

**Children in Care and Child Maltreatment in Manitoba: What Does Research From the
Manitoba Centre for Health Policy Tell Us, and Where Do We Go From Here?**

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Background on the Manitoba Centre for Health Policy and Research in Child Welfare

The Manitoba Centre for Health Policy (MCHP) is a research unit within the Department of Community Health Sciences, in the Faculty of Medicine at the University of Manitoba. MCHP houses the Population Health Research Data Repository (hereafter referred to as the Repository), which is a comprehensive collection of administrative, registry, survey and other databases primarily comprising residents of Manitoba. The Repository was developed to describe and explain patterns of health care and profiles of health and illness, but in the past decade has expanded to include information about services and programs from other departments. This has enabled inter-sectoral research in areas such as health care, education, and social services. MCHP acts as a steward of the information in the Repository for government agencies, RHAs and clinicians. Any project using Repository data must comply with all confidentiality and privacy policies, and must receive prior approvals from the Faculty of Medicine's Research Ethics Board, the government's Health Information Privacy Committee, and the data custodians. All person-level data held in the Repository are de-identified, containing no names or complete addresses. Linkages are possible through the use of an encrypted unique personal identifier. Data are only linked temporarily for the approved projects. Some database information goes back almost 40 years, for the entire population of Manitoba. More detailed information about the MCHP Repository and research using the Repository can be found in Roos & Shapiro (1995; 1999) Roos et al.(2005; 2008) Roos & Nicol (1999), and Brownell et al. (2002).

The Repository consists of databases grouped into six domains: Health, Education, Social, Justice, Registries, and Database Support Files (a detailed listing of the databases within these domains can be found in Table A1 in the Appendix). The Health domain holds records for virtually all contacts with the provincial health care system, the Manitoba Health Services Insurance Plan (including physicians, hospitals, and pharmaceutical prescriptions) of all individuals registered to receive universal health benefits in Manitoba. The Education domain consists of Manitoba grade school and high school (kindergarten through grade 12) records containing enrolment and progress in school, assessments for all children in Grade 3, Grades 7/8, and Grade 12, and course marks for Grades 9 through 12. The Social domain includes program data from Healthy Child Manitoba including Families First screening and evaluation, Healthy Baby program data and scores on the Early Development Instrument (EDI), as well as other social service data such as Income Assistance and Child and Family Services.

At MCHP we have used data in the Repository to study the outcomes for children in care (also referred to as foster care and out-of-home placement). In Brownell et al. (2010), we examined education and social outcomes for youths who had one or more of the following three risk factors: being a child of a teen mom, experiencing poverty (i.e., living in a family that received income assistance for at least 2 months between the time the child was 10 and 17 years), and being involved with Child and Family Services (i.e., being in care or receiving protection/support services¹ at any time between the time the child was 10 and 17 years). This study looked at four different outcomes for youths: completion of high school, completion of 8

¹ Protection services are provided when a child is seen as in need of protection because his/her health or emotional well-being is endangered; these services do not entail removal of the child from the home. Families can also receive voluntary support services, which are services that the family requests to aid in the resolution of family matters. “Protection” and “support” are distinct categories of services, but because these distinctions are often blurred, they were combined (as “receiving services from CFS”) for this analysis.

or more credits in grade 9 (which is a predictor of high school completion (Brownell et al., 2012; King et al., 2007)), receipt of income assistance as a young adult, and giving birth as a teen (females only). We found that for youths whose only risk factor was receiving services from CFS, 57.2% of them completed high school within 7 years of entering grade 9. This is compared to 81.9% of youths with none of the three risk factors. For youths receiving services from CFS who also had lived in families receiving income assistance, only 28.3% completed high school within 7 years of entering grade 9. For youths involved with CFS who also had a teen mom, 38.5% completed high school, and for youths with all three risk factors only 15.8% of them completed high school.

For the other outcomes studied we found similar results: youths receiving services from CFS had poorer outcomes than youths without any risk factors, and the more risk factors they had, the poorer the outcomes. 60.4% of the youths involved with CFS earned 8 or more credits in grade 9 compared to 83.4% of youths with no risk factors. With one additional risk factor, the percent dropped to 30.1% or 41.2% (depending on the risk factor) and with all three risk factors only 20.2% of the youths earned 8 or more credits in grade 9. Whereas only 1.2% of youths with none of the risk factors received income assistance as young adults (18-19 years), 9% to 33.5% (depending on the number of risk factors) of youths involved with CFS received income assistance as young adults. When looking only at the female population of youths, only 2.1% of females with none of the risk factors gave birth during their teens, compared to 10.7% to 44.5% (again, depending on the number of risk factors) of females involved with CFS.

Recognizing that there may be other influences associated with the three risk factors examined in this study, that may be contributing to the poorer outcomes of youths involved with CFS, we conducted multivariate regression analyses to control for the following: age, intellectual disability, emotional behavioural disorder, number of children in the family, area-level SES, area-level percent of Aboriginal residents, mother's marital status and sex. Even once these factors were controlled for, large (and statistically significant) differences in outcomes remained between outcomes for youths with none of the risk factors and outcomes for youths involved with CFS. Thus, the educational and social outcomes of youths who have been in care are poorer than for youths who have not been in care. It should be noted that it is difficult to determine from these analyses whether being in care or the circumstances leading to being in care (or a combination of both) resulted in the poorer educational and social outcomes.

We are not the first to demonstrate poorer outcomes for children in care. Indeed, educational achievement of children in care has long been a concern (Fanshel & Shinn, 1978), particularly since adolescents emancipated from the child welfare system often leave with little to no financial resources, community connections or help from family, making educational achievement that much more important (Tweddle, 2007). Research has indicated that children in care are more likely to struggle in school (Blome, 1997; Burley & Halpern, 2001; Goerge et al., 1992; Scherr, 2007). A large proportion of such children (a) receive special education services (Goerge et al., 1992; Zetlin et al., 2003), (b) have a high rate of absenteeism (Kortenkamp & Ehrle, 2002; Scherr, 2007), (c) are more likely to be suspended or expelled (Kortenkamp & Ehrle, 2002), (d) score 15 to 20 per cent below their peers on state-wide achievement tests (Burley & Halpern, 2001), (e) are much less likely to graduate (Blome, 1997; Burley & Halpern,

2001), and (f) are likely to repeat at least one grade (Sawyer & Dubowitz, 1994; Burley & Halpern, 2001).

In the Manitoba Child Health Atlas Update (Brownell et al., 2008), rates of hospitalization were compared for children 0 to 17 years of age who had been or were in care in 2001/02-2003/04 to those who had not been in care during this time period. Markedly higher hospitalization rates were found for children in care, at almost 3 times higher than rates for children not in care. Some of the most notable differences were for mental disorders, with children in care having hospitalization rates over 10 times higher than children not in care, hospitalizations related to pregnancy and childbirth (i.e., teen births), with children in care having hospitalization rates almost 6 times higher than children not in care, and injuries, with children in care having hospitalization rates over 3 times higher than children not in care.

Work has also been done using the MCHP Repository to study not only rates of hospitalizations, but physician visits, suicide attempts and suicides by children in care compared to children not in care in Manitoba (Katz et al., 2011). This study selected children who were 5 to 17 years of age and who were in care for the first time for at least 30 days between 1997/98 and 2005/06. Children of the same age who had not been in care were used for comparisons. Children in care had almost twice as many hospitalizations, 14% more physician visits, over twice as many suicide attempts and three-and-a-half times the rate of suicide compared to children not in care. These results were found even once additional factors had been controlled for, including age, sex, socioeconomic status, parental psychopathology, and presence of a

psychiatric disorder. This study found that length of time in care and the number of placements did not have a substantial impact on the outcomes.

Katz et al. (2011) also looked at these same outcomes for children in care both before and after they were taken into care, where the “before” period looked at outcomes that occurred in the two-year period prior to the date of the first placement in care, and the “after” period looked at outcomes that occurred on or after the date the child was placed into care until the end of the study period. They found that attempted suicides, admissions to hospital and physician visits were all significantly lower in the period after entering care than the period two years before the placement. The rate of suicide was 73% lower, the rate of hospital admissions was 32% lower and the rate of physician visits was 11% lower in the period after entry into care.

Given that our research at MCHP, and studies elsewhere, has demonstrated that outcomes are poorer for children in care compared to children not in care, it is important to know how many children in Manitoba are affected. According to the Manitoba Family Services and Consumer Affairs (now Manitoba Family Services and Labour) Annual Report for 2010/11, there were 9,432 children in care on March 31, 2011 (Manitoba Family Services and Consumer Affairs, 2011). There were approximately 286,000 children 0 to 17 years of age living in Manitoba in December 2009 (most recent year of data available) according to a report by MCHP (Brownell et al., 2012), which would mean that just over 3% of children 0 to 17 in Manitoba were in care on March 31, 2011. The actual number of children who were in care at any point during that fiscal year was likely higher, since there would be children who went into care sometime in the fiscal year but were no longer in care on March 31, 2011. Brownell et al. (2012)

calculated the prevalence² of children 0 to 17 years of age in care in Manitoba in 2006/07-2008/09 using data from the Child and Family Services Information System (CFSIS) and found that 4% of children had been in care at any time over that period. This is likely an underestimate as not all CFS agencies consistently enter data into CFSIS. When looking over time, the numbers are even greater: by the age of 7 years, 7.5% of Manitoba children have been in care at some time in their lives (Gilbert et al., 2012).

It should be noted that not all children in Manitoba are at the same risk of going into care. Northern Manitoba (in this case, in the former RHAs of Nor-Man, Burntwood and Churchill) has tended to have higher prevalence of children in care than other areas of the province, although in the most recent time period available for analysis, prevalence in the North was not different from the rest of the province (Brownell et al., 2012). This is likely due to incomplete reporting to CFSIS during this time period. Looking only at children in urban areas, where reporting to CFSIS is not problematic, there is a large difference across neighbourhoods, with children from the areas with the lowest income having a prevalence of 14.1% compared to 0.3% in areas with the highest incomes (Brownell et al., 2012). Of note is the fact that 85% of the children in care in Manitoba are Aboriginal (Manitoba Family Services and Consumer Affairs, 2011).

Manitoba has some of the highest rates of children in care in the world. In a study of out-of-home care across several countries, Thoburn (2007) identified Canada as having some of the highest rates in the world, and Manitoba's rate of children in care is one of the highest in Canada (Canadian Child Welfare Research Portal, 2010). In a comparison across 6 countries, Gilbert et

² Prevalence refers to the percent of children in care over a given period of time. Each child is counted only once over the time period.

al. (2012) found that rates of out-of-home placements for children up to 10 years of age were 10 times higher in Manitoba than in Western Australia.

Given the generally poorer outcomes experienced by children in care discussed above, having high rates of out-of-home placements is of concern. Of course, it is difficult to tell from the research presented whether the poorer outcomes experienced by children in care are the result of being in care itself, or the factors that led to the children being in care. There are currently no controlled trials comparing outcomes for children in care to outcomes for children in families receiving intensive home support (Gilbert et al., 2012), which would help to determine the impact of out-of-home care itself. What this means is that thousands of Manitoba children are being placed in care each year, with little evidence that this intervention is effective and will result in the best possible outcomes for the children. In at least some instances, out-of-home placements may actually indicate inadequate funding for preventive or supportive interventions that would allow the child to remain in the home, rather than being an option of last resort after these other interventions have been tried and failed. The large number of children in care in Manitoba also raises questions about the sustainability of providing high quality foster care (Gilbert et al., 2012; O'Donnell et al., 2008).

Public Health Approach to Child Maltreatment

To address not only the potential unsustainability of a quality foster care system, but also the fact that it is likely that only a fraction of children experiencing some form of maltreatment come to the attention of child protection agencies, a public health approach to child abuse and neglect has been advocated (Gilbert et al., 2012; O'Donnell et al., 2008; Gilbert, Woodman &

Logan, 2012). This public health approach would theoretically reduce the risks for child maltreatment, thereby also reducing the need for removing children from their families and homes and placing them into care. A public health approach involves primary, secondary and tertiary prevention strategies, or what are sometimes referred to as upstream, midstream and downstream approaches (McKinlay, 1998). In the field of population and public health, the analogy used to describe these approaches to health and health care involves a dangerous highway with a steep cliff, off of which cars loaded with passengers are continually falling. A downstream approach would suggest building a hospital at the bottom of the cliff to treat the victims; a midstream approach may involve erecting a sign on the highway to warn drivers about the upcoming cliff; whereas an upstream approach would change the environment (in this case the highway) so that drivers are no longer placed at risk (e.g., re-route the highway away from the cliff). While all three approaches or strategies are necessary in promoting health, there has been a disproportionate emphasis on downstream approaches, as opposed to whole population upstream approaches (McKinlay, 1998). The same can be said for child welfare, where the emphasis has been on child protection (downstream) rather than universal prevention (upstream) (O'Donnell et al., 2008; Gilbert, Woodman & Logan, 2012).

In order to understand how a public health approach to child maltreatment would work, it is important to try to understand what factors cause an adult to abuse and/or neglect a child. Belsky (1993) stressed that child abuse and neglect are likely caused by multiple factors at multiple levels including individual, familial, community, and societal levels. Individual (child-level) factors associated with child maltreatment include low birth weight and short gestation, disabilities and chronic health problems, difficult temperaments, and learning and behavioral

difficulties (Sherrod et al., 1984; Spencer et al., 2006; Sprang et al., 2005; Sullivan & Knutson, 2000; Trocmé et al., 2003). Family (parent-level) factors include adolescent parenting, lone-parent status, parents' social isolation, parental mental health problems such as depression, substance abuse, intimate partner violence, parents' own history of child maltreatment and/or lack of positive parenting experiences during childhood (Black et al., 2001; Chaffin et al., 1996; Corse et al., 1990; DePaul & Domenech, 2000; Ekéus et al., 2004; Gilbert et al., 2009; Kelleher et al., 1994; Sidebotham & Golding, 2001; Trocmé et al., 2003). Community characteristics include neighborhood poverty, unemployment, poor housing conditions, higher residential mobility, less extensive social networks, lower levels of social cohesion, and more social isolation (Coulton et al., 1995; Coulton et al., 1999; Drake & Pandey, 1996; Garbarino & Sherman, 1980; Garbarino & Kostelny, 1992; Gilbert et al., 2009; Jack, 2004; Whipple & Webster-Stratton, 1991). Societal factors include not only those related to degree of poverty, such as economic circumstances, but also societal attitudes toward physical punishment and violence (Durrant, 2006). Research at MCHP confirms that many of these factors are significant predictors of infants entering care in Manitoba, including financial difficulties, being in a lone-parent family with no social support, and maternal alcohol or drug use during pregnancy (Brownell et al., 2011).

What are the arguments in favor of a public health approach? Firstly, the current approach of detection, through notifications and investigations, and removal of children to foster care leads to a chronically over-burdened system (O'Donnell et al., 2008). Estimates suggest that 4 to 16% of children are physically abused each year, and 10% are neglected or psychologically abused (Gilbert et al., 2009). Only a fraction of this number of cases is currently

investigated; policies that suggest enhanced detection as a means to address child maltreatment will certainly increase the current burden on the system. Resources steered toward better detection and protection take away from other areas, such as in-home supports and prevention programs. The recent follow-up of the Auditor General's Report (Office of the Auditor General Manitoba, 2012) illustrates this strain on resources and the resulting need to prioritize some services over others. In response to criticisms that recommendations to improve reporting to CFSIS have gone unaddressed, Family Services Minister Jennifer Howard claimed that the government chose to hire more social workers, rather than invest in more computers (Winnipeg Free Press, September 28, 2012). The intent of a public health approach that focuses on upstream (preventive) interventions is to reduce the occurrence of child maltreatment in the first place.

The second argument in favor of a public health approach relates to the fact that only a fraction of child maltreatment cases come to the attention of child protection authorities (O'Donnell et al., 2008; Gilbert, Woodman & Logan, 2012). Indeed, some suggest that cases of child maltreatment that come to the attention of child protection agencies and/or involve police investigations represent only the tip of the iceberg of child abuse and neglect, with the majority of cases going unreported or unknown (PHAC, 2010; Trocme et al., 2005). Thus, regardless of policies such as mandatory reporting by all professionals who have contact with children, detection and reporting of all possible maltreatment is implausible. Universal programming aimed at improving parenting and family functioning could potentially reduce child abuse and neglect, not only for those families that might eventually come in contact with child protection agencies, but also those who won't. A review by Gilbert et al., (2009) documents the long-term

serious consequences of child maltreatment, including not only the extreme and obvious cases of child deaths, but long-term mental and physical health concerns, substance abuse and criminal activity. Programs that reduced child abuse and neglect at the population level would thus have far reaching benefits, for children and their families, as well as society at large.

A third argument in favor of a public health approach to child maltreatment involves economic costs. The old adage “an ounce of prevention is worth a pound of cure” has been demonstrated in numerous early childhood development programs that target high risk children (for example, the Perry Preschool Program (see Schweinhart et al., 2005); the Abecedarian Program (see Campbell et al, 2012; Muenning et al., 2011; Pungello et al., 2010) and the Chicago Parent-Child Centers (see Reynolds & Temple, 2008). For example, the Perry Preschool Program, an intensive 2-year program targeting disadvantaged children and involving both high-quality preschool programming and home visits, has followed participants for over 40 years and estimated that more than \$16 has been saved for every \$1 spent, due to increases in education, employment and incomes and decreases in welfare and justice system costs (Schweinhart et al., 2005). There is little cost effectiveness research in the area of child maltreatment (see for example Meadows et al., 2011); however a study estimating the costs of developing a public health system for delivering population-wide parenting interventions suggest substantial savings could be achieved (Foster et al., 2008).

While arguments that involve economic savings are always appealing, society has a moral obligation to protect children from abuse and neglect in the first place (O’Donnell et al., 2008; Gilbert, Woodman & Logan, 2012). Reading et al., (2009) take this argument one step

further and claim that society has a legal right to protect children from maltreatment, and suggests using the United Nations Convention on the rights of the child (UNCRC) as a framework for addressing child maltreatment, including preventing its occurrence. Canada became a signatory to the UNCRC in 1990 and ratified it in 1991, and as such is bound to it by international law (Wikipedia, nd). Reading et al. point out that the rights-based approach can compliment the public health approach, providing “a legal instrument for implementing policy, accountability, and social justice, all of which enhance public-health responses.” (p. 332).

Providing support to parents is laid out in the UNCRC in Article 18.2:

For the purpose of guaranteeing and promoting the rights set forth in the present Convention, States Parties shall render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities and shall ensure the development of institutions, facilities and services for the care of children. (p. 5, United Nations, 1989)

As Blackstock (2007) points out, Aboriginal children, who are disproportionately represented in the child welfare system in Canada, are more often taken into care for reasons of neglect than abuse, and this neglect is associated with at least two factors that are largely out of the parents’ control: poverty and poor housing. Blackstock calls for the enhancement of “family support services to keep children safely at home, accompanied by sustained investments in community development efforts targeted at poverty eradication and substance misuse” (p. 76) and her call is reinforced by the UNCRC.

Conclusions

The knee-jerk response to severe child abuse and individual deaths, like the case of Phoenix Sinclair, is moral outrage and a need to punish not only the perpetrators of the abuse, but also “the system” that allowed the abuse to occur. Policy responses often revolve around detection and punishment rather than focusing on developing and implementing interventions to improve conditions for children (Gilbert, Woodman & Logan, 2012). But such interventions are necessary in order to reduce and prevent child maltreatment.

What would such interventions look like? A public health approach would involve preventive strategies at multiple levels, from upstream approaches such as social policies affecting all children and their families to midstream targeted approaches for families and children at risk, through to downstream approaches involving child protection in cases of severe maltreatment.

Social policies at the upstream level could involve legislation against corporal punishment (Gilbert et al., 2009), extended parental leave programs, ensuring access to low cost, quality child care, economic reforms that reduce the gap between rich and poor (see for example Marmot et al., 2009), and a guaranteed annual income (see for example Forget, 2011). Parenting programs with a universal component (for example Triple P – see Prinz et al., 2009) are also examples of upstream interventions that could reduce child maltreatment at the population level. The benefit of universal, upstream programs is that they have the potential not only to prevent child maltreatment, but to enhance family functioning and child outcomes at the population level (O’Donnell et al., 2008). Midstream approaches could include targeted home visiting programs, mental health strategies and services, programs that address domestic violence, and substance

abuse programs. Even with extensive and effective prevention programs, downstream or tertiary responses to severe child maltreatment will likely always be necessary. In these cases, it is important that the decisions on how to treat severe child maltreatment are based on the best possible evidence for effective care and outcomes, which may involve intensive family-centred interventions or removal of the child from the home.

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Appendix

Table A1:

