The Social Determinants of Health in Manitoba

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Aboriginal Child Welfare and Health Outcomes in Manitoba

Brad McKenzie and Corbin Shangreaux

The promotion of population health approaches, including the need for attention to the social determinants of health (SDOH) in Canada, has increased in recent years, although there is less evidence of concerted action arising from this focus (Raphael Chapter 2). Discourse on this topic has produced some variation in the list of health determinants; Raphael identifies twelve items, one of which is Aboriginal status. Although more attention has been paid recently to how SDOH affect the well-being of Aboriginal peoples (Loppie Reading and Wien 2009; Native Women's Association of Canada 2007; Reading 2009), there has been little discussion of how these determinants relate to Aboriginal child welfare. The purpose of this chapter is to discuss the connections between developments in Aboriginal child welfare and selected SDOH, with particular attention to Manitoba, and to identify policy developments in Aboriginal child welfare which may be consistent with this perspective.

Aboriginal Child Welfare and the Influence of the Social Determinants of Health

The disproportionate representation of indigenous children in care is common to a number of countries (Tilbury and Thoburn in press). In Canada this was first documented in a serious fashion in the 1980s, when data suggested that Aboriginal children were admitted to the care of the child welfare system at a rate between four and eight times that of non-Aboriginal children (Johnston 1983; McKenzie and Hudson 1985). This pattern has continued; for example, an analysis of children in care data from three sample provinces in May, 2005 found the rate of First Nations children in care was 102 per 1000 compared to 33.1 per 1000 for Métis children and 6.7 per 1000 for non-Aboriginal children (Blackstock et al. 2005). Nationally, 5.5 percent of all First Nations children living on reserve were reported to be in child welfare care in 2003 (Indian and Northern Affairs Canada 2005: 61), a rate estimated at eight times that for all Aboriginal and non-Aboriginal children living in care off-reserve (Auditor General of Canada 2008:2).

Manitoba data tell a similar story. Using figures from the 2006/07 annual report of Manitoba Family Services and Housing (2008a), the rate per 1000 in care for non-Aboriginal children was 5.0, and the comparative rate for Aboriginal children was 84.3 (a disparity rate of 16.9 times the rate for non-Aboriginal children).

Data as of March 31 for 2007, 2008, and 2009 (Manitoba Family Services and Housing 2008a; 2008b; 2009) confirm a continuing pattern of over-representation. Between 2007

and 2009 number of Manitoba children in care increased by 19.2 percent to 8629. The rate of increase was somewhat higher for Aboriginal than non-Aboriginal children (20 percent vs 14.6 percent). At March 2009, Aboriginal children in care made up 86 percent of the provincial children in care population.

Explanations for disproportionality range from micro factors (e.g., historical descriptions of family breakdown and poor parenting practices, discriminatory practices by reporters, and stereotypical responses by child welfare workers) to cultural loss factors (e.g., traditional child caring practices, including kinship patterns) to structural factors (e.g., high unemployment, high poverty rates, poor quality housing, and poor family support services within Aboriginal communities).

Research has demonstrated the link between poverty and child welfare referrals (lindsey 2004). Empirical evidence for these links in Aboriginal communities comes from the 2003 *Canadian Incidence Study of Child Abuse and Neglect* (Trocmé et al. 2003), which was used to examine the causes of the overrepresentation of First Nations children receiving services from the child welfare system (Trocmé, MacLaurin et al. 2005). Findings suggest that both the rates of maltreatment investigations and substantiation (i.e., abuse or neglect has occurred) are higher for First Nations than non-Aboriginal children (58.3 per 1000 versus 44.1 per 1000 for investigations and 30.2 per 1000 versus 20.7 per 1000 for substantiations). Neglect was the primary form of maltreatment in 56 percent of substantiated First Nations investigations and 22 percent of substantiated non-Aboriginal cases. Physical neglect, where the child is at risk of physical harm due to caregiver failure to provide adequate food nutrition or housing, was the primary neglect category, accounting for 39 percent of substantiated First Nations neglect cases. First Nations households involved in maltreatment investigations had lower incomes and poorer housing conditions than non-Aboriginal households.

Evidence that SDOH such as poverty and poor housing contribute to disproportionality demonstrates the need to address these factors in preventing children from coming into care. These findings may also be linked to the length of time in care. Blackstock (2009), in a comparative study of First Nations and non-Aboriginal children in care in Nova Scotia, found that there were few differences between services and characteristics of the children in care, and that poverty, overcrowded housing, and caregiver issues pertaining to substance abuse were primarily linked to difficulties in family reunification once children were admitted to care. Although structural factors such as housing, employment and income, and food insecurity can be linked to neglect for all families, the inadequacy of these basic needs in Aboriginal communities explains at least some of the over-representation of Aboriginal children in care. Data on these issues are summarized by the Assembly of First Nations (2008), which notes that almost one in four First Nations children in 2006 was living in poverty and the rate of disabilities was almost double the rate for all Canadian children. Overcrowding was about double the Canadian rate, and the high school completion rate among First Nations youth was half the Canadian rate. In Manitoba, 2006 Census data indicate that the rate of poverty was 29 percent, almost three times the overall poverty rate of

11.4 percent (CCPA—Mb. 2009: 16). In Winnipeg nearly seven of ten Aboriginal children under six were living below the Statistics Canada pre-tax Low Income Cut-Off (SPCW 2009).

The impact of colonialism on the lower measures of well-being for Aboriginal children and families, including over-representation, has been well documented (McKenzie & Morrissette 2003; Sinclair et al. 2004). It has occurred in two ways. First, colonialism has contributed directly to the prevailing pattern of inequality between Aboriginal people and other Canadians on such determinants of health as poverty, inadequate housing, and lower levels of educational attainment (see Hart Chapter 10), and these factors are linked to increased referrals for child maltreatment. Second, institutional interventions, beginning first with the residential schools and then with the mainstream child welfare system, have played a key role in removing Aboriginal children from their families, communities, and culture instead of introducing policies and services to support families and keep children "closer to home" (Fournier and Crey 1997; McKenzie and Hudson 1985). Beginning with the "sixties scoop," which lasted to the 1980s and beyond, many children were removed permanently and placed in non-Aboriginal resources. Little attention was paid to the importance of family, community, and cultural continuity. The effects were destructive for many children in care, as well as for the families and communities that were devalued and marginalized as "not good enough to care for their own." Although Aboriginal alternative care resources, including kinship care, have increased significantly more recently, many Aboriginal children are still placed in non-Aboriginal resources outside their communities. And even though more efforts to incorporate cultural connections in cross-cultural placements now occur, the disruption caused to family, community and cultural continuity remains a significant challenge.

Capacity Development in Aboriginal Child Welfare

Three of the most important determinants of health affecting child welfare outcomes are cultural continuity, self-determination, and institutional capacity. The importance of culture to Aboriginal child welfare is now more commonly accepted, and empirical support for this has been established in research on suicide in British Columbia, where Chandler and Lalonde (1998) found that communities which had taken active steps to preserve and rehabilitate their cultures had dramatically lower suicide rates than communities where this was not done.

Aboriginal self-determination in child welfare in Manitoba began with the adoption of a delegated model of service delivery for First Nations communities in the 1980s. However, because services on reserves were required to conform to provincial legislation and standards and were subject to the funding policies of the federal government, the degree of autonomy over service delivery has been constrained.

Increased jurisdictional control has occurred under the reform initiatives known as the *Aboriginal Justice Inquiry—Child Welfare Initiative* (Joint Management Committee

2001). A p[illegible]y development process that included engagement with Aboriginal stakeholders resulted in the establishment of four authorities as part of a new governance structure for the delivery of child and family services in Manitoba. *The Child and Family Services Authorities Act* (2002) gives these authorities considerable responsibility over both administrative and policy matters. Three of the new Authorities are Aboriginal: First Nations North, First Nations South, and Métis. The other, the General Authority, is primarily responsible for the delivery of child welfare services to non-Aboriginal people throughout the province, although it also provides services to a significant number of Aboriginal children and families. The three Aboriginal authorities have a province-wide mandate to provide services that are culturally appropriate to their members; however, these services must be consistent with provincial child welfare standards and accountability provisions.

Aboriginal self-determination enables the development of community-based services that incorporate Aboriginal values, beliefs, and traditions, including culturally appropriate practices, and is more likely to lead to capacity-building initiatives at the community level which can offer alternatives to conventional service models.

There are also particular challenges. One is implementation problems, which have affected the development of the new Manitoba model over the past several years.

A second and perhaps more important challenge is infrastructure resource gaps. These are particularly apparent in on-reserve First Nations communities. Manitoba has made some efforts to respond to resource needs in child welfare in recent years, but in 2008 the federal government spent only about 78 cents for on-reserve child welfare services for every dollar spent by the Province for services to off-reserve children and families (Rabson 2009: A4). One reason for this discrepancy is an outdated federal funding formula for on-reserve child welfare services that has not been significantly revised for Manitoba since the early 1990s (Auditor General of Canada 2008). Another reason is that there is no designated allocation for prevention and family support services (Blackstock et al. 2005). Although new funding models have been introduced in some other provinces and there was an agreement in 2009 that the federal government would allocate significantly more resources in 2010/11, this commitment has now been withdrawn (personal communication). A third reason for funding discrepancies is that, unlike larger urban centres, reserve communities do not have a range of voluntary services that can supplement government-funded therapeutic or support services for families. A final resource-related issue is a general lack of flexibility regarding resource allocation throughout the child welfare system, which inhibits agencies from transferring funds from child maintenance (i.e., for children once they are admitted to care) to early intervention and support services. Such policies not only limit the availability of family support services to enable children to remain at home but also restrict efforts to develop community capacity by failing to invest in such services.

The impact of failing to address community capacity issues also has unintended consequences for other institutions that play key roles in supporting the well-being of children. For example, placing children outside the community affects the education

system. In two impoverished First Nations communities, between 50 per[illegible]nd 60 percent of the school-aged children were placed in Winnipeg in 2008, leading to lost revenues for community-based schools that receive funding based on enrolment figures each September. The annual loss in educational operating funds was estimated between $1 million and $2 million for each of these communities, and in one community all classes for kindergarten to Grade Two were cancelled because there were no children for these grades (Shangreaux 2009). The lost revenue affects the range of program options that can be provided to other students, and it has diverted resources from these communities.

Infrastructure capacity is not simply related to resources. New models of service delivery supported by a different approach to policy and practice can also make a difference.

Models for Child Welfare Reform

Differential Response in Child Welfare

Since the mid-90s there has been growing dissatisfaction with service delivery in child welfare, in Canada and elsewhere. The growth in referrals for child protection investigations, related increases in costs, and questions about the effectiveness of the current service model have not been limited to Aboriginal child welfare. In Canada, the rate of investigated children increased by 83 percent between 1998 and 2003 (Trocmé, Fallon et al. 2005). Similar trends have been documented in Australia (Australian Institute of Health and Welfare 2007) and the U.S.A. (Shusterman et al. 2005).

Two different frameworks for organizing child welfare services are identified in the literature (Connolly 2004; Hill et al. 2002). Some characteristics of these frameworks are summarized in Table 1 (next page).

The child protection framework focuses almost exclusively on an individualized response to child maltreatment, largely ignoring factors related to family support and well-being.

Differential response has emerged as an approach which attempts to shift this paradigm to a more family-support orientation. This model is now being implemented in Manitoba. Differential response (DR) or "alternative response" (AR) allows for more than one method of initial response to reports of child abuse and neglect. Typically, service pathways are established: an investigation response which resembles the traditional child protection approach of assessing safety and risk to determine whether neglect or abuse is substantiated and whether placement and/or other types of intervention are required for these cases; and an assessment track or approach which focuses on the assessment of family strengths and needs and the offer of voluntary family support services. The alternative response of assessment and family support services generally occurs in cases where risk is assessed as low or moderate. Substantiation of child maltreatment is not required to trigger services in the AR stream; instead, the level of need is the criterion for opening a case for ongoing services, and these

services are provided on a voluntary basis. Generally, both investigation and AR services are provided by separate service units. Although DR services are not necessarily new, the development of a clearly defined alternative response track, including relevant assessment tools and the use of staff with more training in the delivery of voluntary, family-centred services, does set this model apart from past practice, where family engagement occurred most often *after* a finding of neglect or abuse. DR systems stress the importance of less adversarial assessment responses; voluntary services to fit family strengths, needs, and resources; active engagement with parents and kinship networks; and more extensive use of community resources in partnership with agency services (Child Welfare Information Gateway 2008).

Although data are not yet available for Manitoba, early results, based primarily on the evaluation of differential response systems in the United States, suggest a number of positive effects. For example, an evaluation in Minnesota found that families in the AR stream were seen more often than families in the investigation stream, AR families were more likely to receive services other than case management, and there was greater use of community resources for AR families. As well, AR families reported higher levels of service satisfaction, felt more involved in decision-making, and were less likely to be referred back to the agency for child neglect or abuse after service was terminated (Loman and Siegel 2005). Of particular importance was the shift in service focus. Agencies were provided with resources to respond to the immediate financial needs of families, and this, along with the emphasis on working in partnership with families and other community service providers, was a factor associated with the benefits from this approach.

Table 1: Child Protection and Family Support Orientations in Child Welfare

Child Protection	Family Support
Associated with child protection systems in the United Kingdom, Canada, United States, and Australia. • Primary focus on investigation and placement, with extensive reliance on risk assessment instruments. • Family support services are poorly resourced, located largely outside the child welfare system, and poorly integrated with child protection functions. • Focus is on children's rights and protecting children from harm. • A more legalistic, bureaucratic and adversarial response to child protection. Concentration of state resources on families identified as high risk. • Placement in out-of-home care mainly involuntary.	Associated with child protection systems in Belgium, France, Germany, and the Nordic countries. • Child protection services embedded within broader family support provisions where family services and supports are a first response. • Increased resources devoted to early intervention and support, with these services linked to child protection services by an emphasis on partnerships and collaboration between services. • Emphasis on family connections and flexible family-based service responses to address children's needs. • Less emphasis on coercive authority; state and families viewed as having shared responsibilities for child rearing; more emphasis on partnerships with families. • Assistance is not restricted to those who reach a "threshold of risk"; services available to families at an early stage. • Placement in out-of-home care mainly voluntary.

Source: Adapted from Connolly 2004.

A Community Caring Model

Increased emphasis on a more family-focused, strengths-and-needs-based approach to service delivery in child welfare will help, but other changes are required. One of these is the adoption of a community caring orientation to service delivery, infused with a commitment to traditional Aboriginal values, such as the medicine wheel framework (McKenzie and Shangreaux in press). This model adopts a more holistic approach to caring with an emphasis on connections to family, community, and culture. It expands the family support framework associated with differential response with an emphasis on building community capacity where some of the traditional community supports have been lost. Selected characteristics of the community caring model are illustrated in Table 2.

Table 2: Community Caring Orientation

Community Caring
Associated with indigenous communities, including Maori maraes in New Zealand/Aotearoa and Aboriginal communities in Canada. • Includes family support responses but sees the whole community as a "kind of family"; thus intervention builds on family support and child protection responses to emphasize community responsibility and strengths. • In indigenous communities, the approach often represents a form of resistance to the loss of indigenous children, and the need to build local capacity and traditions as a form of "self-preservation". • Uses conceptual models such as the "circle" and medicine wheel along with a return to tradition as a means of asserting strengths for "self-preservation." • Jurisdictional control over child welfare services is an essential component in building community caring responses. • Methods include family group conferencing, an increased role for local child and family services committees, more collaborative service responses, and a community-oriented practice approach.

Source: McKenzie & Shangreaux in press.

One example of a service delivery model based on community caring principles is West Region Child and Family Services (CFS), a regional First Nations agency serving nine communities in western Manitoba. It is a fully delegated child and family service agency with a governance structure that includes local child and family service committees on each reserve. Most services are delivered by community-based teams. Services are guided by a vision statement that defines the agency as an extension of kinship systems in the communities it serves. The medicine wheel serves as a framework for conceptualizing programs and services.

In 1992 the agency negotiated a flexible funding arrangement with the federal Department of Indian Affairs which allowed it to transfer unspent child maintenance dollars for early intervention and capacity-building initiatives. The agency's experiences with flexible funding have been evaluated on three separate occasions, most recently in 2006 (Shangreaux 2008; Shangreaux and McKenzie 2006). The following summary is based on those results.

In the fiscal year 2004/05, close to 40 percent of the agency's $5 million flexible funding allocation was used to establish and maintain alternative programs. These expenditures were allocated to three broad program initiatives: family support and preservation, alternate care and community prevention. Agency programs are conceptualized as four circles of care.

The *Staying at Home Circle of Care* is focused on maintaining children in their own homes through family supports and early intervention. Since the inception of the pilot project, the rate of on-reserve children entering agency care declined from 10 percent in 1992/93 to 5.2 percent in 2003/04.

The *Family Restoration and Treatment Circle of Care* uses specialized staff to provide practical and therapeutic support services to families where children have special needs and/or are at risk of coming into care. A 2004 survey estimated that 212 children at medium to high risk were receiving adequate care at home as a result of these services rather than having to come into care.

The *Circle of Alternate Care* has focused on developing foster, kinship, and residential care resources closer to home. In addition, a therapeutic foster care program was established as a resource for children that would otherwise have required residential care placements in Winnipeg.

It is the emphasis on *Community Circles of Care* that most reflects a community capacity-building focus. Three general strategies are used within this circle of care. First, there is a major emphasis on recruiting community volunteers, including Elders, to serve as members of local child and family service committees. Training is provided to ensure these committees are empowered to play a role in local decision-making, and the agency regularly engages each community in operational planning and accountability workshops. A second strategy has been to fund positions for community prevention and resource development initiatives. Educational workshops and other

locally based initiatives are carefully planned with local child and family services committees each year, and based on these plans a budget for local prevention work is allocated to each community. A third strategy has involved the initiation of special projects, often as part of a coordinated community response with other community or regional partners. One example of a jointly sponsored initiative is the *Vision Seekers Program* involving life skills, occupational training, and wrap-around services, such as child care. Most adult students who have enrolled in the program are on social assistance, and many have had children who are at risk. Based on 2005 data, most graduates had secured employment and improved parenting outcomes, reducing the likelihood of future out-of-home placement.

Using estimates of costs and benefits completed by Loxley and Deriviere (2005), McKenzie and Shangreaux (in press) estimated that this service model produced savings of approximately $1.5 million in 2004/05. Among reasons for the agency's success was the availability of resources which could be used in a more flexible fashion, strong and stable leadership, and the investment in training and development to build staff capacity and commitment for a new service model.

Conclusions

This chapter has demonstrated the connections between the social determinants of health and two general outcomes in Aboriginal child welfare: the disproportionality of Aboriginal children in care, and the unequal outcomes for too many Aboriginal children, families, and communities. Whereas colonialism, racism, and social exclusion have contributed to these inequalities, self-determination, cultural revitalization, and community infrastructure and resources can mitigate these disadvantages. These attributes must be combined with more holistic models of service delivery if the child and family service system is to make a significant contribution to population health outcomes for Aboriginal children and families.

The current child protection model, which focuses largely on investigation and placement-related services, has failed not only Aboriginal children and families but also those of other cultures in most English-speaking countries. The recent shift to a more family-centred practice model that includes an increased emphasis on partnership with other community service providers may be part of the answer. But the changes that may result from differential response are not revolutionary, and if such services are to make a significant difference in Aboriginal communities, much more is required. We argue that this reform initiative must be combined with a paradigm shift that includes cultural revitalization and a community-caring orientation to service development. This shift must include a major focus on building local capacity through community-based services and the development of alternative programs designed to strengthen communities and keep children "closer to home." Thus the well-being of Aboriginal children and families cannot be achieved without addressing the well-being of the organizations and communities that are connected to their daily lives.

With increased resources, a new, culturally-relevant vision for service delivery and investment in staff training and development, child and family service agencies can make a difference. However, they cannot, on their own, transform communities where poverty, poor housing, and related problems such as substance abuse have had profound effects on parenting. Building healthy communities demands a long term commitment to community engagement and capacity building. This requires strategies that include government commitments to economic development and intersectoral partnerships across different departments and levels of government (i.e., a whole-of-government-approach). An important subset of these approaches may include integrated community-based human services that can reduce service fragmentation, promote a commitment to learning and change, and play a role in shifting services from a preoccupation with alleviating the symptoms of poverty and poor health to one which incorporates sustainable strategies for poverty reduction and health promotion.

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Housing: A Major Problem in Manitoba

Shauna MacKinnon

My yearly income is $9667. After expenses are paid I am left with $2703. That's $225 a month to cover everything including food, bus fare, clothing, toiletries, and laundry. Everything. I have lived in my apartment for three years. I feel safe and comfortable there. But the rent increase is forcing me to find somewhere else to live. There is nothing available.... I just want to have a decent home (CCPA–Mb. 2009a).

Good quality, affordable housing is one of the most important determinants of health. The World Health Organization (WHO) *Ottawa Charter for Health Promotion* (1986) lists shelter as a fundamental indicator of health. The WHO (2007) identifies housing as a basic human right and essential to good health. The United Nations International Covenant on Economic, Social and Cultural Rights (ICESR) includes housing as a basic human right.

As defined by Moloughney (2004) housing is more than the physical space that "shelter" provides. While the *causal* link has not been made specifically, there is very clearly a *relationship* between poor housing and poor health: research shows that residents of poor neighbourhoods have poorer health outcomes than those in richer neighbourhoods.

Housing can contribute to health and social well-being when it provides a sense of security, permanency, and continuity (Moloughney 2004: 2). Safe, affordable, permanent, and good quality housing can lead to improved socio-emotional and physical health and safety; it promotes social inclusion by providing both stability and a base from which to access services and social networks, including employment.

Social housing has been portrayed negatively in recent years as housing that creates ghetto neighbourhoods. But social housing does not have to be this way if adequately funded. It can take many forms. Social housing is that which has some form of ongoing subsidy attached making it accessible and affordable to low-income people. Social housing can be located in the traditional form of publicly owned and managed units. It can be situated in mixed-income developments such as cooperatives or non-profit owned and operated buildings. Since the 1990s governments have bought into the idea that the state should not provide housing as this need is best met through the private market. But the crisis that we now face tells us that the market will not meet the housing needs of many low- and medium-income individuals and families. We know that this is the case because low-income rental housing is simply not profitable for private sector, for-profit developers (MacKinnon and Silver 2009).