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Children's Mental Health Policy

For the One and the Many

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1. Premises

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Childhood

Prenatal – Pre-conception through birth

Infancy – Birth through 12 months

Preschool – 1–5 years

School-age – 5–12 years

Adolescence – 12–18 years

↓

Adulthood – 18 years + beyond

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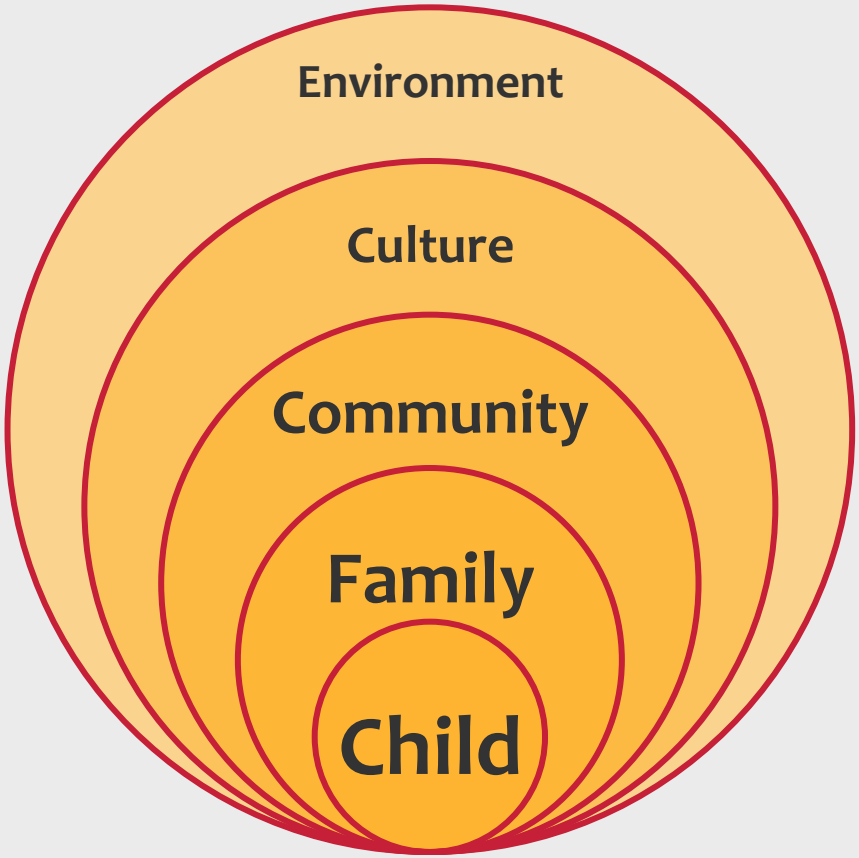
Children in Relationships



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Children's Mental Health

- Social and emotional wellbeing
  - A resource for living and learning
  - Essential for all children to flourish and reach their potential
  - Crucial together with physical and cognitive development

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Policy

"Policymaking 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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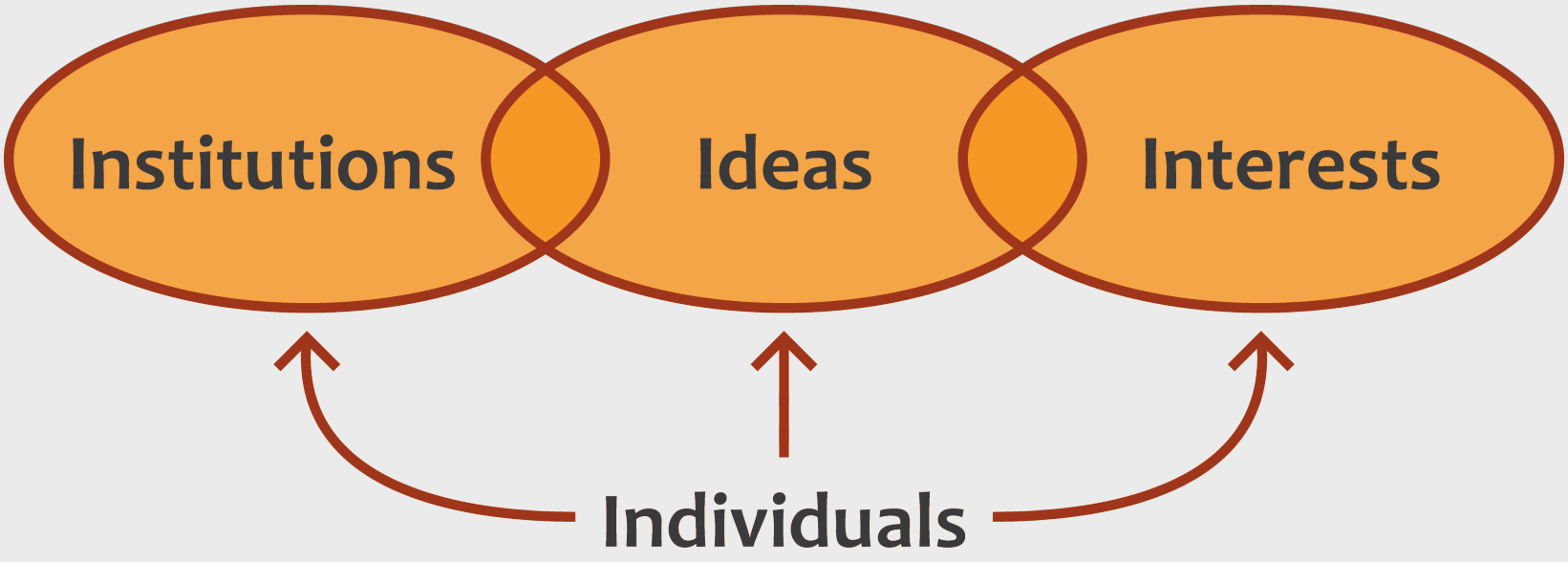
Influences on the Policy Process



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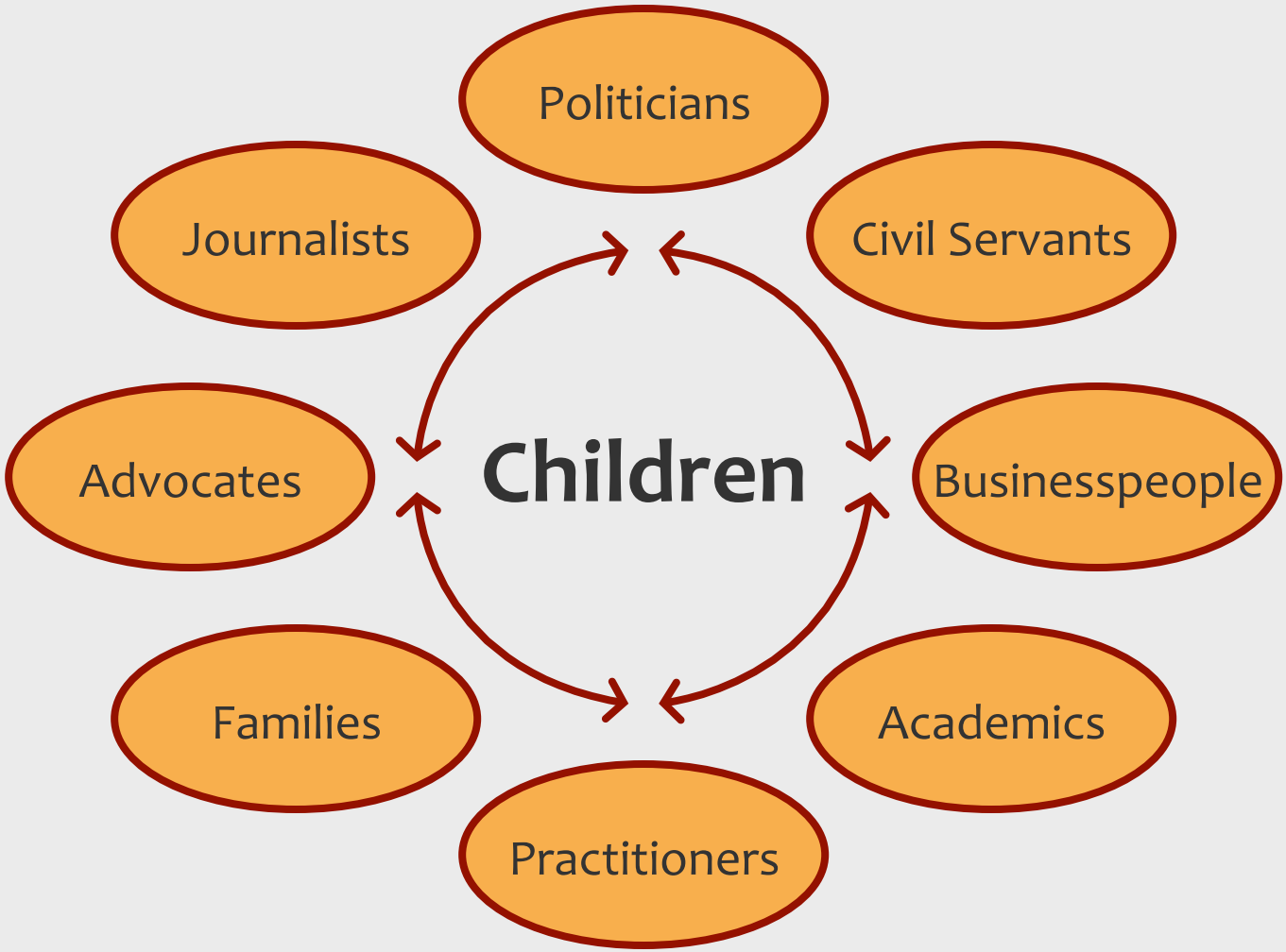

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Children's Mental Health Policy

- Levels
  - Legislative, administrative, clinical / practice
- Jurisdictions
  - National, provincial, regional, municipal / community
- Sectors
  - Public health, primary healthcare, education, community services, child welfare and foster care, youth justice, healthcare including hospitals, income support programs

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CITIZENS

↕

GOVERNMENT

| Minister (elected)

| Deputy Minister (appointed)
| Assistant Deputy Ministers (recruited)
| Executive Directors (recruited)
| Directors (recruited)
| Policy Analysts (recruited)

Independent Officers of the Legislature (appointed)

| Practitioners (recruited/self-employed)

↕

CHILDREN + FAMILIES

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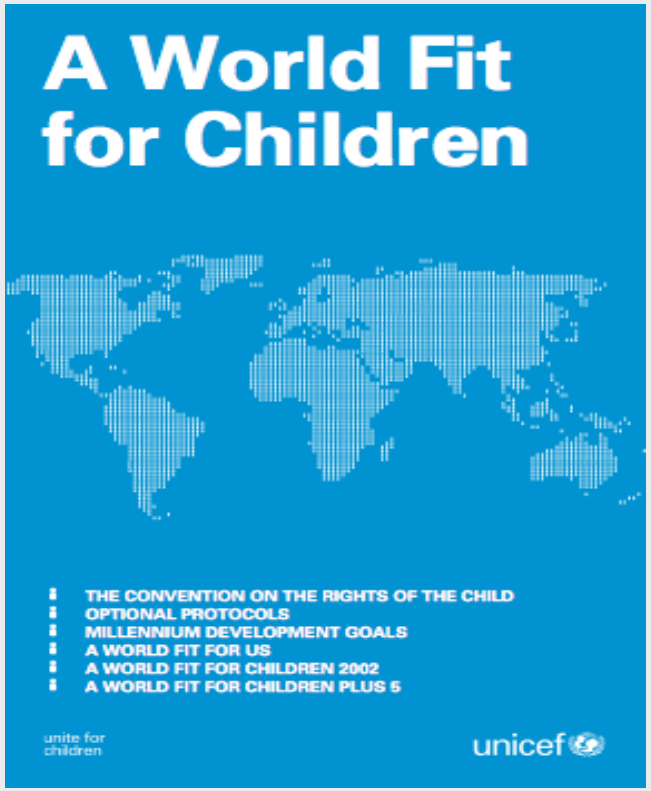
Children's Rights

- *UN Convention on the Rights of the Child* (1989)
  - All children have rights to safety and nurturing, and to opportunities to flourish and contribute
  - All children are a collective responsibility



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2. Policy Problems

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Children's Mental Health for the One

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Melissa

- First Nations girl (15) raised in a remote village, who had moved to town to attend high school
- With peers – while very drunk – conducted a break-in
- A senior citizen was badly assaulted when he came home and found the young people
- Melissa turned herself to police, although peers did not, was charged with assault and sent to custody in the city
- Mental health consultation was sought regarding criminal sentencing (youth vs. adult)

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Melissa

- When seen by the mental health team in custody, Melissa disclosed a lengthy history of parental substance misuse and neglect and violence at home
- She described often being the primary caregiver for her younger siblings until she moved
- She described liking school initially, but having no one to encourage her, so her grades gradually declined
- She also disclosed being sexually assaulted in her village by a group of boys who were never charged

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Melissa

- She was overwhelmed with remorse and sadness – "I want to die – how could I have hurt that old man?"
- Reached by phone, her mother said she struggled, too
  - It was hard to stay sober, fighting off depression and dealing with Melissa's father's drinking and violence
  - Money was a serious problem as were few jobs in the village
  - She wished she had known more about parenting before she had Melissa – "She carried the brunt of my mistakes"
- The village priest said – "I live on the edge of two decaying cultures"

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Melissa

- Mental health diagnoses were made
  - Child maltreatment, anxiety, depression, substance misuse
- Interventions were provided
  - School, traditional carving, basketball, mentoring with elders, psychotherapy
- Melissa started excelling academically, connecting with elders, making plans to pursue higher education
- The anxiety and depression resolved

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Melissa

- Melissa received a youth sentence and was later released into a supportive foster home in the city
- She was able to connect with her mother and siblings
- She pursed post-secondary education
- Her village elders then offered to create a traditional healing circle for her to make amends to her community
- But she declined, asking *them* to make amends to her

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Prevalence of Mental Disorders in Young People

			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	11–17	8,400	66,400
Conduct Disorder	2.1	4–17	14,000	113,000
Major Depressive Disorder	1.6	4–17	10,600	86,100
Autism Spectrum Disorder	0.6	4–17	4,000	32,300
Bipolar Disorder	0.6	11–17	2,100	16,600
Eating Disorders	0.2	11–17	700	5,500
Schizophrenia	0.1	11–17	300	2,800
Any Disorder	**12.6**	**4–17**	**83,700**	**677,900**

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Impact of Childhood Mental Disorders

- Profound adverse *individual* consequences
  - Enormous distress, social exclusion, costs for children, families
  - Most disorders start in childhood then *persist* into adulthood, leading to reduced life chances including reduced education, underemployment, increased physical health problems, increased early mortality

(e.g., Kessler, Fergusson, Rutter, World Health Organization)

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Impact of Childhood Mental Disorders

- Profound adverse *collective* consequences
  - Leading cause of lifelong disability worldwide
  - Costs estimated to exceed $50 billion annually in Canada
  - Many costs are avoidable, e.g., preventing one case of conduct disorder yields $ USD 2–5 million ($ CAD 2.7–6.7 million)
    - Averted costs childhood → adulthood
    - Healthcare, child protection and foster care, special education, income assistance, justice system (police, court, custody, victims' services) costs

(e.g., World Health Organization, various; Lim, 2008; Cohen, 2009)

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Children's Mental Health Service Shortfalls

12.6 % or **700,000** or **1 in 8 –** Canadian children with disorders

84,000 – BC children with disorders

70 % or **500,000 –** Children in need, not being treated in Canada

58,000 – Children in need, not being treated in BC

These shortfalls would never be tolerated for childhood infectious diseases, diabetes or cancer – and should no longer be tolerated for children's mental health

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Inefficiencies Exacerbating the Shortfalls

- Many effective interventions remain unavailable
  - Cognitive-behavioural therapy (CBT) for prevention, treatment
  - Parent training for prevention, treatment
- Ineffective or harmful treatments persist
  - Inappropriate physician prescribing, e.g., antipsychotics
  - Isolating children with deviant peers, e.g., custody
- Services remain fragmented
  - Across levels, jurisdictions, sectors
  - Across disciplines, children's ages, diagnoses

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Is It a Shortage of Money?

- ~ $220 billion total annual health spending in Canada
  - Public-sector share = 70% or $150 billion
  - $1,000 – $25,000 per Canadian (average = $6,100)
  - 95% goes towards health*care* (45% for Canadians > 65 years)
  - 5% goes towards public health (promotion and prevention)
  - 40% of provincial budgets now go towards healthcare

(Canadian Institute for Health Information, 2015)

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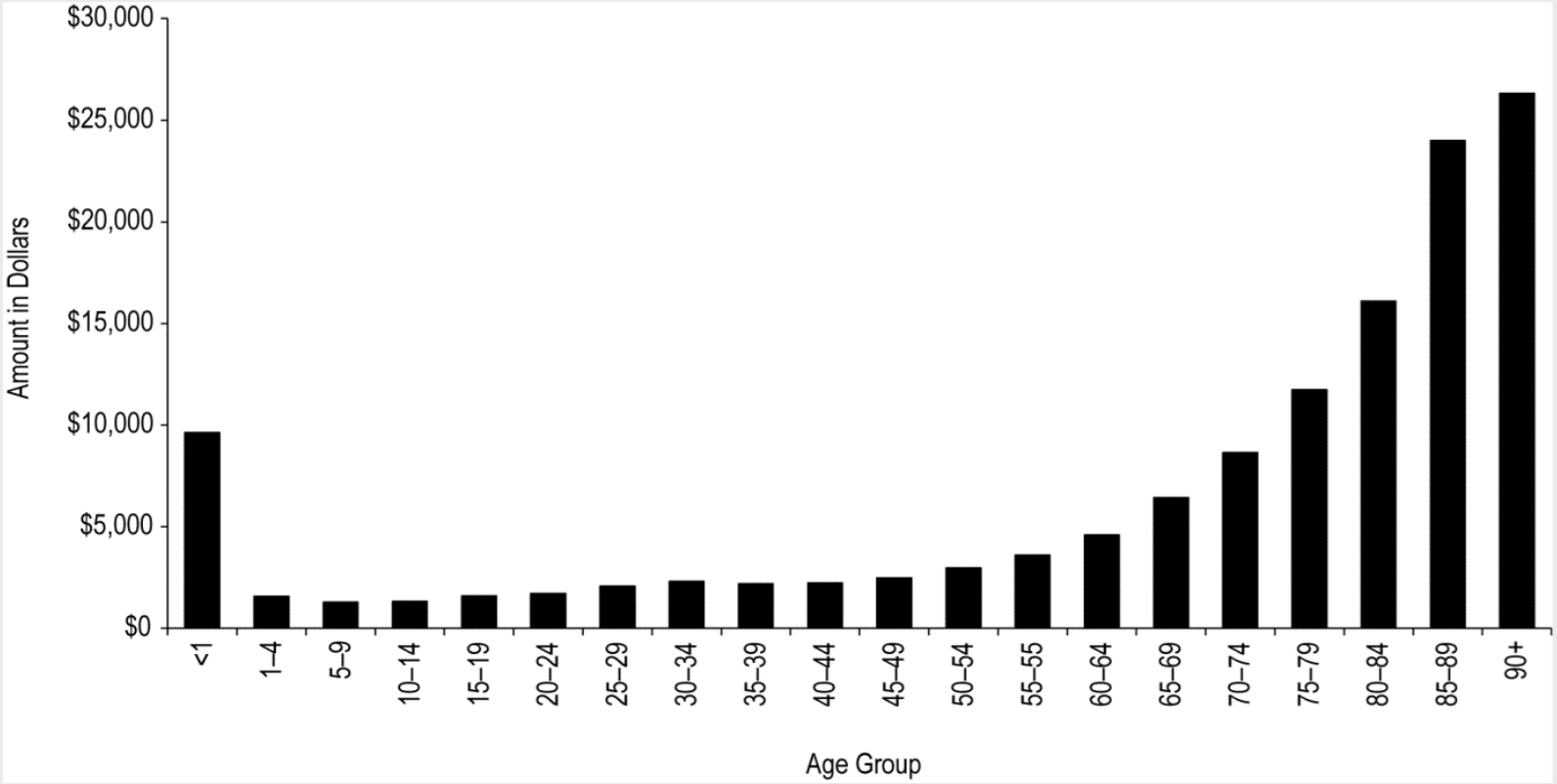
Health Spending in Canada



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Exposing Canada's ugly mental-health secret

ANDRÉ PICARD
The Globe and Mail
Published Sunday, Oct. 13 2013, 5:00 PM EDT

Imagine for a moment that you have a child or teenager who is suicidal, suffering from depression, severe anxiety, an eating disorder, a drug addiction or another mental-health problem. What do you do?

Canadian parents face this every day. The well-to-do pay. The middle-class scrape together the money the best they can, sacrificing so their child can get care. And those without the means wait, or do without care.

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Social Determinants of Children's Mental Health

- Socioeconomic inequities
  - 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, including antisocial behaviour, anxiety, depression, substance misuse

(e.g., Marmot, Wilkinson, Power, ACES studies, Rutter, Hertzman)

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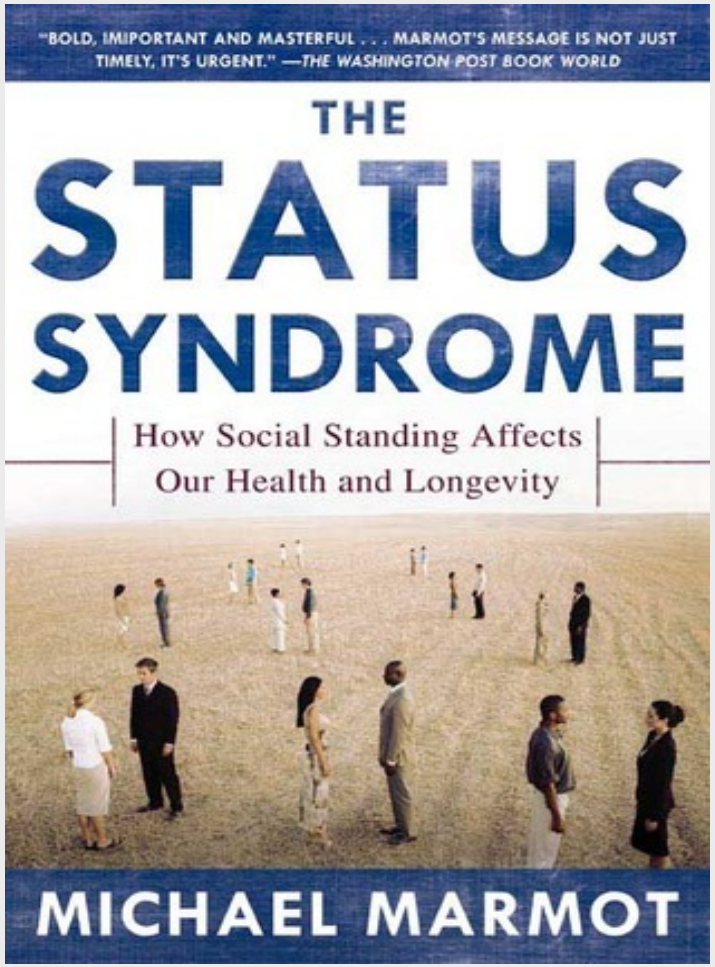

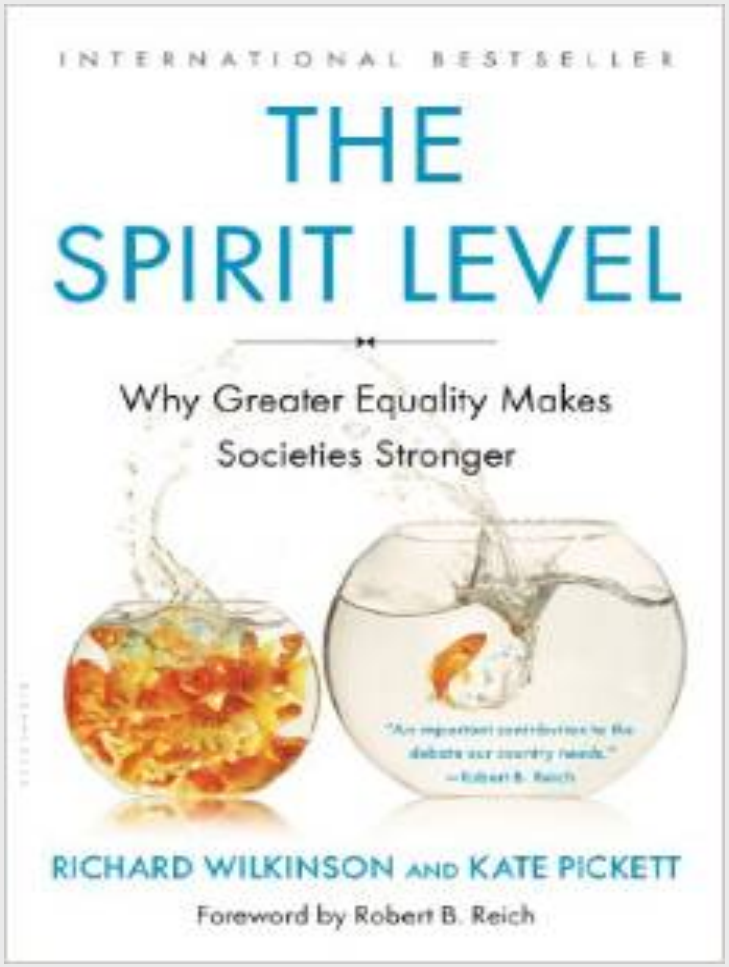

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ORIGINAL CONTRIBUTION

Relationships Between Poverty and Psychopathology

A Natural Experiment

E. Jane Costello, PhD
Scott N. Compton, PhD
Gordon Keeler, MS
Adrian Angold, MRCPsych

Context Social causation (adversity and stress) vs social selection (downward mobility from familial liability to mental illness) are competing theories about the origins of mental illness.

Objective To test the role of social selection vs social causation of childhood psychopathology using a natural experiment.

Design Quasi-experimental, longitudinal study.

Population and Setting A representative population sample of 1420 rural children aged 9 to 13 years at intake were given annual psychiatric assessments for 8 years (1993-2000). One quarter of the sample were American Indian, and the remaining were predominantly white. Halfway through the study, a casino opening on the Indian reservation gave every American Indian an income supplement that increased annually. This increase moved 14% of study families out of poverty, while 53% remained poor, and 32% were never poor. Incomes of non-Indian families were unaffected.

Main Outcome Measures Levels of *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition,* psychiatric symptoms in the never-poor, persistently poor, and ex-poor children were compared for the 4 years before and after the casino opened.

Results Before the casino opened, the persistently poor and ex-poor children had more psychiatric symptoms (4.38 and 4.28, respectively) than the never-poor children (2.75), but after the opening levels among the ex-poor fell to those of the never-poor children, while levels among those who were persistently poor remained high (odds ratio, 1.50; 95% confidence interval, 1.08-2.09; and odds ratio, 0.91; 95% confidence interval, 0.77-1.07, respectively). The effect was specific to symptoms of conduct and oppositional defiant disorders. Anxiety and depression symptoms were unaffected. Similar results were found in non-Indian children whose families moved out of poverty during the same period.

Conclusions An income intervention that moved families out of poverty for reasons that cannot be ascribed to family characteristics had a major effect on some types of children's psychiatric disorders, but not on others. Results support a social causation explanation for conduct and oppositional disorder, but not for anxiety or depression.

JAMA. 2003;290:2023-2029 www.jama.com

THE ASSOCIATION BETWEEN POVERTY and mental illness has been described throughout the world and throughout history.[1-9] Clinicians and researchers have noted the difficulty of untangling the effects of "social causation, . . . adversity and stress associated with low social statuses" from those of "social selection, [which] posits that genetically predisposed persons drift down to or fail to rise out of" poverty.[10]

Recent research has emphasized the role played by genetics in an individual's vulnerability to a wide range of psychiatric disorders. Social selection is an example of a theory consistent with gene-environment correlation, in that affected individuals, and often their family members with them, drift down into poverty (and thus into environments that in themselves increase risk for mental illness), while social causation theories reflect a gene-environment interaction in which genetic risk remains latent unless individuals are exposed to the stress of poverty, often by situations beyond their control. The distinction can be important in suggesting different strategies for prevention or treatment.[11]

For editorial comment see p 2063.

Disentangling the effects of social causation and social selection ideally requires an experimental design that manipulates poverty levels and studies the effects on mental illness.[11] Income ex-

Author Affiliation: Developmental Epidemiology Program, Duke University Medical School, Durham, NC. **Corresponding Author and Reprints:** E. Jane Costello, PhD, Department of Psychiatry and Behavioral Sciences, Box 3454, Duke University Medical School, Durham, NC 27710 (e-mail: jcostell@psych.mc.duke.edu).

ORIGINAL CONTRIBUTION

Association of Family Income Supplements in Adolescence With Development of Psychiatric and Substance Use Disorders in Adulthood Among an American Indian Population

E. Jane Costello, PhD
Alaattin Erkanli, PhD
William Copeland, PhD
Adrian Angold, MRCPsych

Context In a natural experiment in which some families received income supplements, prevalence of adolescent behavioral symptoms decreased significantly. These adolescents are now young adults.

Objective To examine the effects of income supplements in adolescence and adulthood on the prevalence of adult psychiatric disorders.

Design Quasi-experimental, longitudinal.

Population and Setting A representative sample of children aged 9, 11, or 13 years in 1993 (349 [25%] of whom are American Indian) were assessed for psychiatric and substance use disorders through age 21 years (1993-2006). Of the 1420 who participated in 1993, 1185 were interviewed as adults. From 1996, when a casino opened on the Indian reservation, every American Indian but no non-Indians received an annual income supplement that increased from $500 to around $9000.

Main Outcome Measures Prevalence of adult psychiatric disorders and substance use disorders based on the *Diagnostic and Statistical Manual of Mental Disorders* in 3 age cohorts, adjusted for age, sex, length of time in the family home, and number of Indian parents.

Results As adults, significantly fewer Indians than non-Indians had a psychiatric disorder (106 Indians [weighted 30.2%] vs 337 non-Indians [weighted 36.0%]; odds ratio [OR], 0.46; 95% confidence interval [CI], 0.30-0.72; $P=.001$), particularly alcohol and cannabis abuse, dependence, or both. The youngest age-cohort of Indian youth had the longest exposure to the family income. Interactions between race/ethnicity and age cohort were significant. Planned comparisons showed that fewer of the youngest Indian age-cohort had any psychiatric disorder (31.4%) than the Indian middle cohort (41.7%; OR, 0.43; 95% CI, 0.24-0.78; $P=.005$) or oldest cohort (41.3%; OR, 0.69; 95% CI, 0.51-0.94; $P=.01$) or the youngest non-Indian cohort (37.1%; OR, 0.66; 95% CI, 0.48-0.90; $P=.008$). Study hypotheses were not upheld for nicotine or other drugs, or emotional or behavioral disorders. The income supplement received in adulthood had no impact on adult psychopathology.

Conclusion Lower prevalence of psychopathology in American Indian youth following a family income supplement, compared with the nonexposed, non-Indian population, persisted into adulthood.

JAMA. 2010;303(19):1954-1960 www.jama.com

IN 2003 WE PUBLISHED THE RESULTS of a natural experiment in which an income supplement given to all members of one community but to none in another predicted significantly fewer adolescent psychiatric symptoms in the income-supplement group.[1] At the time of the earlier study, the participants were adolescents living at home. They are now adults and in receipt of their own income supplement. This article assesses whether the effects of the family income supplement persist into adulthood, controlling for past and current risk and protective factors, including poverty.

METHODS

Setting and Population

The Great Smoky Mountains Study is a longitudinal study of the development of psychiatric and substance use disorders in rural and urban youth.[2,3] In 1993, a representative sample of 1420 children aged 9, 11, and 13 years at intake was recruited from some 12 000 children of these ages living in 11 counties in western North Carolina, using a household equal probability, accelerated cohort design.[4] Parents of a random sample of 3896 non-Indian youth responded to a brief telephone questionnaire about their child's behavioral problems (FIGURE).[3] All those scoring in the top 25% (1009) and 1 in 10 of those scoring in the lower 75% (337) were invited to joint the study.

American Indian children were oversampled. Potential participants were

Author Affiliations: Developmental Epidemiology Program and Department of Psychiatry and Behavioral Sciences, Duke University Medical School, Durham, North Carolina. **Corresponding Author:** E. Jane Costello, PhD, Department of Psychiatry and Behavioral Sciences, PO Box 3454, Duke University Medical School, Durham, NC 27710 (jcostell@psych.duhs.duke.edu).

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Gene-Environment Interactions

- Dunedin longitudinal studies
  - "Low-MAO-A" genotype + child maltreatment → conduct disorder
  - *Both* genotype *and* maltreatment required → "G X E"
- Similar relationships shown for other disorders
- Mechanisms likely involve variations in gene expression in response to environmental stressors over time

(e.g., Caspi, Cicchetti, Uher)

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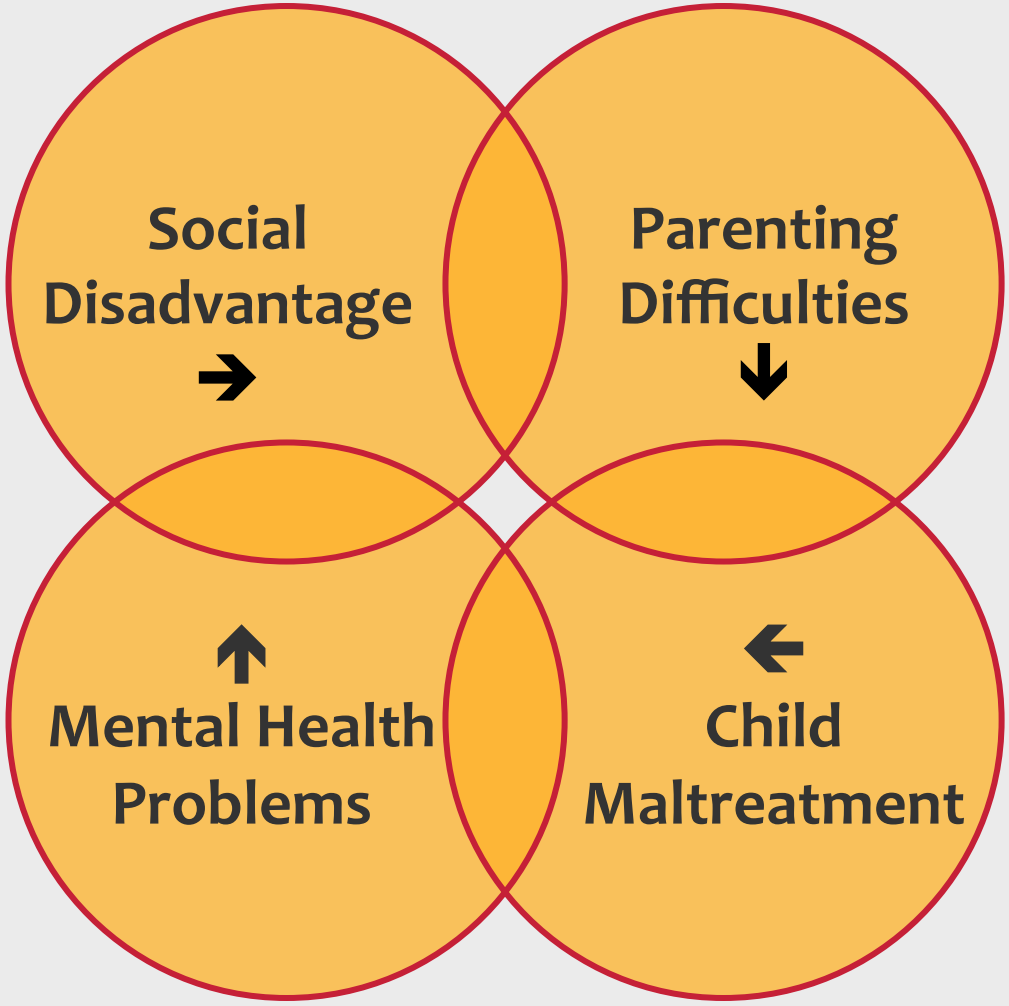

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"Socioeconomically disadvantaged children are two to three times more likely to develop mental health problems. Early childhood interventions as well as a reduction in socioeconomic inequalities at a societal level are needed to improve mental health in childhood."

(Reiss, 2013)

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Socioeconomic Inequities in Canada

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Socioeconomic Inequities in Canada

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TIMES COLONIST

B.C. has Canada's highest inequality of wealth: report

Chad Skelton / Vancouver Sun
September 11, 2014 08:54 AM

• Times Colonist • (b-c)

False Creek, Vancouver: The top 10 per cent of B.C. families have more the half the province's wealth, according to a report from the Broadbent Institute. Photograph By Darryl Dyck

The richest 10 per cent of B.C. families have more than half of the province's wealth, according to a new report from the left-leaning Broadbent Institute.

In contrast, the bottom half of the province has just three per cent of the wealth.

That gives B.C. the highest rate of wealth inequality in the country: In B.C., the richest 10 per cent of families control 56 per cent of the province's wealth, compared to 48 per cent for the country as a whole.

The top tenth's share of all wealth is lowest in the Atlantic provinces (32 per cent) and in Quebec (43 per cent).

The Broadbent report is based on survey data collected by Statistics Canada in 2012, which asked Canadians about their net worth. Net worth is the amount of money a family would have if they sold off all their assets and paid off all their debts.

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Poverty in Canada has 'child's face,' UN says

The Canadian Press Posted: May 29, 2012 3:40 PM ET

Canadians should be doing much more for children growing up in poverty, according to a new UNICEF report that finds Canada lags many other advanced countries. The report by the United Nations child advocacy agency ranks Canada 18th out of 35 industrialized countries when child-poverty rates are compared with overall poverty rates. In addition, Canada is in the bottom third — at 13.3 per cent — when it comes to the percentage of kids in poverty — a slight improvement over the past five years. “The face of poverty in Canada is a child's face,” UNICEF Canada's executive director David Morley said Tuesday. “This is unacceptable.”

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3. Policy Prospects

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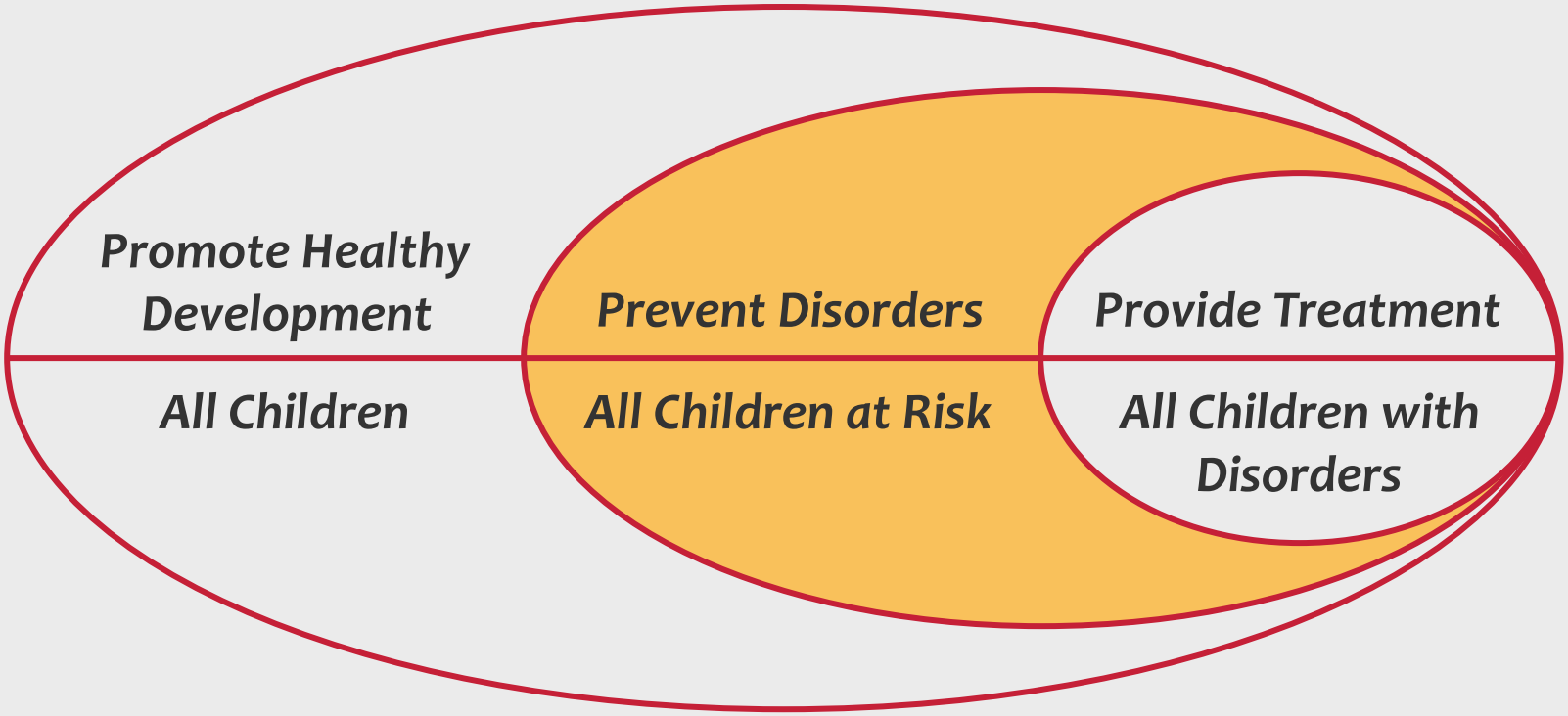
Population Strategy for Children's Mental Health



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"High 5" Preventable Disorders

			Estimated Population Affected	
Disorder	Prevalence (%)	Age (y)	Ontario	Canada
Anxiety Disorders	**3.8**	**4–17**	**80,200**	**204,800**
ADHD	**2.5**	**4–17**	**52,800**	**134,800**
Substance Misuse	**2.4**	**11–17**	**26,000**	**65,100**
Conduct Disorder	**2.1**	**4–17**	**44,300**	**113,200**
Major Depression	**1.6**	**4–17**	**33,800**	**86,200**
Autism Spectrum Disorder	0.6	4–17	12,700	32,300
Bipolar Disorder	0.6	11–17	6,500	16,300
Eating Disorders	0.2	11–17	2,200	5,400
Schizophrenia	0.1	11–17	1,100	2,700
Any Disorder	**12.6**	**4–17**	**266,000**	**679,100**

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Effective Prevention Programs

- **Anxiety** – Improve child coping, e.g., CBT-based *FRIENDS*
- **ADHD** – Improve parenting, e.g., *Incredible Years*
- **Substance Misuse** – Improve parenting and child coping, e.g., *Strengthening Families*
- **Conduct Disorder** – Improve parenting, e.g., *Nurse-Family Partnership, Incredible Years, Triple P, Parent Management Training*
- **Depression** – Improve child coping, e.g., CBT-based *Coping with Stress*

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"Early interventions targeted toward disadvantaged children have much higher returns than later interventions – such as reduced pupil-teacher ratios, public job training, convict rehabilitation programs, tuition subsidies, or expenditures on police. Society currently overinvests in remediation at later ages and underinvests in the early years"

(Heckman, 2006)

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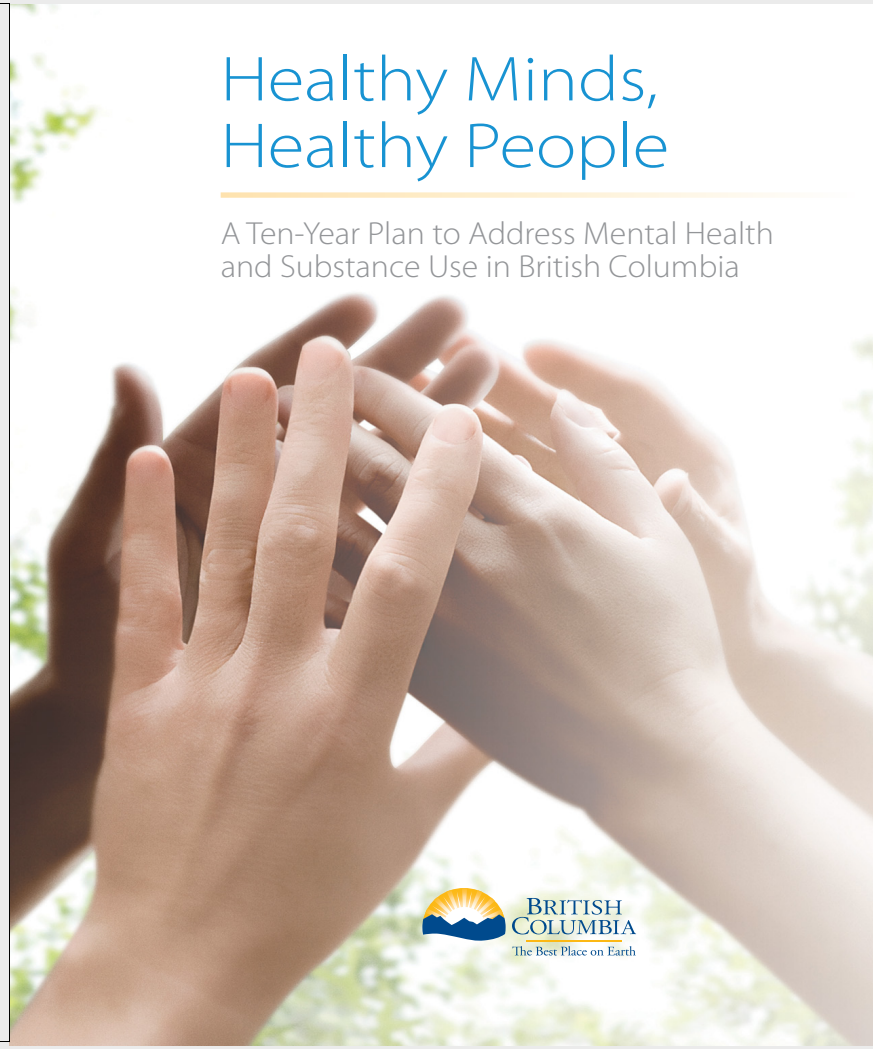
CHILD AND YOUTH MENTAL HEALTH PLAN FOR BRITISH COLUMBIA

February, 2003



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Improving Children's Mental Health

1. **Triple** investments in treatment services to reach *all* children with mental disorders, not just the current 30%
2. **Provide** a coordinated and comprehensive range of *effective* treatments at each stage of development → prenatal → childhood → adolescence
3. **Add** new investments so all children at risk can access effective *prevention* programs, reducing incidence and reducing the need for treatment services
4. **Monitor** child *outcomes* in the population

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4. Policy Exemplars

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Children with Autism

"You have to advocate for your child until they can advocate for themselves."

(Parent Participant; Shepherd, 2015)

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2014 Estimates	BC	Ontario
Number with a Mental Disorder (4–17 Years)	84,000	270,000
All Provincial Government Spending	$44 B	$127 B
Children's Mental Health (CMH) Spending (excluding ASD) (Children's Ministries; Health and Health Authority figures not available)	$79 M	$517 M
CMH Spending as Share of All Provincial Spending	**0.2 %**	**0.4 %**
Spending Per Child with Mental Disorder (excluding ASD)	**$900**	**$1,900**
Spending Per Child with ASD	**$6,000–22,000**	**$10,000**
Increases in ASD Spending in the Past 10 Years	**10 X**	**10 X**

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Children with Autism

"There's a backlash in society now. People are resentful that so much money's being spent on autism. What about kids with other mental health or developmental disorders? Well, I don't think we should not do something for some children because we can't do it for all. *We should be trying to do more for all*."

(Researcher Participant; Shepherd, 2015)

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Nurse-Family Partnership

- Intensive nurse home visiting with young, low-income, first-time parents, starting before children are born
  - Prenatal → child's 2nd birthday
- Significant benefits shown at post-test then over 15–20-year follow-up in 3 US randomized controlled trials
  - Reduced child maltreatment, child behaviour problems, youth crime, early mortality
  - Improved parenting, child cognitive development, maternal economic self-sufficiency

(Olds and Colleagues, 1983 – 2015)

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Nurse-Family Partnership

- Cost-effective over 10–15 years
  - Net $ USD 18,000 ($ CAD 24,000) gained for every child served
  - Net $3 – $6 gained for every $1 invested
- Reduced public spending across multiple sectors
  - Healthcare, child protection and foster care, special education, income assistance, justice system costs (children and mothers)

(Karoly, 2005; Lee, 2008)

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Nurse-Family Partnership

- First Canadian trial being conducted in BC (2011–2021)
  - 1,000 women and children being enrolled 2013–2016
  - Assessing prenatal substance use; child injuries, child mental health and child cognitive development at age two years; and maternal economic self-sufficiency at 24 months post-partum
- Partners
  - BC Ministry of Health; BC Ministry of Children and Family Development; Fraser, Interior, Island, Northern and Vancouver Coastal Health Authorities; Public Health Agency of Canada
  - SFU, McMaster University, UBC, University of Victoria

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FOR IMMEDIATE RELEASE

President Obama's 2010 Budget Funds Evidence-Based Home Visitation Program

Denver, CO (May 7, 2009) — The Federal Home Visitation Program is designed to support the establishment and expansion of evidence-based home visitation programs with federal matching grants to states and territories. The initiative would give priority to program models that have been rigorously evaluated and shown to have positive effects on critical outcomes for families and children. The President includes a total of **$8.6 B** over ten years for this initiative, with $124 M for fiscal year 2010.

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First Nations Children

"Aboriginal youth suicide rates vary substantially from one community to another. Yet youth suicide rates effectively drop to *zero* in those communities where at least half the members reported a conversational knowledge of their own 'Native' language."

(Hallett, 2007)

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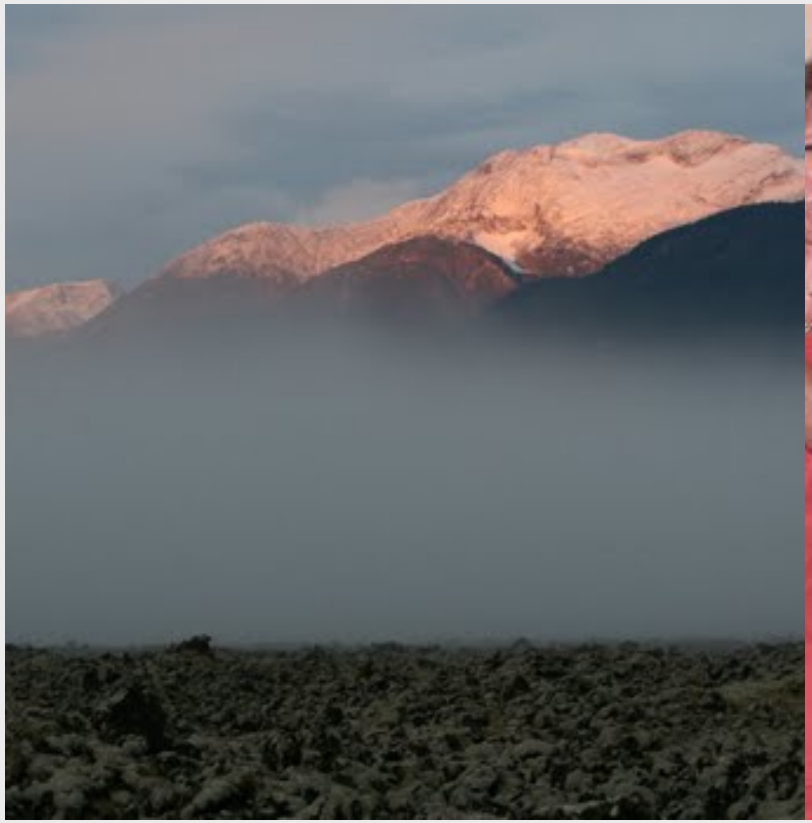
"We are a beacon of hope" (1999)



Charlotte Waddell 2016

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"Land, inland waters, sea, seabed and sky – we are all here to stay" (2005)

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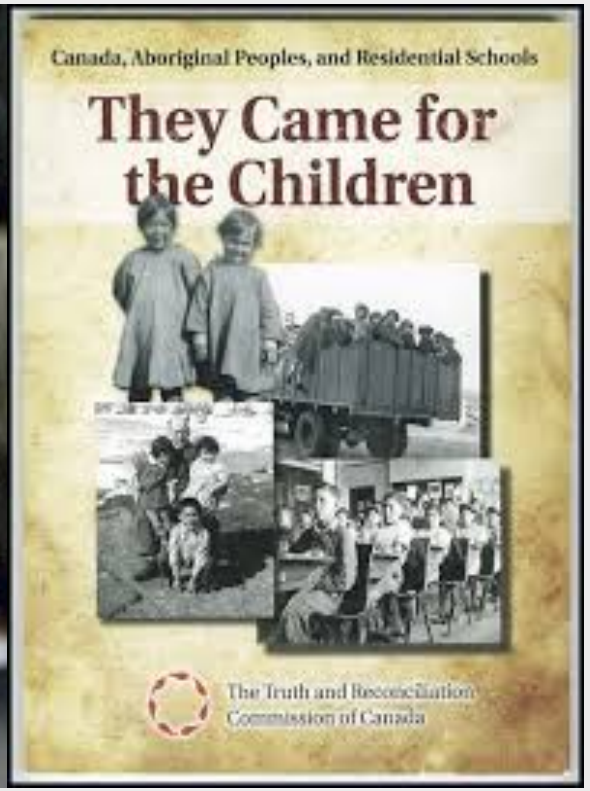
"Canada apologizes" (2008)



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THE GLOBE AND MAIL

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GLOBE EDITORIAL

Providing safe drinking water on reserves is simple. Just do it

The Globe and Mail
Published Tuesday, Oct. 13, 2015 6:30PM EDT
Last updated Wednesday, Oct. 14, 2015 12:03PM EDT

Last January, there were 1,669 Canadian towns under drinking water advisories. By far the most common were advisories to boil tap water for a minute before consuming it.

Thankfully, these advisories are usually lifted quickly, because municipalities are governed by provincial regulations that define clear lines of responsibility and lay out rules on how to respond to problems. It's rare for DWAs to last more than a few weeks.

On native reserves, however, they can go on for decades. It's easy to see why.

Drinking water on reserves is a federal jurisdiction. Ottawa provides 80 per cent of the funding; the local councils build and maintain the systems and are responsible for training the operators and doing regular testing.

So far, so good. But a complex set of regulations from three federal departments (Aboriginal Affairs, Health Canada and Environment Canada), combined with ambiguous guidelines regarding responsibility and enforcement – not to mention the inevitable squabbles over sovereignty – means problems can persist for years.

As a result, in July there were 133 Health Canada drinking water advisories in 126 First Nations communities. Ninety-three of them have been in place for more than two years. One-quarter have been ongoing for more than 10 years. And in a few communities, native residents have been boiling water since the 1990s.

These problems persist in spite of billions of dollars committed in federal budgets for the past 20 years ($3.5-billion from 1995 to 2008 alone, according to Aboriginal Affairs), as well as a 2013 federal law streamlining regulations and oversight. The failure to provide safe drinking water on reserves has become chronic.

This has to end. The next federal government should do an immediate audit of every troubled reserve system. It should then work directly with communities to fix the worst cases, and move on to the less urgent ones after that. If there are issues of sovereignty, local native governments and Ottawa should put

TIMES COLONIST

Comment: First Nations Health Authority moves ahead

Joe Gallagher / Times Colonist
February 5, 2016 08:07 AM

In October 2014, members of the First Nations Health Authority, First Nations Health Council and First Nations Health Directors Association were invited to participate in an auditor general's study to inform Parliament about the efforts undertaken by B.C. First Nations, Health Canada, and the province of B.C. to establish the FNHA in B.C.

The First Nations Health Governance Structure in B.C. welcomed the study and viewed it as both a useful third-party assessment and an opportunity to share our experience with First Nations from across Canada considering similar changes to their health-care services. Our leadership spent more than 50 hours with the auditor general over two weeks at our head offices on Coast Salish territory discussing our journey.

We discussed our governance structure, our consensus-building process, our directives and our current and future operating plans. The report confirms that a key success factor resulting from the process was the acknowledgement by B.C. and Canada that First Nations are entitled to the same level of health services as all provincial residents. This is an important recognition for First Nations communities across Canada and particularly timely considering the Canadian Human Rights Tribunal ruling last week that affirms inequity between on-reserve communities and other Canadians, and that action is needed in this regard.

Health-service gaps exist and have been exacerbated for First Nations communities by a federal obligation for health care through the Indian Act and due to the boundaries of on-reserve and off-reserve service delivery. However, under the Canada Health Act, each province is responsible for health services for all citizens residing within its boundaries.

Thus emerges a jurisdictional mix of responsibility and accountability that can leave First Nations communities lost in the middle of distant partners.

The events that led to the creation of Jordan's Principle and that continue to affect child welfare for First Nations children on-reserve are expressly related to the same jurisdictional issues found in their health-care services across Canada. Previous studies by the auditor general have recommended a new approach for First Nations control of their health services, working in partnership with federal and provincial governments.

This report endorses the B.C. tripartite health-transfer process as a sound approach to overcoming the structural impediments that result in poorer health outcomes for First Nations and acknowledges that, ultimately, FNHA is improving local service delivery on the ground in B.C. First Nations communities with our partners.

For the benefit of other First Nations communities across the country, this report confirms that the consensus-building work of B.C. First Nations was unprecedented in this country and that the ability for First Nations to "speak with one voice" has been instrumental to the success of our work in B.C.

aptn.ca / Aboriginal People's Television Network

During suicide debate Justice Minister says it's time for First Nations to shed Indian Act 'shackles'

By Jorge Barrera
APTN National News

Justice Minster Jody Wilson-Raybould said Tuesday the Trudeau Liberal government aims to "complete the unfinished business of Confederation" and replace the Indian Act with a "reconciliation framework" that would outlast the life of this administration. Wilson-Raybould didn't lead the government side in an emergency debate held late into the night which was triggered by a suicide crisis gripping the small fly-in community of Attawapiskat in Ontario's James Bay region. Yet, her speech was the only one that revealed the extent of the historical vision the Trudeau government has when it comes to reshaping the relationship between the state and the original inhabitants on this land. The Liberals aim to do nothing less than scrap the Indian Act.

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"Our public policy choices make statements about who we are as a society."

(Peter, 2007)

"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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