this problem to worsen; thus, negatively impacting mental health more than any other area. The Caribbean Policy Research Institute (CAPRI) [11], identified approximately 20% of children living in state care having a mental health disorders, 5% of which suffer from severe mental health disorder; depression and anxiety stand at 15%; nervousness, restlessness, worry, and annoyance account for 45% of the sample. Similarly, the UCC researchers' findings, revealed fifty percent (50%) of staff believed that interventions that are offered on-site are ineffective, while 37% believed they are good, which could point to a fair possibility of a gap in the efficacy of mental health interventions in different facilities.

## Studies Related to Jamaica and the Caribbean

Mental health remains a sore topic in childcare facilities in Kingston Jamaica. There is a lack of comprehensive data to assist with understanding the extent of mental health challenges in childcare facilities. The Child Protection and Family Services Agency (CPFSA) have accepted that there are many gaps in the service it provides - specifically for the mental health of the wards. Over the years, there has been more focus on the physical well-being of the wards of the state, while the mental wellbeing has been severely neglected. On June 29, 2023, the Office of the Prime Minister and CPFSA reportedly acknowledged that there is no facility to effectively screen, assess, or provide therapeutic treatment to children displaying behavioral issues, which is a major gap. This gap they exclaimed, makes it difficult to diagnosed and address mental health issues early (OPM, 2023). This has since changed; however, there is still insufficient resources to provide quality service based on the number of children

with mental health needs. Only 8% of children with mental health challenges are receiving interventions and due to the lack of professional and infrastructural resources they are not receiving the appropriate services CAPRI, [12]. There are no accurate or reliable assessment tools used in the available facilities because Child Guidance - the national facility used to assess and treat mental health challenges of children up to 18 years - is considered a clinic-based system with very little resources and limited, underpaid professionals; and the private facilities are unable to bridge the gap CAPRI, [12].

Research done by Liverpool S, et al. [13] has shown that the need for mental health interventions is wide in the English-speaking Caribbean region. However, there is typically little data from the immediate diaspora of Jamaica and other low-income countries to support this need. Children, adolescents, and young people (CAY) mental health and wellness remain a major global public health issue. At least 10% of children and adolescents (CAY) have mental health symptoms, with 50% of them appearing by the age of 14 and 75% by the age of 24. Depressive disorders, anxiety, and other mental or behavior issues are common internalizing and externalizing manifestations, with a high prevalence of comorbidity among CAY. Notably, several research show differences in the frequency of mental health issues between CAY who identify as members of particular minority ethnic groups and those who come from developing, low, and middle-income countries Liverpool S, et al. [13].

This could be closely connected to the fact that children in low economic countries are more likely to be abused and this make them key target for childcare institutions. Often, these are young children and like Erik Erikson stages of development, at certain stages of their development there are activities that help them to achieve the respective virtue so they can matriculate to the next area of their life. Unfortunately, due to the lack of expertise observed with some of the caregivers; some of these children will never have the opportunity to live a wholesome life. For example, a toddler or even a school age child with special needs might create a mess trying to help themselves. According to (McLeod, 2024), where a family of origin may be more understanding and commend that child for their effort; a stress and overworked caregiver will simply get mat and degrade that child calling them names and make them feel ashamed. This can demotivate persons who are especially extrinsically motivated.

This is what Erikson meant when he spoke about "autonomy versus shame and doubt", which is the second stage of development he lamented. The same principle can be applied for the younger children between the ages of 0-18 months. The literature states that children form attachment in the earlier years and Erikson explained that between 0-18 month's children learns whether to trust or mistrust their caregivers. If this is not achieved, it will affect them as they get older. Unfortunately, this is the outcome of many of our childcare participants and the ripple effect of these deficits is becoming a national problem.

## Methodology

### Sample

We have chosen to collect data using a mixed method study design. To facilitate the researchers' data collection, both qualitative and quantitative data on age, family history, psychosocial experiences, coping mechanisms, emotional interpretation of children in state care, demographic data, staff engagement and mental health service provision in state care, employee observations of barriers, and availability of intervention methods were done. The research will be conducted using Google forms or tangible question sheets. Additionally, to examine the accessibility to mental health services in state-run facilities in Kingston, Jamaica and the efficacy of the mental health intervention techniques employed. A sample of 30 participants (22 wards of the state and 8 staff members) participated in this research. The participants were selected using inclusion and exclusion criteria such as who is or was suffering from mental health issues within the facility. These were based on challenges such as behavioural and attention-deficit/hyperactivity disorder (ADHD), which are common in the children's homes in Kingston, Jamaica. Importantly, participants who met the criteria had to be willing to participate in the research with the consent of the facility manager and social worker. They were given a consent form, which outlined the nature of the research and their role as a willing participant.

### Tools

This research employed a mixed-method (qualitative and quantitative) approach, with an administered questionnaire (Appendix A). The study used systematic review tools such as literature reviews, questionnaires, and interviews with a focus on clinically relevant indicators, or those that ensured clinical quality. Similarly, due to space constraints, no emphasis was placed on preventive psychiatric and quality-of-life measures in healthy or non-clinical populations. Research was conducted to evaluate prevention interventions for common mental health problems in young adults. Additionally, the literature reviews was used to determine the credible, effectiveness, ethics, and long-term viability of approaches to supporting children in low- to middle-income countries who have a history of living outside of family care. Long-term care and protection for children who have a history of living outside of family care are post-crisis resources that was also assist to systemically design, promote, and establish healthy, stable, and ideally long-term family-like settings for such children.

### Research Design

According to McCombes S [14], a research design is used to structure and organize studies and respond to research questions. To unearth the contributing factors leading to mental health challenges of children living in state care in Kingston, Jamaica, this research utilized a combination of qualitative and quantitative methods. The qualitative method included gathering and examining non-numerical data to formulate comprehensive ideas and experiences. It was also utilized to compile in-depth information or come up with fresh concepts for further in-depth or protracted investigation. Understanding how people perceive the world entails gathering and interpreting numerical data for statistical analysis Bhandari P, [15]. This will provide ideas for future investigations and also help researchers understand more complex areas of mental health challenges in childcare facilities. Bhandari P, [15] further explained that it can be applied when uncovering comprehensive insights into a situation or to spark fresh research concepts.

The research topic would be best served by an in-depth investigation. Therefore, a quantitative method was also used in this research to quantify the outcomes of these social problems and test the efficacy of mental health services and interventions. This method helped the researchers to gain a better understanding of the responses to the questionnaire and interview. To acquire a fulsome understanding of the mental health issues faced by these children within these institutions, a combination of semi-structured interviews, surveys (questionnaires), and Secondary researches were utilized.

### Data Collection Procedure

The researchers played a critical role in the study's success, from data collection to facilitation and completion. The protection of the participant's rights and confidentiality and making sure they don't feel uncomfortable while participating were two key factors and responsibilities. A mixed research method was used to gather data from the study. The descriptive quantitative methods aimed to answer the "what is" and incorporate observational and survey methods in the data collection. It describes, explains, and validates the findings gathered. Techniques such as data analysis and collection yield variation and correlation in information and focus on specific research questions, methods, and outcomes. Some qualitative methods include observations and first-hand recordings of what is seen, heard, or physically experienced (McCombes). Some children were interviewed, while others along with the caregivers were directed to a Google questionnaire, which they completed online. Questionnaires continued both open and closed-ended questions. Secondary research was also instrumental as it allowed the collection of existing data in the form of texts, images, audio, or video recordings.

Qualitative and quantitative methods have different strengths and weaknesses and are best suited to answer different research questions, including social issues. Therefore, this combination was ideal, as the researcher's interpretation of the data collected relates to the difficulties encountered by Streefkerk. To gather the data that was needed for the study, the researchers utilized a semi-structured interview to create an environment that allows respondents a level of comfort. However, before conducting the survey, permission was sought from the principal social workers and those in charge at the target institutions. The respondents were asked for their consent, and they were assured that the results of the survey would be used only for the study. Thereafter, questionnaires were distributed, interviews conducted, and the data-collected were analyzed. Semi-structured interviews are open ended; hence, it does not limit the respondents to predetermined answers. The data collected were recorded in Microsoft Word for future analysis.

### Statistics

The CDC uses surveys, such as the National Survey of Children's Health, to describe the presence of positive indicators of children's mental health, to understand the number of children with diagnosed mental disorders, and whether they received treatment. In this survey, some parents reported positive, while others reported negative indicators and diagnoses received from a healthcare professional for their child According to the CDC (2022) 9.8% of children living in the Caribbean have been diagnosed with ADHD, which amounts to approximately 6.0 million children. Those with anxiety equate to 9.4%—approximately 5.8 million. Behavior problems stand at 8.9%—approximately 5.5 million—while depression is responsible for 4.4%—approximately 2.7 million. There are other disorders but these are the most commonly diagnosed mental disorders in children ages 3-17 years. Over 7,000 children with mental health concerns were seen at child guidance clinics in 2021, according to the Jamaica Observer (2022). The most recent Economic and Social Survey Jamaica (ESSJ) showed that 4,060 of the 7,345 adolescents who visited the Child Guidance Clinics around the island in 2021 were male. The results suggested that more males in general suffer significant mental health concerns than females. Similarly, state care facilities are predominantly males, which confirm the statistics.

## Results

A total of 22 CAYS - 13 females and 9 males and 8 staff members - 7 females and 1 male from two state-run facilities participated in this research. As shown in Tables 1.1and 2.1, there are a higher percentage of females in the data set for children and adults and the majority of the children are below 18 when compared to the varying age groups. Over

60% of the adults are between the ages of 46-60 years and they are predominantly Jamaicans and Christian (100%), and 87% black children and employees living and working in these facilities. Only 25% of employees are married, while 62% are single and the remaining 12.5% have stated that they have another type of relationship (Table 1).

| Categories | Frequency | Percentage |
|---|---|---|
| **1. Gender** | | |
| Male | 9 | 41% |
| Female | 13 | 59% |
| Total | 22 | 100% |
| **2. Age Group** | | |
| Under 18 | 13 | 59% |
| 18-23 | 9 | 41% |
| Total | 22 | 100% |
| **3. Ethnicity** | | |
| Black | 22 | 100% |
| Total | 22 | 100% |
| **4. Religion** | | |
| Christian | 20 | 91% |
| None | 2 | 9% |
| Total | 22 | 100% |

**Table 1:** CAY's Demographic Information.

| Categories | Frequency | Percentage |
|---|---|---|
| **1. Feelings of living in state care** | | |
| Safe | 7 | 32% |
| Comfortable | 1 | 4% |
| Homely | 3 | 14% |
| Unworthy | 11 | 50% |
| Total | 22 | 100% |
| **Victim of mental health** | | |
| Yes | 13 | 59% |
| No | 9 | 41% |
| Total | 22 | 100% |
| **Deprived of mental health care** | | |
| Yes | 3 | 14% |
| No | 19 | 86% |
| Total | 22 | 100% |

**Table 2:** CAY's Emotional Interpretation.

The table above represents the demographic breakdown of 22 participants across four categories: gender, age, ethnicity, and religion.

The table above represents the emotional interpretation of 22 participants covering three areas: feelings about living in state care, being a victim of mental health challenges, and being deprived of mental health care.

The feelings of the children living in state care are captured in Table 2, varying with unworthy being the most common with 50% and safe with 32%, followed by homeliness at 14% and comfort scoring 4%. An excess of 50% of the children adolescents and youths (CAY) recorded being victims of mental health issues and only 14% reported being deprived of mental health care. 86% have access to some form of mental health care and there's a 50-50% split between children who are affected and not affected by living in state care. There's a 32% predisposition rate with the CAYS and 68% not having any immediate familial connection with mental disorders.

| Categories | Frequency | Percentage |
|---|---|---|
| **Effects of living in state care** | | |
| Little | 11 | 50% |
| None | 11 | 50% |
| Total | 22 | 100% |
| **Predisposition to mental illness** | | |
| Yes | 7 | 32% |
| No | 15 | 68% |
| Total | 22 | 100% |
| **Coping Mechanism** | | |
| Venting | 1 | 4% |
| Talking | 4 | 18% |
| None | 17 | 72% |
| Total | 22 | 100% |

**Table 3:** Effects and Coping Mechanism of CAYS.

The table above is a representation of the effects and coping mechanisms of 22 CAYs and enlisted three areas namely: effects of living in childcare, predisposition to mental health, and coping mechanism. Table 3 shows the coping mechanisms with 72% having no coping mechanisms, 18% talk to someone, and the other 4% vent. Similarly, Table 2 shows 50% of employees being in child care for over 10 years and 62% are caregivers in the facilities, having a tertiary education, and living in an extended family dynamic with 62%. However, there's an equal split relating to the availability of mental health services offered on site (50% each). Thirty-seven and a half percent (37.5%) of staff believed that interventions are

good, leaving 12.5% each for excellent, satisfactory, and poor. Additional mental health services placed Child Guidance on top with 62.5%, followed by private entities with 25%, and the facility offering both at 12.5% (Table 4).

| Categories | Frequency | Percentage % |
|---|---|---|
| **Age** | | |
| 30-45 | 3 | 37.50% |
| 46-60 | 5 | 62.50% |
| Total | 8 | 100% |
| **Gender** | | |
| Male | 1 | 12.50% |
| Female | 7 | 87.50% |
| Total | 8 | 100% |
| **Country of Origin** | | |
| Jamaica | 8 | 100% |
| Total | 8 | 100% |
| **Ethnicity** | | |
| Black | 7 | 87.50% |
| Other | 1 | 12.50% |
| Total | 8 | 100% |
| **Relationship Status** | | |
| Married | 2 | 25% |
| Single | 5 | 62.50% |
| Other | 1 | 12.50% |
| Total | 8 | 100% |
| Religion | | |
| Christian | 8 | 100% |
| Total | 8 | 100% |
| Education Level | | |
| | 5 | 62.50% |
| Tertiary | 2 | 25% |
| Secondary | 1 | 12.50% |
| Other | | |
| Total | 8 | 100% |
| **Family Dynamic** | | |
| Single parent | 2 | 25% |
| Co-parent | 1 | 12.50% |
| Extended Family | 5 | 62.50% |
| Total | 8 | 100% |

**Table 4:** Employees Demographic Information.

The table above is a representation of the demographic information for 8 employees. It covers 8 categories: age, gender, country of origin, ethnicity, relationship status, religion, education, and family dynamic.

| Categories | Frequency | Percentage |
|---|---|---|
| **Childcare Duration** | | |
| 1-5 years | 3 | 37.50% |
| 6-10 years | 1 | 12.50% |
| Over 10 years | 4 | 50% |
| Total | 8 | 100% |
| **Roles in Organization** | | |
| Manager | 1 | 12.50% |
| Caregiver | 5 | 62.50% |
| Axillary | 1 | 12.50% |
| Other | 1 | 12.50% |
| Total | 8 | 100% |
| **Mental Health Services Offered** | | |
| Yes | 4 | 50% |
| No | 4 | 50% |
| Total | 8 | 100% |
| **Efficacy of Services Offered** | | |
| Excellent | 1 | 12.50% |
| Good | 3 | 37.50% |
| Satisfactory | 1 | 12.50% |
| Poor | 1 | 12.50% |
| None | 2 | 25% |
| Total | 8 | 100% |
| **Additional Mental Health Provision** | | |
| Child Guidance | 5 | 62.50% |
| Private services | 2 | 25% |
| Both | 1 | 12.50% |
| Total | 8 | 100% |

**Table 5:** Staff Engagement and Provision of Mental Health in State Care.

The table above represents the staff engagement and provision of mental health services in child care facilities. It includes 8 employees and covers duration in childcare, roles in organization, mental health services offered, efficacy of services, and provision of additional mental health services.

| Categories | Frequency | Percentage |
|---|---|---|
| **Cultural Barriers** | | |
| Yes | 3 | 37.50% |
| No | 5 | 62.50% |
| Total | 8 | 100% |
| **Religion Affects Mental Illness Treatment** | | |
| Strongly agreed | 1 | 12.50% |
| Agree | 4 | 50% |
| Disagree | 3 | 37.50% |
| Total | 8 | 100% |
| **Barrier Affecting Service Access** | | |
| Stigma | 2 | 25% |
| Wait time | 2 | 25% |
| Lack of resources | 2 | 25% |
| No barriers | 2 | 25% |
| Total | 8 | 100% |

**Table 6:** Employees Observations of Barriers Affecting Mental Health in State Care.

| Categories | Frequency | Percentage |
|---|---|---|
| Number of Participants | | |
| 40-50 | 4 | 50% |
| 51-60 | 3 | 37.50% |
| Over 60 | 1 | 12.50% |
| Total | 8 | 100% |
| Varying Age Groups | | |
| 4-18 years | 4 | 50% |
| 3-23 years | 4 | 50% |
| Total | 8 | 100% |
| Wards with Mental Health Challenges | | |
| Yes | 8 | 100% |
| Total | 8 | 100% |
| Availability of Mental Health Service | | |
| Moderate | 3 | 37.50% |
| Limited | 5 | 62.50% |
| Total | 8 | 100% |
| Interventions used by Facility | | |
| Good | 3 | 37.50% |
| Ineffective | 4 | 50% |
| Normal | 1 | 12.50% |
| Total | 8 | 100% |

**Table 7:** Employees Interpretations of the effect of mental health on State Care Occupants.

The table represents the employees' observation of barriers affecting mental health services in state care. A total of three categories were covered in this area with a total of 8 employees. Cultural and religious barriers were covered as well as the general barriers affecting mental health services in the public space.

Thirty-seven and a half percent (37.5%) outlined in Table 5 identified culture as a barrier, while the remaining 62.5% does not. 12.5% and 50% of the sample strongly agreed that religion affects mental health treatment. The other 37.5% percent disagreed. Stigma, wait time, lack of resources, and no barriers all accounted for 25% of the overall findings (Table 6).

The table above represents the interpretation of the effect of mental health services in state care. It covers 5 categories and utilized a total of 8 employees. The number of participants, varying age groups, the availability of mental health services, and interventions used by the facilities were covered (Table 7).

| Categories | Frequency | Percentage |
|---|---|---|
| **Possible underlying factor(s)** | | |
| Predisposition | 4 | 50% |
| Attention seeking | 2 | 25% |
| Lack of appropriate development | 2 | 25% |
| Total | 8 | 100% |
| **Symptoms of children with mental illness** | | |
| Attention disorder | 1 | 12.50% |
| Schizophrenia | 1 | 12.50% |
| Depression | 4 | 50% |
| Behavioral disorder | 2 | 25% |
| Total | 8 | 100% |
| **Care and supervision of affected wards** | | |
| Medications | 4 | 50% |
| Appropriate monitoring | 2 | 25% |
| More monitoring needed | 2 | 25% |
| Total | 8 | 100% |
| **Relationship with mental health children** | | |
| Comparison between boys and girls? | | |
| Yes | 4 | 50% |
| No | 4 | 50% |
| Total | 8 | 100% |

**Table 8:** Availability of Mental Health Services and Interventions.

Table 8 is a representation of the availability of mental health services and interventions in childcare facilities. It includes 8 employees and covered a total of four categories which includes: possible underling factors, symptoms of children with mental illnesses, care and supervision of affected wards, and relationship with mental health children.

Captured in Table 8 is fifty percent (50%) employees reporting predisposition of CAYs, while attention seeking and lack of appropriate development accounted for the other 50% equally (25% each). The most common symptoms identified in persons who experience mental disorders in state care are depressive symptoms at 50%, behavioral disorder – 25%, attention and schizophrenia rounding off at 12.5% each, with medication as the primary source of treatment scoring 50% and appropriate monitoring and the need for more monitoring standing at 25% each.

## Discussion

The aim of this research is to examine the contributing factors to the mental health challenges of children living in state care in Kingston, Jamaica and to garner the efficacy of our aim and objectives; we incorporate the objectives with findings from the research. Based on the data gathered to evaluate the availability of mental health services in childcare facilities, half of the employee sample stated that state care institutions provide mental health services, which is consistent with goal number one. The conclusion, however, is that there are varying perspectives on the efficacy of the services offered. For example, those rating the services as poor or none are indicators that more assessment needs to be done in the quality of service being provided.

Objective number two was cemented in the interpretations of service barriers affecting mental health in state care. The data collected from the employees perceived cultural barriers such as religion to influence mental health treatment. In light of this, there's a need to improve the accessibility of mental health services by addressing these barriers. To investigate the approaches of mental health intervention used in state care, we utilized the emotional interpretations of the children. The results that tapered with unworthiness and predisposition speaks to objective number three. What these findings do is highlight the importance of evaluating the mental health intervention approaches, so that the necessary improvement can be made to create more effective intervention approaches.

Individuals in state care face barriers on a daily basis and mental health services are no exception. It's this reason the "Smile Bus" is used instead of a mental health unit. Objective number four identifies barriers individuals face in seeking and receiving appropriate mental health services. Employees' observation of barriers and religious perception on the influence of mental health treatment address this objective. It is further complimented by the stigma identified in Table 2.3. The data on the availability of mental health services and interventions and their limitations are also quite relevant to this objective. What this data revealed is that more needs to be done to eliminate the barriers identified through this research so the mental health and interventions services offered in state care facilities can improve.

Children in state care are prone to mental health disorders owing to a number of factors in agreement with studies done by CAPRI [11]. The trend and interpretations differ in the CAYs from that of the employees, where for example, the young people are not aware of any mental health challenges in them - predispositions or otherwise and that the interventions that are put in place are efficient. Whereas, employees data revealed that all the children have some form of mental health challenge and a number of them are predisposed to mental disorders.

The culture, ethnicity, and religious beliefs of some of the CAYs living in state care are indicators of a lack of diversity and a strong influence in these areas. CAYS who are not predisposed but suffer from a mental health challenge could be questionable as the environs and overall care can contribute to the development of a mental disorder.

The findings contextualized the objectives, which leads into the overall aim of this research. It revealed how each finding contributes to a broader understanding of the different factors that contribute to mental health challenges of children living in state care facilities and highlight the importance of addressing them.

The data gathered is confirmation that not much is being done for the improvement of mental health services and interventions offered in state care facilities. In fact, there have been limited resources over the years and with the number of CAYS that are now exposed to the child care system, it will only increase the need for a more comprehensive mental health service and intervention.

## Limitations

One of the research's shortcomings was that it was challenging to locate a state care facility for understudy. Because victims of mental health disorders were reluctant to come forward and talk about their experiences, the sample size limited the scope of this research. Furthermore, caregivers were hesitant to take part out of concern for their jobs. The sample population may not provide an accurate representative of the population due to selection bias in participant recruitment. A few of the data collection techniques were expensive and time-consuming. The interpretation of gathered data could

become unclear. It's possible that some of the information acquired from the analysis is inconclusive and needs more investigation. Obtaining participants was the most difficult task for the researchers. The facilities in collaboration with CPFSA run a tight shift. Person must be cleared before they can get close enough to interact with the CAYS and this is understandable. Due to the circumstances of these CAYs, too many persons take disadvantage of them in the name of 'help'; therefore, it's our solemn duty to protect them at all cost. CPFSA's protocols have recently become more stringent after the carelessness of the previous CEO. She was accused of breaching her moral responsibilities and CPFSA's mandate, when she entrusted the well-being of young girls to the care of a charged felon with a diagnosis of inter alia – which means that he is said to have little to no awareness of his inappropriate behaviors. Thus, sexually abusing the CAYs within the childcare facilities and evidence suggested that CPFSA was aware of the accused reputation prior to the accusation Johnson J, [16]. These are some of the child safeguarding breaches that occur because the accused was said to be providing gifts to the facilities. Therefore, to prevent further abuse of these vulnerable CAYs, the rules for facility visits and interactions had to change. Consequently, gathering the appropriate data for this research took jumping through many hoops with constant supervision.

## Recommendations

UNICEF (2018), reports that a collaborative study done with JFJ to assess the state care system in Jamaica shows that the standard of care provided to state wards is less than favorable. The article states that the most common occurrence category is physical abuse, and it primarily affects boys who are under state care. On the other hand, girls were significantly more likely to self-harm, attempt suicide, or experience sexual abuse at the hands of an adult facility employee. The findings raise potential implications that affects the mental well-being of the children, adolescents, and youths (CAY) housed in state run facilities and to mitigate such implications, the following steps were recommended for actions needed moving forward:

**Comprehensive Assessment and Monitoring and Early Interventions**

Data points to the significant mental health challenge of some children feeling unworthy and suffering from possible mental health issues. A holistic mental health assessment of children living in state care needs to be done to identify specific mental health needs, which can help guide the intervention process. The Illinois Department of Children and Family Services (IDCFS, 2024) identified the need for a holistic mental health service for children living in state care and believed that this should be implemented at most 30 days after entering the childcare facility. Interventions could be in the form of play therapy for age-appropriate children and cognitive behavioral therapy for those who are older. IDCFS (2024) suggest that this will help to determine how to best meet the mental health needs of children and young people in childcare facilities and also assist the CAYs to have a better understanding of what is happening to them and identify possible triggers, so they can develop positive coping mechanisms. The intervention(s) will not only treat the signs and symptoms but an ongoing process that will also help to empower them, build self-esteem, and increase their resilience.

**Continuous Research and Data Collection**

Additionally, while the data shows that there is relatively fair access to mental health care; it also shows a gap that questions the efficacy of the strategies and emotional support that is available. This area requires more in-depth research and continuous monitoring to gain further understanding of the strategies that are most effective for which area(s) as well as the social and systemic factors that might be contributing to these challenges. Chrystal S, et al. [17] lamented that although some monitoring takes place in the state care facilities, there's no evidence that speaks to the effectiveness of a positive outcome or consistency in relations to the value and priority of those most affected. The researchers suggested that the state should implement psychotropic over sight systems to eliminate over-prescribing and ensure that treatment for children in state care are appropriate Chrystal S, et al. [17]. Furthermore, accountability is important in assessing the social and systemic factors that contribute to the depreciation of the mental capacity of the CAYs living in state care facilities [18-25].

**Adequate Resource and Staffing**

A policy review is also crucial to ensure that children in state care don't just have access to mental healthcare but also quality and effective intervention services. Where policies are skewed or lacking, advocating for these adjustments will be beneficial for those presently living in state care and future participants. Clinicians also have an obligation to be knowledgeable of the interventions they use and culturally competent in understanding the treatment approach used with the client, based on their needs. The manner in which practices are implemented; especially with vulnerable members of the society - underserved population such as ethnically, social, and racial diverse groups - can influence the outcome of the treatment (Substance Abuse and Mental Health Services Administration (SAMHSA), 2021, p. 1). Without the required cultural competence, the clinician is liable to miss important verbal or nonverbal cues, which could be instrumental in the treatment plan [26,27].

**De-Stigmatize and Educate the Public about Mental Health**

Barriers to accessing mental health services that were identified are indicators that varying solutions are needed.

Training and education for the general public will not only decrease stigmas but also foster awareness to the importance of understanding mental health challenges and seeking help. Morgan, Barrett, and Silvera postulated that Jamaica historically paid scant regards to mental illnesses and victims are frequently alienated by families or stigmatized by the community. Therefore, advocating and raising awareness will further compound this recommendation, thus aiding the elimination of stigmas surrounding mental health issues. Workshops, ongoing collaborative campaigns with the Ministry of Health and other non-government entities, through education in the communities and providing further sensitization using flyers and other social media platforms are a few ways that this recommendation may be implemented [28].

**Cultural Sensitivity, Awareness, and Collaboration**

More importantly, culture and religion have been the cornerstones that have been shaping societies for generations; as well as contributed to a number of mental health challenges being treated incorrectly or left untreated. In the data gathered, the results showed that these factors still have a negative perception towards mental health care. Developing a culturally sensitive program that's geared toward diversity of children in state care and providing culturally competent training to staff and other professionals could help to understand and more effectively address cultural barriers that affect mental health services. Studies have shown that culturally competent care can lead to can lead to a better mental health outcome for CAYs living in state care facilities. More onboarding coaching and training can also be incorporated into the facilities cultural strategy plan to help employees become more knowledgeable, aware, and skilled in working with children who have mental health challenges. Furthermore, forming a collaborative partnership with community leaders and pastors to provide support that aligns with the religious and cultural beliefs of the client will address the religious and cultural deficits as well as promote inclusivity and diversity in state care and the wider community [29].

## Conclusion

Mind the Gap [9] states that more expansion of currently implemented evidence-based programs that address children's mental health needs is necessary in general but even more in state care facilities. The governance system needs to be strengthened. Adequate service providers are needed to improve the mental health system for children in state care who suffer for months or years while awaiting the service of a clinician. Collaboration between public and private entities will mitigate the exorbitant deficit in providing resources to supplement the services. The complex interplay of mental health professionals and other surrounding factors in addressing mental health challenges within state care is significant in the overall perception, reception, and care interventions in improving the mental health and overall well-being of children living in state care.

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