A Parent's Responsibility:

Government's obligation to improve the mental health outcomes of children in care

SEPTEMBER 2022

Representative for Children and Youth

Sept. 20, 2022

The Honourable Raj Chouhan
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria, B.C., V8V 1X4

Dear Mr. Speaker,

I have the honour of submitting the report *A Parent's Responsibility: Government's obligation to improve the mental health outcomes of children in care* to the Legislative Assembly of British Columbia.

This report is prepared in accordance with Section 20 of the *Representative for Children and Youth Act* which gives the Representative authority to make special reports to the Legislative Assembly if the Representative considers it necessary.

Sincerely,

Dr. Jennifer Charlesworth
Representative for Children and Youth

pc: Ms. Kate Ryan-Lloyd
Clerk of the Legislative Assembly

Ms. Karan Riarh
Committee Clerk, Legislative Assembly

Contributors

The Representative would like to acknowledge with gratitude all those who shared their perspectives and made this report possible, including Indigenous Child and Family Service Agencies, Dr. Charlotte Waddell and her team at the Children's Health Policy Centre at Simon Fraser University, RCY Executive Lead Alan Markwart and the RCY project team members from Systemic Advocacy, First Nations, Métis and Inuit Research, Communications and Reviews & Investigations.

This is the Representative for Children and Youth's report. Appended to this report is the report by the Children's Health Policy Centre at Simon Fraser University, *Children in Care: Reducing Needs While Improving Mental Health Outcomes*.

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Territorial Acknowledgment

The Representative and staff, who do their work throughout the province, would like to acknowledge that we are living and working with gratitude and respect on the traditional territories of the First Nations peoples of British Columbia. We specifically acknowledge and express our gratitude to the keepers of the lands on the traditional territories of the Lheidli T'enneh peoples (Prince George) and the Songhees and Esquimalt Nations (Victoria), where our offices are located.

We would also like to acknowledge our Métis and Inuit partners and friends living in these beautiful territories.

Introduction

The poor outcomes for far too many young people who age out of government care under the *Child, Family and Community Service Act (CFCS Act)* have been well documented, including by this Office: there are much higher rates of homelessness, lower educational attainment, lower attachment to the workforce, lower rates of income and poorer mental health among youth leaving care and transitioning to adulthood as compared to their non-care peers.[1] Much to its credit, government is in the course of introducing a suite of new services and supports for young adults who have previously been in care to improve these outcomes.[2]

But is there more that could be done earlier to avoid or mitigate these poor outcomes? The Representative strongly believes that there is. To list just a few examples documented by this Office in the recent past: much more could be done to improve planning for children in care,[3] to better support stability of placement and all the dimensions of belonging for children in care,[4] to improve high school graduation rates,[5] and to allocate equitable funding of services for First Nations, Métis, Inuit and Urban Indigenous children living off-reserve so that enhanced prevention and support services can be provided, and so that removals can be avoided.[6]

Another vital area is mental health services for children in care. Through her function of providing individual advocacy support for thousands of children in care and her reviews of literally hundreds of reports of critical injuries and multiple deaths each month, the Representative routinely encounters cases where the mental health needs of children in care are not being adequately addressed, or are not

[1] See Representative for Children and Youth, *A Parent's Duty: Government's Obligation to Youth Transitioning into Adulthood* (Victoria, B.C.: Representative for Children and Youth), 2020.

[2] B.C. Budget 2022 enables emergency measures introduced during the pandemic – including Temporary Housing Agreements, Temporary Support Agreements and increased flexibility of the Agreements with Young Adults (AYA) program – to be made permanent. Beginning in 2022/23, there will be a new $600 a month rent supplement for youth leaving care. Youth Transitions navigators will be available to support youth as young as 14 to access services in their transition to adulthood. The following year will see the expansion of the AYA program to include counselling, medical benefits, increased life skills training and the introduction of an earning exemption. In 2024/25, young adults will receive a guaranteed income benefit from age 19 to 20 and a further 84 months of financial support if they are participating in approved programs. (Source: MCFD Intranet)

[3] See Representative for Children and Youth, *Beyond Compliance: Ensuring quality in care planning* (Victoria, B.C.: Representative for Children and Youth), 2022.

[4] See Representative for Children and Youth, *Skye's Legacy: A Focus on Belonging* (Victoria, B.C.: Representative for Children and Youth), 2021.

[5] See Representative for Children and Youth, *Room for Improvement: Toward better education outcomes for children in care* (Victoria, B.C.: Representative for Children and Youth), 2017.

[6] See Representative for Children and Youth, *At a Crossroads: The roadmap from fiscal discrimination to equity in Indigenous child welfare* (Victoria, B.C.: Representative for Children and Youth), 2022.

being addressed at all.[7] These inadequacies and gaps run the full gamut of service provision, including screening and assessment, wait lists for service or no service at all, lack of culturally attuned and relevant mental health care for First Nations, Métis, Inuit and Urban Indigenous children and youth, inadequate intensity of service, lack of coordination of services and collaborative planning, inadequate discharge planning, and limited or largely non-existent "step-up/step-down" services in relation to tertiary care hospital services.

Given these concerns, the Representative has commissioned a series of research briefs to better understand the prevalence, priorities and promising practices related to mental health and wellness for children and youth in care, including Indigenous children. For the first report in this series, the Representative sought the expertise of the Children's Health Policy Centre (CHPC) at Simon Fraser University to carry out a rigorous review of the scientific literature and produce a research report, appended, that tries to answer three key questions:

- What does the scientific literature tell us about the prevalence of mental health problems amongst children in care?
- What programs and services are scientifically proven to be effective in preventing the maltreatment of children so the need to bring them into care can be avoided?
- Once children are in care, what programs and services are scientifically proven to be effective in preventing and treating mental health problems?

A summary and discussion of the key findings and implications of the CHPC report are described below, including a review and discussion of policy and program planning responses to this issue by the Ministry of Children and Family Development (MCFD), which is responsible for both child welfare services under the *CFCS Act* as well as Child and Youth Mental Health (CYMH) services, and by the Ministry of Mental Health and Addictions (MMHA).[8] This will be prefaced by a review of previous reports on the issue of mental health services for children and youth in general – and for children in care in particular – by the Representative and others, together with some relevant RCY data and case information.

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[7] In 2021/22, the Representative dealt with 1,795 individual advocacy requests involving 1,811 children, youth and young adults, and 2,516 in-mandate reports of critical injuries and deaths. A report of a critical injury or death may include information about mental health services if MCFD's Child and Youth Mental Health Services (CYMH) are involved or other mental health services such as those provided by a health authority or private practitioner are referenced in the report. Importantly, after a report is received, the case file information about the critically injured or deceased child in care that is contained on MCFD's Integrated Case Management (ICM) system is reviewed in detail which, amongst other matters, enables the Representative to ascertain whether mental health services have been provided by CYMH, health authorities or other means such as Foundry or private clinicians. As well, RCY advocates typically immerse themselves in the day-to-day details of service delivery, which enables them to ascertain the involvement of mental health services and the adequacy of those services.

[8] MCFD is responsible for CYMH services, which include community-based mental health services for children and youth, as well the Maples Adolescent Treatment Centre and Youth Forensic Psychiatric Services. Otherwise, health authorities are responsible for the provision of mental health hospital services such as are found at BC Children's Hospital, Ledger House, the Carlisle Youth Concurrent Disorders Centre and regional in-patient adolescent psychiatric units.

Previous Reports and Information

The Office of the Representative for Children and Youth has had long-standing concerns about the adequacy of mental health services for children and youth, including for children in care, and has released a number of related reports with recommendations. The most salient of these include:

- *Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C.* (2013), which, amongst other matters, called for the establishment of a minister responsible for youth mental health and adequate resources to develop and implement a full continuum of mental health services for youth ages 16 to 24.
- Two investigative reports, one in 2014 and the other in 2016, which detailed the inadequacies of mental health services for Indigenous children, and both of which called for appropriately resourcing mental health services for children generally and, in particular, for Indigenous children.[9]
- *Paige's Story: Abuse, Indifference and a Life Discarded* (2015), which, amongst other matters, recommended that mental health screening tools be immediately applied to assess the needs of every Indigenous child when they are taken into care.
- *Missing Pieces: Joshua's Story* (2017), an investigative report which called upon the Ministry of Mental Health and Addictions to lead the planning and implementation of a full continuum of mental health services for children and youth.
- The investigation into the death of Alex Gervais – *Broken Promises: Alex's Story* (2017) – which recommended that MCFD ensure that children and youth in care who have identified mental health concerns receive timely and uninterrupted mental health services and that Aboriginal Child and Youth Mental Health (ACYMH) services be sufficiently resourced so it is able to accommodate all Indigenous children and youth who require screening, assessment and/or outreach services in a timely manner.
- The most recent report on planning for children in care – *Beyond Compliance: Ensuring quality in care planning* (2022) – which found that one of the strongest themes to emerge from interviews with social workers, team leaders and foster caregivers was the limited availability of community-based services for children and youth, the most significant of which were mental health and addiction services, which is especially challenging in smaller communities.[10]

As well, the Representative has previously released statements and commissioned reports about how the pandemic has both illuminated the inadequacies of existing service systems and aggravated concerns about the mental health needs of children.[11]

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[9] See Representative for Children and Youth, *Lost in the Shadows: How a Lack of Help Meant a Loss of Hope for One First Nations Girl* (Victoria, B.C.: Representative for Children and Youth), 2014. See also Representative for Children and Youth, *A Tragedy in Waiting: How B.C.'s mental health system failed one First Nations youth* (Victoria, B.C.: Representative for Children and Youth), 2016.

[10] *Beyond Compliance*, p. 17.

[11] See C. Waddell, C. Schwartz, J. Barican, D. Yung, D. Gray-Grant, *Covid-19 and the Impact on Children's Mental Health* (Vancouver, B.C.: Children's Health Policy Centre, Simon Fraser University), 2020. See also Canadian Council of Child and Youth Advocates, "Children's advocates call for significant planning and investment for young people now and after the pandemic on National Child and Youth Mental Health Day," Statement, May 7, 2021.

The Representative's concerns were echoed and amplified in a comprehensive review undertaken by the Select Standing Committee on Children and Youth in 2016, *Final Report, Child and Youth Mental Health in British Columbia: Concrete Actions for Systemic Change*. That report identified significant weaknesses and gaps in the service system and made a number of wide-ranging recommendations for reform of – and investment in – the system of child and youth mental health services, including the appointment of a dedicated minister. Notably, that report recognized the particular vulnerabilities of children in care, recommending that government:

> *"Provide all children in care with access to mental wellness programs, early intervention and clinical services."*[12]

The Representative has also heard directly from Indigenous Child and Family Service Agency (ICFSA) Directors (formerly known as Delegated Aboriginal Agency Directors) who are responsible for providing services to more than half of the Indigenous children and youth in care in the province, and who continue to witness the crisis in mental health and substance use amongst Indigenous children and families every day.[13] Delivering a culturally relevant continuum of supports that wraps around Indigenous children, youth, families and communities is, in their view, critical. The Directors have routinely highlighted the urgency of addressing the lack of mental wellness and substance use services, of the need to invest additional funding, and of providing funding flexibility to ensure alignment with Indigenous cultures and worldviews. To underscore that need and to provide a framework for service delivery, the Directors have developed *Culture is Healing: An Indigenous Child and Youth Mental Wellness Framework* (see text box).

Culture is Healing

Culture is Healing is an Indigenous Child and Youth Mental Wellness Framework developed by B.C.'s ICFSA Directors and practitioners in response to the mental wellness crisis facing Indigenous children, families and communities. ICFSAs have been providing culturally based child and family services to over 120 First Nations communities, as well as Métis and urban populations throughout the province for over 30 years. This experience has positioned ICFSA Directors to expertly inform approaches to wellness that are rooted in Indigenous values and beliefs. Despite this expertise, ICFSAs have neither been adequately resourced nor recognized to provide the full continuum of wellness supports, including for CYMH.

Culture is Healing is grounded in the Aboriginal Policy and Practice Framework (APPF, 2015) rooted in traditional values and beliefs and improving outcomes for Indigenous children, youth, families and communities through restorative policies and practices. *Culture is Healing* takes a holistic approach to well-being by integrating the four guiding principles drawn from the APPF and adopted by the ICFSA Directors' Forum:

- culture-centred
- inclusive and accountable
- wellness-focused
- child-, youth-, family- and community-centred

[12] Select Standing Committee on Children and Youth, *Final Report, Child and Youth Mental Health in British Columbia: Concrete Actions for Systemic Change* (Victoria, B.C.: Legislative Assembly of British Columbia), 2016, p. 49.

[13] See the Indigenous Child and Family Services Agency Directors *Our Children, Our Way website*, https://ourchildrenourway.ca.

Government has taken some significant steps to address concerns about the well-documented inadequacies of mental health services. In 2017, a new Ministry of Mental Health and Addictions was created, which was followed by the June 2019 release of a 10-year plan, *A Pathway to Hope: A Roadmap for making mental health and addictions care better for people in British Columbia* (the Roadmap*)*. That plan, which has a major focus on child and youth mental health, sets out priority actions for the first three years, which involve the incremental implementation of new services and supports for children and youth, such as the expansion of Foundry centres to new locations (23 total by 2024) for youth 12- to 24-years-old, the establishment of new multi-disciplinary integrated child and youth teams in school districts (20 total by 2024), and new step-up/step-down services. Certainly, children in care can access these new services as they are being incrementally – though not universally – implemented. Despite the previous identification of significant concerns and recommendations regarding mental health services for children in care, however, the Roadmap is silent with respect to services for this population and, apart from Indigenous peoples, for other distinct sub-populations of children and youth who have heightened mental health vulnerabilities, such as children and youth with special needs and gender-diverse youth. The Representative will have more to say about these latter sub-populations of young people in the coming months.

In October 2019, MCFD released the *Child and Youth Mental Health Service Framework.*[14] The service frameworks being developed by MCFD are intended to describe what services and supports need to be available for the children, youth, families and communities the ministry serves, how they can be accessed and the outcomes these services and supports are intended to achieve. Despite previous recommendations, and despite CYMH and child welfare services being administered by the same ministry, this service framework is also silent in relation to mental health services for children in care.[15]

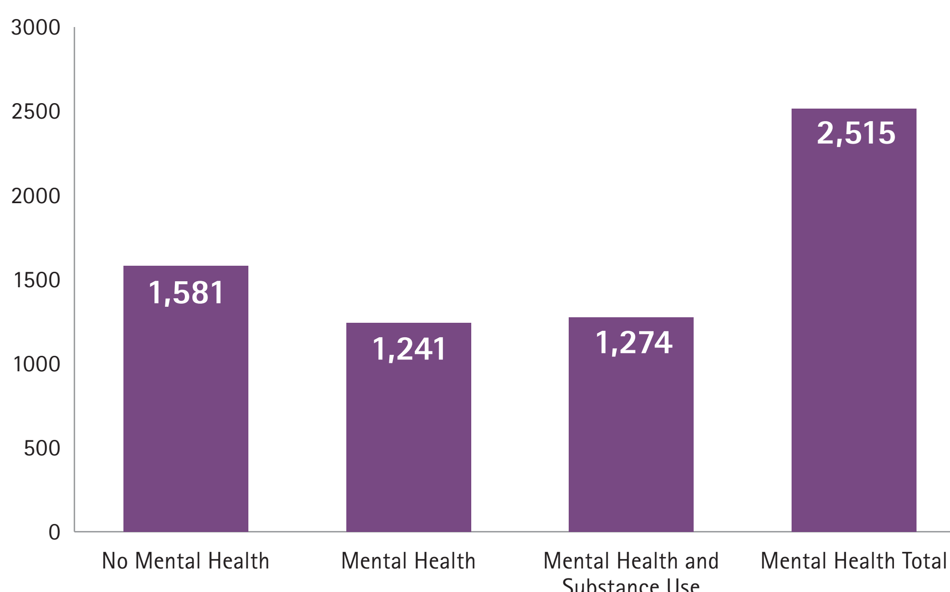
[14] This service framework was last updated on April 15, 2020.

[15] The only indirect reference to mental health services for children in care in the CYMH framework is to *"consultation services"* to *"other MCFD program areas"* (p.6), which could include child welfare, services to children and youth with special needs and youth justice.

Critical Injuries Reported to the Representative

The *Representative for Children and Youth Act* (*RCY Act*) requires public bodies responsible for reviewable services,[16] which includes services under the *CFCS Act*, to report critical injuries[17] and deaths of children and youth in receipt of those services to the Representative. An analysis of reports of critical injuries between April 1, 2018 and Dec. 31, 2021 was conducted to ascertain the frequency and characteristics of critical injuries where the file records indicate confirmed or suspected mental health diagnoses.[18] In that nearly three-year period, there was a total of 4,096 critical injuries. As Table 1 indicates, 2,515 or 61 per cent of those related to a child or youth who had either a confirmed or suspected mental health diagnosis alone or a confirmed or suspected concurrent mental health and substance use diagnosis.

Table 1 – Children In Care Critical Injuries By Mental Health Status, April 1, 2018 to Dec. 31, 2021



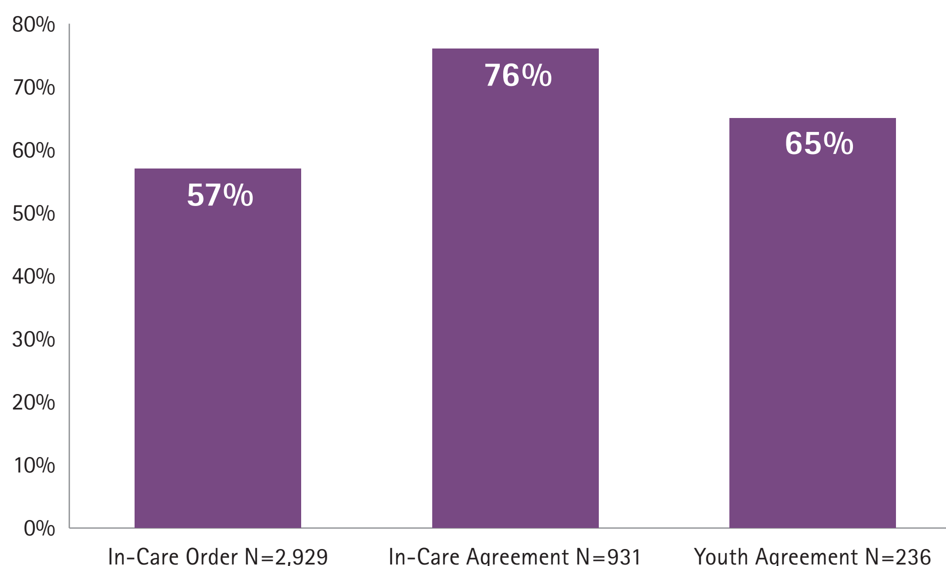
Legal status under the *CFCS Act* can vary, and may include Orders (Continuing, Temporary or Interim Custody), Care Agreements (Voluntary or Special Needs Care Agreements) and Youth Agreements (ages 16 to 19). Care Agreements and Youth Agreements may be put in place due to the child or youth's mental health challenges that preceded the agreement, so these two groups may be more likely to have a history of confirmed or suspected mental health diagnoses. Table 2 confirms this: critically injured children under Care Agreements are appreciably more likely to have a history of mental health challenges but nonetheless, the rates are very high for all three groups.

[16] Reviewable services are defined in s.1 of the *RCY Act* as *"services and programs under the* CFCS Act *or the* Youth Justice Act*, and mental health and addiction services."* Only reports from those receiving services under the *CFCS Act* are included in the analysis in this section.

[17] Critical injury is defined in s.1 of the *RCY Act* as an injury that *"may result in the child's death, or cause serious or long-term impairment of the child's health."*

[18] A "*confirmed*" mental health diagnosis means a qualified clinician has diagnosed the child or youth. A "*suspected*" diagnosis arises when a child or youth has been formally referred or screened and is awaiting clinical assessment or when behaviours such as significant and repeated self-harm or suicide attempts indicate probable mental health concerns.

Table 2 – Critically Injured Children and Youth with Confirmed or Suspected Mental Health Challenges, by Care Type April 1, 2018 to Dec. 31, 2021



The types of injuries and characteristics of the children and youth varied to some degree according to care type. In brief summary, the critically injured children and youth who were subject to an in-care order and had a history of confirmed or suspected mental health diagnosis were more likely to:

- experience a critical injury that was suicide-related (33 per cent), involved emotional harm such as loss of a loved one[19] (31 per cent) or sexual violence (19 per cent)
- be an adolescent (ages 13 to 18)
- be female (60 per cent), noting seven per cent were gender-diverse,
- be Indigenous (68 per cent), and
- reside in a staffed residential setting (58 per cent).

Since they relate only to children in care who have been reported with critical injuries, these data are not necessarily representative of all children in care. Nonetheless, the very high rates of confirmed or suspected mental health diagnoses and of the serious injuries they have experienced underscore the significant vulnerabilities and needs of this population of children.

[19] The Representative documents a child or youth's loss of a significant person in their lives (e.g., parents and other caregivers) as an emotional harm injury. Some of these losses are attributable to the toxic drug supply and drug poisonings, COVID-19-related deaths, suicides and violence, including domestic violence.

Implications of the CHPC Findings About Prevalence

A striking finding of the CHPC review is the very high prevalence of mental health disorders amongst children in care. According to the meta-analysis of epidemiological studies involving representative samples of children in care, which employed rigorous diagnostic measures, about half (49 per cent) of children in care were diagnosed with at least one type of mental disorder, which is nearly four times greater than the rate (12.7 per cent) found in the general population of children. Looking at specific diagnoses:

- the prevalence of anxiety disorders is more than three times higher amongst children in care than in the general child population (18 per cent versus 5.2 per cent)
- nearly 10 times higher for depression (12 per cent versus 1.3 per cent)
- 40 times higher for post-traumatic stress disorder (4 per cent versus 0.1 per cent)
- about three times higher for attention-deficit/hyperactivity disorder (11 per cent versus 3.7 per cent), and
- much higher for behavioural disorders such as conduct disorder (20 per cent versus 1.3 per cent) and oppositional defiant disorder (12 per cent versus 3.3 per cent).

These findings are drawn from epidemiological studies of children in care in Europe, the United States and the United Kingdom. It is notable that similar studies have not been conducted in B.C., nor elsewhere in Canada.

There is no sound reason to believe that prevalence rates amongst children in care in B.C. are any less than what is reported in these other Western countries. Indeed, it is possible that prevalence may be even higher in B.C. For example, over the past many years, the population of children in care has nearly halved, which is a very welcome change. One implication of that change, however, is that as less serious cases are diverted away from the child protection system by way of the enhanced use of alternative measures, the smaller population of children remaining in care may have a greater degree of complexity and acuity of concerns, including mental health. This is a phenomenon that the Representative has witnessed over the course of the past several years, has been identified through the Representative's individual advocacy data and is an issue very frequently referenced by community service providers throughout the province.[20]

Similarly, while the population of children in care has substantially declined, Indigenous children have comprised an increasing proportion of the in-care population, to the point where Indigenous children are now more than two-thirds (67.9 per cent) of the in-care caseload.[21] An Indigenous child in B.C is

[20] As indicators of complexity, the amount of time that RCY advocates spend in case meetings has more than doubled (+122 per cent) in the past three years, while the number of case files that remain open for longer than six months has nearly doubled (+81 per cent) in the past year alone.

[21] As of March 31, 2022. Source: MCFD Corporate Data Warehouse. While the Indigenous in-care population has declined by nearly 20 per cent in the past five years, the extent of child protection (over-) involvement in the lives of Indigenous children and families has not appreciably changed: the combined total of Indigenous children in care and in out-of-care options as of March 31, 2022 was only two per cent less than five years earlier whereas, in contrast, the combined total for non-Indigenous children declined by nearly 27 per cent in the same period.

nearly 19 times (18.8) more likely to be brought into care than a non-Indigenous child.[22] Given the intergenerational impacts of historical and contemporary colonial and racist policies and the unique cultural and socio-economic circumstances of First Nations, Inuit, Métis and Urban Indigenous peoples, it would not be surprising to find that the overall prevalence of mental health diagnoses – or specific types of conditions such as depression and PTSD – may be even greater amongst Indigenous children in care.

These propositions about factors potentially influencing prevalence rates in B.C. are, of course, speculative. Such speculation should not be necessary. We should have – and indeed need to have – B.C.-specific data to appropriately inform service planning and more effectively meet the mental health needs of children in care in this province. The Representative believes that it is vitally important for MCFD to directly conduct or commission comprehensive research that identifies the prevalence of the range of mental health disorders amongst children in care and then utilize those data to inform the development and implementation of appropriate services to respond to identified needs.

While the prevalence of mental health disorders overall – and of different types of diagnoses specifically – is yet to be determined in B.C., these international data are the best available working guide and, as mentioned, there is no sound reason to believe that prevalence rates are lower in B.C. than in these other countries. That may be especially true because, as will be discussed, the mental health prevention and treatment services available to children in care in this province are not robust.

While there have not been systemic studies of the prevalence of mental health disorders amongst children in care in B.C., it appears to at least be understood and accepted that the rates amongst children in care are much higher than the rates of those not in care.[23] The experience of the pandemic has served to remind us of the need to target resources to the most vulnerable – in that case to the elderly, people in congregate care settings and immunocompromised individuals. If children in care are a sub-population that is known to be especially vulnerable to mental health issues, one would expect that there would similarly be a specific targeting of suitable resources to address these needs. Or, put another way, one would expect that a reasonable parent who knows, for example, that their child has approximately a 50 per cent chance of experiencing a serious disorder would ensure that periodic screening and assessment resources were put into place to detect onset at the earliest possible time, and then to mobilize appropriate services. But that is not the case with children in care, who are far more likely to experience mental health concerns than their non-care counterparts.[24] In contrast, youth involved in the justice system, which is another distinct population served by MCFD that is also known to be at higher risk

[22] See Ministry of Children and Family Development, *2021/22 Annual Service Plan Report*, August 2022. The actual reported rate per 1,000 children (0- to18-years) was 1.8 for non-Indigenous children and 35.8 for Indigenous children.

[23] For example, MCFD's *Care Plan Practice Guide* (October 2014) expressly states at page 15: *"Research indicates that youth in care have a much greater likelihood of being diagnosed with a mental illness…"* (but then goes on to address medication management). As well, the 2016 report of the Select Standing Committee on Children and Youth states that a joint ministry presentation acknowledged a much greater prevalence of psychiatric disorders amongst children in care. See *Child and Youth Mental Health: Concrete Actions for Systemic Change*, p. 49.

[24] MCFD's *CYMH Service Inventory Summary 2020* reported that there are 72 CYMH teams across the province, three of which have Integrated Services with child welfare services and one that provides a combination of Indigenous and Integrated Services.

of mental health concerns,[25] benefit from a dedicated mental health assessment and treatment service – Youth Forensic Psychiatric Services.[26]

CYMH and child welfare services are administered by the same ministry, but the policies and standards of each service stream make little reference to the mental health needs of children in care. A review of the CYMH policies and standards found only one vague reference to a 2002 policy[27] and to a 2006 standard[28] that refer to CYMH clinicians providing education and consultation to other ministerial staff or other professionals, while the CYMH Referral and Intake Response Scale identifies as a *"consideration"* that children in the care of the government (amongst other sub-populations) are at higher risk of significant mental health and/or substance use problems.[29]

Similarly, a review of MCFD's policies for youth in care[30] and care planning guidelines[31] indicates little direct attention to the mental health needs of children in care. The policy respecting assessment and planning makes no mention of mental health needs, while the policies respecting initial and ongoing health care needs are almost entirely focused on medical, dental, optical and immunization needs, with mental health being mentioned only once.[32]

These policies, standards and practice guidelines are clearly inadequate to the task of ensuring the needs of children in care are fully addressed. Given the high prevalence of mental disorders amongst children in care, one would expect that social workers would be provided with both the clear practice direction and the resources to ensure that every child in care receives trauma-informed and culturally appropriate mental health screening after admission to care and periodically thereafter (or otherwise, as situationally indicated) and then, as required, referred for appropriate assessments, services and supports.

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[25] See Heather Gretton and Robert Clift, "The mental health needs of incarcerated youth in British Columbia, Canada," *International Journal of Law and Psychiatry 34*, no. 2 (2011): p. 109-15. This is an example of where an MCFD service stream did conduct a mental health prevalence review of the youth justice in-custody population (205 admissions), which found that 92 per cent of males and 100 per cent of females met the criteria for at least one mental health disorder (including substance abuse).

[26] Youth Forensic Psychiatric Services (YFPS) provides general mental health assessment and individualized treatment services to young offenders, consultation services to youth probation officers and youth custody centres and highly specialized, multi-disciplinary violent offence and sexual offence treatment programs to youth who present a high risk to the public. YFPS is also responsible for inpatient assessment, outpatient treatment and case management services to those youth found Unfit to Stand Trial or Not Criminally Responsible by Reason of Mental Disorder. Source: MCFD intranet.

[27] See Ministry of Children and Family Development, *Child and Youth Mental Health Policy*, Sept. 2002, Policy Number B-7.

[28] See Ministry of Children and Family Development, *Child and Youth Mental Health Standards*, Aug. 31, 2006, p. 6.

[29] See Ministry of Children and Family Development, *Child and Youth Mental Health Referral and Intake Response Scale*, July 10, 2015.

[30] See Ministry of Children and Family Development, *Child and Youth in Care policies – Chapter 5*, last revised April 2022.

[31] See Ministry of Children and Family Development, *Care Plan Practice Guide*, October 2014.

[32] See Ministry of Children and Family Development, *Child and Youth in Care policies – Chapter 5*, Policy 5.6. Child and Youth Mental Health Services are only mentioned once through these policies in relation to threat assessments when a child in care poses a risk to school staff or other students.

Implications of the CHPC Findings About Interventions

Happily, the CHPC report identifies some program interventions that, according to rigorous scientific standards of evaluation, are effective in preventing child maltreatment so children need not be brought into care, and some programs that are effective in preventing and treating mental health disorders amongst children who are brought into care. These findings provide us with insights as we review existing service approaches in B.C.; in particular, whether there is an organized system of the same or similar evidence-based services and supports available in B.C.

With respect to primary prevention services that are proven to prevent child maltreatment, the Ministry of Health and health authorities have – commendably – widely implemented the Nurse-Family Partnership (NFP) program, which is one of the proven programs in the CHPC review. NFP is targeted to young, at-risk mothers and involves ongoing nurse visiting from pregnancy through the first two years of the infant's life. Moreover, the B.C. program is being rigorously evaluated, which is a first in Canada.[33]

Since services and supports in the early years are one of the Representative's current strategic priorities, she will have more to say in the coming months about these vitally important primary prevention approaches.

It is a different picture, however, with respect to mental health prevention and treatment services for children in care. As with the absence of a routinized process of mental health screening and assessment of children in care discussed earlier, there is also an absence of an organized system of targeted, trauma-informed and evidence-based mental health intervention services for children in care which, given high prevalence rates, one would expect to exist. According to MCFD's own internal reports, efforts to develop such services through the Children and Youth with Complex Care Needs model of care (CYCCN) have fallen short of their intended goal to provide *"the right services, at the right time, and in a way that supports coordinated, coherent, and collaborative care"* and as a result, the mental health needs of children in care are not being met.[34] None of the evidence-based programs identified as successful in the CHPC review have been implemented systemically in B.C. nor, as far the Representative is aware, even locally.[35] They should be considered for implementation.

[33] See Nicole Catherine and Charlotte Waddell, *BC Healthy Connections Project: Scientific Team Update*, June 8, 2020, Children's Health Policy Centre, Simon Fraser University. NFP is being delivered to more than 60 communities across four regional health authorities.

[34] In 2014, MCFD implemented the Children and Youth with Complex Care Needs (CYCCN) Model of Care, a specialized clinical service for children in care that has three components: the Complex Care Unit at the Maples Adolescent Treatment Centre, contracted community care beds in Prince George and Vernon, a Provincial Outreach Team and the community-based Complex Care Intervention (CCI) services. The program has limited scope and is principally oriented to children with concurrent developmental disabilities at the provincial level. An operational review of the provincial CYCCN services in 2019 found that over the course of 5½ years the program had served only 66 children through outreach services, 29 children in contracted community care beds and 25 children at the Complex Care Unit, with extraordinarily high per diem rates in the residential components due to very low occupancy rates (CYCCN Residential Services Utilization Review Summary Report, draft report, MCFD, Sept. 23, 2019). The report also notes that efforts to expand community based CCI services were abruptly abandoned in 2019. As of the time of this report, the CYCCN Model of Care continues to be under review for potential reconfiguration.

[35] The Representative is aware that the Incredible Years program has been implemented in some locales, however, the CHPC review did not find that this program was effective.

The CHPC report notes that some of the programs that were found to be effective included Indigenous participants (although the program effects were not disaggregated). There is little literature and research about specific programs that address the mental health needs of Indigenous children in care specifically, or Indigenous children generally. The Representative believes this is a result of a lack of investment in Indigenous-led research about mental health and wellness care due to systemic discrimination and colonial bias that persists in the mental health field. The ICFSA Directors' framework, *Culture is Healing*, also speaks to the need to shift practice and system responses given that current approaches have failed to effectively reach and serve Indigenous children and families.

Services for Indigenous children and families have too often not been tailored to their needs and circumstances and have mostly been delivered by mainstream service providers using Western modalities of care. More program development and evaluation, led or co-led by Indigenous peoples themselves, is needed to identify the services and programs that are most effective for Indigenous children in care, and Indigenous children generally. Importantly, services for Indigenous children and families must be delivered within the context of the traumatic impacts of colonization on the mental health and well-being of First Nations, Inuit, Métis and Urban Indigenous children and families and also ensure that Indigenous children and youth in care are afforded the opportunity to meaningfully connect to their culture and community. The Representative will be addressing the mental wellness crisis facing Indigenous children and youth in care as part of this series in the coming months.

The Rights of Children in Care

The *United Nations Convention on the Rights of the Child* (*UNCRC)*, which was ratified by Canada in 1991, sets out the civic, political, legal, social welfare, educational, health and cultural rights of children.[36] Article 24 of the *UNCRC* requires that:

> *"States parties recognize the right of the child to the enjoyment of the highest attainable degree of* ***health****… "* (emphasis added)

It is universally accepted that health includes mental health and wellness. The World Health Organization defines "health" on its website as *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."*[37]

Further, the *United Nations Declaration on the Rights of Indigenous Peoples*[38] (*UNDRIP)*, the advancement of which has been enabled by both federal and provincial domestic legislation,[39] states in Article 24:

> *"Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and* **mental health***. States shall take the necessary steps with a view to achieving progressively the full realization of this right."* (emphasis added)

The statutory rights of children in care are set out in s.70 of the *CFCS Act*. Unlike the *UNCRC* and *UNDRIP*, however, the s.70 *CFCS Act* rights do not specify mental health nor include the more encompassing language of "health" but, unfortunately, a much more narrowly framed right: *"… to receive medical and dental care when required."*[40] This is clearly inadequate.

MCFD is currently engaged in a process of review of the *CFCS Act*, with a view to reforming and modernizing that legislation. In the Representative's view, this proposed modernization presents a good opportunity for the ministry to re-state the rights of children in care to include a right to receive appropriate and timely health care, including mental health care.

[36] United Nations General Assembly, *United Nations Convention on the Rights of the Child* (New York, N.Y.: UN Headquarters), 1989. Children are defined in the *UNCRC* as under the age of 18.

[37] World Health Organization, https://www.who.int/about/governance/constitution. Accessed June 10, 2022.

[38] United Nations General Assembly, *United Nations Declaration on the Rights of Indigenous Peoples* (New York, N.Y.: UN Headquarters), 2007.

[39] The federal government's *United Nations Declaration on the Rights of Indigenous Peoples Act* received Royal Assent on June 21, 2021, while B.C.'s *Declaration on the Rights of Indigenous Peoples Act* received Royal Assent on Nov. 28, 2019.

[40] *Child, Family and Community Service Act*, RSBC 1996, Section 70(1)(g).

Conclusion and Recommendations

The CHPC report confirms that there is an extraordinarily high prevalence of mental health diagnoses amongst children in care and that there are program services that are proven to be effective in the prevention and treatment of mental health disorders for this highly vulnerable population. Despite this, and despite previous identification of this issue and recommendations for reform, the province has not instituted a system of universal screening and assessment, nor implemented targeted and effective mental health intervention services for children in care.

In making the recommendations below that involve ICFSA Directors, who are responsible for services to more than half of the Indigenous children in care, the Representative recognizes that some First Nations are not served by ICFSA Agencies and some are engaged in the development of their own Indigenous Governing Bodies under the federal *Act respecting First Nations, Inuit and Métis children and families*. The intention of the Representative's recommendations is to enhance the knowledge and understanding about mental health concerns experienced by all children who are in care or at risk of admission into care, and to ensure that systematic action is taken to screen, assess and address mental health concerns in a timely, trauma-informed and culturally attuned way. It is hoped that this report, recommendations and the subsequent actions taken to fulfill the recommendations will be of value to all agencies that are concerned about the well-being of young people facing mental health challenges, including those currently responsible for children in care and those that will be resuming responsibility in the years to come.

The Representative recommends:

1. The Ministry of Children and Family Development (MCFD) and Indigenous Child and Family Services Agency (ICFSA) Directors, in collaboration with the Ministry of Mental Health and Addictions (MMHA), co-lead comprehensive research to identify the prevalence of the range of mental health disorders amongst children in care in B.C., and thereafter utilize these disaggregated data to inform service planning.

   Research to be completed by Dec. 31, 2023.

2. MCFD and ICFSA Directors, in collaboration with the MMHA, co-lead the development and implementation of policies and processes for initial mental health screening by qualified professionals of all children who are at risk of admission into care, or who have been admitted into care, with periodic and situational screening after initial screening, as required. This screening is to be carried out in a trauma-informed and culturally safe and relevant manner – including the potential development of validated Indigenous-specific screening instruments over the longer term – with disaggregated data being centrally collected and analyzed to inform service planning on an ongoing basis.

   Screening processes to be implemented by Dec. 31, 2023.

3. MCFD and ICFSA Directors, in collaboration with MMHA, co-lead the development and implementation of plans for targeted, voluntary[41] assessment services (where indicated by screening) and evidence-based, voluntary mental health program services for children in care and children at risk of being brought into care, with particular attention to culturally appropriate and trauma-informed services for First Nations, Inuit, Métis and Urban Indigenous children. These plans should be incorporated into the operational planning for MMHA's *Pathway to Hope* and MCFD's *Child and Youth Mental Health Service Framework*.

   Plans to be completed by Dec. 31, 2023, with full resourcing included in Budget 2024/25 and implementation beginning by April 1, 2024.

4. The development and implementation of the recommendations above regarding research, screening, assessment and program services be informed by and aligned with the ICFSA Directors' *Culture is Healing: An Indigenous Child and Youth Mental Wellness Framework*.

   To be initiated by Dec. 31, 2022.

5. MCFD to provide capacity-building funding to the ICFSA Directors to support ongoing leadership, engagement and consultation to support the implementation of the Representative's recommendations as contained in this report.

   Funding to be provided by Dec. 31, 2022.

6. As part of the planned reform of the *Child, Family and Community Service Act*, MCFD to include an amendment to the statutory rights of children in care so it is clear that these children have a right to health care, including mental health care.

   To be completed by Sept. 30, 2025.

[41] The proposed assessment and treatment services would, of course, be community-based and voluntary. Involuntary services are only permitted under the *Mental Health Act* in very limited circumstances and result in hospitalization (and/or extended leave). Under s.17 of the *Infants Act*, a child or youth under the age of 19 is able to consent to their own health care (including mental health assessment or treatment) if the health care provider is satisfied that the child understands the nature and consequences and the reasonably foreseeable risks and benefits of the health care. In practice, this typically means that capable children who are 12-years-old or older can and do consent to their own health care. If a child is not capable, the guardian has the legal authority to consent to the child's health care.

Children in Care: Reducing Needs While Improving Mental Health Outcomes

A Research Report

September 2022

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We celebrate the Indigenous Peoples on whose traditional territories we are all privileged to live and work.

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Executive Summary

Children in government care face extraordinary challenges. This includes many young people coming into care because they have experienced maltreatment. Then once in the care system, many continue to experience avoidable adversities, such as multiple changes of placement which can result in inconsistent caring relationships, school disruptions and cultural disconnections. These children also face higher rates of mental disorders, lower rates of high-school graduation and more conflicts with the law. Compounding these issues are the unfair burdens faced by Indigenous children who often experience overinvolvement of the child welfare system, an ongoing legacy of colonialism.

Given these challenges, a crucial goal is to reduce the need for care placements by better supporting families to prevent child maltreatment. When this is not possible, many children who come into government care need interventions to encourage their well-being, including preventing and treating mental health challenges. This research report therefore aims to identify: 1) effective programs for better supporting families so there is less need for children to come into care; 2) the prevalence of mental disorders for children in care to estimate the degree of burden facing this population; and 3) effective programs for preventing and treating mental disorders for children in care.

To meet these objectives, we conducted three systematic reviews. Our first review identified several successful programs for preventing child maltreatment. For averting problems before they occur, Nurse-Family Partnership stood out — according to two high-quality studies. For preventing further maltreatment, Parent-Child Interaction Therapy and Multisystemic Therapy stood out — each reducing at least one form of maltreatment. Our second review identified a much higher burden of mental disorders for children in care, with prevalence approximately four times higher than in the general population of children. Our third review identified successful prevention and treatment programs for addressing mental well-being for children who have come into government care. For prevention, both Fostering Healthy Futures and Middle School Success reduced mental disorder symptoms including substance use. For treatment, both Parent Management Training – Oregon and Multidimensional Treatment Foster Care led to benefits including reducing symptoms of conduct disorder, substance use, depression and psychosis.

These findings can inform efforts to improve the well-being of some of British Columbia's most disadvantaged children. Preventing maltreatment is the first priority. Ensuring adequate supports for families and adequate investments in programs that can prevent children from needing to enter government care are therefore crucial. The programs highlighted here provide examples. Yet even after maltreatment has occurred, children and families can still benefit from programs that prevent further occurrences. Programs such as those highlighted here should therefore also be offered. Then, if children do come into care, beyond ensuring that their basic needs are met, they also need to be provided with timely and effective mental health care, such as the prevention and treatment programs outlined in this review. In turn, these investments and commitments will honour and uphold children's rights — providing hope and supporting their flourishing.

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1. Background

1.1 Government care in British Columbia

Most children in British Columbia (BC) live with their families who provide supportive, nurturing and loving environments. (We define children as all those aged 18 years and younger.) Some families, however, struggle to meet children's needs, such that government care is required. The most recent data indicate that 5,259 children were in government care in BC in March 2021.[1] Most children (90%) enter care due to court orders for protection purposes[2] with reasons including: neglect (71.5%); physical harm (8.5%); emotional harm (3.2%); sexual abuse/exploitation (0.9%); and other maltreatment (4.1%).[3] Once in the care system, placement options vary — mainly involving foster home placements with caregivers in the community but also including contracted care placements such as staffed group homes, as well as independent living arrangements for older adolescents.[4–5]

But the burden is not shared equally in that care placements for Indigenous children in BC far exceed those for non-Indigenous. In fact, Indigenous children in BC are about 18 times more likely to be in care than their non-Indigenous counterparts.[4] The reasons for this principally lie with ongoing legacies of colonialism in Canada — which included the forced removal of thousands of children from their families and communities into residential schools, essentially deeming Indigenous Peoples unfit to be parents.[6] Moreover, residential schools resulted in intergenerational harms by interrupting many survivors' ability to be caring parents.[6] These policies, as well as ongoing inequities and injustices — including underfunding of services for Indigenous children and families relative to other Canadians — continue to contribute to the child welfare system being overinvolved in the lives of Indigenous children and families.[7–8]

Many children continue to face extraordinary challenges after they enter government care. For some, this includes added avoidable adversities, such as lack of placement stability. For example, 34.0% of BC children in care experience at least one change of placement in any given year[2] — when *any* moves without good reason can greatly disrupt children's lives including their caring relationships, their schooling and their cultural connections.[9] Children in government care are also more likely to experience mental disorders than other children.[10] Compounding these challenges, outcomes for children leaving government care are also often troubling. For example, a recent systematic review of 32 studies conducted in Europe and the United States (US) found that children who had been in foster care had lower rates of high-school graduation, less stable employment, lower employment earnings, and more conflicts with the law, as well as periods of homelessness.[11] High rates of homelessness, less educational attainment, less attachment to the workforce and lower incomes also have been documented for youth leaving the care system in BC.[12–13] Given the hurdles that children face before, during and after entering government care, it is crucial to reduce the need for out-of-home placements by preventing child maltreatment. At the same time, when prevention has not been possible, children who do come into care need to be provided with effective interventions. Such interventions can support their well-being by preventing mental health challenges and by treating these when they occur.

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1.2 Goals of this research report

For this research review, we aimed to inform policy-making by identifying:

1. Effective programs for preventing or reducing rates of child maltreatment so there is less need for children to come into government care;
2. The prevalence of mental disorders for children in care to estimate the population burden; and
3. Effective programs for preventing and treating mental disorders for children in government care.

The overarching goal is to ensure that all children in BC can flourish and that all children and families can receive the programs and services they need, when they need them.

2. Methods

We conducted three systematic reviews for this report. The first focused on programs aimed at preventing child maltreatment. The second focused on the prevalence of mental disorders for children in government care. The third focused on prevention and treatment interventions aimed at improving mental health for children in care. We conducted comprehensive searches for all three topics using methods adapted from the *Cochrane Collaboration* and *Evidence-Based Mental Health*. For prevention and treatment interventions, this involved seeking evaluations that used randomized controlled trial (RCT) methods. For the prevalence of mental disorders this involved seeking meta-analyses of epidemiological studies that were conducted in representative samples of children in care and that used rigorous diagnostic measures. Tables 1–3 provide the inclusion criteria for the three reviews.

Table 1. Inclusion Criteria for Studies on Preventing Child Maltreatment

- Focused on children ≤18 years
- Random assignment to intervention or control/comparison groups (i.e., no intervention or usual care)
- Clear descriptions of participant characteristics, settings and interventions
- Programs aimed to prevent child maltreatment
- Programs evaluated in high-income countries for applicability to Canadian policy and practice
- For primary prevention, <50% of families had prior child protective services (CPS) involvement at study outset
- For secondary prevention, ≥50% of families had prior CPS involvement at study outset
- Follow-up was ≥ three months from the end of the intervention
- Attrition rates were ≤20% at follow-up and/or intention-to-treat analyses were used
- Outcome indicators included maltreatment reports from at least one independent source (e.g., CPS records or hospital records with substantiation of maltreatment) at follow-up
- Level of statistical significance reported for maltreatment outcomes*

* Studies were excluded where authors indicated lack of statistical power for assessing maltreatment outcomes

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Table 2. Inclusion Criteria for Meta-analyses on Mental Disorder Prevalence

- Focused on children in care ≤18 years (e.g., foster or group homes or independent living arrangements)
- Clear descriptions of review methods including database sources, keywords and inclusion criteria
- Focused on original epidemiological studies conducted in high-income countries
- Detailed summaries provided of characteristics of included studies
- Prevalence reported for current mental disorders based on *Diagnostic and Statistical Manual of Mental Disorders* or *International Classification of Diseases* standards
- Reliable and valid diagnostic measures used to assess prevalence
- Original study quality assessed and considered in the analyses
- Results included meta-analyses of prevalence including confidence intervals and tests of heterogeneity

Table 3. Inclusion Criteria for Studies on Improving Mental Health for Children in Care

- Focused on children ≤18 years
- Random assignment to intervention or control/comparison groups (i.e., no intervention or usual care)
- Clear descriptions of participant characteristics, settings and interventions
- Interventions aimed to improve the mental health of children in government care
- Interventions evaluated in high-income countries for applicability to Canadian policy and practice
- For prevention, programs aimed to reduce the incidence of new cases of mental health problems
- For treatment, interventions aimed to address existing mental health problems
- Follow-up was ≥ three months from the end of the intervention
- Attrition rates were ≤20% at follow-up and/or intention-to-treat analyses were used
- Outcome indicators included ≥ two reliable and valid mental health measures from ≥ two informant sources at follow-up
- Level of statistical significance reported for mental health outcomes*

* Studies were excluded where authors indicated lack of statistical power for assessing mental health outcomes

Our database searches identified 1,223 articles on preventing maltreatment, 53 articles on the prevalence of mental disorders for children in government care and 931 articles on mental health interventions for children in care. For all topics, after title screening, two authors independently assessed all relevant abstracts. Applicable studies were then retrieved and independently assessed by two authors who identified those that met all inclusion criteria. We next extracted and summarized data, again with independent verification by a second author. For intervention studies, we only extracted outcomes with specific relevance to the given topic. For example, for maltreatment prevention, we excluded data related to hospitalizations

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that were not specifically due to maltreatment. At every stage, any differences were resolved by consensus involving the larger team. The Appendices provide more information about our search processes as well as definitions of research terms.

Throughout the report, we use *parents* to refer to biological, adoptive and/or step-parents; in most cases, parents refers to biological parents. Meanwhile, we use *foster parents* to refer to individuals caring for children through formal arrangements with child protection agencies. We use *controls* to describe both control and comparison groups. (The former includes participants who received no intervention while the latter includes participants who received a less intensive intervention, such as typical care.) For interventions, we report duration as developers originally intended where possible; where these data were not available, we report either average or maximum duration.

This report is based on research evidence drawn from high-quality quantitative studies. For estimating prevalence, we relied on a meta-analysis using pooled prevalence from studies conducted in representative populations of children in care using rigorous diagnostic measures — because these standards help ensure the most accurate data.[14–15] For assessing prevention and treatment interventions, we relied on RCTs because these methods are a strong form of scientific evidence for assessing impact.[16–17] We nevertheless acknowledge that these methodologies have limitations — including often under-representing Indigenous Peoples, methods and perspectives.[18–19] Many more studies are needed involving Indigenous children — that are led by Indigenous Peoples and informed by Traditional Knowledge as well as Western scientific methods.

Overall, the burden of mental disorders is much greater — and is unacceptably high — for children in care.

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3. Preventing Child Maltreatment

3.1 Primary prevention of child maltreatment

We accepted five RCTs evaluating four different primary prevention programs. These programs aimed to avert child neglect or abuse prior to it ever occurring. One program — Family Connects — was delivered universally to all families in a given community.[20–22] The other three programs were delivered to at-risk families including two evaluations of Nurse-Family Partnership (NFP)[23–24] and single evaluations of SafeCare+[25] and of Child FIRST.[26] All four programs involved home visits.

Family Connects was delivered to all families with newborn children within a given American county.[20] During the first home visit, nurses assessed family needs and provided parenting education on topics such as feeding and safe sleeping practices.[21] Families with no health or psychosocial risks received no further intervention.[22] Moderate-risk families received one to three additional sessions in which nurses addressed specific concerns such as parent well-being or family violence. Meanwhile, nurses referred high-risk families to community resources tailored to the specific needs and made one to two more follow-up contacts to ensure connections with services. Nurses then provided a final telephone call approximately one month after their last contact to determine if families required any additional assistance.[22]

NFP focused on American girls and young women who: had no previous live births; had yet to reach their 25th week of gestation; and were younger than 19 years, socio-economically disadvantaged or unmarried.[23] During home visits, nurses taught parenting skills and promoted maternal health and life course planning. Visits spanned approximately 2½ years and were scheduled every other week during pregnancy, weekly during the first six weeks postpartum, then on a diminishing schedule until children reached age two years.

The second NFP study focused on Dutch girls and young women who: were pregnant for the first time; were fewer than 28 weeks gestation; were younger than 26 years; had limited formal education; and had at least one other risk factor such as financial or housing challenges.[24] Nurse home visits were based on the American NFP curriculum, with adaptations for the local context. Ten visits were scheduled during pregnancy followed by 20 visits during each of the child's first and second years.

SafeCare+ focused on American parents who: were 16 years or older; experiencing problematic substance use, other mental health issues or intimate partner violence; and caring for children aged five years or younger.[25] During home visits, providers taught knowledge and skills related to child health, home safety and parent-child bonding. While the visiting schedule was flexible, parents received 36 hours of service, on average, over six months.

Child FIRST focused on American families with children aged five to 36 months who were at high risk, for example, due to family socio-economic disadvantage, parental substance use or child social or emotional problems.[26] During home visits, mental health practitioners and case managers taught parenting skills and helped families connect with additional community-based services. Although home visits were designed to occur weekly, families participated in an average of 12 visits over five months. Table 4 describes all four RCTs.

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Table 4. Studies on the Primary Prevention of Child Maltreatment

Program	Approach	Sample size	Child ages at start (country)
Universal			
Family Connects [20–22]	1–4 home visits + 1 phone call by nurses; including teaching parenting skills to all families + addressing specific concerns for moderate-to-high-risk families	531	3–12 weeks (United States)
Targeted			
Nurse-Family Partnership (NFP) [23]	32 home visits (average) by nurses; including teaching parenting skills + promoting maternal health-related behaviours + life course planning from early-mid pregnancy to child's 2nd birthday	300	Prenatal (United States)
NFP [24]	As above except 50 home visits (maximum)	460	Prenatal (Netherlands)
SafeCare+ [25]	36 hours (average) of home visits by home-based providers; including promoting parenting skills + parent-child bonding over 6 months	105	Birth–5 years (United States)
Child FIRST [26]	12 home visits (average) by mental health practitioners + case managers; including promoting parenting skills + connecting families to other needed services over 5 months	157	5–36 months (United States)

Family Connects, the sole universal program, did not make a significant impact on CPS investigations for suspected maltreatment.[20] Specifically, 17.7% of Family Connects children were the subjects of one or more CPS investigations compared to 21.8% of controls. Due to the low number of substantiated investigations for maltreatment (1.9%) it was not possible to test for differences between Family Connects and controls for this parameter.[20]

Among the targeted programs, the first NFP study found significantly fewer substantiated child protective services (CPS) maltreatment reports involving either the mother as abuser or the child as victim for NFP families compared with controls.[23] The program led to as much as 50% reductions in maltreatment — with maternal incidence being 0.3 for NFP versus 0.7 for controls, and child incidence being 0.4 for NFP versus 0.7 for controls. Findings were based on CPS records from pregnancy until children were 15 years old.[27, 23]

The second NFP study also resulted in significantly fewer child maltreatment reports for NFP families compared with controls, based on CPS records from pregnancy until children were three years old.[24] (In the Netherlands, CPS deems approximately 93% of reports to be valid.) These records showed that 10.7% of NFP children had CPS reports compared to 18.9% of controls — in other words, relative risk for NFP children was lowered by 42%.

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The SafeCare+ study found that fewer intervention parents had CPS reports for maltreatment — 20.8% for SafeCare+ versus 31.5% for controls. (Reports judged to be malicious or clearly inappropriate were excluded.) However, due to sample size concerns, analyses were conducted only on the number of days until the first CPS report.[25] There was no significant difference between SafeCare+ and controls for this parameter — even though the median length of time to first CPS report was nearly doubled for SafeCare+ (201 days) versus controls (103 days).

Child FIRST resulted in significantly fewer child maltreatment investigations compared with controls, based on CPS records from when families first joined the study through follow-up of approximately 2½ years.[26] In fact, control families had more than double the odds of a CPS investigation. Table 5 details outcomes for all four RCTs.

Table 5. Findings on the Primary Prevention of Child Maltreatment

Program	Follow-up	Outcomes*	
Universal			
Family Connects [20]	4½ years	NS	Investigations for child maltreatment from CPS records
Targeted			
Nurse-Family Partnership (NFP) [27, 23]	13 years	↓	Substantiated child maltreatment reports from CPS records
NFP [24]	1 year	↓	Child maltreatment reports from CPS records (relative risk = 0.6)
SafeCare+ [25]	1½ years	NS	Median length of time until first CPS report
Child FIRST [26]	2½ years	↓	Investigations for child maltreatment from CPS records (odds ratio = 2.1)

CPS Child protective services
NS No significant difference between program families and controls
↓ Statistically significant reductions for program families versus controls
* All studies assessed maltreatment outcomes from family's initial study involvement to final assessment (rather than at intervention end)

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3.2 Secondary prevention of child maltreatment

We accepted five RCTs evaluating five different secondary prevention programs. (These programs aim to avert further abuse or neglect for children who have already been maltreated.) These programs included Intensive Nurse Home Visitation,[28] Healthy Families,[29] Promoting First Relationships,[30] Parent-Child Interaction Therapy (PCIT; standard and enhanced versions),[31] and Multisystemic Therapy for Child Abuse and Neglect (MST).[32] While all programs aimed to enhance parenting skills, there was significant variation in delivery formats and settings. Three involved home visiting exclusively focused on parents[28–30] while two involved sessions delivered in homes and clinics with components for both parents and children.[31–32]

Intensive Nurse Home Visitation focused on Canadian parents who had recent CPS involvement due to physical abuse or neglect of a child aged 12 years or younger.[28] The child had to be living with their family or there had to be an immediate plan for the child to return home. During the home visits, nurses provided intensive family supports, education about child development and links to other needed services. Over the program's two-year delivery, visits were scheduled weekly for six months, then every two weeks for six months, then monthly for one year.

Healthy Families focused on American parents who were at risk for parenting difficulties— with a subsample meeting the inclusion criteria for this report, namely mothers who had had CPS involvement in the five years prior to joining the study.[29] During home visits, family support workers promoted parent-child attachment, fostered safe and nurturing home environments and encouraged positive parenting. Visits were scheduled every other week during the prenatal period, weekly until children were six months old, then as needed until children reached age five years.[29, 33]

Promoting First Relationships focused on American parents who had recently been reported to CPS for maltreatment involving their children who were aged 10 to 24 months.[30] During home visits, service providers focused on increasing parents' awareness of their children's social and emotional needs, increasing children's safety and security and helping parents understand their own needs. Visits were scheduled weekly for 10 weeks.

PCIT focused on American families involved with CPS due to physical abuse of children aged four to 12 years.[31] In standard PCIT, parents attended a six-session group focused on increasing their motivation to make changes to their parenting, while children concurrently attended a safety and skill building group. This was followed by 12 to 14 individual parent-child sessions on improving parenting skills. Then parents and children participated separately in four-session follow-up groups — where parents worked on challenges with implementing their new parenting skills while children practiced social skills. Enhanced PCIT involved the full program plus individually augmented services for concerns such as parental depression or substance use, as well as home visits to help parents strengthen their skills. Both standard and enhanced PCIT took six months to complete.

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MST focused on American families involved with CPS due to the physical abuse of children who were aged 10 to 17 years.[32] During individual family sessions, which occurred in homes or other locations of participants' choosing, therapists helped families develop safety plans, fostered positive relationships with CPS and helped parents accept responsibility for their past behaviour with their children. Added challenges such as problem-solving or communication were also addressed as needed. Frequency varied from daily to once a week based on family needs. MST was delivered over eight months, on average. Table 6 describes all five RCTs.

Table 6. Studies on the Secondary Prevention of Child Maltreatment

Program	Approach	Sample size	Child ages at start (country)
Intensive Nurse Home Visitation [28]	51 home visits by nurses; including intensive family support, education + links to needed supports over 2 years	163	Birth–12 years (Canada)
Healthy Families [29, 33]	Home visits* by family support workers; including promoting parent-child attachment, safe + nurturing home environments + positive parenting from pregnancy to child's 5th birthday	104	Prenatal–3 months (United States)
Promoting First Relationships [30]	10 home visits by service providers; including promoting awareness of child's needs + safety as well as parents' own needs over 10 weeks	247	10–24 months (United States)
Parent-Child Interaction Therapy (PCIT)	6 group parent sessions to enhance motivation to change, 6 group child sessions to bolster safety + skills + 12–14 parent-child sessions to increase parenting skills + 4-week follow-up groups for parents + children separately over 6 months	112	4–12 years (United States)
PCIT Enhanced [31]	As above + home visits supporting parenting skills + augmented services addressing parent well-being over 6 months		
Multisystemic Therapy for Child Abuse and Neglect [32]	88 therapy hours (on average) provided by therapists including developing safety plan, fostering positive relationships with CPS + helping parent accept responsibility for child abuse over 8 months (on average)	90	10–17 years (United States)

* Total number of home visits was not reported

The Intensive Nurse Home Visitation study found no significant differences for program participants compared with controls in overall rates of child physical abuse (33.0% versus 43.1%) or neglect (46.6% versus 51.4%) based on CPS records at one-year follow-up.[28] However, nurse-visited families showed a significantly *higher* recurrence of substantiated child physical abuse or neglect compared with controls

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(23.6% versus 10.8%) based on hospital records at one-year follow-up. The authors speculated that this result may have been due to children's medical care needs being identified more often for nurse-visited families.

For Healthy Families, there were no significant differences for program participants compared with controls in overall child maltreatment rates (41.5% versus 60.4%), which included any type of abuse or neglect based on CPS records at two-year follow-up.[29] However, Healthy Families participants were significantly less likely to receive family preventive, protective or placement services (38.0% versus 60.0%) initiated in response to CPS reports at two-year follow-up.

The Promoting First Relationships study found no significant differences for program participants compared with controls regarding maltreatment allegations (29.0% versus 31.6%) based on CPS records at one-year follow-up.[30] However, children whose parents participated in the program were significantly less likely to be removed from the home for substantiated maltreatment (5.6% versus 13.0%). In fact, control children had 2.5 times higher chances of being removed from the home by one-year follow-up.

Standard PCIT resulted in significantly fewer child physical abuse reports for program participants compared with controls (19.0% versus 48.6%) based on CPS records at 22-month follow-up.[31] However, Enhanced PCIT did not perform as well, with no significant differences for these families compared to controls (36.3% versus 48.6%).

MST resulted in no significant differences for program participants compared with controls regarding youth being maltreated (4.5% versus 11.9%) or parents being abusive (2.3% versus 4.8%) based on CPS records at four-month follow-up.[32] However, MST youth were significantly less likely to experience out-of-home placements (13.3% versus 28.9%) — albeit with a small effect size ($\varphi = 0.2$). The MST study also assessed maltreatment outcomes based on youth and parent self-reports at eight-month follow-up.[32] Compared with the control condition, MST was significantly more effective at reducing severe assaults such as parents punching or kicking their children, according to both youth and parents, with moderate effect sizes. As well, MST parents committed significantly fewer "minor" assaults including spanking and slapping, according to youth but not parents, with a small effect size. Similarly, MST parents perpetrated less psychological aggression, such as screaming or swearing, according to youth but not parents, again with a small effect size. Finally, MST parents were significantly less neglectful according to both youth and parent reports, with a large effect size by youth report but small by parent report. Table 7 on the next page details outcomes for all five RCTs.

Maltreatment causes many serious social and emotional problems for children — and constitutes a serious violation of children's rights.

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Table 7. Findings on the Secondary Prevention of Child Maltreatment

Program	Follow-up*		Outcomes
Intensive Nurse Home Visitation [28]	1 year	NS	Physical abuse or neglect from CPS records
		↑	Physical abuse or neglect from hospital records
Healthy Families [29]	2 years	NS	Confirmed exposure to any type of maltreatment from CPS records
		↓	Family support for preventive, protective or placement services initiated in response to CPS reports (adjusted odds ratio = 0.4)
Promoting First Relationships [30]	1 year	NS	Maltreatment allegations from CPS records
		↓	Child removal from home for substantiated maltreatment from CPS records (hazard ratio = 2.5)
Parent-Child Interaction Therapy (PCIT) +	1¾ years		Standard PCIT
		↓	Physical abuse from CPS records
PCIT Enhanced [31]			Enhanced PCIT
		NS	Physical abuse from CPS records
Multisystemic Therapy Child Abuse and Neglect [32]	4 months	NS	Physical abuse of youth from CPS records
		NS	Physical abuse by parents from CPS records
		↓	Child removal from home from CPS records (ϕ = 0.2)
		↓	Severe assaults from youth/parent reports (2 of 2; Cohen's *d* = 0.5 and 0.6)
		↓	Minor assaults from youth/parent reports (1 of 2; Cohen's *d* = 0.1)
		↓	Psychological aggression from youth/parent reports (1 of 2; Cohen's *d* = 0.2)
		↓	Neglect from youth/parent reports (2 of 2; Cohen's *d* = 0.9 and 0.3)

NS No significant difference between program families and controls
CPS Child Protective Services
↑ Statistically significant increases for program families versus controls
↓ Statistically significant reductions for program families versus controls
* All studies assessed maltreatment outcomes from family's initial study involvement to final assessment (rather than at intervention end)

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4. Prevalence of Mental Disorders for Children in Care

We accepted one meta-analysis that included eight epidemiological studies reporting on mental disorder prevalence in representative samples of children in government care, including foster and group homes.[10] (Robust BC data were not available on this issue.)[34] In total, 3,104 children were included in these studies which were conducted in France, Germany, Norway, the United Kingdom and the United States. All studies assessed the prevalence of mental disorders using diagnostic interviews. In addition to reporting the prevalence of children experiencing any disorder, the authors also reported rates for any anxiety disorder, attention-deficit/hyperactivity disorder (ADHD), conduct disorder, depression, oppositional defiant disorder and posttraumatic distress disorder (PTSD). Authors assessed methodological quality using a validated checklist for epidemiological studies.[10]

For children in care, the overall pooled prevalence of any mental disorder was 49%[10] — or approximately four times higher than the 12.7% overall prevalence found in the general population of children.[35] While prevalence was higher for all disorders assessed for children in care, as shown in Table 8, rates of conduct disorder, depression and PTSD were particularly elevated among children in care relative to the general population of children.[10, 35] In fact, for children in care rates of PTSD were 40 times higher, rates of conduct disorder 15 times higher and rates of depression nine times higher. Overall, the burden of mental disorders is much greater — and is unacceptably high — for children in care.

Table 8. Estimated Prevalence of Mental Disorders for Children in Care

Disorder	Estimated prevalence for general population[35]	Estimated prevalence for children in care[*10]	Estimated number of BC children in care affected[†]
Conduct disorder	1.3%	20%	1,050
Any anxiety disorder	5.2%	18%	950
Oppositional defiant disorder	3.3%	12%	630
Depression	1.3%	12%	630
Attention-deficit/hyperactivity disorder	3.7%	11%	580
Posttraumatic stress disorder	0.1%	4%	210
Any disorder	**12.7%**	**49%**	**2,580**

* Meta-analysis reported prevalence data for children in care in whole numbers and for a limited number of disorders only

† Number of BC children in care affected represents *expected* rather than *actual* estimates at any given time; estimates calculated based on rates derived from population-based child epidemiological prevalence studies[10] which were then applied to BC estimates for the number of children in care,[1] rounded to the nearest 10

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5. Fostering Better Mental Health Outcomes

5.1 Prevention programs

We accepted four RCTs evaluating four different programs that aimed to prevent mental health problems for children in government care. The four programs included Incredible Years + Co-Parenting,[36] Incredible Years – Dina,[37] Fostering Healthy Futures[38] and Middle School Success.[39] All but one program aimed to avert behaviour problems.

Incredible Years + Co-Parenting focused on American parents and foster parents of children aged three to 10 years who were at high risk for behaviour problems.[36] This intervention started with a 12-session training program for both parents and foster parents on the effective use of praise and rewards as well as setting limits and addressing misbehaviour. This was followed by a 12-session co-parenting program involving both parents and foster parents learning together about open communication and negotiation skills. Parent leaders delivered the intervention over three months.

Incredible Years – Dina focused on American children aged five to eight years who were at high risk for behaviour problems.[37] Children participated in a 12-session skills group learning about emotion recognition, problem solving and anger management. Foster parents, and parents if available, also attended three group sessions on strategies to assist children in applying their new skills. Clinicians delivered the program over three months.

Fostering Healthy Futures focused on American children aged nine to 11 years who were in out-of-home care due to maltreatment.[38] Taking a strengths-based approach, the overall aim was to foster healthy development. To this end, children participated in a 30-session skills group focused on cognitive-behavioural techniques to address concerns including emotion recognition, problem solving and anger management. Children also had 30 individual mentoring sessions to help them apply their new skills in everyday life and to encourage their involvement in positive recreational activities. Clinicians and graduate-student mentors delivered both components over nine months.

Middle School Success focused on American girls aged 10 to 12 years, aiming to prevent behaviour problems, substance use and related concerns.[39] Girls first participated in a skills group to learn strategies for maintaining healthy relationships with positive peers and for increasing self-confidence — twice weekly for three weeks. This was followed by 40 individual coaching sessions to provide ongoing support during the first year of middle school. Meanwhile, foster parents participated in a skills group to learn behavioural reinforcement approaches to encourage positive engagement in home, school and community settings — twice weekly for three weeks. This was followed by 40 group sessions for foster parents to support their ongoing use of behavioural approaches during the girls' first year of middle school. Facilitators and practitioners delivered the program over 11 months. Table 9 on the next page describes all four RCTs.

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Table 9. Studies on Preventing Mental Health Problems for Children in Care

Program	Approach	Sample size	Child ages at start (country)
Incredible Years + Co-Parenting [36]	*Foster Parents + Parents:* 12 group sessions by parent leaders including parenting skills such as giving praise + limit setting plus 12 co-parenting sessions including open communication + negotiation skills over 3 months	64	3–10 years (United States)
Incredible Years – Dina [37]	*Children:* 12 group sessions by clinicians including emotion recognition, problem solving + anger management *Foster Parents + Parents:* 3 group sessions by clinicians including helping children apply learned skills over 3 months	94	5–8 years (United States)
Fostering Healthy Futures [38]	*Children:* 30 group CBT sessions by clinicians including emotion recognition, problem solving + anger management plus 30 individual mentoring sessions by graduate students including applying skills + doing recreational activities over 9 months	426	9–11 years (United States)
Middle School Success [39]	*Children:* 6 group sessions by facilitator including healthy relationship skills followed by 40 individual sessions for ongoing support *Foster Parents:* 6 group sessions by facilitator including developing behavioural reinforcement system followed by 40 group sessions to support its ongoing use over 11 months	100	10–12 years (United States)

Incredible Years + Co-Parenting failed to produce mental health benefits for children at three-month follow-up.[36] Specifically, there were no significant differences compared with controls regarding behaviour problems according to parent, foster parent or teacher reports.

Incredible Years – Dina also failed to produce benefits at three-month follow-up.[37] Here, too, there were no significant differences compared with controls regarding behaviour problems according to either foster parent or teacher reports. As well, control children displayed significantly *better* emotional and behavioural regulation according to foster parent ratings — but not teacher ratings — at three-month follow-up.

Fostering Healthy Futures resulted in children having significantly fewer mental disorder symptoms at six-month follow-up, with a small effect size, compared with controls.[38] (Symptoms of posttraumatic stress, anxiety, depression and behaviour problems were assessed using a composite measure based on child, parent and caregiver ratings.) However, there were no significant differences compared with controls for child reports of satisfaction at home, at school and with their friendships and health.

Middle School Success resulted in girls engaging in significantly less substance use compared to controls at two-year follow-up, with a moderate effect size.[39] (Alcohol, cannabis and tobacco were combined on this self-report measure.) In contrast, the intervention had no impact on girls' conduct disorder symptoms at two-

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year follow-up. The program also had no impact on a composite measure of mental disorder symptoms — which included anxiety, depression and behaviour problems — at one-year follow-up according to foster parent ratings. Table 10 details findings for all four RCTs.

Table 10. Findings on Preventing Mental Health Problems for Children in Care

Program	Follow-up	Outcomes	
Incredible Years + Co-Parenting intervention [36]	3 months	NS	Behaviour problems (3 of 3 measures)
Incredible Years – Dina [37]	3 months	NS	Behaviour problems (2 of 2 measures)
		↓	Emotional + behavioural regulation (1 of 2 measures)
Fostering Healthy Futures [38]	6 months	↓	Mental disorder symptoms (Cohen's d = 0.3)
		NS	Life satisfaction
Middle School Success [39]	1 year	NS	Mental disorder symptoms
	2 years	↓	Substance use (tobacco, alcohol + cannabis; Cohen's d = 0.5)
		NS	Conduct disorder symptoms

NS No significant difference between program children and controls
↓ Statistically significant reductions for program children versus controls

5.2 Treatment approaches

We accepted six RCTs evaluating two treatments for children in government care: Parent-Management Training – Oregon (PMTO; two RCTs) and Multidimensional Treatment Foster Care (MTFC; four RCTs). All focused on children experiencing behaviour problems — with the exception of one PMTO study which included children with either emotional or behaviour problems.[40] The timing of entry into care also differed. For the PMTO studies, children were already living in foster care.[40–41] In contrast, for two MTFC studies, on enrollment teens were randomized either to an MTFC placement or to a different form of out-of-home care such as a group home.[42–44] The remaining two MTFC studies randomized youth to an MTFC placement or treatment-as-usual — which could involve residential care, foster care, independent living and/or living with parents.[45-46] PMTO and MTFC both focused on parents and foster parents, although one PMTO study and all MTFC studies included components for children.

The first PMTO study focused on American families with children aged three to 16 years who were living in foster care and experiencing significant emotional or behavioural problems, where there was an established goal of the child returning to their family.[40] Each session began with practitioners meeting alone with parents to focus on parenting skills including providing appropriate supervision, solving problems and using appropriate discipline. Practitioners also delivered family sessions so parents could practice their new skills. Practitioners typically met with families twice a week, for up to six months, until the program was completed.

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The second PMTO study focused on Dutch foster parents caring for children aged four to 12 years whose behaviour difficulties were severe enough to put their placements at risk.[41] Therapists taught foster parents strategies such as providing adequate supervision, solving problems, setting limits and engaging positively. The intervention was delivered weekly, with an average of 21 sessions over six to nine months.

The first MTFC study focused on American foster parents, parents and boys aged 12 to 17 years who had committed serious offences — resulting in the youth justice system ordering foster care placements.[42] Prior to the youth being placed, case managers provided foster parents with 20 hours of training focused on providing close supervision and setting clear rules and limits. This was followed by weekly groups and daily phone calls for foster parents to ensure ongoing support and problem solving. The boys participated in weekly therapy sessions covering solving problems, learning to take others' perspectives and express themselves non-aggressively. Boys and their parents also participated in weekly family therapy sessions covering parent management training including supervision, encouragement, discipline and problem solving. Case managers and therapists delivered the intervention over one year.

The second MTFC study focused on Swedish foster parents and children aged 12 to 17 years who were diagnosed with conduct disorder.[46] The intervention is as described above with some minor variations, for example, in the duration of various program components.

The third MTFC study had the same delivery and inclusion criteria as the second, described above, with some minor exceptions. For example, youth were aged 12 to 18 years.[45]

The fourth MTFC study focused on American foster parents, parents and girls aged 13 to 17 years who had been court-mandated to community-based, out-of-home care due to chronic "delinquency."[43] The intervention is as described above for the first MTFC evaluation. Table 11 on the next page details all five RCTs.

When children come into care,

there is a collective ethical responsibility to ensure their well-being

— including their mental health.

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Table 11. Studies on Treating Mental Health Problems for Children in Care

Program	Approach	Sample size	Child ages at start (country)
Parent Management Training – Oregon (PMTO) [40]	*Parents:* training sessions* by practitioners focused on supervision, problem solving + discipline *Children + parents:* family therapy sessions* by practitioners focused on parents practicing new skills over 6 months	918	3–16 years (United States)
PMTO [41]	*Foster parents:* 21 (average) sessions by therapists including supervision, problem solving + limit setting over 6–9 months	88	4–12 years (Netherlands)
Multidimensional Treatment Foster Care (MTFC) [42]	*Foster parents:* 20 hours of training by case managers + therapists focused on supervision + rule setting followed by weekly supervision focused on problem solving *Children:* weekly individual therapy sessions focused on problem solving, perspective taking + non-aggressive self-expression *Children + Parents:* weekly family therapy focused on parent management skills over 12 months	85	12–17 years (United States)
MTFC [46]	As above except program delivered over 9–12 months	46	12–17 years (Sweden)
MTFC [45]	As above including program delivered over 12 months	35	12–18 years (Sweden)
MTFC [43–44]	As above except program delivered over 6 months	166	13–17 years (United States)

* Total number of sessions was not reported

The first PMTO study showed benefits. Specifically, intervention children had significantly fewer mental disorder symptoms by caseworker and parent reports compared to controls at six-month follow-up.[47]

The second PMTO study, however, failed to show benefits.[41] There were no significant differences between PMTO children and controls regarding mental disorder symptoms according to either foster parent or teacher reports at four-month follow-up.

The first MTFC study resulted in intervention boys having significantly fewer criminal charges for violent behaviour (21.6% versus 38.1%) based on official criminal records, and less violent behaviour by self-report, at one-year follow-up.[48] As well, at six-month follow-up, compared with controls who lived in group homes, MTFC boys reported significantly less cannabis, tobacco and other drug use including cocaine, “speed,” LSD, heroin, “mushrooms,” PCP, morphine and inhalants.[49] However, there was no difference in alcohol use.[49]

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The second MTFC study failed to produce benefits at one-year follow-up.[46] Specifically, there were no significant differences compared with controls for mental disorder symptoms according to youth self-report or parent ratings.[46]

The third MTFC study also failed to produce benefits at one-year follow-up.[45] As with the second study, there were no significant differences compared with controls for mental disorder symptoms according to youth self-report or parent ratings.[45]

The fourth MTFC study found that girls receiving the intervention had significantly fewer criminal charges based on official criminal records, and spent significantly fewer days in correctional facilities based on self-report, at 1½ year follow-up.[44] MTFC girls also had fewer psychotic and depressive symptoms at 1½ year follow-up.[50, 43] In fact, MTFC girls had about half the odds of having depressive symptoms than controls. There were, however, no differences compared with controls regarding self-reported engagement in violent behaviours. Longer-term follow-up found that MTFC girls continued to have fewer depressive symptoms, as well as less substance use (with a moderate effect size), at 8½ year follow-up compared to controls.[51–52] However, there were no significant differences compared with controls in suicidal ideation or attempts at this longer-term follow-up.[51] Table 12 on the next page details the findings from all six treatment studies.

When children in care have mental health problems,

it is imperative to provide effective treatments — quickly, for all in need.

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Table 12. Findings on Treating Mental Health Problems for Children in Foster Care

Program	Follow-up	Outcomes	
Parent Management Training – Oregon (PMTO)[47]	6 months	↓	Mental disorder symptoms (2 of 2 measures)
PMTO[41]	4 months	NS	Mental disorder symptoms (2 of 2 measures)
Multidimensional Treatment Foster Care (MTFC)[48–49]	6 months	↓	Cannabis use
		NS	Alcohol use
		↓	Tobacco use
		↓	Other drug use
	1 year	↓	Criminal charges for violent behaviour
		↓	Engagement in violent behaviour
MTFC[46]	1 year	NS	Mental disorder symptoms (2 of 2 measures)
MTFC[45]	1 year	NS	Mental disorder symptoms (2 of 2 measures)
MTFC[43–44, 50–52]	1½ years	↓	Criminal charges
		↓	Days in correctional facilities
		NS	Engagement in violent behaviour
		↓	Depressive symptoms (odds ratio = 0.6)
		↓	Psychotic symptoms
	8½ years	↓	Depressive symptoms (Cohen's $d = 0.4$)
		↓	Substance use (Cohen's $d = 0.5$)
		NS	Suicidal ideation
		NS	Suicide attempts

↓ Statistically significant reductions for program children versus controls

NS No significant difference between program children and controls

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6. Discussion

6.1 Summary

We found evidence that child maltreatment can be prevented by providing supports to parents. This included two home-visiting programs — NFP that successfully reduced the incidence of maltreatment[23–24] and Child FIRST that successfully reduced the likelihood of investigations for child maltreatment.[26] Both programs started early — prenatally for NFP and in very early childhood for Child FIRST. Both also assisted disadvantaged families to improve their parenting and helped parents to address their own life challenges. Evidence for NFP was particularly compelling given positive findings from two RCTs, including one with very long-term follow-up.[23–24]

Yet findings were more equivocal for secondary prevention. Of five programs assessed, only two showed success in preventing re-abuse. PCIT reduced the recurrence of physical abuse while MST reduced the recurrence of physical abuse, psychological abuse and neglect.[31–32] PCIT provided parenting and child skill building groups, while MST provided family therapy focused on developing safety plans and helping parents accept responsibility for their behaviours. Some secondary prevention programs have also been associated with poorer outcomes. For example, families who received Intensive Nurse Home Visitation had higher rates of physical abuse and neglect.[28]

We also found very high rates of mental disorders for children in government care. Specifically, a rigorous meta-analysis found that overall prevalence was 49%,[10] nearly four times higher than the 12.7% rate seen in the general population of children.[35] This means that an estimated one in every two children in government care is likely to meet criteria for at least one mental disorder. Consequently, the treatment needs for children in care are considerable. Interventions for preventing and treating conduct and anxiety disorders are particularly needed given the high prevalence of these conditions for children in care. However, it must be acknowledged that high rates of behaviour disorders can be a result of avoidable adverse childhood experiences — for example, often reflecting maltreatment by caregivers and multiple placements within the care system.[10, 53] Therefore these underlying causal issues also need to be addressed.

Yet we also found that prevention programs can improve mental health for children in government care. Both Fostering Healthy Futures and Middle School Success led to positive outcomes.[38–39] Fostering Healthy Futures, delivered to children, significantly reduced child mental health symptoms. Middle School Success, delivered to girls and their foster parents, significantly reduced girls' substance use, including at two-year follow-up. In contrast, the two Incredible Years studies did not show success, with one evaluation even showing better outcomes for control children[36–37] — underscoring the importance of carefully evaluating interventions.

For children in government care with mental health concerns, both treatment interventions showed evidence of success in at least one study. PMTO involved helping parents develop their parenting skills, including providing appropriate supervision and discipline, while MTFC involved developing the same

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skills with foster parents. The MTFC studies also included weekly therapy for participating teens, both individually and with their parents. In the one successful PMTO study, the program led to fewer child mental disorder symptoms generally and fewer behaviour problems specifically.[47] In the two successful MTFC studies, the program led to multiple benefits for children including reduced substance use, fewer criminal charges and fewer depressive and psychotic symptoms.[43–44, 48–52]

6.2 Policy and practice implications

Meet children's and families' basic needs. Every family in BC should have the resources and supports they require to meet their children's basic needs. However, despite many families' best efforts, 7.2% of children in BC still live in households where incomes are very low and where it is difficult to meet even their basic needs.[54] These circumstances are occurring in a province where some household incomes are very high — resulting in levels of income inequality in BC that are higher than many other high-income jurisdictions.[55] The need to address poverty has been identified as a significant factor to addressing violence against children in BC.[56] Consequently, greater efforts are needed to lessen income inequality in BC. Reducing family socio-economic disparities in turn supports the health and social well-being of children and their families. When families can meet basic needs, this also mitigates the likelihood of child maltreatment and childhood mental disorders.[57–58]

Invest in preventing child maltreatment. Maltreatment causes many serious social and emotional problems for children — and constitutes a serious violation of children's rights.[59] While not every case can be prevented, effective programs can nevertheless reduce the incidence. NFP, in particular, is supported by robust research evidence based on trials in both the US and the Netherlands. NFP should therefore be a priority as a prevention offering. To this end, BC has invested in a rigorous evaluation of NFP — including with Indigenous children and families. Results will inform future investments in this province and in Canada. (In BC, the program has already been shown to reduce maternal cigarette and cannabis use during pregnancy; other child and maternal findings will follow later in 2022.)[60] Secondary prevention programs should also be considered. Two programs — PCIT and MST — both reduced at least one form of maltreatment. So while primary prevention is always the highest policy priority, these programs offer guidance on how to effectively avert further maltreatment.

Prevent mental health problems for children in government care. When children come into care, there is a collective ethical responsibility to ensure their well-being. Given very high rates of mental disorders for these children, mental health interventions are crucial. To this end, successful prevention programs for this population should be used to lower the burden where possible. Fostering Healthy Futures and Middle School Success were both designed to support mental well-being for children in care — and both showed some success. As well, many other programs have rigorous evidence of success in preventing childhood mental disorders in the general population and could also be offered.[61] When BC children come into care, their mental well-being should be supported by providing effective prevention programming tailored to their specific needs.

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Offer effective mental health treatment services for children in government care. When children in care have mental health problems, it is imperative to provide effective treatments — quickly, for all in need. PMTO and MTFC are successful treatments specifically designed for children in care that can reduce conduct, substance use, depression and psychotic symptoms. These programs will likely be particularly helpful given very high prevalence of conduct disorder and depression for children in care. Consequently, these programs, or programs modelled after them, should be offered to BC children in care who have these mental health problems. For children in care with other mental health concerns typical for this population, such as anxiety, ADHD and PTSD, treatments with proven success in the general population should be offered.[61]

Evaluate ongoing mental health needs for children in care in BC. Preventing the need to come into care remains the highest priority. But given the high prevalence of mental disorders for children in care,[53] ongoing evaluation data are needed to inform improvements in services. Aiming to ensure timely access to effective prevention and treatment programs for all children in need, such data could include: measuring child mental health status in the population as a whole using well-established measures like the Brief Child and Family Phone Interview;[34] identifying mental health problems early; and tracking the provision of mental health services and service gaps for all children.

Honour Indigenous children and families and communities. There is also a collective ethical obligation to uniquely support the well-being of Indigenous children. Studies on SafeCare+, Promoting First Relationships, PCIT, Middle School Success and MTFC included Indigenous participants, a starting point for inclusion. But more Indigenous-led studies are needed on culturally appropriate programming. Beyond research, however, the overinvolvement of the child protection system in the lives of Indigenous children reflects the continuation of longstanding public policies that have harmed Indigenous children and families and communities.[62, 6] BC and Canada have adopted the UN Declaration on the Rights of Indigenous Peoples, an historic development.[63–64] Yet many calls to action from the Truth and Reconciliation Commission of Canada's report still await enactment.[6, 65–66] Honouring these calls — and honouring Indigenous children — a crucial next step is ensuring that funding for Indigenous children's services reaches parity with that for non-Indigenous children.[7] Addressing this basic equity issue in turn will help reduce the number of Indigenous children in care, while improving their chances for mental health and flourishing.

On balance, our findings suggest that much can be done to improve children's mental health and overall well-being — by preventing the conditions that lead to children needing to come into care, and by preventing and treating mental health problems when children do come into care. Implementing effective programs such as we have outlined here is also a way of honouring children's rights. These rights are particularly important where the needs are greater — as with children who may be at risk of child maltreatment and with children who have come into government care. They have already coped with so many challenges and should not be asked to cope with inadequate services as well.

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Appendices

Search strategy

For this research report, we used systematic review methods adapted from the *Cochrane Collaboration* and *Evidence-Based Mental Health* to search for randomized controlled trials (RCTs) of interventions aimed at preventing childhood maltreatment and improving the mental health of children in government care. We built on work from our previous publications on the same topics by updating those systematic review searches.[67–68] Tables 13 through 15 outline our search strategies for each topic which followed database conventions for ensuring comprehensive identification of potentially relevant articles.

Table A1. Search Strategy for Studies on Maltreatment Prevention Programs

Databases	▪ CINAHL, ERIC, Medline and PsycINFO
Search Terms	▪ Child abuse, maltreatment, emotional abuse, neglect, physical abuse, psychological abuse, sexual abuse, abandonment, domestic violence, intimate partner violence, spouse abuse or battered women and prevention, intervention or treatment
Limits	▪ Peer-reviewed articles published in English between January1998 and November 2021 ▪ Child participants aged 18 years or younger ▪ RCT methods used

Table A2. Search Strategy for Mental Disorder Prevalence Studies for Children in Care

Databases	▪ Medline and PsycINFO
Search Terms	▪ Mental disorders or psychiatric disorders and epidemiology, prevalence or surveys and child welfare, foster, residential, out-of-home, local authority care, child maltreatment or youth welfare institution
Limits	▪ Peer-reviewed articles published in English (with no date limiters) ▪ Child participants aged 18 years or younger ▪ Meta-analysis methods used

Table A3. Search Strategy for Studies on Improving Mental Health for Children in Care

Databases	▪ CINAHL, ERIC, Medline and PsycINFO
Search Terms	▪ Foster care, treatment foster care, multidimensional treatment foster care, specialized foster care, wraparound foster care, kinship care, group care, group home, residential care or residential setting
Limits	▪ Peer-reviewed articles published in English between January 2007 and November 2021 ▪ Child participants aged 18 years or younger ▪ RCT methods used

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Research terms explained

Policy-makers need high-quality prevalence data to estimate population needs and to inform service planning. Optimally, prevalence data are derived from **meta-analyses** of multiple high-quality epidemiological studies because the resulting pooled data provide the most comprehensive estimates. To derive accurate prevalence estimates, original studies included in meta-analyses should also measure disorders in **representative samples** — that is, subsets of participants chosen probabilistically to reflect the total population of interest. As well, prevalence studies should use **rigorous diagnostic measures** — that is, instruments that are reliable and valid in identifying "cases" of mental disorders in children.

Policy-makers also need high-quality evidence about whether a given intervention works to help children. **Randomized controlled trials** (RCTs) are a particularly rigorous method for assessing intervention effectiveness. In RCTs, participants are randomly assigned to intervention or control groups. Randomizing participants — that is, giving everyone an equal likelihood of being assigned to a given group — helps to ensure that the intervention is the only difference between the groups. In turn, this process provides confidence that any benefits are due to the intervention rather than due to chance or other factors.

To determine whether an intervention provides benefits, researchers analyze relevant outcomes. If an outcome is **statistically significant**, it helps provide certainty that the intervention was effective rather than appearing that way due to chance. The studies included in this report used the typical convention of having at least 95% confidence that results reflected the intervention's real impact. As well, some included studies determined whether the intervention was clinically meaningful by assessing the degree of difference the intervention made in the young person's life. This was achieved by calculating outcome **effect sizes**, which provide a quantitative measure of the strength of the relationship between the intervention and the outcome. The studies we included reported a variety of effect sizes as described below.

- **Cohen's *d*** has the following standard interpretations: 0.2 = small effect; 0.5 = moderate effect; and 0.8 = large effect.
- **Hazard ratio** reflects the rate at which intervention and control participants experienced an event at a given time; for example, children of parents who did not receive a prevention intervention had 2.5 times higher chances of being removed from the home for maltreatment by one year follow-up.
- **Phi (ϕ)** has the following standard interpretations: 0.1 = small effect; 0.3 = moderate effect; and 0.5 = large effect.
- **Odds ratio** indicates the increased or reduced odds of an outcome occurring; for example, having only 50% odds of maltreatment investigations after participating in a prevention intervention.
- **Relative risk** indicates the degree to which children were less at risk of being maltreated when their parent participated in the intervention, with 0.6 reflecting 40% less risk.

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Competing interests: Charlotte Waddell is co-leading BC's randomized controlled trial on Nurse-Family Partnership, one of the interventions discussed in this review.

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