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Intergenerational transmission of out-of-home care in Sweden: A population-based cohort study

Elizabeth Wall-Wieler^{a,*}, Ylva Almquist^b, Can Liu^{b,c}, Bo Vinnerljung^{b,c}, Anders Hjern^{b,c}

^a Department of Community Health Sciences, University of Manitoba, S110-750 Bannatyne Ave, Winnipeg, Manitoba, R3E 0W2, Canada

^b Department of Public Health Sciences, Stockholms Universitet, SE-106 91, Stockholm, Sweden

^c Department of Medicine, Karolinska Institutet, SE-171 77, Stockholm, Sweden

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ABSTRACT

The objective of this study is to examine the intergenerational transmission of out-of-home care. This population-based study used data from the Swedish National Registers and included all children born in Sweden between 1990 and 2012 (followed for up to 13 years), whose parents were both born in Sweden between 1973 and 1980 (278 327 children; 145 935 mothers; 146 896 fathers). Cox regression models are used to obtain crude and adjusted hazard ratios (HR) of OHC placement among children based on parents' history of OHC. Compared with children whose parents both did not have a history of OHC, the risk of being placed in OHC was greater when both parents spent time in OHC (crude HR = 48.70, 95% CI 41.46–57.21; adjusted HR = 3.04, 95% CI = 2.54–3.64), however, children who had only one parent who spent time in care were also at higher risk (mothers only adjusted HR = 2.37, 95% CI = 2.08–2.70; fathers only adjusted HR = 1.33, 95% CI = 1.13–1.55). The crude rate of placement in OHC was highest for children whose parents were placed in care during adolescence, but after adjusting for social and behavioral covariates, children whose parents were in care in early childhood were at greater risk of OHC than children whose parents were in care in adolescence. To reduce this intergenerational transmission of OHC, more supports should be provided to parents who spent time in OHC to ensure a successful transition to parenthood.

1. Introduction

Within families, the outcomes of one generation are often transmitted to the next generation. Outcomes tend to remain similar across generations due to elements of nature and/or nurture. For example, genetics (nature) have been largely attributed to the correlations in health at birth across generations (Currie & Moretti, 2007), whereas learned behavior (nurture) is generally considered the mechanism for the transmission of violence (Black, Sussman, & Unger, 2010). Intergenerational transmission has also been attributed to cumulative advantage/disadvantage; the disadvantage an individual experiences grows over time, which results in descendants starting at a level of disadvantage, making it difficult for them to catch up (DiPrete & Eirich, 2006). These mechanisms are likely contributing to children being at greater risk of placement in out-of-home care (OHC) when their parents had a history of OHC (Mertz & Andersen, 2017).

OHC is a strong indicator of family instability, often occurring because of abuse or neglect. The intergenerational transmission of

* Corresponding author.

E-mail address: wallwiee@myumanitoba.ca (E. Wall-Wieler).

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OHC has been attributed in part to an intergenerational transmission of parenting styles, as children who experienced abuse or neglect are themselves more likely to abuse or neglect their children (Widom, Czaja, & DuMong, 2015). However, this intergenerational transmission is also likely mediated by an accumulation of disadvantage. Individuals who spend time in care face significant disadvantages when they enter adulthood, often resulting in lower socioeconomic status (e.g. education, employment), higher rates of criminal justice system involvement, substance use, and mental illness (Braciszewski & Stout, 2012; Brownell et al., 2015; Doyle, 2008; Hook & Courtney, 2010; Pecora, White, Jackson, & Wiggins, 2009; Vinnerljung & Hjern, 2011). In turn, these social and behavioral characteristics have been identified as a strong predictor of having a child placed in OHC (Fong, 2016; Putnam-Hornstein & Needell, 2011; Wall-Wieler, Roos, Brownell, Nickel, & Chateau, 2018).

While previous research has identified potential mechanisms for intergenerational transmission of out-of-home care, the magnitude of this transmission and the impact of these mechanisms have not been examined using large population-based cohorts. Linkages across the Swedish National Registers provide a unique opportunity to gain a better understanding of the intergenerational transmission of OHC. These data allow us to examine whether risk of placement differs when both parents had a history of placement in care (compared with having only one or neither parent with a history of OHC). Having one parent who was not placed in care could provide stability and reduce the child's likelihood of placement in OHC. In Sweden, most young children entering care do so for reasons related to parental behavior, whereas older children are more often placed in care due to antisocial behavior (e.g. delinquency or substance abuse) (Vinnerljung, Sallnas, & Westermark, 2001). Examining differences in risk of OHC among children whose parents were placed in care before and after age 13 allows us to examine the role of transmission of parenting styles. Additionally, the linkages of OHC data with several health and social databases allows us to control for mediating effects of parental social and behavioral factors. This study aims to provide a better understanding of the magnitude of and mechanisms behind the intergenerational transmission of OHC, which can be used to identify high-risk groups that could benefit from targeted interventions.

2. Methods

2.1. Setting and data

Swedish child welfare is administered by 290 municipalities that have considerable legal and fiscal autonomy in relation to the central government. National child welfare legislation provides a 'framework' for the local authorities' activities, further developed in guidelines produced by the National Board of Health and Welfare, but legislation falls short on explicit criteria for placement in out-of-home care or for reuniting the family after a care episode. In similar fashion, the legislation contains no binding obligations for municipalities to provide rehabilitative services to parents having had a child placed in societal care (Hessle & Vinnerljung, 1999). Between three and four percent of the child population are at some time placed in foster or residential care before age of majority, usually for a relatively short time (Vinnerljung, Hjern, Weitof, Franzén, & Estrada, 2007). Unlike such jurisdictions as Canada (outside of Quebec), Britain, and the United States, juvenile delinquency and other forms of antisocial behavior (e.g. illicit drug abuse) falls under the jurisdiction of child welfare authorities.

Study data were provided by national registers held by the Swedish National Board of Health and Welfare (the Medical Birth Register, the Hospital Discharge Register, the National Child Welfare Register), the National Council for Crime Prevention (the National Register of Criminal Convictions), and Statistics Sweden (the Multi-Generation Register, the Register for the Total Population, and the Longitudinal Integrated Database for Health Insurance and Labor Market Studies (LISA by Swedish acronym), and the Swedish Parent Register). These de-identified registries were linked at the individual level using a unique personal identification number. The Regional Ethics Committee in Stockholm approved this study (dnr: 2010/5:1); all data was anonymized and therefore did not require informed consent.

2.2. Cohort

The study cohort includes all children born in Sweden between 1990 and 2012, whose parents were both born in Sweden between 1973 and 1980, and parent and child did not moved out of Sweden before 2013 (278 327 children, 145 935 mothers, and 146 896 fathers). Biological parents were identified in the Multi-generation Registry. All children were followed from birth until they were placed in OHC, died, or the study end date (December 31, 2012), whichever came first; children were followed for at most 13 years.

2.3. Variables

2.3.1. Outcome

The outcome of interest is whether a child was placed in OHC care before age 13. As previously stated, in Sweden, conditions of the parent are primarily the reason for a child being placed in OHC during childhood, whereas placement in OHC during adolescence is often due to conditions of the child. In this study, we are interested in examining the mechanisms for a child being placed in OHC due to parental conditions.

2.3.2. Covariates

The intergenerational transmission of OHC is likely affected by a cumulation of disadvantage and mediated by parental social and behavioral characteristics. To adjust for this potential mediation, parental factors that could be identified in the linked Registries are included. Parental social variables, obtained from the Register of the Total Population and the LISA database, are examined in the

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