

3.

Reflections and Recommendations

This is the first time that we, the Child and Youth Officer and the Provincial Health Officer, have worked together on a joint report. As far as we know, it is also the first time that cross-government administrative data have been linked in this way and reported on publicly to provide a more extensive picture of children in care than the Ministry of Children and Family Development on its own can provide.

This first report is on health services utilization and mortality of children in care. As the cross-ministry data we look at expands to include data from the education, employment and income assistance, and criminal justice systems, the picture of children in care will become fuller.

The Medical Services Plan, PharmaNet, Vital Statistics and hospitalization data have limitations and need to be interpreted with caution. However, in combination they do provide useful information about how children in care compare with the general child population in British Columbia in relation to the utilization of a variety of health services, some health outcomes, and mortality. They also raise important questions that require further research.

We reflect below on highlights from the data that strike us as particularly important. We bring to our joint reflections separate perspectives – a focus on child welfare and a focus on public health. It falls within both our mandates to independently advise government about how to improve the health and well-being of all children in British Columbia, including children in care. We have therefore followed our reflections with recommendations to government about how it can fulfill its special responsibility as the guardian of children in care to improve their outcomes. These recommendations flow not just from the data in this report, but also from what we have come to know in our work as Child and Youth Officer and Provincial Health Officer.

3. Reflections and Recommendations

Although our mandates as Child and Youth Officer and Provincial Health Officer – and therefore our perspectives – differ somewhat, we hold common views about effective approaches to improving health and well-being outcomes for children and youth. As this is our first joint report, we believe that it is important to identify these common views. In the first section of this part of the report, we have summarized them and related them to improving outcomes for children in care.

In the second section, we set out our reflections on the data and our recommendations arising from it and from what we know from other sources.

In the final section, we report on what we have learned from our joint project about the importance and challenges of collecting cross-ministry data to better understand the state of health and well-being of children and youth in British Columbia. We also make recommendations about how to build on this first step that we have taken together.

3.1

Our Common Views About Effective Approaches

Prevention and health promotion

We share the view that investment in health promotion and prevention of poor outcomes brings with it the greatest promise for improving health and well-being outcomes for all children, including children in care.

Many children in care have health problems when they enter care. In many cases, these health problems are a contributing cause of the children coming into care; their parents (who themselves are often vulnerable) are unable to meet the challenges of parenting children with significant health problems. Depending on their severity, these health problems cause children in care to be more vulnerable and less able to deal with the challenges of life. They increase the risk of poor long-term outcomes, such as low educational attainment levels and inability to form healthy social relationships. Preventing these health problems in the first place could result in fewer children coming into care, and will reduce the risk of poor outcomes for those children who come into care for other reasons.

We know from the data that a child in care is more likely than the average child to have congenital anomalies and poor perinatal health. While not all congenital anomalies and poor health at birth can be prevented, scientific research is improving our understanding of their causes, and some preventive interventions are becoming available. For example, the incidence of spina bifida (one of the congenital anomalies reflected in the data as more prevalent among children in care) can be, and has been, reduced through folic acid supplementation before and during pregnancy.

Sudden Infant Death Syndrome (SIDS) provides another example of the effectiveness of prevention. The mortality data indicate that SIDS remains the second leading cause of mortality from natural causes for children in care, but the number of deaths caused by SIDS has declined over time. This trend reflects effective SIDS prevention programs, such as “back to sleep” and educational programs aimed at reducing smoking in the presence of infants.

Yet another example from the data of the potential of a preventive approach relates to the revelation that the most common reason for hospitalization of children is dental work. Access to preventive dental care would likely change that fact.

Fetal Alcohol Spectrum Disorder (FASD) provides an example – not from the data, but of relevance to children in care – of when prevention could have a significant impact. The databases we examined do not give information about the prevalence of FASD among children in care; however, we know from other sources that it is high. Alcohol consumption during pregnancy is probably the most common preventable cause of congenitally acquired mental and behavioural disabilities in children in British Columbia. The prevention of FASD could have a significant impact on outcomes for children in care, and again possibly reduce the numbers of children who have to be brought into care in the first place.

We welcome the provincial government's recent Act Now initiative aimed at increasing access to services for women at risk of using alcohol during pregnancy. We encourage the development of a provincial FASD prevention strategy, including community development, health promotion and targeted strategies to raise awareness of the disability and risks associated with alcohol and substance use during pregnancy.

Early diagnosis and intervention

We share the view that early diagnosis of disabilities and appropriate interventions can make a significant difference in improving outcomes for affected children and their families.

Some congenital anomalies and effects of poor health at birth will stay with a child for a lifetime. However, if the disabilities caused by these congenital defects and poor early health conditions are identified early, strategies to increase a child's adaptive skills and to support families in managing the consequences of the disabilities can reduce the risks of poor outcomes for these vulnerable children.

Again using FASD as an example of relevance to the children in care population, children with FASD have a significantly greater likelihood of school failure, unemployment, and encounters with the justice system. If

FASD is left undiagnosed, the behavioural patterns of those affected are misunderstood and increase the likelihood of these poor outcomes. While the particular needs of children with FASD vary from child to child, it is known that generally they respond well to structure. Early diagnosis and education of significant adults in the lives of children with FASD will reduce the risks that these children face in childhood, adolescence and adulthood.

Early childhood development

We share the view that the most effective way to promote the health and well-being of children, especially vulnerable children (which children in care generally are), is through early childhood development strategies.

Whenever public investment in strategies to improve outcomes for children and youth are being considered, the critical importance of the early years of life in the development of the child must be stressed. Although interventions later in life can be effective, it is in these early years that the foundation is established for competence and coping skills that will affect learning, behaviour and health throughout a child's life. In these early years, children thrive within families and communities that can meet their physical and developmental needs and provide security, nurturing, respect and love.

Four key areas for strengthening early childhood development were identified for action by governments and communities by the Canadian First Ministers in September 2000:

- the promotion of healthy pregnancy, birth and infancy
- improved parenting and family supports
- strengthened early childhood development, learning and care opportunities
- strengthened community supports.

We agree with these priorities. The Provincial Health Officer's 2002 annual report, *The Health and Well-being of People in British Columbia*, and the Child and Youth Officer's special report, *Healthy Early Childhood Development in British Columbia: From Words to Action*, make specific recommendations on how British Columbia can move forward in the area of early childhood development.

Reinforcing inherent resiliency

We share the view that the most effective strategies to improve outcomes for high-risk youth, both in and out of care, are those that enhance their resiliency and acknowledge and build on their strengths.

Resilience research has focused on the reality that the majority of children and youth at high risk of poor outcomes develop to adulthood without those risks being realized. The research has identified certain factors (known as “protective factors”) that are associated with positive development despite high risk. These are:

- caring relationships with supportive caregivers and other adults
- high expectations, and
- opportunities for participation and contribution.

(For a more thorough discussion of this approach, see the Child and Youth Officer’s Issue Paper 4, *Towards a Strengths-Based Approach to Government Policy and Services for Children and Youth in British Columbia.*)

The data presented in this report showing that in general children in care use more health services is evidence both of poorer outcomes and of the fact that children in care are at higher risk than the general population. We also know from other research that children in care are over-represented in a variety of categories of children and youth at high risk of poor outcomes.

Being in care creates its own particular challenges for providing high-risk children with the caring relationships, high expectations, and opportunities for participation and contribution that they need to improve their chances of healthy development to adulthood. For example, having been removed from their families reduces opportunities to develop long-term relationships with caring adults. Being moved frequently from foster home to foster home (a reasonably common experience for children in care) exacerbates a lack of connection with significant adults in their lives, as does the fact that the ongoing guardianship responsibility of government and the involvement of foster parents officially ceases at age 19.

Once again children in care with FASD provide a good example. We know that the behaviours of these children often alienate them from their caregivers and other adults with whom they interact. Their behaviour creates low expectations, which in turn lowers their self-esteem, which is likely already

low because of their disabilities. They especially need adults to recognize their strengths and not be put off by their behaviour. Their behaviour and the low expectation that others have of them are obstacles to their being provided with opportunities to participate and to learn the value of contribution. These children need more, not fewer, opportunities to participate because it takes them longer to learn by experience. Also, they need to be encouraged to participate in order to experience success, develop competence, contribute, and feel good about themselves. Youth with FASD particularly need a network of adult support as they make the transition to adulthood and have to navigate adult systems that their disabilities make difficult to access. Youth with FASD who age out of government care at 19 are less likely to have that network of adult support.

We believe that if the outcomes for children and youth in care are to improve, the individual planning and management for these children and youth should be directed at enhancing their resiliency and identifying, acknowledging and building on their strengths.

Special strategies for Aboriginal children

We share the view that special strategies are required for Aboriginal children and youth in British Columbia, and that these strategies must be developed in partnership with Aboriginal communities.

The Provincial Health Officer's 2001 annual report, *The Health and Well-being of Aboriginal People in British Columbia*, reveals unacceptable gaps in the health status of Aboriginal people in British Columbia, although it does provide evidence of steady improvement in many health indicators. These disparities in health status between Aboriginal people and the general population in British Columbia are paralleled in socio-economic status and are longstanding. They are the cumulative result of complex historical and contemporary factors that include historical loss of culture and political institutions, colonization, racism, and residential school experiences, which have had multigenerational impacts.

These same factors have led to a disproportionately high number of Aboriginal children and youth in care. The fact that currently almost half of children in care are Aboriginal suggests the need to develop, in conjunction

with Aboriginal communities, particular strategies for improving outcomes for them – strategies that take into account the complex historical and contemporary factors that got them there in the first place. We know that the Ministry of Children and Family Development is currently engaged in a joint effort with Aboriginal communities to do that, and we support that effort.

The *Child, Family and Community Service Act* has as one of its guiding principles that the cultural identity of Aboriginal children should be preserved. The Ministry of Children and Family Development has policies and programs designed to further that principle. At the same time, the disconnection of Aboriginal youth in care from their cultural and community roots is a continuing reality that increases the likelihood of their engaging in high-risk activities. Their over-representation in the criminal justice system attests to this. (See the Child and Youth Officer's Issue Paper 5, *Aboriginal Youth and the Youth Criminal Justice System*, for further discussion of this issue.)

Strategies for improving outcomes for Aboriginal children and youth in care should find ways of enhancing their sense of belonging by engaging the Aboriginal community in the development and implementation of these strategies, and by including a cultural component in responses to at-risk behaviours.

3.2

Our Reflections on the Data

General observations

We are pleased to note that the data analyzed in the report show that between 1997 and 2004, there is evidence of improvement in a number of health and well-being outcome measures for children in care. For example, mortality rates for children in care show a continuation of the downward trend noted in the Provincial Health Officer's 2001 report *Health Status of Children and Youth in Care in British Columbia: What do the Mortality Data Show?*. The teen pregnancy rate appears to be falling among children in care. Rates of respiratory conditions and injuries are falling more rapidly in the children in care population than in the general population.

Yet the data still show significantly higher rates of health problems and health services utilization for children in care than for children in the general population in most of these areas, as well as in others. While children in care usually experience the same health problems as do children in the general population, they clearly experience more health problems than other children do. This makes them more vulnerable.

Government (through the Director under the *Child, Family and Community Service Act*) is the guardian of these vulnerable children. It therefore has a special responsibility to take steps to prevent, and if prevention is not possible to manage, the health problems experienced by children in care. In its role as the maker and implementer of public policy, government is also well-placed to develop strategies to do that. These strategies should include proper assessment and individualized treatment plans, as well as ongoing training and support for both guardianship and protection line staff and caregivers in managing these conditions.

We note that, with some exceptions, the data suggests similar health outcomes for Aboriginal and non-Aboriginal children in care. In the general population, however, Aboriginal children have poorer health outcomes than non-Aboriginal children. This discrepancy may well have to do with the fact that the socio-economic backgrounds of children in care are similar regardless

of whether they are Aboriginal or non-Aboriginal; whereas in the general population, Aboriginal children on average live in poorer socio-economic circumstances than the average non-Aboriginal child.

Certain elements of the data, which we reflect on below, cause particular concern for children and youth in care, and raise issues for further study. These are:

- the higher prevalence of respiratory conditions
- the higher rates of death and intentional and unintentional injury and poisoning, caused by motor vehicle accidents, suicide and poisoning, especially among adolescents
- the higher prevalence of depression and anxiety
- the higher prevalence of hyperkinetic syndrome and the high use of cerebral stimulants to treat it
- the earlier and higher rates of pregnancy and use of contraception among females
- the poorer health indicators for youth between the ages of 19 and 25 who were previously in care.

Respiratory conditions

While respiratory illness is the most common medical condition affecting all children in British Columbia, we note that children in care exhibit higher levels of service utilization and diagnoses for respiratory illnesses, and receive a higher level of antibiotic therapy, than do other children.

The data do not tell us *why* children in care experience more respiratory problems, but we may speculate that higher rates of pre-term births among children in care may be a contributing factor. Another factor, given that housing conditions in communities with lower socio-economic status, including reserves, are notoriously poor, may be the presence of environmental contaminants like moulds, fungi, dust and second-hand tobacco smoke, as well as overcrowding in substandard dwellings.

While children in care may have been exposed to these conditions before coming into care, and while there is clearly a social imperative to prevent these conditions by improving housing conditions on reserves and generally for those with lower socio-economic status, there is one environmental contaminant that can be banned from their immediate surroundings: reducing the amount of second-hand smoke to which children in care are exposed

will almost certainly reduce their level of respiratory problems. Because of its contractual relationship with foster parents, the Ministry of Children and Family Development is in a unique position to have an impact on the prevalence of respiratory problems among children in care, by making a smoke-free environment a requirement for foster homes.

Intentional and unintentional injuries and poisonings

Intentional and unintentional injuries and poisonings are higher among youth in care. At the same time, it is important to note that while children in care have higher rates of hospitalization (and deaths) for these causes, in the past decade rates of injuries and deaths have been steadily declining. This indicates that we are on the right track.

The two most common non-natural causes of deaths of children in care between 1986 and 2005 were suicide and motor vehicle accidents. Among the most common reasons for hospitalization of children in continuing care in the adolescent years and early adulthood are assaults, poisonings, suicide-related issues and injuries resulting from motor vehicle accidents. Children in care also have a higher rate of hospitalization for injuries of undetermined cause – that is, whether they are accidental or intentionally self-inflicted, and in the case of adolescent and young adult females, for poisonings categorized as accidental. It is quite likely that some of these hospitalizations are connected to suicide attempts.

This data raises a concern about suicide among youth who are or have been in care. There is an Aboriginal aspect to the issue of suicide that we want to highlight. We know that the high risk of suicide is an issue for Aboriginal youth in general and for Aboriginal youth in care.

The research on Aboriginal youth suicide suggests that a sense of belonging is a crucial protective factor that reduces the risk of suicide. For Aboriginal children and youth, this means an understanding of themselves as Aboriginal. Connection to their culture and community is important in strengthening their sense of belonging. (For a further discussion of preventing Aboriginal youth suicide, see the Child and Youth Officer’s special report, *Sayt K’üüilm Goot – Of One Heart: Preventing Aboriginal Youth Suicide Through Youth and Community Engagement*.)

Recommendation 1:

For the Ministry of Children and Family Development

Introduce a policy of no smoking inside foster homes.

Recommendation 2:

For the Ministry of Children and Family Development

Engage in a renewed effort to connect Aboriginal children and youth in the continuing care of the government with their cultural and community roots to enhance their sense of belonging.

We know from other research that alcohol and other drugs are often contributing factors in assaults, accidental poisonings and motor vehicle accidents involving youth. Targeted programs aimed at promoting reduced and safer use of alcohol and drugs have proven effective. The data revealing higher-than-average injuries caused by assaults, accidental poisonings and motor vehicle accidents for youth who are or have been in care suggest the potential value of a targeted educational initiative among children and youth in care about the risks connected with alcohol and drugs.

Depression and anxiety disorders

Sixty-five per cent of children and youth in care have been diagnosed at least once with a mental disorder, compared with 17% of the general population. Among the most common diagnoses, especially for females in the adolescent years, are depression and anxiety disorders. The prescribing of psychotherapeutic (e.g., anti-depressants and tranquilizers) and anxiolytic drugs (e.g., anti-anxiety medications) for adolescent females in care is similarly high.

This data, along with the injury data referred to above, suggest that anxiety and depression are among the mental health problems that children in care experience at significantly higher rates than do the general child population in British Columbia.

Having said that, we need to introduce a note of caution about inferences to be made from the data. The Ministry of Children and Family Development, in its research in this area, has estimated that about 13% of children and youth suffering from serious mental health problems receive treatment. This indicates that these conditions are under-treated in the general population. The high identification and pharmaceutical treatment of mental health conditions among children and youth in care could in part be a sign of better access to needed services. Unfortunately, no data are available to determine the frequency of use of counselling services by this same group. (Counselling services are generally considered an important part of treatment, often preferable to pharmaceutical interventions).

Nevertheless, it is fair to assume that rates of depression and anxiety disorders are high among children and youth in care. Children and youth with mental disorders of this type are in the high-risk category for poor outcomes such as poor school performance and dropping out of school.

Recommendation 3:

For the Ministry of Children and Family Development

Promote education of youth in care about managing the risks of alcohol and drug use.

We know that factors in the child's environment affect the incidence and course of psychiatric and mental disorders. In particular, we know that stress is a factor leading to increased depression and anxiety disorders. Stress can be caused by the presence of risk factors like poverty, parental substance abuse, and domestic violence (including child abuse), which will have been experienced by many children and youth before they come into care. Children in care will also have experienced the stress of being removed from their families, and the multiple stresses of being in care, including the disruption of moving placements and schools, and the uncertain futures for many older youth as they face the post-majority years without adequate skills and support. All of these stressors combine to increase the risk that children in care will suffer from depression and anxiety.

In addition to its guardianship responsibilities, the Ministry of Children and Family Development has responsibility for child and youth mental health. Those with particular responsibility for child and youth mental health within the ministry have developed a Child and Youth Mental Health Plan. The first phase of that plan has involved a research-policy partnership with researchers formerly with the Mental Health Evaluation and Community Consultation Unit (Mheccu) at the University of British Columbia and now with the Centre for Applied Research in Mental Health and Addiction (CARMHA) at Simon Fraser University, and has brought together panels of experts to look at epidemiological and other research-based evidence to determine, among other things, best practices for the prevention, identification and treatment of prevalent child and youth mental health conditions like depression and anxiety.

This raises the question of whether the Ministry of Children and Family Development, in fulfilling its guardianship responsibilities, has been applying to the children and youth in its care what it has learned through its efforts in the child and youth mental health field. Does the ministry know which children and youth in care suffer from anxiety and depression and what treatment they are receiving? What efforts, if any, are being made to apply best practices for identification and treatment of anxiety and depression to the children and youth in the guardianship of the Director under the *Child, Family and Community Service Act*? Are there environmental conditions that the Ministry of Children and Family Development in its guardianship role could change to reduce risk and enhance protective factors?

Recommendation 4:

For the Ministry of Children and Family Development

Using the expertise connected with the Child and Youth Mental Health Plan, conduct a review of the current status of identification and treatment of children and youth in care with anxiety and depression disorders, and develop a strategy to implement identified best practices.

An example of an initiative connected to Phase 1 of the Child and Youth Mental Health Plan is the Ministry of Children and Family Development's funding and production, through Mheccu, of a series of documentary videos on mental health issues affecting children and youth, which have been aired on the Knowledge Network channel and are available online. The series includes *Beyond the Blues: Child and Youth Depression* and *Fighting Their Fears: Child and Youth Anxiety*, two excellent documentaries that provide youth and their parents with information about how to recognize early symptoms of depression and anxiety disorders, and effective strategies to combat the debilitating effects of these disorders. The information in the videos is presented by top clinicians in child and youth mental health in British Columbia, backed by the best research available. There are also knowledge tools that accompany the videos, including *Dealing with Depression: Antidepressant Skills for Teens*, a workbook that is featured in one of the videos as an effective aid for youth struggling with symptoms of a depressive disorder.

With the knowledge coming from their research partnership with Mheccu, the Ministry of Children and Family Development should be particularly well placed to apply the lessons learned to the children in its care. Foster parents and guardianship social workers, in particular, should be well versed in the lessons portrayed in the videos, so that they can support children and youth in care who suffer from these prevalent mental health disorders.

Cerebral stimulants and hyperkinetic syndrome

Males in care are 10 times more likely than the general population of male children to be prescribed cerebral stimulants, such as Ritalin. Although females in care are less likely than males in care to be prescribed these stimulants, they are still 12 times more likely to be treated with them than are female children generally. The high use of cerebral stimulants for hyperkinetic conditions among children in care raises questions and concerns.

Cerebral stimulants are used to treat Attention Deficit Hyperactivity Disorder (ADHD) and other hyperkinetic syndromes. While research has shown these stimulants to reduce hyperactive, impulsive and inattentive behaviours, it has also raised questions about their use, including whether their use translates ultimately into a better prognosis with respect to outcomes, such as educational and occupational achievement. Questions have also been raised about the safety of stimulant use, particularly with pre-school children (Vitiello, 2001).

Recommendation 5:

For the Ministry of Children and Family Development

Educate children and youth in care, foster parents and guardianship social workers about anxiety and depression, and the identification and management of them.

Recommendation 6:

For the Ministry of Children and Family Development

Consult with the College of Physicians and Surgeons, and other appropriate professional organizations, about steps that could be taken to determine whether the prescribing practices of physicians treating children in care are appropriate.

It is perhaps predictable that children coming into care will exhibit behaviours that are difficult to manage. We need to understand better whether the pattern of high use of cerebral stimulants for children in care reflects effective diagnosis and treatment – or over-medicating of children in care. If over-medication is occurring, responsibility lies with the individual physicians who are doing the prescribing and with the medical community as a self-governing profession. As the guardian of children in care, government also has a responsibility to determine whether the high use of cerebral stimulants for the children in its care is in the children’s best interest. Behavioural disorders is one of the areas of focus in the first phase of the Child and Youth Mental Health Plan. The Ministry of Children and Family Development has access to expertise in this area that should assist in reviewing this question.

Government has access to data that could lead to helpful research on the subject of the long-term effectiveness and safety of cerebral stimulants. Academic researchers in British Columbia are well placed to undertake research to answer the question of what long-term impact this high rate of cerebral stimulant use has on children in government care. The Ministry of Children and Family Development has a responsibility and a potentially important leadership role to play in pursuing research in this area.

Early and higher rates of pregnancy and use of contraception

We note that both pregnancies and contraception use occur earlier and at higher rates for females in care than for the general population. Females in continuing care became pregnant at a rate four times that of the general population and were prescribed contraceptives about 3.5 times as often between the ages of 12 and 19. This suggests an earlier onset of sexual activity among youth in care. Higher levels of early sexual activity and pregnancy are closely associated with other risk behaviours, such as drug and alcohol use, dropping out of school, and street involvement, which in turn bring with them an increased likelihood of exploitation, and sexually transmitted diseases.

Furthermore, compared with mothers in their twenties and thirties, teenaged mothers and their infants are likely to have poorer physical, emotional and social outcomes. The results of teenage girls having babies, whatever their motivation, leads to dropping out of school and the curtailment of opportunity for the young mother. It also has implications for parenting capacity.

Recommendation 7:

For the Ministry of Children and Family Development

Take immediate steps to engage and collaborate with academics to conduct research into the issue of whether children in care are being appropriately medicated with cerebral stimulants.

The access to reproductive services for young women in care suggested by the data may be a good thing. What the data do not tell us is whether caregivers are prepared for the level of sexual behaviours in their charges indicated by the data. Nor does it tell us whether effective anticipatory counselling and guidance are provided for caregivers or the youth in their care.

Public health authorities and other community organizations, such as Options for Sexual Health (formerly Planned Parenthood BC), do important work in this area and sexually active youth in care should be afforded easy access. In addition, there is an existing network of Pregnancy Outreach Programs targeting high-risk pregnancies that reaches many young pregnant women. All pregnant females in care should be referred to these programs. (This would likely require an expansion of the programs.)

The high level of post-majority health issues

The data indicates poorer health in the immediate post-majority years (19 to 25) for children in care than for the general population in that age group. Females experience continuing high rates of respiratory problems. Hospitalization for injuries remains high, particularly for suicide attempts, assaults, motor vehicle accidents and accidental poisonings. Accidental poisonings for females who have been in care peak at age 22. Mental health issues remain high for former youth in care to age 25, especially for females.

The transition from adolescence to adulthood is a critical developmental period. Difficulties in handling relationships and emotions and the many challenges of adulthood affect the prevalence of anxiety, depression, and acting-out behaviours.

Most supports for youth in continuing care end when they turn 19. The adult system does not provide the same level of support. Those services that are available in the adult system (e.g., mental health and addiction services) are not easily accessible to young people living in destabilized situations who do not have the skill or experience to deal with adult bureaucracies. These young people need supportive adults to help them navigate the system and to advocate for themselves. Young people who have been in care often do not have adults who will play this role for them once they reach 19 and the government's guardianship responsibility ends.

Recommendation 8:

For the Ministry of Children and Family Development

Address sexuality issues of children and youth in care proactively by working in conjunction with public health authorities and other resources to:

- make sex and parenting education and supports available both during and on leaving care, and
- provide foster parents with training on sex and parenting education and early pregnancy interventions.

Recommendation 9:

For the provincial government

Invest in and develop a cross-ministry plan for post-majority supports for youth leaving care who require adult services, with the Ministry of Children and Family Development taking the lead role.

3.3

Learning From and Building on This Initiative

We have learned some lessons from this joint initiative about how cross-ministry administrative data can be used in the future to gain insights into the health and well-being of children in British Columbia, in particular children in the government's care.

We have learned that collecting cross-ministry data has its challenges and that the data itself has its limitations. We believe that some of these challenges and limitations can be overcome and we make some recommendations to achieve that end.

We have also learned that the service and outcome data currently available within government provides an important research tool to help understand the children in care population, to measure outcomes over time for children in care, and to raise questions and potentially evaluate public policy strategies to improve those outcomes.

Challenges in collecting and analyzing data

The experience of collecting the data for this and other reports in this series has revealed challenges in the sharing of cross-ministry data for purposes outside the purposes of the ministry having control over the data.

We began this initiative in early 2005 and it took us more than a year to get the data we needed. While we have at times felt frustrated with the slowness of our progress in obtaining the data, we have been told by others, who have in various roles toiled to achieve the cross-ministry sharing of data for public policy research purposes, that we have experienced unique success.

The obstacles that we have experienced in accessing the data have on occasion only been overcome by a strong assertion of the statutory mandate of the Child and Youth Officer. Despite a very clear and general statement in the *Office for Children and Youth Act* of the Child and Youth Officer's entitlement to information necessary for the carrying out of her duties and

responsibilities, this entitlement was from time to time questioned – although in every instance it was ultimately acknowledged.

We were asking for data that identified individuals and included personal information, and the resistance to providing the information was most often framed as concern for the protection of individual privacy and the perceived limitations imposed by the *Freedom of Information and Privacy Act* (FOIPPA). (In fact, the *Office for Children and Youth Act* expressly provides for entitlement to the data despite any other enactment, including FOIPPA.) Recognizing the personal aspects of the data, we took steps to set up protocols to maintain confidentiality. We were happy to work with the public body from which we were seeking the data to ensure continued confidentiality. However, the reluctance in some quarters to share the data did not always end there, suggesting that legitimate privacy concerns, and confusion over the role of FOIPPA, were not the only cause of the reluctance. In our view, our experience (and that of others who have tried to advance cross-ministry sharing of information) may be evidence of the existence of a culture, perhaps inherent in government or any large bureaucracy, of a strong sense of “ownership,” to the exclusion of perceived outsiders, of the data they have collected and housed.

While we see major public policy benefits to the cross-ministry sharing of data quite separate from its use by officers such as the Provincial Health Officer, the Child and Youth Officer and the future Representative for Children and Youth, we believe that these officers have an important role to play in collecting, analyzing and commenting on linked administrative data if it is to be used to independently monitor government-funded services for children and youth. If this role is to be effective, the entitlement of the Representative for Children and Youth to this data must be clear.

In his report, *BC Children and Youth Review: An Independent Review of BC's Child Protection System* (April 7, 2006), the Honourable Ted Hughes recommended that the *Representative for Children and Youth Act* clearly provide for the creation, use and disclosure of linked data sets for purposes specified in the act. We have some concern that that act in its current form may be more restrictive than the *Office for Children and Youth Act* in that regard. It contains a provision for information-sharing agreements between the Representative and public bodies that may be taken to imply that the Representative's entitlement to the information is conditional upon reaching

agreement with the public body. By doing this it potentially sets up a negotiating dynamic that could be used to delay the efficient transfer of data in the future.

We are not suggesting that this was the intention of the drafters of the act, but it may be an unforeseen consequence. Fortunately, this is a consequence that can be remedied, as we understand that the Ministry of Attorney General is conducting a consultation process and will be proposing amendments to the act for consideration by the Legislature.

Measuring outcomes and a report card for children in care

The data set out in the second part of this report provides a baseline from which to begin tracking health services utilization and outcome measures in order to determine whether the health and well-being of children in care is improving over time. As additional measures become available, they can be added to further enrich our understanding.

Meanwhile, more consideration should be given to which measures are most useful as indicators of health and well-being outcomes. Work has already been done on a provincial and national level to identify health and well-being indicators for children in care. It makes sense to build on, although not be slowed down by, this work. Also, further research could usefully be done to better understand the causes of some of the patterns observed in the data that has been collected. This would clarify what measures would be most helpful in understanding how well children in care are doing in British Columbia.

In considering the best outcome measures, it may become apparent that the currently accessible administrative data has gaps. In that case, consideration should be given to how those gaps could be filled in a manageable and reliable way.

While there is preliminary work to be done, we believe that a report card could and should be developed, using the measures identified as most helpful, and the current administrative data, possibly supplemented by other data that could be collected and accessed reasonably easily.

We also believe that the Provincial Health Officer and the new Representative for Children and Youth should have a role in this reporting process.

Recommendation 10:

For the Ministry of Attorney General

Propose amendments to the *Representative for Children and Youth Act* that make clear the Representative's immediate entitlement to cross-ministry data required for the purposes of the act.

Because of an inevitably limited research capacity in these two offices, the responsibility for the actual collection and linking of the data on an ongoing basis may rest better with the relevant ministries, or with BC Stats. (See Ian McKinnon’s paper, “BC’s Children in Care: Improving data and outcomes reporting,” prepared for the *BC Children and Youth Review*, for an overview of British Columbia’s data capacity.)

On the other hand, involving officers not responsible for the provision of direct services for children, youth and families, but with mandates to further the interests of children and youth, would increase the credibility of the reporting. It would ensure that concern about possible negative reflection on a given ministry arising from the data would not get in the way of providing the public with a full and accurate picture of the state of health and well-being of children in care in British Columbia.

Using data for evaluating government policies and programs

It has been the policy of government in recent years to encourage the use of outcome measurements to evaluate the effectiveness of its strategies. Developing meaningful outcome measures is often a challenge, in part because of the lack of relevant and accessible data. The data collected in this initiative and analyzed for this report and the other reports in this series could provide a base for outcome measures to evaluate the effectiveness of programs and policies undertaken by the Ministry of Children and Family Development on behalf of children in care.

Digging more deeply into causes

This report and the others planned for the series are intended to describe service utilization and outcomes for children in care. The data does not identify the causes of the patterns observed. Making causal connections between the provision of services and outcomes requires more complex research than was undertaken in this initiative. British Columbia is fortunate to have considerable research expertise in academic and research units that have the capacity to do such research.

For example, the research done for this report (and those planned) does not tell us what the impact of being in care has on the children. To explore this issue, the Child and Youth Officer for British Columbia is partnering

Recommendation 11:

For the new Representative for Children and Youth

In collaboration with the Provincial Health Officer, develop a regular report card on identified and generally accepted indicators of the health and well-being of children in care, using the data in this report (and in the others planned for this series) as a baseline.

Recommendation 12:

For the Ministry of Children and Family Development and the provincial government

Consider using outcome measures from the data generated by this initiative as a baseline against which to evaluate programs and policies designed by the ministry to better the health and well-being of children in care.

in a project with the Human Early Learning Partnership at the University of British Columbia, which has the expertise to dig more deeply into the data to consider this question of impact. The study will compare the outcomes for a sub-set of children in care with a similar group of children who did not come into care.

We believe that this kind of initiative should become the norm for government. Knowing more about the impact of being in care may throw light on the ongoing debate about the significance, in terms of the long-term interests of children, of the fluctuation in the numbers of children in care over time. Also, a better understanding of the causes of poorer outcomes for children in care, including the impact of being in care, will be useful in the development of strategies to improve outcomes.

Recommendation 13:

For the Ministry of Children and Family Development and the provincial government

Engage in collaborative research with research communities outside of government to dig more deeply into the causes of poorer outcomes for children in care and to study the impact, if any, of being in care on specific outcomes for children in care.

