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Effects of presence in prefectures of short-term therapeutic institutions for emotionally disturbed children on the types of children that have to be taken care of in self-reliance support facilities and foster homes

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Abstract

Objective: The purpose of this study was to investigate how the presence in prefectures of institutions for short-term treatment of children with mild emotional disturbances affects the types of children that have to be taken care of in self-reliance support facilities and foster homes and the appropriateness of this care. These short-term therapeutic institutions (referred to here as STTIs) can either admit children needing treatment for a short period or treat them on an out-patient basis. Besides providing treatment, such facilities also provide consultation and other forms of assistance.

Method: Data collected in 2009 on children living in all types of children's institutions (foster homes, self-reliance support facilities, etc.) were analyzed in terms of the basic attributes of the children, their psychiatric and psychological characteristics (presence of disorders, psychiatric consultations, maltreatment experiences in their former living environment, and 17 items reflecting their tendency to manifest emotional and behavioral disorders), and the adequateness of care currently provided (according to staff members working in these institutions). Comparisons were then made between the data for children living in prefectures with one or more STTIs and the data for children living in prefectures without an STTI.

Results: In prefecture with STTIs, foster homes and self-reliance support facilities have to cover the needs of a higher number of children. Looking at the characteristics of children placed in foster homes depending on the existence of STTIs in the prefecture, results show that, in prefecture without an STTI, a higher number of children had emotional and behavioral disorders (8 items out of 17) and psychosomatic disorders. Children were also more likely to need mental health and psychological treatment. On the other hand, in self-reliance support facilities, 4 items of emotional and behavioral disorders were more likely to be positive and 5 items less likely. This shows that the characteristics of children placed in foster homes and self-reliance support facility vary depending on whether STTIs exist in the prefecture.

Conclusion: The results showed significant variations in the characteristics of children placed in self-reliance support facilities and foster homes between children living in a prefecture with at least one STTI and those living in a prefecture without one. They also showed that STTIs are used to treat children with emotional and behavioral disorders that self-reliance support facilities and foster homes are unable to handle. Future research should focus on examining the effectiveness of STTIs.

keywords: short-term therapeutic institution for emotionally disturbed children, children's institution, psychiatric and psychological treatment, maltreatment experience, emotional and behavioral disorders

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I. Introduction

Since the establishment of measures for assisting orphans after the Second World War, the system of child protection in Japan as well as society itself has been through many transformations. The current child protection system includes six types of children's institutions: infant homes (*nyûji-in*), foster homes (*jidô yôgo shisetsu*), short-term therapeutic institutions for emotionally disturbed children (*jôcho shôgai-ji tanki chiryô shisetsu*) (referred to here as STTIs), maternal and child living support facilities (*boshi seikatsu shien shisetsu*), children self-reliance support facilities (*jidô jiritsu shien shisetsu*), and homes for self-reliance (*jiritsu shien hômu*). As of March, 2012, there were 2,843 children in infant homes (7.0% of all placements in children's institutions), 28,533 in foster homes (70.5%), 1,140 in STTIs (2.8%), 6,250 in maternal and child living support facilities (15.4%), 1,331 in children self-reliance support facilities (3.3%), and 340 in homes for self-reliance (0.08%) [1]. That is, more than 40,000 children were in children's institutions, and foster homes (with about 70% of the placements) represent the core of the Japanese child protection system.

Child protection also includes care provided by foster care families (*sato-oya*). In this type of care, the responsibility for raising the child is transferred to a foster family (selected by the prefecture) and is provided when the child has no guardians or when the guardianship is considered inappropriate. While 7,669 families are currently registered as potential foster care families, the number legally responsible for raising a foster child is only 4,244, and the total number of foster children is only 4,930. Foster care in Japan also includes family homes (*famiri hômu*) taking care of 686 children [1]. These homes also provide care in a family environment (the house of caregivers) but the main difference with foster care families is that three caregivers at least are living in the same home. Besides, a family home can take care of 5 to 6 children at the same time (against up to 4 children in the case of foster care families). From an international point of view, foster care is still not frequently provided in Japan [2], and the foster care system in home care is still underdeveloped, covering only 10.8% of the 45,367 children in the child protection system.

The transformations through which the system of child protection in Japan has been since the Second World War reflect the evolution of the social structure. For example, children's institutions were initially primarily a substitute for the family, providing care to children without a home (war orphans, etc.) or whose family faced great poverty. In contrast, most placements nowadays are made

because the birth parents maltreated or neglected the child or were unable to provide a proper education to the child. A similar trend can be seen in Australia, Ireland, Israel, Sweden, England, and the U.S. as a greater number of children with behavioral and emotional disorders due to maltreatment are also being taken care of by the state in these countries [3-7]. The reasons for placement have thus become more complex, and the system must provide care to children who have been maltreated or neglected and thus need medical attention as well as to children who have lost their birth parents.

In Japan, 53.4% of children living in foster homes have experienced maltreatment, and 23.4% have some sort of mental and physical impairment, leading to an increasing need for specialized care. The average length of stay is also getting longer (currently 4.6 years), with 10.9% of children staying more than 10 years [1].

Of the children's institutions mentioned above, the focus here is on STTIs. The Children Welfare Act, Article 43, Paragraph 5, defines them as facilities admitting children with mild emotional disturbance for a short period or treating them on an out-patient basis. They also provide consultation and other assistance to the children even after being discharged. Psychotherapists and child psychiatrists at STTIs provide counseling, psychotherapy, consultation, and assessment of behavioral and emotional disorders. Compared to that at other care facilities for children, the length of stay is relatively short (2.1 years on average) [1]. Moreover, STTIs provide counseling and guidance on child education to residents of the community. As the length of stay is relatively short, children placed in an STTI usually return to their family or are placed in a foster home upon discharge. This explains why STTIs also provide after care such as day care services.

A look at the characteristics of children in STTIs shows that 75% of them have suffered maltreatment, 26% have pervasive development disorder, 12.8% have a light or medium intellectual deficit, 40% are being treated by a child psychiatrist, and 35% are on medication [8].

In Japan, there is no clear definition of emotional disturbance for children. However, as suggested by the appellation "short-term therapeutic institutions for emotionally disturbed children," STTIs were created to take care of children who need psychological care because they are suffering from psychological difficulties and because they are facing various difficulties in their daily life. Thus, it seems reasonable to consider that emotionally disturbed children are children who need psychological care because they are suffering from psychological difficulties and because they are facing various difficulties in their daily life. The term "emotionally disturbed" was formerly used to describe a "perturbation of emotion." However, its use created

various issues as it was difficult to identify the characteristics of children who would fall into this category. Moreover, “disturbed” in Japanese also means handicapped and was thus considered inappropriate (especially by the families and children themselves) for describing children with psychological difficulties. Another problem was the use of “short-term” when the average length of stay exceeded two years. For these reasons, the government stated in a notice dated 29 March 2012 that “psychological care facility for children” could be used instead of “STTI.” This also indicates that the government has recently developed an interest in this type of institution.

Children self-reliance support facilities were formerly called “juvenile education and protection centers” (*kyōgo-in*) and targeted children who, according to child guidance centers and family courts, “have committed or are at risk of committing offenses.” The appellation was changed to “children self-reliance support facilities” by a revision of the child welfare law in April 1998. At the same time, these facilities began to take in “children who need lifestyle guidance due for example to their family environment.” As a result, the functionality of these facilities was extended to enable the provision of after-care services, community support services, family adjustment services, and short stay services. The decreasing number of placed children in these facilities may be related to this extended functionality [9]. Despite their smaller staffs, these facilities started taking care of difficult cases, e.g., children needing highly specialized care, including children with behavioral and emotional disorders.

The child protection system in Japan has traditionally focused on securing placements of children in foster care homes and has gradually loosened the requirements placed on each type of facility in terms of the child’s age and condition despite the inability of some institutions to provide specialized health care to an increasing number of children with behavioral and emotional disorders. Although STTIs and children self-reliance support facilities were designed especially to provide this type of care, it appears that they are still insufficiently developed and not fully operational.

Data from the National Child Abuse and Neglect Data System (NCANDS) in the United States [10] suggest that only children with severe disorders are placed in institutions. The data showed that 78.3% of them were neglected, 17.8% were physically abused, 9.5% were sexually abused, 7.6% were psychologically abused, 2.4% were medically neglected, and 9.6% had experienced another type of maltreatment. These rates are quite similar to the rates of maltreated children placed in STTIs in Japan. Obviously, it is not possible to simply compare these data because of the contextual differences and the

fundamentally different approach to collecting data (data from the United States are based on the number of maltreatment reports that were actually certified as maltreatment cases), but the U.S. data supports the observation that STTIs in Japan are taking care of children who have experienced serious maltreatment and thus are at high-risk of developing behavioral and emotional disorders.

In November 2000, a national movement in Japan known as “21st Century Healthy Parents and Children” recognized the need for facilities, such as STTIs, that can take care of the increasing number of maltreated children and called for the implementation of at least one STTI in each prefecture by 2010 [11]. Moreover, the “Vision for Children and Childcare” called for the implementation of 47 STTIs before 2014 [12]. However, there are still some prefectures in Japan without an STTI [13].

In our study, we investigated the current child protection system in Japan, focusing on the role of short-term therapeutic institutions. The presence of STTIs in prefectures and their occupancy rates were determined using the national database on child protection created in 2009. We focused on the effects that the presence and non-presence of STTIs in a prefecture have on placements in foster homes and in children self-reliance support facilities by comparing the basic attributes and psychological and psychiatric characteristics of children placed in these institutions. By determining the effect of STTIs on other facilities, we can offer insights into the future direction of the child protection system needed in Japan.

II. Method

1. Data

In 2009, a study of all types of child protection facilities in Japan collected data on about 36,200 institutionalized children (complete enumeration). These data were collected for children living in 441 foster homes (representing 87.7% of all foster homes in 2009) and in 45 support facilities (representing 77.6% of all support facilities in 2009).

The data included the child’s date of birth, gender, and length of stay in the facility, the number and types of placements the child had had, the difficulties in caring for the child, the child’s domicile before the placement, the child’s family, the child’s certified disabilities, the child’s mental and physical health, the existence or non-existence of maltreatment experiences, the appropriateness of the placement (according to staff members working in the facility), and 17 items assessing the tendency of the child to manifest behavioral and emotional disorders. These data were obtained through a questionnaire filled

in by a doctor or facility staff member and through the collection of assessment grids used in child consultation centers.

2. Ethical considerations

An explanation of the ethical considerations was sent along with the questionnaire. It assured the respondents of confidentiality and explained their right to refuse to participate in the study. It stated that, by sending back the questionnaire, they agreed that the data could be used for the purpose of this study. The Ethics Committee of the National Institute of Public Health approved the study (approval number NIPH-TRN#08003).

3. Analytical method

Using data from the Ministry of Health, Labour and Welfare [13], we created a variable for the presence or non-presence of STTIs in prefectures and calculated the STTI occupancy rate for each prefecture with an STTI.

First, we compared the number of foster homes and support facilities, as well as the coverage of each of these facilities (in terms of number of children), in prefectures with STTI and prefectures without STTI. The coverage of each facility was calculated using population data provided by the Ministry of Internal Affairs and Communications on the number of children under age 20 per municipality [14].

Then, comparisons were made on the basis of whether a prefecture had an STTI or not in terms of the attributes of children (gender and age) in foster homes and support facilities, length of stay, certified disability, psychosomatic disorder, mental health and psychological treatment, adequateness of care currently provided (according to staff members), rate of abused children, and 17 items assessing the tendency to manifest emotional and behavioral disorders. This tendency was assessed on the basis of not only the doctor's diagnosis but also on staff observations.

III. Results

1. Presence of STTIs in prefectures

As shown in Table 1, STTIs were implemented in 33 different locations (prefecture, city designated by government ordinance or core city) in Japan as of October 2010. At the scale of prefectures, this means that only 30 of the 47 prefectures of Japan have implemented at least one STTI.

Hyogo prefecture had the highest STTI occupancy rate (97.1%), followed by the city of Hiroshima city with 96.4%, Wakayama and Shiga prefectures with 93.3%, Osaka city with 90.7%, and Sendai city, Shizuoka prefecture and Tottori prefecture with 90.0%.

The lowest occupancy rates were for Mie prefecture

Table 1 Number and occupancy rate of STTIs in each prefecture or major city (2010.10)

Prefecture or major city	Number of STTIs (A)	Capacity (B)	Actual number of placements (C)	Occupancy rate (%) (C/B)
Hyogo	1	35	34	97.1
Hiroshima city	1	28	27	96.4
Wakayama	1	30	28	93.3
Shiga	1	50	46	92.0
Osaka city	2	75	68	90.7
Sendai city	1	40	36	90.0
Shizuoka	1	50	45	90.0
Tottori	1	30	27	90.0
Nagano	1	19	17	89.5
Aichi	2	85	76	89.4
Osaka	3	154	136	88.3
Yokohama city	1	56	49	87.5
Gifu	1	48	42	87.5
Nagasaki	1	40	35	87.5
Kumamoto	1	35	29	82.9
Kagoshima	1	35	29	82.9
Iwate	1	50	40	80.0
Kyoto	1	30	24	80.0
Yamaguchi	1	50	40	80.0
Gunma	1	38	30	78.9
Hokkaido	1	50	37	74.0
Kagawa	1	30	22	73.3
Saitama	1	50	36	72.0
Ibaraki	1	40	26	65.0
Kochi	1	30	13	43.3
Aomori	1	30	12	40.0
Nagoya city	1	35	13	37.1
Fukuoka	1	50	18	36.0
Shimane	1	20	7	35.0
Kyoto city	1	35	12	34.3
Okayama	1	50	17	34.0
Tochigi	1	35	7	20.0
Mie	1	40	5	12.5

with 12.5%, followed by Tochigi prefecture with 20.0%, Okayama prefecture with 34.0%, Kyoto city with 34.3%, Shimane prefecture with 35.0%. There is thus a large gap in the occupancy rate between prefectures, some with a rate greater than 90% and some with a rate below 40%.

2. Presence of STTIs and situation of children in self-reliance support facilities and foster homes

The differences in the rate of self-reliance support facilities and foster homes, and in the coverage of each of these facilities, depending on the presence or non-presence of STTIs in the prefecture are summarized in Table 2.

Prefectures with an STTI had a higher proportion of foster homes (55.8% vs. 44.2%) and a lower proportion of support facilities (46.5% vs. 53.5%).

Table 2 Effect of presence or non-presence of STTIs on establishment of foster homes and support facilities and on number of placements

	STTI present	STTI not present	Total
Number of facilities(%)			
Foster homes	246(55.8%)	195(44.2%)	441
Support facilities	20(46.5%)	23(53.5%)	43
Coverage aged under 20 population per facility			
Foster homes	61305.7	41899.7	
Support facilities	754060.7	355236.7	

However, looking closely at the coverage (the number of children in prefectures divided by the number of facilities), it appears that, in prefecture with STTIs, each foster home and children self-reliance facility has to cover the needs of a higher number of children (61305.7 against 41899.7 children per foster home and 754060.7 against 355236.7 children per self-reliance support facility).

3. Presence of STTIs and characteristics of children placed in children self-reliance support facilities and foster homes

The basic attributes of children in foster homes and support facilities are shown in Table 3 broken down by the presence and non-presence of STTIs in the prefecture. No significant differences were observed regarding the gender ratios.

The age and length of stay of children in foster homes and support facilities were slightly higher for prefectures without an STTI. According to the medical files and staff members, a higher number of children are provided with psychiatric and psychological treatment and a higher proportion of children are considered to have psychosomatic disorders in prefectures without an STTI. Moreover, the number of children who had experienced physical abuse, neglect, and psychological abuse (other than sexual abuse and other specific types of abuse) was higher in those prefectures. The number of positive items for assessing the tendency to manifest emotional and behavioral disorders was also significantly higher, with an average of 9 positive items out of 17, and the number of children considered by the staff members to be receiving inadequate treatment was significantly higher in these prefectures.

Gender differences were not seen for the self-reliance support facilities. In prefectures without an STTI, children self-reliance support facilities had a higher rate of children with physical disorders. Moreover, even though the number of children with mental disorders was lower, psychological therapy was more likely to be used. This result suggests that, when STTIs does not exist in the prefecture, self-reliance support facilities take care of children with behavioral and emotional disorders

instead of STTIs and that, when STTIs does exist in the prefecture, self-reliance support facilities take care of children with mental disorders that STTIs does not include.

The fact that STTIs and support facilities does not take care of children with the same disorders become even more apparent when comparing the behavioral and emotional disorders of children placed in support facilities depending on whether STTIs exist in the prefecture.

The rate of children in support facilities who had experienced neglect and other types of maltreatment was lower in prefectures without an STTI. Four behavioral and emotional disorders were more common in prefectures without an STTI: issues with the educator, substance use, self-injurious behavior, and issues of group adaptation. Six other ones were less common: eating disorder, sleeping disorders, deficiency to develop language skills, mental retardation, bullying other children within the institution, and being bullied by other children within the institution.

IV. Discussion

1. Effect of presence of STTI on placement appropriateness

That some children are inappropriately placed in children's institutions is commonly known by employees of these institutions. In Tokyo, which does not have an STTI, the metropolitan government recognized in 2009 that inappropriate care may be provided to some children placed in children's institutions due to the lack of an STTI and thus suggested a "reinforcement of the medical care provided to abused children." It was estimated that approximately 10% of children placed in foster homes in Tokyo should actually be in an STTI [15].

Our research supports this common knowledge and the statement of the Tokyo Metropolitan Assembly of the Japanese Communist Party. It empirically revealed that, in prefectures without an STTI, children who should be in an STTI due to their condition generally ended up in foster homes and support facilities. It thus provides clear

Table 3 Characteristics of children placed in foster homes and support facilities according to the presence or non-presence of STTIs in prefecture

		Foster homes			Support facilities		
		STTI present (N=14,219)	STTI not present (N=10,828)	P value	STTI present (N=749)	STTI not present (N=752)	P value
Age (years)	Mean (SD)	12.0 (4.3)	12.1 (4.3)	*	15.5 (1.7)	15.5 (2.1)	
Length of stay (years)	Mean (SD)	5.6 (3.7)	5.8 (3.8)	*	2.0 (0.8)	2.1 (1.1)	
Sex	Male (%)	7584 (53.6)	5829 (54.1)		510 (68.5)	516 (68.8)	
	Female (%)	6570 (46.4)	4947 (45.9)		234 (31.5)	234 (31.2)	
Disability certification							
Physical disability certification	Yes (%)	232 (1.6)	182 (1.7)		10 (1.3)	10 (1.3)	
Intellectual disability certification	Yes (%)	530 (3.7)	392 (3.6)		8 (1.1)	8 (1.1)	
Mental disability certification	Yes (%)	338 (2.4)	263 (2.4)		5 (0.7)	8 (1.1)	
Psychosomatic disorders							
Physical disorders	Yes (%)	2995 (21.3)	2592 (24.4)	**	98 (13.2)	126 (16.9)	*
Mental disorders	Yes (%)	2658 (18.9)	2386 (22.3)	**	370 (49.7)	283 (38.1)	**
Mental Health and psychological treatment							
Visits in psychiatric services	Yes (%)	673 (4.8)	700 (6.5)	**	133 (17.8)	139 (18.6)	
Medication prescribed by psychiatric services	Yes (%)	420 (3.0)	451 (4.2)	**	118 (15.8)	106 (14.2)	
Other hospital visits	Yes (%)	1243 (8.9)	1128 (10.5)	**	55 (7.4)	69 (9.1)	
Other medication	Yes (%)	882 (6.3)	803 (7.5)	**	46 (6.3)	59 (8.0)	
Psychological therapy within the institution	Yes (%)	2433 (24.4)	3198 (29.8)	**	140 (18.8)	254 (33.9)	**
Maltreatment experience							
Maltreatment experienced	Yes (%)	8064 (57.0)	6771 (62.9)	**	518 (69.6)	475 (63.3)	*
Physical abuse	Yes (%)	3652 (22.2)	2644 (24.4)	**	241 (32.2)	278 (37.0)	
Sexual abuse	Yes (%)	346 (2.4)	305 (2.8)		40 (5.3)	29 (3.9)	
Neglect	Yes (%)	5598 (39.3)	4793 (44.3)	**	338 (45.1)	292 (38.8)	
Psychological abuse	Yes (%)	1897 (13.3)	1635 (15.1)	**	152 (20.3)	174 (23.1)	
Other types of abuse	Yes (%)	117 (0.8)	98 (0.9)		0 (-)	5 (0.7)	
Hard to tell	Yes (%)	113 (0.8)	129 (1.2)	**	4 (0.5)	5 (0.7)	
Behavioral and emotional disorders							
Autistic tendency	Yes (%)	1460 (11.7)	1238 (13.2)	**	99 (15.9)	118 (19.1)	
Issues with the educator	Yes (%)	1808 (19.5)	1380 (20.3)		280 (64.8)	184 (55.4)	**
Tendency toward attention deficit or hyperactivity	Yes (%)	3294 (26.5)	2702 (28.8)	**	281 (43.6)	285 (45.0)	
Tendency toward antisocial behavior	Yes (%)	3993 (28.8)	3206 (30.2)	*	561 (76.1)	537 (74.1)	
Tendency toward depression	Yes (%)	1057 (9.4)	1014 (11.8)	**	117 (18.6)	151 (21.3)	
Tendency toward learning disabilities	Yes (%)	2348 (24.1)	1841 (24.8)		209 (32.7)	214 (33.6)	
Substance use	Yes (%)	770 (9.6)	650 (10.5)		269 (37.6)	212 (30.9)	**
Self-injurious behavior	Yes (%)	840 (6.1)	711 (6.7)	*	129 (18.7)	101 (14.4)	*
Issues of group adaptation	Yes (%)	2455 (21.9)	2146 (24.9)	**	449 (62.1)	398 (55.7)	**
Social withdrawal	Yes (%)	209 (5.2)	179 (5.8)		41 (12.9)	39 (12.0)	
Elimination disorders	Yes (%)	1528 (19.2)	1111 (19.0)		27 (6.3)	27 (9.6)	
Eating disorders	Yes (%)	628 (5.6)	580 (6.8)	**	41 (5.5)	60 (8.9)	*
Sleeping disorders	Yes (%)	592 (5.3)	583 (6.8)	**	51 (6.9)	89 (13.2)	**
Deficiency to develop language skills	Yes (%)	2097 (15.1)	1695 (16.0)		92 (12.7)	162 (23.0)	**
Mental retardation	Yes (%)	3005 (22.0)	2198 (20.9)	*	146 (19.7)	176 (25.3)	*
Bullying other children within the institution	Yes (%)	2389 (17.4)	1882 (17.9)		198 (26.8)	239 (33.2)	*
Being bullied by other children within the institution	Yes (%)	1890 (13.9)	1401 (13.4)		168 (23.1)	202 (28.4)	*
Placement considered as inappropriate	Inappropriate	1163 (8.3)	1271 (12.0)	**	92 (12.4)	108 (14.6)	

P value was calculated using independent t-test for continuous variables and χ^2 test for categorical variables.

** $P < 0.01$; * $P < 0.05$.

evidence that children are more likely to receive inappropriate care in prefectures without an STTI.

The results are less conclusive for support facilities and do not suggest that some of the children placed in foster homes should actually be in an STTI. The number of placements that employees would consider inappropriate was substantial for foster homes while the number was negligible for children self-reliance support facilities. The recent change in policy extending the role of children self-reliance support facilities to enable them to take care of increasingly difficult cases can be

interpreted as recognition that foster homes are not appropriate for such cases. However, as discussed later, differences were seen in the behavioral and emotional disorders of children placed in children self-reliance support facilities depending on whether an STTI was present or not in the prefecture. This suggests that these facilities may have to take in children with differing characteristics depending on whether there is an STTI in the prefecture.

Our research is based on the hypothesis that the presence of an STTI in the prefecture should affect the

placement of children in other facilities such as foster homes and children self-reliance support facilities.

It is important to note that placements in an STTI represent only 3% of all placements in children's institutions and that, even if the goal of implementing 47 STTI by 2016 is reached, the number of children being treated in an STTI in each prefecture would not exceed a few dozen. Thus, considering that more than half of the children in foster homes and two-thirds of the children in children self-reliance support facilities have experienced maltreatment, the role that STTIs may be able to play in the future seems limited.

Nevertheless, even though the average length of stay in an STTI keeps increasing, STTIs were initially created to provide short-term care and thus allow temporary transfer from foster homes. STTIs may be better suited as a back-up for psychiatric and psychological treatment through short stays and temporary placements than for multi-years treatment of maltreated children who have been admitted. Considering that some STTIs have been implemented in hospitals and are focusing on this type of care, it may be worthwhile to encourage this back-up function of STTIs.

2. Effect of presence of STTI on situation in foster homes and children self-reliance support facilities

When comparing the situation in foster homes and children self-reliance support facilities, it appears that, even though no significant differences were seen in the disability certifications, children placed in foster homes in a prefecture without an STTI are more likely to have physical and psychiatric disorders. In the case of children placed in children self-reliance support facilities, the same tendency was seen for physical disorders while psychiatric disorders were more likely to be seen in children self-reliance support facilities when there was an STTI in the prefecture. Considering that children in children self-reliance support facilities are placed there because they would be difficult to take care of in other facilities, this trend suggests that STTIs do not have the capacity to take care of all the children with psychiatric disorders and thus have to rely on placements in children self-reliance support facilities.

Higher rates of children provided with psychiatric and psychological treatment in foster homes were seen when there was no STTI in the prefecture while higher rates were seen only for psychological therapy in children self-reliance support facilities. This is understandable given that children self-reliance support facilities are a closed environment, so visits to external medical facilities are naturally uncommon. Moreover, considering that STTIs were created to provide this type of psychological therapy, it is not surprising that the number of children in

need of psychological care is higher in children self-reliance support facilities when there is no STTI in the prefecture.

The rate of children with a maltreatment experience is higher for children placed in foster homes but lower for children placed in children self-reliance support facilities when there is no STTI in the prefecture. This may be related to our finding that, in prefectures without an STTI, an increased number of children were placed not due to maltreatment but to misbehavior.

Eight behavioral and emotional disorders were more frequent in children placed in foster homes when there was no STTI in the prefecture: autistic tendency, tendency toward attention deficit or hyperactivity, tendency toward antisocial behavior, tendency toward depression, self-injurious behavior, issues of group adaptation, eating disorders, and sleeping disorders. In prefectures with STTIs, only mental retardation was more common. This means that, when there is no STTI in the prefecture, children who should be in disabled children facilities due to their severe behavioral and emotional disorders end up in foster homes and that many children with mental retardation are placed in foster homes.

The types of emotional behavioral disorders in children living in self-reliance support facilities that varied depending on the presence of an STTI in the prefecture differed from those in children living in foster homes. When there was an STTI in the prefecture six disorders were less frequent in children living in children self-reliance support facilities: eating disorders, sleeping disorders, language skills development deficiency, mental retardation, bullying, and being bullied. On the other hand, four disorders were more frequent: issues with the educator, substance use, self-injurious behavior, and problems with group adaptation. This suggests that the types of emotional and behavioral disorder that STTIs and children self-reliance support facilities can deal with are different.

These results suggest that the presence of an STTI in the prefecture affects the placement of children in foster homes and children self-reliance support facilities. In Japan, child guidance centers screen children needing help and determine the best placement option. In prefectures with an STTI, these centers have another placement option. Moreover, since STTIs are targeted at a specific population of children, there are clear standards on which to base the decision. In prefectures without an STTI, the standards for determining the best placement are rather vague, leading to an increase in inappropriate placements. This means that the screening function of child guidance centers is hindered by the lack of STTIs in the prefectures.

To cover the needs of maltreated children and to be

able to treat emotional and behavioral disorders by providing specialized care, it is crucial to promote and support the screening function of child guidance. The results of this study help clarify the characteristics of children in the child protection system and thus support a more effective screening process.

3. Future challenges in promoting STTIs

The child protection system has focused on taking care of children with various problems. However, most children's institutions are not currently equipped to provide the specialized care needed to deal with the recent increase in the number of children with emotional and behavioral disorders. Children's institutions were initially more a place for children to live than a therapeutic facility, so providing medical services for the children in an everyday setting may have been considered inappropriate.

As of October 2010, STTIs were implemented in only 33 prefectures and government ordinance cities, which is less than half of all prefectures and government ordinance cities (47.8%). According to the Ministry of Health, Labour and Welfare, only five local authorities are currently implementing or planning on implementing an STTI [13], and there is no indication that this number will increase in the near future. However, implementing more STTIs is obviously necessary considering the rapid increase in the number of maltreated children.

The main reasons given for this shortfall in the number of STTIs implemented are "Difficulty in finding managing agents," "Difficulty in finding psychotherapists and doctors," and "Lack of children to place in such an institution." It appears that the recognition of the importance of STTIs varies greatly among municipalities [13], showing not only a lack of comprehension by some municipalities about the actual situation but also the problem of funding the construction of STTIs. Thus, the lack of STTIs is not only the responsibility of municipalities but also of the national government, which has failed to make a strong case for the construction of STTIs and does not provide strong enough incentives for their construction.

In the U.S., where the child protection system is centered on placements in foster families, supporting data has been collected [6]. One study has revealed, for example, that 60% of children placed in foster family return to their former home in less than six months [16]. Other studies have shown that 70 to 80% of the children receiving out-of-home care had experienced maltreatment in their previous home and that, overall, the foster care system is effective in preventing abuse [17-20]. Other studies revealed that the incidence of neglect or physical maltreatment by the birth parents decreased after the child returned home [21-23].

However, empirical studies on the outcomes of the child protection system in Japan are still remarkably lacking [24]. Moreover, since the Japanese system is based on residential placement rather than on foster family placement, there is a strong need to conduct research specific to the situation in Japan to clarify how this child protection system affects the emotional and behavioral disorders of children. Moreover, Japan should also conduct research on the care provided by STTIs and the outcome of this care, as STTIs are actually able to provide the care needed to treat emotional and behavioral disorders.

There have been few studies that focused on how the presence of an STTI in the prefecture affects other children's institutions. Future research should focus on examining the effectiveness of STTIs and how better cooperation between STTIs, foster homes, and children self-reliance support facilities could improve the care provided to children. At the same time, clinical studies are needed to reveal how the care provided in foster homes and children self-reliance support facilities differs depending on the presence of an STTI in the prefecture.

V. Conclusion

By comparing the characteristics of children in foster homes and children self-reliance support facilities depending on the presence or non-presence of an STTI in the prefecture, we found that some children who should be in an STTI due to their maltreatment experience and/or their emotional and behavioral disorders actually ended up in a foster home. We also found that, when those placements are made, they are considered inappropriate by the staff members of foster homes.

When there is an STTI in the prefecture, children self-reliance support facilities tend to have a higher rate of children with psychiatric disorders and who are more likely to have issues with the educator and problems with group adaptation and to exhibit self-injurious behavior and use substances, which suggests that these children should not be placed in an STTI but in a self-reliance support facility.

Our results show that the presence of an STTI in the prefecture affects the placement of children in foster homes and children self-reliance support facilities. They also suggest that STTIs are used as a last resort for children with maltreatment experience and/or behavioral and emotional disorders.

Thus, future research should focus on clearly defining the purpose of each type of child care institution so that appropriate care can be provided and on collecting data regarding the care provided in each type of institution, the possible cooperation between institutions, and the outcome of care.

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