Journal of Inclusive Education
Vol.5, Issue 1, 2021, 15–38

Contextual Factors Affecting Mental Health Services for Children with Comorbid Conditions of Learning and Intellectual Disability

Afsheen Masood[1]
Muhammad Sulman[2]
Shazia Aslam[3]

Abstract

The current explorative research has been designed with the pivotal aim of divulging multidimensional perspective from diverse stake holders on the phenomenon of parental, familial and service-delivery factors likely to affect the mental health services for children with learning and intellectual disability. The investigation was laid out through qualitative research design and focus group was adopted to execute data collection. The sample comprised of parents and clinicians extending their services in the domain of special need care in Lahore, Pakistan. The data was collected by means of open-ended stimulus questions that were designed in order to elicit stakeholders' candid responses. An interpretive description approach was adopted. The findings suggest that there exists marked consensus among clinicians and parents on factors affecting mental health services for children with mental retardation. There were some discrepant perspectives however on the point of which factors played more salient role. According to the viewpoints of clinicians, mental health services and rehabilitation efforts were adversely affected by parental psychological distress and poorer family involvement and limited reciprocity in rehabilitation efforts by family members. Contrary to this, parents maintained that inadequate resources and poorly trained professionals, in addition to limited involvement of

---

[1] Assistant Professor, Institute of Applied Psychology, University of the Punjab, Lahore. Corresponding Author's Email: drafsheenmasood15@gmail.com
[2] Ph.D. Scholar, Faculty of Media & Communication Studies, University of Central Punjab, Lahore. Email: muhammadsulman81@gmail.com
[3] Assistant Professor, Applied Psychology Department, Queen Mary College Lahore. Email: shaziaaslamqmc@gmail.com

practitioners affected the mental health services and rehabilitation efforts towards children with intellectual disabilities.

***Keywords*:** focus group, intellectual disability, mental health, parental and clinician factors

Introduction

There is growing interest in developing countries to focus on such factors that affect or compromise the provision of services to special needs population. In this regard there have been multiple studies executed in developed countries in order to bridge up the gap between community and research so that special needs children's mental health and rehabilitation services could be made better. One such systematic attempt is to integrate the evidence-based practices (EBPs) by merging them with community-based services so that services delivered to special needs children could be improved. There have been multiple empirical views that have stressed on combining community based practices with evidence based services (Silverman and Hinshaw 2008: Herschell et al. 2004). This has been prevalent to view special needs people with scorn, presuming them as deviant and deficient segment of the society that require continuous care and supervisions. They are regarded as having little value to the society as they are destined to perform menial or inconsequential tasks. This has been maintained that around 2 to 6% of the population in Pakistan has a comorbid state of intellectual and learning disability (Mirzaetal. 2009). This has been revealed by the empirical evidences that mental disorders are at least two to four times more prevalent in people with intellectual and learning disability as juxtaposed with normal population (Simonoff, 2005).

There is greater stride to seek mental health services for such people in adolescents and early adulthood as they start exhibiting multifarious behavior problems in addition to their dispositional limitations. It has been evident that intellectual and learning disability may affect people in multiple psychiatric dimensions such as by lowering their self-esteem; producing psychological distress; aggravating their peevishness and anger; rigidity; lower self-efficacy and frustration. The compromising features of poor cognitive ability and diminished social competence lead to make this situation more adverse. In Pakistan from past two decades, the services for special needs individuals have improved multifold. There are many public and private sector institutes that are striving to extend their specialized care services for special needs children by shifting their focus from hospital and clinical set ups to community based centers. In past one decade particularly, there are specialized services introduced for special needs people as shift has taken place in triad form e.g. care management in mainstreams; incorporation of social, educational and developmental care in their essential trainings; greater emphasis has been laid on mental health services in addition to primary health care services. Research appears to offer the respite of information in such prevalent scenario. Leading educational and rehabilitation health practitioners have also urged the need for constructive change for people with learning disabilities by incorporating the evidence about effective interventions (Hoagwood & Kolko 2009).

Fixen et. al. (2005) have stressed that evidence based practices offer promising outcomes for expanding and extrapolating the mental health services for people with intellectual and learning disability. However, due need lies in examining the contextual factors which lie relevant to community (Chorpita et al. 2008). This exposition of contextual factors can only be achieved when familial and clinician based practices and perspectives are probed (Herschell et. al. 2004; Silverman & Hinshaw 2008). Although insight into contextual factors of mental health services is very critical to the implementation of EBPs, rigorous review of contextual, social and cultural factors could only help in delivery of evidence-based services. Also important here is to mention that contextual factors are only relevant in some specific context (Hoagwood & Kolko 2009). According to Kazdin (1998), role of parents among all familial factors is extremely important in determining the efficacious delivery of mental health and rehabilitation services to special needs population. The family structure and family support also seems to play crucial role in determining the efficient supply of mental health and rehabilitation services for such people (Logan & King 2001). Gunther et. al. (2003) has argued that familial stress plays very important role in making the inefficient services delivery for special needs children. Hammen et al. (1999) maintained that family s’s involvement is very significant in availing the services for their children. Iterative review of controlled randomized trials executed on evidence based interventions also reveal that its outcomes cannot be ascertained through controlled studies and may be yielding better insights through examining evidence based qualitative studies (Plath 2006). Some empirical perspectives have focused on limited economic states as affecting the evidence based practices for children with intellectual and learning disability. A contextual review of Pakistani perspectives reveals that there are multitude impediments in establishing and ascertaining the evidence-based learning disabilities practices. The most obvious seems to be the limitation in building the transfer of knowledge from other allied disciplines invoking rehabilitation such as delivery practitioners e.g. physiotherapists etc., mental health rehabilitation officers and health professionals from comorbidities. Another surging challenge appears to be the more grounding on empirical perspectives and lesser on evidence records. A thorough reviewing of the clinical scenarios further reveal that learning disability has been directly transferred from adult psychiatry. Since the scope and horizon of both forms of practices vary so the same practices may not sound beneficial for people with learning disabilities. Despite the realization that good evidence based practice for special needs population is definitely needed, the nature and delivery of services for special needs segment of this particular special needs population is still diffused and unreported. From non-Governmental sectors there are multiple milestones achieved so far. There is appreciable expansion in field projects, community teams, establishment of special needs centers and in-patient assessment facilities. These changes are by far not uniform and may require envisaging of common goals.

The evidence of behavior disorders among people with learning disorders is least attended issue among Pakistani community. Whether behaviors disorders constitute an environmental problem or they are essential element in the course of learning disability are intriguing research phenomenon. The research in this domain has been quite limited and scanty due to the fact that there have been practical issues pertaining methodological problems, ethical considerations, and service capability (Reyno & McGrath 2006; Schoenwald et al. 2000).

Other dimension of revisiting the contextual factors may involve parent and family-based contextual factors. These have been further delineated as having dimensions of personal, social, and psychological dynamics that exert their effects from home or outside and tend to be significant in implementing and consuming the mental health services for people with special needs having behavioral issues (Chronis et al. 2004; Sexton & Alexander 2005). There have been some adverse factors affecting treatment engagement such as minimal parental participation, time constraints, inadequate resources an compromised social status and perceived worth of people with special needs (Beauchaine et al. 2005; Chronis et. al. 2004). This is specifically significant given that is the main component of virtually all evidence based practices for children with special needs (Miller & Prinz 2003). Parental involvement characteristically involves active participation of parents in rehabilitation programs, their inputs in management sessions and their reciprocal investment in therapeutic strategies, their interest in managing their loved one with special needs outside of therapeutic sessions and positive attitudes (Reyno & McGrath 2006; Southam-Gerow et. al. 2001). According to Eyberg et al. (2008) there are some factors that may warrant attention in community care such as family history of psychopathology, presence of other members requiring specialized care, substance abuse, marital conflict, parental stress, treatment expectations, cultural acceptance of disability and socioeconomic status. The concern paid in treatment and therapeutic follow ups have also been cited as of utmost importance in evaluating the efficacy of evidence based practices (Beauchaine et. al. 2005). This has also been suggested that factors mediating or moderating the implementation of evidence based practices must be taken care of while assessing the overall applicability of EBPs to community care. Previous empirical research evidences on EBP are mainly western and they do not essentially involve the traditional family set ups of eastern culture.

Another important matter to be highlighted here is that family samples becoming part of such investigations may differ from community family samples that appear to face the brunt of contextual factors in more deleterious form (Baker-Ericze´n et al. 2010). A few research programs investigating special needs community from client perspective have been initiated but no conclusive findings are available so far in Pakistani hospitals and special needs institutes. Evidence based practices as observed in field of special needs practice highlight two types of challenges e.g. quantitative and qualitative (Chorpita & Nakamura, 2004). Thus this investigation also systematically attempts to dig out the meaningful imperative differences between research and community samples. Gaining comprehensive consideration of both clinician and parent perspectives is likely to help in service context. Seeking a more perspective based approach from clinicians and parents in this regard may yield particularly helpful information as both stakeholders would be involved. This also becomes all the more important as clinicians and parents have shown very poor agreement most of the times on child symptoms, severity of behavioral issues, treatment expectations and goals and current functioning levels (Garlandet al., 2004; Casper 2007). A fewer researches have been undertaken on evaluating the clinicians practices but rarely if ever the focus has been laid on adoption of diverse study methods such as qualitative, or mixed ‘‘hybrid’’ methods. Just because of all these aligned arguments the current research has been designed to amass information from clinicians and parents from their own unique individualized perspectives. Principal goals and research questions of the current study were to describe (1) What contextual factors are specified by clinicians and parents for affecting the evidence based practices for people with special needs? (2) How frequently each individual reported some specific factor and what was the worth, significance or value of each of the factors for both stakeholders e.g. parents and clinicians?

Methodology

This research has been designed by means of exploratory research design wherein open-ended stimulus questions were designed to elicit stakeholders’ candid responses. An interpretive description approach was adopted. Focus groups were arranged for both parents and clinicians. Gleaning data from both clinicians and parents provided the leverage for collecting information from both ends to get unbiased picture.

Setting and Sample

The data was collected from parents and clinicians who have special needs children and adolescents within age ranges of 8 to 18 years. For this a metropolitan based city data was included. Some rehabilitation institutes executing their evidence based practices were short listed and accessed for data collection. Only geographically bound region was targeted due to limitation of resources. In order to conduct focus group and in-depth interviews, 12 clinicians and 12 parents were taken.

Inclusion Criterion

Clinicians and parents' inclusion in the targeted sample relied on certain stipulated factors such as clinicians were selected only if they had at least two years' experience of dealing with children, having intellectual disability or Learning disorders as prior diagnosed condition. The children who were reported to such clinicians with reports of comorbid conditions were also screened as apt participants for inclusion in the targeted sample. Majority of clinicians as participants had postgraduate specialization degree and were taken from government institutes and had been in clinical practice for more than five years. Clinicians had been practicing both in-patient and out-patients settings, they had been supervising internee clinical psychologists and had the dual role of therapist and supervisor; most of them were females and were currently working with special needs' children and their families.

As far as the parents' inclusion was involved, only the parents who spent maximal time for taking care of the basic needs of their children, were included. Parents were primary caretakers and were genuinely representative of community just as clinicians were genuine representatives of mentalhealth service-providers. Only those having intact families were taken. Ethics considerations were kept into mind and only those willing to participate on voluntary basis were included. Most of the parents' representatives were mothers who claimed to be primary caretakers; only two were fathers who maintained that they took care of their children as their wives were not very close to their children.

Table 1

Sociodemographic and economic characteristics of participants (12+12)

Participants	Parents M (SD)	Clinicians M (SD)
Age	38.21(7.55)	29.08 (3.78)
Educational Level	13.02(2.11)	15.66(6.23)
Income	Rs. 67,234/-	Rs. 37,213/-
Marital Status	f	f
Married	8	9
Separated	2	1
Divorced	2	2

Note. M=Mean; SD=Standard Deviation; f=Frequency

Tools

Following tools were utilized to collect the data from participants:

a. Sociodemographic and Economic Characteristics

A customized sheet was developed in order to seek information from study participants about their sociodemographic and economics characteristics. The data was sought individually on one-to one basis with special emphasis on adhering with APA ethics consideration of informed consent, confidentiality, anonymity etc. Clinicians' sheet and participants' sheet varied in terms of clinicians' adding their professional training and expertise details. An in-depth, semi-structured Focus Group Interview protocol guide was developed in alignment with technical review of three relevant subject specialists. This contained all forms of focus group discussion based, probing and analytical questions for smooth conduction and execution of focus groups.

Procedure

Focus groups were preplanned and each focus group lasted for more than 2 hours. All of the participants were provided with consent form and ethics guidelines; followed by information sheet that contained the details of study and background questionnaire. Clinicians gave all details of their professional domain in addition to their personal expertise and line of practices while parents shared their demographic details of education, gender, income, family type and family size, and occupation. Researcher acted as main moderator and each of the sessions was initiated by presenting a welcome note. Study agenda, formalization of rules, policies and procedures were briefed; thorough introduction of research study was imparted. In order to develop rapport, a brief session of informal discussion was held. Some refreshments were served and then formal discussions were initiated. First query was posed to participants; this stimulus question was warm up question asking for what are the possible parent and family-based issues that are likely to affect a child's mental health and treatment modalities? 2. What services in mental health were available for special needs children? 3. What contributes in determining the Special needs' children mental health systems?

All stimulus questions were planned and arranged on the basis of goals and target of the study. Clinicians were also asked for assessment, evaluation, management and treatment of mental health conditions of children with special needs. A rigorous pilot study was undertaken that helped in establishing the authenticity, validity and reliability of assessment procedures. Six senior experts were consulted in this regard and all the issues identified by them in phrasing of the questions were addressed before further administration. As group consensus was obtained, the list of questions was finalized. After examining the explored content from participants, every participant from each of the focus groups were requested to respond to a predetermined list of contextual factors determining the efficacy of mental health services for children with special needs. These contextual factors had been sought from comprehensive literature review. Numerous contextual factors arose but only those significant and relevant were included as final target. This phase oriented data acquisition helped in collecting their spontaneous responses as well as post focus group inquiry through list of contextual factors helped in ascertaining the obtained information and prompting them for their views on any aspect that they had missed earlier. This helped in verifying whether these factors had emerged during focus group discussion or not and helped in determining their applicability and also served as validation check. This also helped in generating, refining, and formalizing the coding. While concluding every focus group, parents were extended thanks for investing their time and their audio/video taped contents were shown to them if they requested for. All this data was immediately transcribed within a day after recording and recordings were trashed once the analysis had been undertaken in order to ensure the confidentiality and anonymity of the responses from participants.

Data Extraction and Themes Generation

All of the respondents were sought out for focus group after approval from concerned authorities institutes and after written signed informed consent. This was followed by focus groups and individual face-to-face in-depth interviews. The interview protocol was semi-structured and all the participants were engaged in five to six participants' based focus groups. This lasted for two hours followed by 30 minutes individual session of in-depth interview. A graduate student was rigorously trained by the main investigator and throughout the data collection process she was supervised. Formal permission to digitally record the data was granted by all the participants after assurance of confidentiality and anonymity. The verbatim were systematically transcribed and their recorded content was wasted as per commitments with respondents. The data was screened and filtered cautiously for data analysis by entailing line-by-line coding, categorization and interconnection of emergent codes within and across transcripts. This was followed by systematic review of all of the codes, subsequent identification of emergent patterns and its extraction and distillation into themes. In this heterogeneous points were addressed tactfully in order to examine them within groups and across groups. Here significant step was to adhere with rigor of qualitative results by maintaining their authenticities and trustworthiness. This was achieved by demonstrating inter-rater review. For this an objective, independent subject expert coder and the principal investigator were involved. Initial data analysis was done followed by peer debriefing. Data saturation was rechecked. All the finalized themes and subthemes were corroborated via triangulation.

Data Analysis

Content analysis was mainly used for analysing the content/ responses from clinicians and parents. A list of codes was prepared in alignment with priori list of parent, family and clinicians' based contextual factors. Thematic analysis was done while amalgamating features of grounded theory methods. This means that content hence generated was coded in the light of quoted texts; which helped in adding to priori list of codes and more comprehensive coding was obtained by including those codes and themes as well that were not lying in priori list earlier. The textual information thus arranged was in bulk and required essential condensation by implementing systematic coding in addition to categorizing that was undertaken by identifying words-patterns, frequency of use, and their associative relations Grbich (2007). According to Grbich (2007), just because of frequency of words/repetition, researcher can estimate or foresee the significance and worth certain theme. Two separate raters were used to encode the content in order to increase reliability of rating; mutual consensus was built and frequency of utterances of certain responses was given special attention. The original list of codes had 20 factors, further expanded to add 8 factors more from parents and 7 factors from clinicians. This was led by constant comparative method (Glaser and Strauss 1967), with which codes were condensed and collapsed which resulted in ultimate 7 thematic factors. Higher order themes were relied on and subthemes were merged within them to add data clarity. This exercise led to accumulation of long list of codes into five leading themes e.g. a. parental well-being/ mental health b. parenting challenges c. family experiences d. parental stressors e. Attitude towards treatment.

The data was analyzed by employing NVivo 2.0 software. This aids in structuring qualitativecoded material into categories (Tappe 2002). This helps in executing the comparative pattern analysis where it can be observed how frequently diverse groups maintain certain statement or content or experiences (Bazeley 2007). Frequencies of each of the contextual factors were calculated using statistical (SPSS) software. Percentiles were constructed. This was based on total number of utterances across all factors. The juxtaposition of all factors helped in gaining insight about their relevance and salience at the wake of occurrence. According to Miles and Huberman (1994) counting relevant themes by means of computing the frequencies and percentages help in detecting and categorizing patterns.

Results

Diverse perspectives from parents and clinicians were obtained. Theme category indicated the parent/familial or clinicians based contextual factors that affected the efficacy of mental health services for special needs children. In this regard, straight questions being asked were directly reported. A concise conclusive crux presented to encompass the familial/parental and clinician's levels of meanings for each of the factors. The interlinking of these factors and their relevance to main objectives is also given. An operational definition was also additionally added for each of the factors during the finalizing of the codes.
The findings henceforth are displayed below:

Table 2

Contextual factors affecting evidence based practices as per parents and clinicians' perspective

Thematic Categories	Clinicians	Parents
1. Parental Well-being		
i. Physical	Fatigue, exhaustion, feeling overwhelmed, psychosomatic conditions	Medical and health issues
ii. Psychological	Psychological Distress: anxiety, stress and depression, Insomnia, disordered eating, frustration	Anxiety, depression, Substance use and abuse

2.	Parenting Challenges/ issues	Substantial parental stress as aresult of taxing demands (i.e., work overloads; care-ordeals etc. Ineffective parenting including unrealistic punishments, impulsivity in disciplining, immature parenting, unrealistic expectations of children	Communication problems, unrealistic expectations Conditional acceptance of the symptoms of special needs children,
3.	Family Experiences	Parental history of maltreatment, child abuse, faith system relating stigmas, Acculturation differences across groups.	Family environment, prior experiences with other children, birth order to special needs child
4.	Family Relations	Marital discord; domestic violence/intimate partner violence, sibling relationship quality and support, attachment issues	Spousal relationship discord, violence and abuse patterns in family interactions, lack of emotional reciprocity, fail attachments
5.	Environmental Stressors	Household composition (nuclear vs. joint), daily/frequent household stressors (i.e., transportation issues, availability of resources, financial strains)	multiple home environments, housing issues, financial constraints due to special needs care of the child, day to day hassles, household Stressors and social strains.
6.	Parental Attitude towards Treatment	Adequacy of social support system, access to treatment facilities, resistance to treatment, poor compliance and regularity in adhering to treatment, poor follow up	Lack of family Involvement, intermittent involvement in therapy session, demotivation to work for child’s betterment, despondency over minimal betterment in child’s symptoms

In-depth interviews data divulged more dimensional details and this was analyzed through Interpretative Phenomenological analysis. The goal was to encompass the individuality of the responses of the parents and clinicians as far as the adequacy of resources and services are concerned. This was aligned with identified themes from focus group to yield substantial supporting facts. Below given is the thorough detail of the analysis:

Parental physical and psychological well-being was operationalized as physical and cognitive well-being of the caregivers and encompassed parental psychopathological symptoms if any (anxiety: 55%, Sleep disorders 35% and Depression: 62%; parental substance use and abuse (12 %); poor intellectual functioning of the primary caretaker or parents (28%); medical issues of the parents (46%). Depression in this regard accounted for maximal utterances by the parents.

Parents as primary care taker reported: “I experience more pangs of anxiety and depression now than ever before”; some maintained that “when my child manifests more symptoms, “I start experiencing greater psychological distress and encounter sleep issues as well”. According to another parent “I think mental health is definitely affected when we are dealing with challenging behaviors and mental health issues of special children”. This was endorsed by 82% of the clinicians who maintained that parental psychopathology does impair ability to work with the special need child. As per their utterances “Majority of the parents that turn up to us are dealing with their own mood states”. According to another clinician, “sometimes we have to refer parents for psychiatric help for their own selves before they can cater to their child’s needs”.

Parenting challenges refers to various demands and role related burdens that children with special needs levy on their parents. In this regard majority of the parents held the view that parenting stress was colossal most of the time and imposed on them taxing demands due to work-overloads and special care related ordeals. Some parents reported that they felt guilty on their penalizing behaviors towards special needs children i.e. “I feel after punishing my son as if I have committed some sin and that keeps them guilty for days and sometimes this emerges as major conflict cum challenge whether to use punishment for disciplining them or to let them get spoiled”. Another mother maintained that “I get erratic and punish my kid for something that was inadvertently done by him; I later on, realize that I had been expecting from him something that was larger than its human abilities”. Unrealistic expectations were reported by clinicians’ as well as gruesome demands by some of the parents of special needs children. As one therapist maintains that “some parents want to have in their children the behaviors that are not even shown by typically developing children with normal disposition”. This particular themes was agreed on by both parents and clinicians that in their impulsive planning parents of special needs children adhere from their special children such weird expectations that are difficult to be fulfilled by even their normal children but they get to realize this much later. Parenting competence was discussed by majority of the clinicians. Parents always overestimated their abilities to parent the child and claimed that they could assess their child the best and this was source of dissensions sometimes between them and the clinicians. They refused to admit that parenting skills required any training rather maintained that parental experiences lead to expertise in parenting skills.

According to one of the parents special needs’ child parenting drains you thoroughly” whereas clinicians reported that most of parents of special needs who report them with dual disorders report that they are kind of stuck in crisis mode all the time’’. Only 20 percent parents maintained that they felt incompetent to take care of their special needs child by stating that “Everything we do for her seems to go futile and we fail every time we try to do anything for her as parents”. Clinicians also maintained that they felt starkly while interacting with some parents that “They were highly incompetent even to take care of their normal children”.

Family Experiences was also linked with parenting as this encompassed issues such as attachment issues with parents, if parents were abused in their own childhood, if they had conflicts with their children; or there were intergenerational dissensions; the issues related to religion and culture were also included here. Family experiences as source of impacting the mental health care services were not very influential as only 3 parents uttered this as affecting the mental health services for children. Clinicians however reported that parents’ own childhood experience and their resilience or frustrations from their past experiences determined their interactional patterns in the family. As one of the clinician said that “most of the parents of special needs’ children want to impose the terms and ways in which they themselves were raised and parents fail to admit the trans generational changes that are definitely very important in determining the life experiences”.

Family Relationship refers to the interaction patterns that in this transcribed data for analysis, the subthemes included marital conflicts and discords (15%); domestic abuse (45%), familial violence patterns (65%); poor attachments (25%); communication barriers/gaps (40%). Some of the verbatim substantiating these subthemes are “ I don’t remember when did we enjoy in family last time” , “ there is continuous state of fear and abuse in my family due to my abusive husband”, “ My wife is always complaining and faults finding due to which I never talk much with her and stick to limited communication”. While clinicians generated the factors such as parental poor attachment with their children, siblings neglect, family environment that was markedly stressed all the time”.

Environmental stressors involved momentous challenges or sources of conflict that disrupt family’s environment. Instability of resources and inadequate income emerged as leading challenges and subthemes. Detachment from social interactions, poor social support, avoiding neighborhood and abusive social relationship were further generated from parents’ statements. “There are most of the time out of pocket expenses due to presence of special needs child in my family and that keeps me disturbed for long”. As per verbatim of another parent “special needs services are all based on private sector as at governmental level services are inadequate and expenses incurred for child’s treatment bring a lot of pressure on me”. Clinicians also indicated the same and stated that impact of financial stress on families led them to report negatively and dissatisfied with their experiences in treatment”.

Parents’Attitudes about formal special needs’ services was somehow adverse. Most of the parents reported expansive health services (75%); poor community support system (45%); lack of access to better services (65%); deprivation of social opportunities of care (70%); parental disagreements/ rigidity/ resistance to treatment or treatment procedures; poor familial involvement; pessimistic expectations out of children’s treatment services. A main concern uttered by majority of parents (85%) was that of clinicians ‘‘don’t listen.’’ This is corroborated by empirical western literature and subsequently reported by clinicians and parents during the focus groups in the current investigation. This element was uttered more by clinicians than parents (85% vs. 25%). According to clinicians ‘‘lack of family involvement’’ factor was most crucial and pertinent factor (80% of utterances by clinicians). Parents reported maximally of inadequate resources. Some of the parents maintained that health care service providers were careless and not concerned (65%). Some reported that they were frustrated from health care providers of their children (75%). Some parents unswervingly felt like the clinicians were ‘‘blaming’’ them. As per one of the verbatim “ I have to put up struggle not only with my son’s care and special needs rather also with all these people who do not know how to extend support to special care families”; “Clinicians are mostly blaming us for their poor skills”; Contrary to this stand the verbatim of clinicians’ who mostly maintained that families and parents of children with special needs were not ready to invest in their efforts for the betterment of their children and they were rigid and resistant to adoption of changes in their dealings with their special needs children. Clinicians in this way held up more narrow approach while addressing inadequate social support from special needs’ children families.

Crux of juxt a position of Parents’ and Clinicians’ reported familial and contextual factors affecting mental health care services for children

This is very important here while juxtaposing parental and clinicians’ reported factors that both express consensus over the point that parenting issues and corresponding contextual factors play pivotal role in affecting child mental health treatment outcomes. Parents’ attachment issues, poor involvement in the course of treatment, poor community support, inadequate income, lack of opportunities for better treatment access and negative expectations were most reported themes. As per clinicians’ stance, parental stress, rigidity and lack of cooperation by parents, lack of domestic harmony, poor siblings’ involvement and poor family relations somehow affected special care services to special needs’ children the most.

Discussion

Mental health services for children in developing countries like Pakistan are meager even for normally developing children. When we talk about special needs children and corresponding mental health challenges that they pose as they start growing with advancement of age, the situation is quite murky and bleak. This investigation targeted the systematic inquiry for exploring the parents' and clinicians' perspective so that those factors could be address in family counseling sessions and while psycho-education sessions. This is important to be addressed as mental health care services and therapeutic interventions with children will directly be affected by that. Results from current exploratory research study indicate that clinicians and parents alike admit multifarious familial and contextual factors that impact interventions for children with special needs. There were 20 min codes gleaned from respondents' verbatim and they were refined further and through constant comparative method, total six codes were extracted. Various subthemes were subsumed under main higher order themes. This rigorous extrapolation exercise led to accumulation of long list of codes into six leading themes.There had been many insightful findings during this study. Foremost being the fact that most of the parents admitted that their parental and familial factors affected the evidence based practices for their special needs children. Most of them expressed their concerns over that their personal factors were causing direct effect on their child's problems and treatment. In general practice however, these contextual factors are never discussed or assessed as being significant. Parents rightly identified economic restraints and parental stress due to taxing demands of taking care of special needs child and inadequate support and lack of trust and reliance on clinician as salient in affecting the child's treatment settings. In this way parents had been quite individualistic in their perspective. Contrary to that, health care givers' responses were dissonant. There was reflection of global perspective by clinicians' responses. They expressed their perspective based on accumulation of their clinical experiences and related experiences with care-takers of special needs' children.

References

Addis, M. E., & Krasnow, A. D. (2000). A national survey of practicing psychologists' attitudes toward psychotherapy treatment manuals. *Journal of Consulting and Clinical Psychology*, *68*(2), 331-339.

Addis, M. E., Wade, W. A., & Hatgis, C. (1999). Barriers to dissemination of evidence-based practices: Addressing practitioners' concerns about manual-based psychotherapies. *Clinical Psychology Science and Practice, 6*(4), 430-441.

Andreasen, A. R. (1983). Cost-conscious marketing research. *Harvard Business Review*, *83*(4), 74-79.

Attride-Stirling, J., Davis, H., Farrell, L., Groark, C., & Day, C. (2004). Factors influencing parental engagement in a community child and adolescent mental health service: A qualitative comparison of completers and non-completers. *Clinical Child Psychology and Psychiatry*, *9*(3), 347-361.

Baker-Ericze´n, M., Hurlburt, M., Brookman-Frazee, L., Jenkins, M., & Hough, R. (2010). Comparing child, parent, and family characteristics in usual care and empirically supported treatment research samples for children with disruptive behavior disorders. *Journal of Emotional & Behavioral Disorders*, *18*(2),82-99. doi:10.1177/1063426609336956.

Bazeley, P. (2007). *Qualitative data analysis with NVivo*. Thousand Oaks, CA: Sage.

Beauchaine, T. P., Webster-Stratton, C., & Reid, M. J. (2005). Mediators, moderators, and predictors of1-year outcomes among children treated for early-onset conduct problems: A latent growth curve analysis. *Journal of Consulting and Clinical Psychology*, *73*(3), 371-388.

Becker, C. B., Zayfert, C., & Anderson, E. (2004). A survey of psychologists' attitude towards and utilization of exposure therapy for PTSD. *Behaviour Research and Therapy*, *42*, 277-292.

Boyatzis, R. (1998). *Transforming qualitative information: Thematic analysis and code development.* Thous and Oaks, CA: Sage.

Casper, E. S. (2007). The theory of planned behavior applied to continuing education for mental health professionals. *Psychiatric Services*, *58*(10), 1324-1329.

Chorpita, B. F., Bernstein, A., & Daleiden, E. L. (2008). Driving with roadmaps and dashboards: Using information resources to structure the decision models in service organizations. *Administration and Policy in Mental Health*, 35(1-2), 114-123.

Chorpita, B. F., & Nakamura, B. (2004). Four considerations for dissemination of intervention innovations. *Clinical Psychology: Science & Practice*, *11*(4), 364-367.

Chronis, A. M., Chacko, A., Fabiano, G. A., Wymbs, B. T., & Pelham, W. E., Jr. (2004). Enhancements to the behavioral parent training paradigm for families of children with ADHD: Review and future directions. *Clinical Child and Family Psychology Review*, *7*(1), 1-27.

Eyberg, S., Nelson, M., & Boggs, S. (2008). Evidence-based psychosocial treatment for children and adolescents with disruptive behavior. *Journal of Clinical Child & Adolescent Psychology*, *37*(1),215-237.

Farkas, M., Gagne, C., Anthony, W. A., & Chamberlin, J. (2005). Implementing recovery oriented evidence based programs: Identifying the critical dimensions. *Community Mental Health Journal*, *41*(2),141-159.

Garland, A. F., Lau, A. S., Yeh, M., McCabe, K. M., Hough, R. L., &Landsverk, J. A. (2004).Racial and ethnic differences in utilization of mental health services among high-risk youths. *American Journal of Psychiatry*, *162*(7), 1336-1343.

Glaser, B. G., & Strauss, A. L. (1967).*The discovery of grounded theory: Strategies for qualitative research.* New York: Aldine.

Grbich, C. (2007). *Qualitative data analysis: An introduction.* Thousand Oaks, CA: Sage.

Gunther, N., Slavenburg, B., Feron, F., &Os, J. V. (2003). Childhood social and early developmental factors associated with mental health service use. Social Psychiatry and *Psychiatric Epidemiology*, *38*,101-108.

Hammen, C., Rudolph, K., Weisz, J. R., Burge, D., & Rao, U. (1999). The context of depression in clinic referred youth: Neglected areas in treatment. *Journal of the American Academy of Child and AdolescentPsychiatry, 38*, 64-71.

Herschell, A. D., McNeil, C. B., & McNeil, D. W. (2004). Clinical child psychology's progress in disseminating empirically supported treatments. *Clinical Psychology: Science and Practice*, 11, 267-288.

Hill, M. (2006). *Social policy in the modern world*. Oxford: Blackwell.

Hoagwood, K., &Kolko, D. (2009). Introduction to the special section on practice contexts: A glimpse into the nether world of public mental health services for children and families. *Administration and Policy in Mental Health and Mental Health Services Research*, *36*(1), 35-36.

Kazdin, A. E. (1998). *Research design in clinical psychology*. Needham Heights, MA: Allyn & Bacon.

Logan, D. E., & King, C. A. (2001). Parental facilitation of adolescent mental health utilization: A conceptual and empirical review. *Clinical Psychology: Science & Practice, 8*(3), 319-333.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis*. Thousand Oaks, CA: Sage.

Miller, G. E., & Prinz, R. J. (2003).Engagement of families in treatment for childhood conduct problems. *Behavior Therapy*, *34*(4), 517-534.

Mirza, I., Tareen, A., Davidson, L. L., & Rahman, A. (2009). Community management of intellectual disabilities in Pakistan: a mixed methods study. *Journal of Intellectual Disability Research*, *53*(6), 559-570.

Morgan, S. B. (1988). The autistic child and family functioning: A developmental family-systems perspective. *Journal of Autism and Developmental Disorders*, *18*, 263-280.

Nelson, T. D., Steele, R. G., & Mize, J. A. (2006). Practitioner attitudes toward evidence-based practice: Themes and challenges. *Administration and Policy in Mental Health and Mental Health ServicesResearch*, *33*(3), 398-409.

Plath, D. (2006). Evidence-based practice: Current issues and future directions. *Australian Social Work*, *59*(1), 56-72.

Reyno, S. M., & McGrath, P. J. (2006). Predictors of parent training efficacy for child externalizing behavior problem: A meta-analytic review. *Journal of Child Psychology and Psychiatry*, *47*(1), 99-111.

Schoenwald, S. K., Brown, T. L., & Henggeler, S. W. (2000). Inside multisystemic therapy: Therapist, supervisory, and program practices. *Journal of Emotional & Behavioral Disorders*, *8*, 113-127.

Sexton, T. L., & Alexander, J. F. (2005). Functional family therapy for externalizing disorders in adolescents. In J. Lebow (Ed.), *Handbook of clinical family therapy* (pp. 164-194). New Jersey: Wiley.

Simonoff E. (2005). Children with psychiatric disorders and learning disabilities.*BMJ (Clinical research ed.)*, *330*(7494), 742-743. doi:10.1136/bmj.330.7494.742

Silverman, W. K., &Hinshaw, S. P. (2008). The second special issue on evidence-based psychosocial treatments for children and adolescent: A 10-years update. *Journal of Clinical Child and AdolescentPsychology*, *37*(1), 1-7.

Southam-Gerow, M. A., Kendall, P. C., & Weersing, V. R. (2001). Examining outcome variability: Correlates of treatment response in a child and adolescent anxiety clinic. *Journal of Clinical ChildPsychology*, *30*(3), 422-436.

Spring, B., Pagoto, S., Kaufmann, P. G., Whitlock, E. P., Glasgow, R. E., Smith, T. W., et. al. (2005). Invitation to a dialogue between researchers and clinicians about evidence-based behavioral medicine. *Annals of Behavioral Medicine*, *30*(2), 125-137.

Tappe, A. (2002). *Using Nvivo in qualitative research*. Melbourne, Australia: QSR International.

Citation of the Article:
Masood, A., Sulman, M & Aslam, S., (2021). Contextual factors affecting mental health services for children with comorbid conditions of learning and intellectual disability. *Journal of Inclusive Education, 5*(1), 15-38

Received on: 12th May 2021
Revised on: 7th December 2021
Accepted on: 7th December 2021