For the One and the Many: A Population Health Approach for Children's Mental Health

Charlotte Waddell

May 2, 2013

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Overview

- Definitions
- Meeting the Needs of the One
  - Case study
- Meeting the Needs of the Many
  - Recent research evidence
  - Ongoing policy and service shortfalls
- Implications for Policy and Practice

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Definitions

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Policy-Making

"Policy-making is about making and implementing collective ethical judgments."

(Greenhalgh and Russell, 2006)

"How *do* we decide — for the one and the many?"

(Daly and Cobb, 1994)

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Mental Health

- Social and emotional wellbeing
  - A resource for living and learning
  - Enables resilience in face of adversity
  - Essential for *all* children to flourish and meet their potential

Mental Disorders

- Clinically significant conditions involving *both* symptoms *and* impairment → impeding healthy child development at home, at school, and in the community
- Defined by *Diagnostic and Statistical Manual* (DSM) or *International Classification of Diseases* (ICD)
- Consistent definitions are crucial → for ensuring accurate assessments and appropriate interventions

THE GLOBE AND MAIL

Number of U.S. ADHD diagnoses 'astronomical'

ALAN SCHWARZ and SARAH COHEN
The New York Times News Service
Published Monday, Apr. 01 2013, 12:33 PM EDT
Last updated Monday, Apr. 01 2013, 12:37 PM EDT

Nearly 1 in 5 high-school-age boys in the United States and 11 percent of school-age children overall have received a medical diagnosis of attention deficit hyperactivity disorder, according to new data from the federal Centers for Disease Control and Prevention.

These rates reflect a marked rise over the last decade and could fuel growing concern among many doctors that the ADHD diagnosis and its medication are overused in American children.

The figures showed that an estimated 6.4 million children ages 4 through 17 had received an ADHD diagnosis at some point in their lives, a 16 percent increase since 2007 and a 53 percent rise in the past decade. About two-thirds of those with a current diagnosis receive prescriptions for stimulants like Ritalin or Adderall, which can drastically improve the lives of those with ADHD but can also lead to addiction, anxiety and occasionally psychosis.

"These are astronomical numbers. I'm floored," said Dr. William Graf, a pediatric neurologist in New Haven and a professor at the Yale School of Medicine. He added, "Mild symptoms are being diagnosed so readily, which goes well beyond the disorder and beyond the zone of ambiguity to pure enhancement of children who are otherwise healthy."

And even more teenagers are likely to be prescribed medication in the near future because the American Psychological Association plans to change the definition of ADHD to allow more people to receive the diagnosis and treatment. ADHD is described by most experts as resulting from abnormal chemical levels in the brain that impair a person's impulse control and attention skills.

While some doctors and patient advocates have welcomed rising diagnosis rates as evidence that the disorder is being better recognized and accepted, others said the new rates suggest that millions of children may be taking medication merely to calm behavior or to do better in school. Pills that are shared with or sold to classmates — diversion long tolerated in college settings and gaining traction in high-achieving high schools — are particularly dangerous, doctors say, because of their health risks when abused.

The findings were part of a broader CDC study of children's health issues, taken from February 2011 to

Prevalence

- Estimated numbers of children with *clinically significant mental disorders* — and therefore needing intervention — in the population at any given time

Interventions

- Prevention programs
  - Addressing risks *before* disorders develop → reducing the numbers with *avoidable* disorders early in the lifespan
    - *Universal*
    - *Targeted*
- Treatment services
  - Addressing symptoms *after* disorders develop → alleviating distress, reducing symptoms and impairment
    - *Psychotherapies*
    - *Medications*

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Evidence-Based Interventions

- Research evidence is just one source of information among many for guiding policy and practice
  - Careful assessment, cultural competence, therapeutic relationships are always essential
- But research evidence suggests where to start, how to benefit more children, how to avoid harm
- Randomized controlled trials (RCTs) as the "gold standard" for evaluating interventions, e.g.,
  - *Cochrane Collaboration, Evidence-Based Mental Health*

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Evidence-Based Policy and Practice

"How do we *know* that we're doing the right things, and that we're doing them right?"

(Drucker, 1993)

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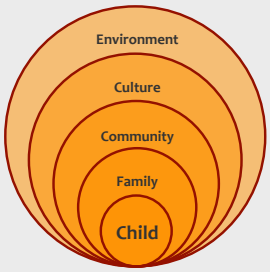
Healthy Child Development in Relationships



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Meeting the Needs of the One

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Case Study

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Melissa

- Aboriginal girl who grew up in a remote northern village
- Now living with relatives in town, to attend high school
- With a group of teens — intoxicated — conducted a break-and-enter wherein a popular senior citizen was assaulted and badly injured
- Melissa turned herself in to police, although peers did not, was charged with assault
- Mental health consultation was sought regarding sentencing (youth versus adult penalties)

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Melissa

- When seen by the mental health team in youth custody in the city, Melissa discloses a lengthy history of parental alcoholism, neglect and violence
- She moved to her relative's home to "get away"
- But then she started drinking, missing school, hanging out with antisocial peers
- She further discloses she was the primary caregiver for her four younger siblings until she moved, so she is extremely worried about their safety now, too

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Melissa

- She admits to longstanding anxiety and depression, including suicidal thoughts
- Overwhelmed with remorse at her role in the assault, she has also been cutting herself in custody
- She describes no positive adult supports
- She describes liking school initially, years ago, but having no one to help or encourage her
- She also then discloses being sexually assaulted in her village two years ago by a group of local boys

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Melissa

- Reached by phone, Melissa's mother says she struggles hard to stay sober, while fighting off depression and dealing with Melissa's father's drinking and violence
- Money has always been a problem as there are few jobs in the village
- The mother says she wishes she had known more about parenting before she had Melissa: "She carried the brunt of my mistakes"
- She did not know about the sexual assault

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Melissa

- Psychiatric diagnoses are made including child maltreatment, depression, and anxiety
- Mental health team commences treatment (psychotherapy) and oversees school and recreational activities (carving and basketball) in youth custody
- A mentoring program with Aboriginal elders is started
- Depression and anxiety resolve
- Melissa starts excelling academically, connecting with elders, making plans to pursue higher education

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Melissa

- Melissa receives a youth sentence and is later released into a supportive long-term foster placement in the city
- She re-establishes contact with her mother and siblings
- She makes amends to the person she assaulted
- Village leaders offer to create a traditional healing circle — for her to make amends, and for others to make amends for harming *her* in the past
- Melissa agrees, then sets a long-term goal of becoming a leader in her community

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Meeting the Needs of the Many

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Recent Research Evidence

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Prevalence of Children's Mental Disorders

- Recent high-quality epidemiologic surveys (2003 – 2013)
  - Relatively high-income countries (not including Canada)
  - Representative population samples (average 5,000)
  - DSM-IV or ICD-10 diagnostic criteria (including impairment)
  - Multiple mental disorders, range of ages, both boys and girls
- Meta-analyses → BC estimates
  - No existing BC survey or similar high-quality data
  - New Ontario Child Health Survey starting later this year
    - 10,000 children and youth → findings expected in 2018

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Prevalence of Children's Mental Disorders

			Population Affected (#)	
Disorder	**Prevalence (%)**	**Age (y)**	**BC**	**Canada**
Anxiety Disorders	3.8	4–17	25,300	204,400
ADHD	2.5	4–17	16,600	134,500
Substance Use Disorders	2.4	4–17	15,900	129,100
Conduct Disorder	2.1	4–17	14,000	113,000
Major Depressive Disorder	1.6	4–17	10,600	86,100
Autism Spectrum Disorders	0.6	5–16	3,400	27,400
Bipolar Disorder	0.6	11–17	2,100	16,600
Eating Disorders	0.2	5–17	1,200	10,000
Schizophrenia	0.1	9–13	200	1,900
Any Disorder	**12.6**	**4–17**	**83,700**	**677,900**

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Impact of Children's Mental Disorders

- Profound adverse *individual* consequences
  - Most disorders persist across the lifespan
  - Reduced life chances, e.g., education → employment
  - Increased mortality
  - Social exclusion
- Profound adverse *collective* consequences
  - Leading cause of lifelong disability worldwide
  - Annual costs estimated at > $50 billion in Canada

(e.g., Kessler, Fergusson, Rutter, WHO, Dewa)

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Emerging Evidence on Social Disadvantage

- Poor socioeconomic status relative to others
  - Associated with poor mental and physical health outcomes
  - Independent of lifestyle and healthcare services
- Family socioeconomic adversity in childhood
  - Associated with mental health problems in adulthood, e.g., antisocial behaviour, anxiety, depression, substance abuse
  - Mechanisms likely involve biological responses to chronic stress influencing gene-environment interactions over time

(e.g., Marmot, Wilkinson, Power, Rutter)

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Emerging Evidence on Social Disadvantage

- Observational studies
  - Ensuring "one good enough" adult → childhood **resilience** despite adversity
  - Gene-environment interactions → maltreatment → development of **conduct disord**er
  - Gene-environment interactions → maltreatment → development of **depression**

(e.g., Werner, Caspi, Cichetti)

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Emerging Evidence on Social Disadvantage

- "Experimental" studies
  - Improving disadvantaged parents' knowledge and skills → reduced child maltreatment → reduced child **behaviour** problems and improved child learning outcomes
  - Addressing early childhood deprivation → reduced child **behaviour** problems and improved child learning outcomes
  - Improving disadvantaged parents' incomes → better parenting → reduced child **behaviour** problems → reduced adult **substance use** disorders

(e.g., Olds, Schweinhart, Costello)

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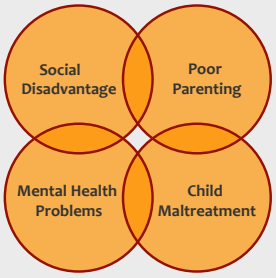
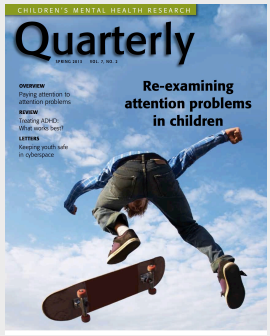


Recent Intervention Studies

- Intervention evidence is predicated on ensuring:
  - Thorough, culturally-competent assessments
  - Comprehensive, culturally-competent child and family supports
- "Best evidence" inclusion criteria
  - Interventions identified in past *Children's Mental Health Research Quarterly* issues (based on systematic review methods) or through new searches of peer-reviewed literature
  - Positive benefits according to **two or more RCTs** evaluating outcomes in children (with at least one of the two RCTs using placebo controls for medications)



Effective Interventions for Anxiety Disorders

- **Prevention**
  - **Cognitive-behavioural therapy (CBT)** prevents the development of diagnoses and/or symptoms in children (e.g., *FRIENDS*)
- **Treatment**
  - **CBT** reduces diagnoses and symptoms in children and youth; eye-movement desensitization and reprocessing reduces symptoms in children and youth
  - Antidepressant medication (**fluoxetine** only) reduces symptoms in children and youth

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Effective Interventions for ADHD

- **Treatment**
  - **Behavioural therapy**, **CBT**, and **parent training** reduce symptoms in children
  - **Stimulant medications** (methylphenidate, dextroamphetamine, and atomoxetine only) reduce symptoms in children and youth

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Effective Interventions for Substance Misuse

- **Prevention**
  - **Resistance skills training** and **parent training** prevent the development of disorders and/or symptoms in children and youth
- **Treatment**
  - **CBT** and **family therapy** reduce symptoms in children and youth; motivational training reduces symptoms in youth

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Effective Interventions for Conduct Disorder

- **Prevention**
  - **Parent training** and **social skills training** prevent the development of diagnoses and/or symptoms in young children (e.g., *Nurse-Family Partnership, Incredible Years, Triple P*)
- **Treatment**
  - **Parent training** reduces diagnoses and symptoms in children and youth; **CBT** combined with parent training and family therapy reduces symptoms in children and youth (i.e., *Multi-Systemic Therapy*)

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Effective Interventions for Depression

- **Prevention**
  - **CBT** prevents the development of diagnoses and/or symptoms in children and youth
- **Treatment**
  - **CBT** reduces diagnoses and symptoms in children and youth; interpersonal psychotherapy reduces symptoms in children and youth
  - Antidepressant medication (**fluoxetine** only) reduces symptoms in children and youth

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Effective Interventions for Autism

- **Treatment**
  - **Intensive behavioural intervention** improves cognitive and language abilities and adaptive behaviours in young children
  - **Newer antipsychotic medications** (risperidone and aripiprazole only) reduce repetitive and challenging behaviours, where these are severe and have not responded to intensive behavioural treatments

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Effective Interventions for Eating Disorders

- **Prevention**
  - **Media literacy training** prevents the development of symptoms in children and youth
- **Treatment**
  - **Family therapy** reduces anorexia symptoms in children and youth

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Effective Interventions for Other Disorders

- **Bipolar Disorder**
  - **Newer antipsychotic medication** (risperidone only) reduces manic symptoms in youth
- **Schizophrenia**
  - **Newer antipsychotic medications** (risperidone and olanzapine only) reduce psychotic symptoms in youth

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Ongoing Policy and Service Shortfalls

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Policy and Service Shortfalls

- At any given time, an estimated **12.6%** of children — or **84,000** in BC — have one or more clinically significant mental disorders requiring interventions
- The majority — **67% or two thirds —** of children with mental disorders do *not* receive specialized mental health services now
- Few prevention programs available
- These shortfalls would not be tolerated, e.g., for childhood cancer or diabetes

(Waddell, 2013)

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Inefficiencies Exacerbating the Shortfalls

- Many evidence-based interventions are unavailable, while ineffective interventions persist
- Children's services are highly fragmented, e.g.,
  - Federal → provincial → regional/local jurisdictions
  - Public health, early childhood, primary healthcare, secondary/ tertiary healthcare, children's mental health, education, child protection, youth justice service sectors
  - Preconception → prenatal → birth → infancy → early childhood → middle childhood → adolescence → adult stages

(e.g., Waddell, Beidas)

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Current Health Investments

- Canada makes substantial health investments
  - Nearly $200 billion annually ($3,000 – $20,000 per Canadian)
  - 94% → healthcare, mainly for older Canadians (aged 65 +)
  - 6% → public health, including promotion and prevention

(Canadian Institute of Health Information, 2012)

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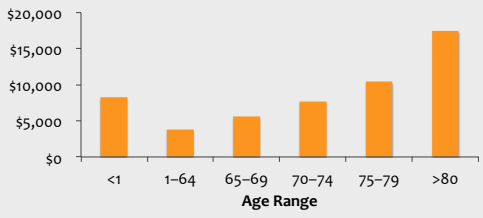
Health Spending Per Capita



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Canada Revenue Agency / Agence du revenu du Canada — Canada

Benefits

Universal child care benefit (UCCB)

The UCCB is designed to help Canadian families, as they try to balance work and family life, by supporting their child care choices through direct financial support. The UCCB is for children under the age of 6 years and is paid in instalments of $100 per month per child.

MyAccount For individuals

QuickAccess For individuals

Enrolment for the UCCB is processed through the Canada child benefits application or by applying online on My Account by using the *Apply for child benefits* service.

The Automated Benefits Application is a joint partnership between the Canada Revenue Agency (CRA) and the Vital Statistics Office of the participating provinces.

Get it fast. Sign up for direct deposit

How to apply for direct deposit

Last payment: April 19, 2013
Next payment: May 17, 2013

New: Subscribe to the benefit recipients – payment issuance electronic mailing list to be notified when the next UCCB payments will be issued.

My Account allows you to manage your benefits and credits, and **apply for the UCCB online**. You can also use Quick Access to view the status of your benefit and credit payments.

Forms and publications - child and family benefits

Frequently asked questions about the universal child care benefit

Application and eligibility	Payments
Contact the CRA about your UCCB	Direct deposit
Taxability	Balance owing – benefits overpayment
Where to mail your forms	

Date Modified: 2013-04-19

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The Washington Post Blogs

James Heckman: In early childhood education, 'Quality really matters.'

By Dylan Matthews, Updated: February 14, 2013

James J. Heckman is the Henry Schultz Distinguished Service Professor of Economics at the University of Chicago. He shared the 2000 Nobel for his work on correcting for selection biases when doing econometric studies, developing techniques which he applied to measuring everything from the economic effects of civil rights laws on African-Americans to the economic benefits (or lack thereof) of GEDs. Recently, he has done considerable work on early childhood education, including detailed studies of the Perry preschool experiment. Wonkblog interviewed him in 2010 on that subject.

We spoke on the phone Wednesday night. A lightly edited transcript follows.

Dylan Matthews: The Abecedarian and Perry experiments provide pretty definitive evidence that individual preschool programs have strong effects, but Obama's been touting certain statewide programs like Oklahoma's. What's the evidence for those like?

James Heckman: I would be cautious. I'm instinctively cautious because I'm an academic. The Perry and ABC (Abecedarian) and some others, the nurse-family partnership, have not only had randomized trials, but have also followed people up for decades. The Perry people are now 50 years old. The ABC people, now they're close to 40. We actually can follow them in a way that the other programs don't follow their participants. The state programs have relatively short-term evaluation plans.

And I think, you're right, they're not randomized controlled trials, so I'm a little cautious. I don't find them as convincing. As far as I know they're not of the same quality. I have not personally relied on them. That's not to say they're bad programs, they just haven't been evaluated as thoroughly.

Look, a program that has been promoted strongly in Oklahoma, I do know and it's Educare, and it was primarily put forward by George Kaiser. And they're just now conducting evaluations of Educare, and I know because some of it is being conducted here in Chicago, by people I know and respect. Educare is based on a program that has been evaluated. It is an improvement on the Abecedarian program for which the results are highly favorable. Evidence from the Abecedarian program provides a solid "lower-bound" of what Educare's results will probably be.

The evaluations of the other Oklahoma programs are short run in nature and have not yet established long run benefits of the program, but they might appear.

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THE GLOBE AND MAIL

Ottawa woman gives autistic son to government after long delay for care

OTTAWA — The Canadian Press
Published Wednesday, May. 01 2013, 7:21 PM EDT
Last updated Wednesday, May. 01 2013, 7:31 PM EDT

An Ottawa mother says she was at her breaking point when she decided to drop off her son at a government office on Tuesday.

Amanda Telford says she can no longer care for her son, Philippe, 19, who has the mental capacity of a two-year-old and is non-verbal.

Telford says her son has wandered away from home several times over the last few weeks and she spent Monday at a hospital after he took prescription medication that he wasn't supposed to.

She took him to the Ottawa Office of Developmental Services Ontario, which is responsible for finding living arrangements for adults with developmental disabilities.

Philippe has been on the waiting list for a year and a half.

Telford is hopeful that delivering her son to the office will draw attention to their plight.

"I'm on medical leave from work," she said. "I am not able to keep this young man safe anymore."

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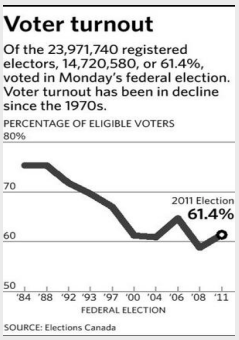

Children's Rights

- In Canada, 20% of children remain "vulnerable" → experiencing serious and chronic *multiple* adversities → experiencing avoidable *causes* and *consequences* of mental disorders

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Canada 17th out of 29 wealthy countries in child well-being index: Unicef - The Globe and Mail 15/05/13 9:06 AM

THE GLOBE AND MAIL

Canada 17th out of 29 wealthy countries in child well-being index: Unicef

The Canadian Press
Published Wednesday, Apr. 10 2013, 8:38 AM EDT
Last updated Wednesday, Apr. 10 2013, 9:25 AM EDT

Canada ranks 17th out of 29 so-called wealthy countries when it comes to the well-being of children, according to a new study from Unicef, the United Nations children's agency.

Unicef graded the 29 countries in five categories and Canada's best ranking was 10th in the area of housing and environment.

The UN agency placed Canada 14th in educational well-being, 15th in material well-being, 16th in behaviour and risks and a low 27th in health and safety.

Canada scored third-best on smoking, with Unicef saying only four per cent of children aged 11, 13 and 15 reported smoking at least once a week.

The same can't be said for cannabis, with Canada sitting 29th and last with 28 per cent of children saying they have used cannabis within the past year.

When it comes to obesity, Canada is third from the bottom, with 20.24 per cent of children aged 11, 13 and 15 deemed overweight based on the body mass index.

Canada ranked 21st in bullying, with 35 per cent of children aged 11, 13 and 15 report being bullied at school at least once in the past couple of months. Unicef also placed Canada 22nd in infant mortality.

David Morley, Unicef Canada's president and CEO, says the report shows there's a lot of work to be done.

"The fact that our children rank in the bottom half when compared to other industrialized nations simply isn't good enough," Morley said.

"It is clear Canada can do better. Protecting and promoting the well-being of our children must become a national priority."

The Netherlands remains the overall leader in the study and is the only country ranked among the top five

http://www.theglobeandmail.com/news/national/canada-17th-out-of-29-wealthy-countries-in-child-well-being-index-unicef/article10047576/ Page 1 of 2

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Global rankings: Although inequality between countries is falling, inequality within countries is rising - The Globe and Mail 15/05/13 9:06 AM

THE GLOBE AND MAIL

ROHINTON MEDHORA

Global rankings: Although inequality between countries is falling, inequality within countries is rising

ROHINTON MEDHORA
The Globe and Mail
Published Friday, Mar. 15 2013, 6:00 AM EDT
Last updated Friday, Mar. 15 2013, 6:00 AM EDT

The doyen of global rankings, the Human Development Index, computed by the United Nations once ripen, was released on Thursday. Canada has slipped a notch (to 11th place from 10th) since last year – but the real story is in the lower reaches of the rankings.

Every country in the world where the data exist has a higher human development score today than it did in 2000, with developing countries' scores growing faster. The gains are evenly spread across the components of the index – income, life expectancy and education.

Behind the numbers lies the larger trend that also forms the theme of this year's report, The Rise of the South. The pace of change is impressive. China and India have doubled per capita output during the past 20 years, a rate twice as fast as that during the Industrial Revolution, and covering many more people.

The financial crisis of 2008 laid bare more than just the weak underpinnings of many Western economies. China, and before it other Asian Tigers such as South Korea and Malaysia, underwent transformation at eye-popping rates of economic growth and poverty reduction. None of these countries did so with any discernible influence from liberal Western nostrums.

While much of the West – with Canada an important exception – continues to be mired in economic and political gridlock, Asian and many Latin American economies have slowed down more modestly. And what has come to be known as the African renaissance of 5 per cent or higher growth rates and greater democratization that started 15 years ago proceeds apace.

In short, the countries of the world are converging; risks to global stability lie not only in its dicey far-flung corners but at the failing, yet still salient, epicentres of the U.S. and Western Europe; and no region or school of thought has a monopoly on good ideas for growth and human development.

This suggests four broad trends for policy and scholarship.

http://www.theglobeandmail.com/commentary/global-rankings-although-ineq...ents-is-falling-inequality-within-countries-is-rising/article8788115/ Page 1 of 2

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Tasered B.C. boy was failed by system, children's rep says - The Globe and Mail 13-05-09 12:58 AM

THE GLOBE AND MAIL

CHILD WELFARE

Tasered B.C. boy was failed by system, children's rep says

DIRK MEISSNER
VICTORIA — The Canadian Press
Published Thursday, Feb. 07 2013, 2:34 PM EST
Last updated Thursday, Feb. 07 2013, 8:46 PM EST

Children in British Columbia with complex-care needs that can manifest themselves in violent rages deserve more from the child welfare system than being locked in windowless rooms or tranquilized by doctors, says a report detailing the failed care of an 11-year-old boy who was zapped by an RCMP taser.

Serious errors made by the Ministry for Children and Family Development left the boy open to abuse and neglect in his family home and in the numerous other homes where the ministry placed him, said the report released on Thursday by B.C.'s children's representative Mary Ellen Turpel-Lafond.

One foster family regularly kept the boy locked in a shed on a rural property. Another put him in cold showers to punish him for wetting his bed, and his parents raised him for the first two years of life in an atmosphere of domestic violence, alcohol abuse, starvation and neglect, the report stated.

The report, "Who Protected Him? How B.C.'s Child Welfare System Failed One Of Its Most Vulnerable Children," finds 20 critical injury reports involving the boy, including nine injury reports after the April, 2011, police Taser incident in Prince George that made national headlines.

"The sad reality of this report is that the Tasering by the police of this boy at 11 years old is probably one of the least traumatic things that happened to him when I look at the 20 critical incidents reported to my office, including nine since the Tasering," Ms. Turpel-Lafond said at a news conference.

The report states the taser incident occurred in April, 2011, six days after the boy was moved to a new group home, his 15th move since 2001.

The incident escalated after the boy barricaded his bedroom door and escaped through a window. About an hour later, he was located in a nearby trailer stabbing at the walls and upholstery with two steak knives he found there, stated the report.

The boy stabbed the group home manager below the 8th after climbing out of the trailer's window and fled to another home. Three RCMP officers arrived shortly afterward, and after a standoff during which the boy continued to hold one of the knives, he was jolted as he dropped out of the home.

http://www.theglobeandmail.com/news/british-columbia/tasered-bc-boy-was-failed-by-system-children-rep-says/article4654706/ Page 1 of 3

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Second case within a week in which the culprit is too young to be locked up

Boy, 11, 'cuffed for car theft

Vancouver police say they were surprised that the boy driving a stolen car could see over the steering wheel, he was so small. Witnesses reported the car lurching out of control, narrowly missing a pedestrian **Story, A3**

Jason Payne — The Province

PROVINCE PHOTO EXCLUSIVE Vancouver police interview an 11-year-old they say was at the wheel of a stolen car being driven erratically in East Vancouver Wednesday night. They say his two accomplices, aged 12 and 13, made him drive because he's too young to be charged.

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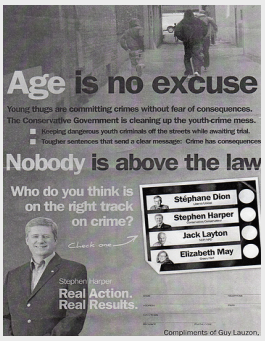

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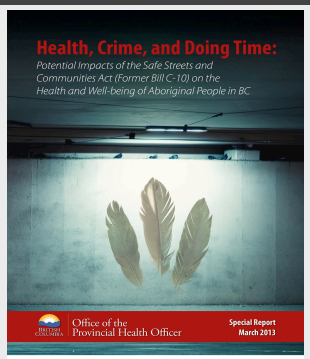
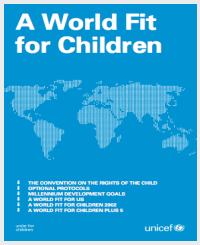


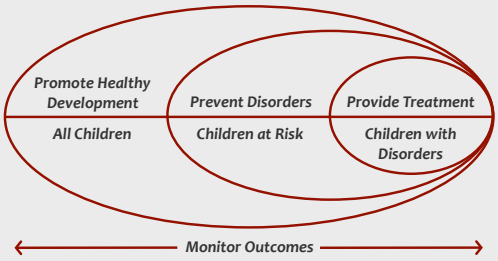
Implications for Policy and Practice

Children's Rights Revisited

- *UN Convention on the Rights of the Child* (1989)
- All children have rights
  - To safety + nurturing
  - To opportunities to thrive
  - To the conditions that create good mental health
- All children are a collective responsibility that we all share



Population Health Approach for Children's Mental Health



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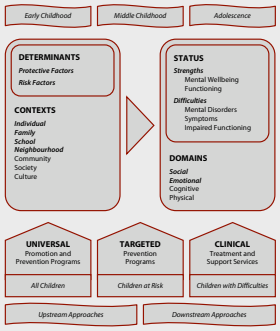

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Building on Positive Examples

- Advocating for children, starting early in life, e.g., BC, other provinces/territories, First Nations across Canada
- Coordinating children's services, e.g., Manitoba
- Making children's mental health plans, e.g., BC, Ontario
- Forging research-policy-practice partnerships to effect change, e.g., BC, Manitoba, Ontario, Nova Scotia
- Making new prevention investments, e.g., BC
  - *FRIENDS* → being offered to all children in BC schools
  - *Nurse-Family Partnership* → being evaluated across BC

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"Children are the living messages
we send to a time we will not see."

(Postman, 1994)

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Thank You!

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