Published in final edited form as:

J Interpers Violence. 2021 February ; 36(3-4): NP1193–1204NP. doi:10.1177/0886260518754871.

Health and Health Needs of Children of Women Seeking Services for and Safety from Intimate Partner Violence

Kristine A. Campbell,

University of Utah, Department of Pediatrics, Salt Lake City, Utah

Raquel Vargas-Whale,

Driscoll Children's Hospital, Department of Pediatrics, Corpus Christi, Texas

Lenora M. Olson

University of Utah, Department of Pediatrics, Salt Lake City, Utah

Abstract

Background—Children exposed to intimate partner violence (IPV) are at increased risk for health problems. The moment that a mother seeks services for or safety from IPV may be a window of opportunity to offer needed health care for her children.

Objectives—To describe perceptions of child health conditions and needs among mothers seeking services for or safety from IPV, and to compare results in shelter- vs community-based samples.

Methods—A cross-sectional survey between Fall 2013–Winter 2014 of women with at least one child 3–11 years of age seeking services at an urban YWCA, which supports a residential IPV shelter and a community-based family justice center. Child health conditions were captured using the Children with Special Health Care Needs survey and the Strengths and Difficulties Questionnaire. Prevalence of health conditions among IPV-exposed children were compared to population norms. Perceived child health and health needs in the residential vs community settings were compared.

Results—Women (n=48) completed surveys related to 91 children. Special health care needs (25%) and behavioral health (52%) problems were significantly higher in our sample than in general populations. Almost one-quarter (24%) of children had a current need for general medical care and almost one-half (44%) had a current need for behavioral health care. No significant differences in child health conditions or needs between residential and community settings were observed.

Conclusions—These findings extend prior research describing the health problems faced by children exposed to IPV by describing maternal perceptions of child health and need for health

Corresponding Author: Kristine A. Campbell, University of Utah, Department of Pediatrics, Primary Children's Hospital, Eccles Outpatient Building, 4E-200, 81 North Mario Capecchi Drive, Salt Lake City, Utah 84113, kristine.campbell@hsc.utah.edu, 801-662-3605.

Financial disclosure:

Dr. Campbell's institution receives financial compensation for expert witness testimony provided in cases of suspected child abuse for which she is subpoenaed to testify.

care in a critical moment of seeking help for IPV. Community agencies may use this window of opportunity to support child health and household safety.

Over the course of a lifetime, 25–30% of women in the United States experience intimate partner violence (IPV) (Black et al., 2011). Women between the ages of 20–34 years are at highest risk for IPV, making IPV disproportionately common in families with young children. Recent estimates suggest that fifteen million children in the U.S. are exposed to IPV every year (McDonald, Jouriles, Ramisetty-Mikler, Caetano, & Green, 2006). While there is no broadly accepted definition of “exposure” to IPV, some children may experience physical or psychological abuse, while others may witness violence between caregivers, and others may live without direct exposure to violence but in a home impacted by the threat of violence and abuse that is hidden from children (Christian, Scribano, Seidl, & Pinto-Martin, 1997; Evans, Davies, & DiLillo, 2008; Hamby, Finkelhor, Turner, & Ormrod, 2010; McGuigan & Pratt, 2001). These risks are significant enough that in some states, IPV exposure alone has been defined as a form of child maltreatment subject to mandated child abuse reporting statutes (Child Welfare Information Gateway, 2016).

Children with a history of IPV exposure have a higher prevalence of clinically important short and long-term physical and behavioral health problems compared to children without a history of exposure (Bair-Merritt, Johnson, Okelo, & Page, 2012; Breiding & Ziembroski, 2011; Evans et al, 2008; Kitmann, Gaylord, Holt, & Kenny, 2003; Litrownik, Newton, Hunter, English, & Everson, 2003). In the short term, children exposed to IPV are more likely to experience problematic school and other learning behaviors, increased anxiety, depressive symptoms, hyperarousal response, aggressive behavior, psychosomatic health conditions and other internalizing and externalizing behaviors compared to children who are not exposed. While short-term physical health impacts are less understood, over time, childhood exposure to IPV is associated with emergence of adult health consequences ranging from mental illness, substance abuse, risky sexual behavior and suicidality to obesity, hypertension, and cardiovascular disease (Dube, Felitti, Dong, Giles, & Anda, 2003; Felitti et al., 1998). Diminished engagement with preventive health care services, increased involvement in high risk health behaviors, and biological response of the neuroendocrine stress response may all serve as pathways between exposure to IPV and health outcomes (Bair-Merritt et al., 2008; Bair-Merritt et al., 2012; Duke, Pettingell, McMorris, & Borowsky, 2010; Hunter, Minnis, & Wilson, 2011; Saltzman, Holden, & Holahan, 2005). Resolution of IPV and appropriate trauma therapies can lessen or ameliorate the behavioral problems seen in children exposed to IPV (Campbell, Thomas, Cook, & Keenan, 2013; Cohen, Mannarino, & Iyengar, 2011; Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007; Timmer, Ware, Urquiza, & Zebell, 2010).

This evidence suggests that a critical moment to address general and behavioral health concerns in children occurs when a mother seeks services for or safety from IPV. If a maternal choice to resolve IPV in her household can influence the health and well-being of her children, understanding how a mother perceives a child’s health at the point of this decision is critical. Recognizing this gap in our understanding of maternal perceptions of child health at this decisive moment, the aims of this study were threefold: to describe maternal perceptions of the general and behavioral health conditions and needs of children

when their mothers are seeking services for safety from IPV; to compare the health conditions and needs of the children with IPV exposure living in the community to those in a shelter setting; and to support efforts of IPV service providers in meeting the health needs of children with IPV exposure.

Methods

Study Design and Setting

This was a cross-sectional survey of women seeking IPV services from the YWCA Utah. This urban campus includes two distinct centers for individuals impacted by IPV: a residential IPV shelter, which provides temporary housing for women and children facing homelessness as a result of IPV, and a community Family Justice Center, which provides services and referrals to support individuals living in the community with IPV (Gwinn, Strack, Adams, Lovelace, & Norman, 2007; Kamimura, Parekh, & Olson, 2013). The Institutional Review Boards of the University of Utah and the Utah Department of Human Services approved the research.

Participants and Procedures

English and Spanish-speaking mothers seeking IPV services through the YWCA were recruited over one week of each month between 10/2013-01/2014. After reviewing informed consent with an investigator, participants completed an anonymous paper survey in English or Spanish for each child age 3–11 years living with the mother in her community household or shelter residence at least 4 days per week.

Survey

Design—The survey instrument reflects a collaborative partnership between University of Utah researchers and YWCA Utah staff in response to a perceived high prevalence of health problems among children living in the residential shelter. While addressing these concerns, YWCA staff recognized an institutional tendency to overlook potential health conditions and needs among children of women seeking services from the community setting, who were often unknown to YWCA staff. Working together, researchers and staff developed a survey instrument to address both the pragmatic needs of the community organization and the primary objectives of the researchers.

Exposure—The exposure of interest was the shelter vs community setting for children of mothers seeking services for IPV.

Outcomes—Maternal report of child health conditions, reflected as the presence of a special health care need (SHCN) and/or the presence of a clinically significant behavioral problem, was the primary outcome. An SHCN was defined as a positive response to the Children with Special Health Care Needs Screener, a 5-item tool used widely to identify children who are at risk for chronic physical, developmental, behavioral, or emotional conditions requiring services and resources beyond those typically needed (National Survey of Children with Special Health Care Needs, 2010; van Dyck et al., 2002). A clinically significant behavioral problem was defined as a Total Difficulties score above the 90th

percentile for age and sex in a normative U.S. population on the Strengths and Difficulties Questionnaire, a widely used 25-item screener which relies on parent report of positive and negative child attributes (Goodman, 2001). The chosen cut-point has been cited as a predictor of child psychiatric disorders (Stone, Otten, Engels, Vermulst, & Janssens, 2010).

Additional descriptive characteristics were collected to provide a broad comparison of these two populations. Maternal variables included depressive symptoms (a raw score of 3 or more on Patient Health Questionnaire-2 is associated with a positive predictive value for any depressive disorder of >80%), length of time living with IPV, and general demographics. We chose not to collect descriptors of IPV type or severity, other than length of time, as it is unknown how maternal experiences with IPV translate to child exposures (Child Welfare Information Gateway, 2016). Child variables included exposure to events associated with IPV (involvement with Child Protective Services (CPS), witness to parental arrest, and ongoing contact with abusive partner) and general demographics. In addition, we collected a measure of parenting stress for each child using the Parenting Stress Index-Short Form (a standardized score of 90 or more suggests clinically significant parenting stress) (Haskett, Ahern, Ward, & Allaire, 2006; Kroenke, Spitzer, & Williams, 2003).

Survey analysis

We used descriptive statistics to report the prevalence of SHCN and the presence of clinically significant behavioral conditions among children of women seeking services for or safety from IPV. These outcomes, as well as other characteristics of interest, were compared among children in the shelter vs community setting. A mixed effects Poisson regression was used to adjust for clustering of children within family groups. To compare the prevalence of SHCN in our sample to the prevalence in Utah, we selected one child from each family group at random and compared the proportion of children with SHCN in this sample to the prevalence of SHCN in the general population. A similar procedure was used to compare the prevalence of clinically significant behavioral conditions in our sample to a general U.S. population sample. All analyses were conducted using STATA/SE 13.1.

Results

Forty-eight women (n= 48) completed surveys related to 91 children. The majority of our participants were over 24 years of age, identified a minority racial or ethnic background, reported IPV present for more than one year, and described symptoms concerning for depression (Table 1). While we identified no statistically significant demographic differences between women living in the community and women living in the IPV shelter, several observations are worth noting. Women living in the community were somewhat older and more likely to report living with IPV for more than a year than women living in the shelter. From maternal report, children living in the shelter were more likely to have had CPS involvement, witnessed parental arrest, or be a source of clinically important parenting stress than those children still living in the community. Children in the community, in contrast, were more likely to have ongoing contact with a partner abusive to his or her mother.

In terms of child health concerns, a substantial majority of mothers of children in both settings were able to identify a primary health care provider for their child. Overall, almost one-quarter of mothers reported a need for medical care and almost one-half reported a need for behavioral health care (Table 2). Children in the community setting were slightly more likely to have a current need for a medical appointment, while those in the shelter setting were more likely to have a need for behavioral health services. These differences varied across racial and ethnic minority groups (results not shown), but small sample size made interpretation of these data unreliable.

While the incidence of special health care needs and clinically significant behavioral health problems were similar among children in both study settings, they were higher in our population than observed in normative samples. Selecting one child at random from each family cluster, 27.1% of children from our sample met accepted definitions for children with special health care needs compared to 13.0% of children from our state identified in a 2010 national survey ($p=0.004$). Fifty percent of children of women seeking services for and safety from IPV had total problem scores in the 90th percentile of a normative U.S. sample for the Strengths and Difficulties Questionnaire ($p<0.001$). These differences reflect both clinically important and statistically significant differences for these children and their mothers.

Discussion

Summary

In this cross-sectional survey of mothers of children 3–11 years of age seeking services for or safety from IPV, we identified health conditions and needs among families living in the residential shelter as well as in the community. Our study is unique in describing a high incidence of child health conditions and needs, particularly in behavioral health, identified by mothers living in both settings. Given evidence supporting the ability to change well-described trajectories of poor physical and behavioral health among children exposed to IPV, recognizing the opportunity to assist both mother and child when she is seeking help for IPV may provide a critical opportunity to improve two or more lives in the same moment (Campbell et al., 2013; Cohen et al., 2011; Graham-Bermann et al., 2007; Timmer et al., 2010).

When we began this study, our community partners recognized the behavioral health needs of children in the residential shelter and hoped to better understand maternal perceptions of the children's physical and behavioral health needs. As the project progressed, however, our partners also identified a gap in our understanding of the health needs of children of women seeking IPV services from the community setting. Our findings suggest that maternal perceptions of unmet health needs for community children is as high or higher than those for children living in the shelter setting. This information may be particularly important in the community setting, where mothers often seek help while children are in school or with friends and therefore relatively invisible to the center staff.

Our findings suggest an opportunity to evaluate potential benefit of innovative child health care delivery through IPV service programs. Staff in residential shelter settings should

engage mothers regarding the physical and behavioral health of children in the shelter. Workers in community or walk-in centers should be encouraged to elicit information regarding maternal perceptions of her child's health needs, even when that child is not present at the time of the encounter. Community partnerships with medical and mental health care providers familiar with trauma-informed care may result in efficient and effective care for children who may otherwise be receiving sporadic care in urgent care or emergency room settings (Bair-Merritt et al., 2008; Duffy, McGrath, Becker, & Linakis, 1999; Keeshin, Oxman, Schindler, & Campbell, 2015). Small grant programs may support pilot programs for integrated care programs, offering on-site, trauma-informed medical and mental health care to families in both settings.

Limitations and future directions

Our results should be considered in the context of several limitations. Our findings reflect only maternal perceptions of child health and child health needs. This measure may both overestimate or underestimate true child health concerns, particularly in a population where maternal distress is high. Despite this limitation, these mothers are the primary caregivers for these children. Perceptions of behavioral health problems will influence parent child interactions, just as perceptions of medical health needs will influence health seeking behavior for children. As a cross-sectional survey, we cannot determine whether physical and behavioral health problems reported by mothers for children in the shelter settings have resolved or increased with the transition into the shelter. Our findings of similar or higher concerns among children in the community, however, suggest that these concerns are not simply a reflection of moving into the shelter. This remains a critical question for our community partners. A longitudinal study of children living with IPV and their transition from community to shelter and back into the community is warranted to provide better insight into the interaction of childhood traumatic experiences. Finally, as a small community sample, we recognize that our results may not generalize to other settings or states. Of particular concern are whether differences in maternal perceptions of child health and health care needs by race, ethnicity, and culture require different response from community partners. Similar evaluation of maternal perceptions of child health in other settings may help in the development of programs that are responsive to local community needs.

Acknowledgments

The authors thank the YWCA Utah, which partnered with us throughout this project, and the women seeking assistance from the YWCA, who shared their information with us for this research.

Funding:

Research reported in this manuscript was supported by the Eunice Kennedy Shriver National Institute of Child Health and Human Development of the National Institutes of Health under award number K23HD059850 (PI Campbell). The content is solely the responsibility of the authors and does not represent official views of the National Institutes of Health.

References

- Bair-Merritt MH, Crowne SS, Burrell L, Caldera D, Cheng TL, Duggan AK. 2008; Impact of intimate partner violence on children's well-child care and medical home. *Pediatrics*. 121(3):e473–480. DOI: 10.1542/peds.2007-1671 [PubMed: 18310168]
- Bair-Merritt MH, Johnson SB, Okelo S, Page G. 2012; Intimate partner violence exposure, salivary cortisol, and childhood asthma. *Child Abuse Negl*. 36(7–8):596–601. DOI: 10.1016/j.chiabu.2011.12.002 [PubMed: 22858093]
- Black, MC, Basile, KC, Breiding, MJ, Smith, SG, Walters, ML, Merrick, MT, Stevens, MR. The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: 2011. Retrieved 09/27/2017 from http://www.cdc.gov/ViolencePrevention/pdf/NISVS_Report2010-a.pdf
- Breiding MJ, Ziembroski JS. 2011; The relationship between intimate partner violence and children's asthma in 10 US states/territories. *Pediatr Allergy Immunol*. 22(1 Pt 2):e95–100. DOI: 10.1111/j.1399-3038.2010.01087.x [PubMed: 20735803]
- Campbell KA, Thomas AM, Cook LJ, Keenan HT. 2013; Resolution of intimate partner violence and child behavior problems after investigation for suspected child maltreatment. *JAMA Pediatr*. 167(3):236–242. DOI: 10.1001/2013.jamapediatrics.324 [PubMed: 23318576]
- Child Welfare Information Gateway. Child witnesses to domestic violence. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau; 2016. Retrieved 09/27/2017 from <https://www.childwelfare.gov/pubPDFs/witnessdv.pdf#page=3&view=Summaries%20of%20State%20laws>
- Christian CW, Scribano P, Seidl T, Pinto-Martin JA. 1997; Pediatric injury resulting from family violence. *Pediatrics*. 99(2):E8.
- Cohen JA, Mannarino AP, Iyengar S. 2011; Community treatment of posttraumatic stress disorder for children exposed to intimate partner violence: a randomized controlled trial. *Arch Pediatr Adolesc Med*. 165(1):16–21. DOI: 10.1001/archpediatrics.2010.247 [PubMed: 21199975]
- Dube SR, Felitti VJ, Dong M, Giles WH, Anda RF. The impact of adverse childhood experiences on health problems: evidence from four birth cohorts dating back to 1900. *Prev Med*. 2003; 37(3):268–277. [PubMed: 12914833]
- Duffy SJ, McGrath ME, Becker BM, Linakis JG. 1999; Mothers with histories of domestic violence in a pediatric emergency department. *Pediatrics*. 103(5 Pt 1):1007–1013. [PubMed: 10224180]
- Duke NN, Pettingell SL, McMorris BJ, Borowsky IW. 2010; Adolescent violence perpetration: associations with multiple types of adverse childhood experiences. *Pediatrics*. 125(4):e778–786. DOI: 10.1542/peds.2009-0597 [PubMed: 20231180]
- Evans SE, Davies C, DiLillo D. 2008; Exposure to domestic violence: A meta-analysis of child and adolescent outcomes. *Aggression & Violent Behavior*. 13(2):131–140. DOI: 10.1016/j.avb.2008.02.005
- Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med*. 1998; 14(4):245–258. [PubMed: 9635069]
- Goodman R. 2001; Psychometric properties of the strengths and difficulties questionnaire. *J Am Acad Child Adolesc Psychiatry*. 40(11):1337–1345. DOI: 10.1097/00004583-200111000-00015 [PubMed: 11699809]
- Graham-Bermann SA, Lynch S, Banyard V, DeVoe ER, Halabu H. 2007; Community-based intervention for children exposed to intimate partner violence: an efficacy trial. *J Consult Clin Psychol*. 75(2):199–209. DOI: 10.1037/0022-006x.75.2.199 [PubMed: 17469878]
- Gwinn C, Strack G, Adams S, Lovelace R, Norman D. 2007; The Family Justice Center Collaborative Model. *Saint Louis Public Law Review*. 27:79–120.
- Hamby S, Finkelhor D, Turner H, Ormrod R. 2010; The overlap of witnessing partner violence with child maltreatment and other victimizations in a nationally representative survey of youth. *Child Abuse Negl*. 34(10):734–741. DOI: 10.1016/j.chiabu.2010.03.001 [PubMed: 20850182]

- Haskett ME, Ahern LS, Ward CS, Allaire JC. 2006; Factor structure and validity of the parenting stress index-short form. *J Clin Child Adolesc Psychol.* 35(2):302–312. DOI: 10.1207/s15374424jccp3502_14 [PubMed: 16597226]
- Hunter AL, Minnis H, Wilson P. 2011; Altered stress responses in children exposed to early adversity: a systematic review of salivary cortisol studies. *Stress.* 14(6):614–626. DOI: 10.3109/10253890.2011.577848 [PubMed: 21675865]
- Kamimura A, Parekh A, Olson LM. 2013; Health indicators, social support, and intimate partner violence among women utilizing services at a community organization. *Womens Health Issues.* 23(3):e179–185. DOI: 10.1016/j.whi.2013.02.003 [PubMed: 23660431]
- Keeshin BR, Oxman A, Schindler S, Campbell KA. 2015; A Domestic Violence Shelter Parent Training Program for Mothers with Young Children. *Journal of Family Violence.* 30(4):461–466. DOI: 10.1007/s10896-015-9698-6
- Kitzmann KM, Gaylord NK, Holt AR, Kenny ED. 2003; Child witnesses to domestic violence: a meta-analytic review. *J Consult Clin Psychol.* 71(2):339–352. [PubMed: 12699028]
- Kroenke K, Spitzer RL, Williams JB. 2003; The Patient Health Questionnaire-2: validity of a two-item depression screener. *Med Care.* 41(11):1284–1292. DOI: 10.1097/01.MLR.0000093487.78664.3C [PubMed: 14583691]
- Litrownik AJ, Newton R, Hunter WM, English D, Everson MD. 2003; Exposure to Family Violence in Young At-Risk Children: A Longitudinal Look at the Effects of Victimization and Witnessed Physical and Psychological Aggression. *Journal of Family Violence.* 18(1):59–73.
- McDonald R, Jouriles EN, Ramisetty-Mikler S, Caetano R, Green CE. 2006; Estimating the number of American children living in partner-violent families. *J Fam Psychol.* 20(1):137–142. DOI: 10.1037/0893-3200.20.1.137 [PubMed: 16569098]
- McGuigan WM, Pratt CC. 2001; The predictive impact of domestic violence on three types of child maltreatment. *Child Abuse Negl.* 25(7):869–883. [PubMed: 11523866]
- National Survey of Children with Special Health Care Needs. NS-CSHCN 2009/10. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 04/27/2017 from <http://www.childhealthdata.org/>
- Saltzman KM, Holden GW, Holahan CJ. 2005; The psychobiology of children exposed to marital violence. *J Clin Child Adolesc Psychol.* 34(1):129–139. DOI: 10.1207/s15374424jccp3401_12 [PubMed: 15677287]
- Stone LL, Otten R, Engels RC, Vermulst AA, Janssens JM. 2010; Psychometric properties of the parent and teacher versions of the strengths and difficulties questionnaire for 4-to 12-year-olds: a review. *Clin Child Fam Psychol Rev.* 13(3):254–274. DOI: 10.1007/s10567-010-0071-2 [PubMed: 20589428]
- Timmer SG, Ware LM, Urquiza AJ, Zebell NM. 2010; The effectiveness of parent-child interaction therapy for victims of interparental violence. *Violence Vict.* 25(4):486–503. [PubMed: 20712147]
- van Dyck PC, McPherson M, Strickland BB, Nessler K, Blumberg SJ, Cynamon ML, Newacheck PW. 2002; The national survey of children with special health care needs. *Ambul Pediatr.* 2(1):29–37. [PubMed: 11888436]

Table 1

Demographics and experiences

	Total n (%)	Community n (%)	Shelter n (%)	Incidence Rate Ratio (95% CI)
Maternal characteristics	n=48	n=18	n=30	Community: Shelter
Maternal age < 25 years	4 (8.5)	2 (11.8)	2 (6.7)	1.4 (0.3–6.3)
Hispanic ethnicity	29 (61.7)	11 (61.1)	18 (62.1)	1.0 (0.4–2.5)
Minority race	10 (21.3)	4 (22.2)	6 (20.7)	1.1 (0.3–3.2)
High school graduate	28 (59.6)	11 (64.7)	17 (56.7)	1.2 (0.5–3.4)
Living with IPV > 1 year	32 (69.6)	14 (87.5)	18 (60.0)	3.1 (0.7–13.5)
Depressive symptoms	24 (58.5)	9 (56.3)	15 (60.0)	0.9 (0.3–2.4)
Child characteristics	n=91	n=35	n=56	Community: Shelter
Child age 3–5 years	30 (33.0)	11 (31.4)	19 (33.9)	1.0 (0.4–2.1)
Male sex	48 (53.3)	20 (57.1)	28 (50.9)	1.1 (0.5–.3)
History of CPS involvement	31 (34.8)	8 (23.5)	23 (41.8)	0.6 (0.3–1.5)
Witness to parental arrest	25 (28.1)	7 (20.6)	18 (32.7)	0.7 (0.3–1.8)
Contact with abusive partner	25 (28.4)	12 (36.4)	13 (23.6)	1.4 (0.6–3.4)
High parenting stress	34 (43.6)	11 (39.3)	23 (46.0)	0.8 (0.2–1.9)

Table 2

Child health concerns reported by mother

	Total n=91 (%)	Community n=35 (%)	Shelter n=56 (%)	Incidence Rate Ratio Community: Shelter (95% CI)
Primary health care provider	77 (84.6)	29 (82.9)	48 (85.7)	0.8 (0.3–2.3)
Special health care need	23 (25.3)	9 (25.7)	14 (25.0)	1.1 (0.5–2.5)
Need for medical care	22 (24.4)	10 (29.4)	12 (21.4)	1.4 (0.6–3.3)
Significant behavioral problem	47 (51.7)	18 (51.4)	29 (51.8)	1.0 (0.5–2.1)
Need for behavioral health care	39 (43.8)	16 (48.5)	23 (41.1)	1.2 (0.5–2.7)