

Government Monitoring of the Mental Health of Children in Canada: Five Surveys (Part I)

Wade Junek MD, FRCPC^{1,2}

Abstract

Objective: Canadian governments spend billions of dollars yearly on programmatic interventions, intended to improve the mental health of children, without recommended monitoring of children's mental health. The Canadian Academy of Child and Adolescent Psychiatry monitored governments' progress in producing reports. **Method:** Five evolving surveys were done during 2002, 2004, 2005, 2006 and 2008. Initially, progress was monitored then later surveys examined challenges that inhibited monitoring, the need for a national strategy, an indicator framework and an agency to do the monitoring and the role of non-government organizations. The 2008 survey requested the three most important indicators governments desired, and created clarity in the definition of monitoring reports in contents, criteria, qualities of indicators and potential names. For comparison purposes, a Partnership Model to survey populations was evaluated. **Results:** Over five surveys, 13 of 14 governments affirmed the desire for monitoring and 64 publications were reviewed and categorized. No reports met criteria for 'monitoring reports'. The Partnership Model was used successfully in 11 Provincial-Territorial governments. **Conclusions:** It was reassuring that governments supported monitoring and were producing reports. The Partnership Model may offer a suitable alternative for governments. Results of 2006 and 2008, discussion, conclusions and references are in Part II.

Key words: government, population surveillance, mental health, children

Résumé

Objectifs: Au Canada les gouvernements dépensent chaque année des milliards de dollars pour mettre en place des programmes d'intervention destinés à améliorer la santé mentale des enfants, mais ne font pas de recommandations sur le suivi de la santé mentale de ces derniers. L'Académie canadienne de psychiatrie de l'enfant et de l'adolescent a procédé à un suivi des progrès des gouvernements et des rapports qu'ils publient. **Méthodologie:** Cinq sondages évolutifs ont été effectués en 2002, 2004, 2005, 2006 et 2008. À l'origine, les sondages portaient sur les progrès accomplis; par la suite, ils analysaient les problèmes qui nuisaient au suivi, le besoin de stratégie nationale, la mise en place d'indicateurs, la création d'une agence chargée du suivi, et enfin le rôle des organisations non gouvernementales. Le sondage de 2008 portait sur les trois principaux indicateurs demandés par le gouvernement, et clarifiait la notion de rapport de suivi, du point de vue du contenu, des critères, des qualités et du nom à donner aux indicateurs. Un modèle de partenariat destiné à sonder les populations a été évalué pour comparaison. **Résultats:** Dans les cinq sondages, 13 des 14 gouvernements ont demandé à avoir un suivi; soixante-quatre publications ont été analysées et classées par catégorie. Aucun rapport ne satisfaisait aux critères de rapport de suivi. Le modèle de partenariat a été utilisé avec succès dans 11 gouvernements provinciaux-territoriaux. **Conclusions:** Il est rassurant de constater que les gouvernements s'intéressent au suivi et produisent des rapports. Le modèle de partenariat peut être une solution acceptable pour les gouvernements. On trouvera dans la deuxième partie de cet article les résultats, les discussions, les conclusions et les références des sondages de 2006 et de 2008.

Mots clés: gouvernement, suivi de la population, santé mentale, enfants

¹Department of Psychiatry, Dalhousie University, Halifax, Nova Scotia

²IWK Health Centre, Halifax, Nova Scotia

Corresponding email: wade.junek@iwk.nshealth.ca

Submitted: November 27, 2010; Accepted: June 30, 2011

In writing about mental disorders in children Waddell et al noted, “no other group of disorders has such a profound effect on the development and wellbeing of children and youth, and on their families and communities” (Waddell, McEwan, Hua, Shepherd, 2002). They also summarized research from a number of epidemiological studies and estimated the prevalence of mental disorders at 14-27% with a general agreement that 20% of children may have moderate or severe mental disorders sufficient to impair functioning. Despite the high prevalence rates and profound effects, the number of children receiving specialized clinical services has been estimated at fewer than one in five in Canada (Offord et al, 1987 and Offord et al, 1989).

The combination of large prevalence rates and inability of clinical services ever to meet this rate strongly supported the need for population health approaches in addition to targeted and clinical approaches (Offord et al 1998). This paper, and its companion Part II, examined the attempts by governments to monitor the mental, emotional, behavioural and cognitive health status and functioning of infants, children and youth (‘mental health of children’).

In a 2005 review, Barnes described a long history of public sector monitoring in some countries and less to none in others (Barnes, 2005). Many countries did not have any overall governance organizing structure for children, which complicated the collection of data and attempts to find the relevant information in one central source.

A number of organizations (World Health Organization, International Society for Child Indicators, Child Trends, and The Annie E. Casey Foundation) and institutions (University of Chicago, Duke University) have promoted research on child mental health indicators and publication of reports (see respective references). UNICEF Innocenti Research Centre reported the use of positive indicators of mental well-being as a major trend over recent years (Lippman, Moore, McIntosh, 2009).

During 1999 and 2000, four Federal-Provincial-Territorial (F-P-T) committees published discussion documents (Health Canada, 1999a; Health Canada, 1999b; Health Canada, 2000a; Health Canada, 2000b) proposing and endorsing a need for monitoring children’s mental health. A further F-P-T Communiqué of a First Ministers’ meeting committed the signatory governments (Quebec exempted) to “make regular public reports on outcome indicators of child well-being using an agreed upon set of common indicators” (Government of Canada, 2000). Six of the 11 chosen indicators were relevant to the monitoring of mental health in early childhood development, ages 0–6 years (Government of Canada, 2002).

The federal government has participated in two large ongoing child mental health surveys. In the first, Canada participated in four of the seven survey years (four-year intervals) of the World Health Organization Collaborative Cross-national Study (WHO-CCS): Health Behavior in School-aged Children (HSBC), (11-, 13-, and 15-years old, over 7000 children per survey, questions from HSBC survey with added Canada-only questions) (Public Health Agency of Canada). In the second, Statistics Canada conducted the National Longitudinal Survey of Children and Youth (NLSCY) and collected data from over 35,000 children in biennial surveys from cycle 1 in 1994-1995 to cycle 7, 2006-2007 (Statistics Canada a). NLSCY data have been used by researchers to publish a wide variety of papers (Statistics Canada b) but have not given rise to regular child mental health indicator reports or to reports of trends over the survey years. For both NLSCY and HBSC, the numbers of children surveyed were inadequate to provide results useful for regions within the provincial and territorial (P-T) jurisdictions.

The need for monitoring arose from common themes. It was difficult to do the best policy making, priority setting, planning and resource allocation without information and feedback. It was not possible to know if there were changes in the mental health of children over time and between various jurisdictions (provinces, territories and their regions). Efforts to monitor children receiving services that may include some components of mental health were further complicated by the fact that these children were seen in various government departments including but not limited to: health, children and family, young offender, education, drug dependency and social services. In one document (Health Canada, December 2000 b) it was hypothesized that the present situation consisted of a collection of services and only the construction of components of feedback loops involving monitoring could allow the collection to evolve into a defined system despite the common, but incorrect, use of the word “system”.

In addition to direct public sector monitoring, beginning with the governments of Manitoba and British Columbia in partnership with a research centre, the Offord Centre for Child Studies, surveys were conducted using the Early Development Instrument (EDI) to assess children during their school entry year (age five). The EDI assessed 5 areas: social competence, emotional maturity, language and cognitive development, communication and general knowledge, and physical health and well-being (Offord Centre). By 2009, the partnership included another research organization, the Human Early Learning Partnership (HELP) (Human Early Learning Partnership) and the Council for Early Child Development (CECD), (Council for Early Child Development a). This collection of P-T governments, school boards, research centres and the CECD will hereafter be shortened to the Partnership Model. The ever expanding

Table 1. Survey of 14 Federal-Provincial-Territorial Governments—Overview

2002	Letter to Minister responsible for the mental health of children
2004	Designing the processes and steps leading to published reports
2005	Reviewing the progress of governments on their processes and steps
2006	Current monitoring and uses, challenges to monitoring and general comments
2008	Defining: desired indicators, reports and supportive environments

reach of this model was noted in the work of Janus of the Offord Centre in her maps of EDI use noted on the website of the CECD (Council for Early Child Development b).

The Canadian Academy of Child and Adolescent Psychiatry (CACAP) shared the beliefs about monitoring expressed in the F-P-T documents. In addition, the CACAP supported all levels of governments in the adoption of good governance practices whereby programme expenditures should be justified by monitoring outcomes. Across all 14 F-P-T governments, total expenditures for programmes expressly in existence to help all children achieve optimal mental health were over two billion dollars yearly (Dingwall, 1995). Given the above circumstances, in 2002 the CACAP, through its Advocacy Committee, decided to write all F-P-T governments to learn what indicators they were using to monitor the accountability for monies spent on interventions. Upon learning that the nine replying governments supported the concept but were not monitoring, the CACAP decided to begin a survey process that evolved over the years to learn more about the processes, challenges and goals of governments with respect to monitoring. The CACAP would examine the government's monitoring of the mental health of children.

Method

2002 Letter to the Minister Responsible for the Mental Health of Children

In 2002, a letter was sent to the 14 F-P-T Ministers responsible for the mental health of children with a simple accountability request, "What measurement(s) of the mental and emotional health and well-being of Canadian children and youth has your government adopted to provide accountability for monies spent in efforts to improve this status?"

Since all nine replying governments supported the concept and none had indicators they were monitoring for accountability, in 2004 the decision was made to enter into a survey process. The results of surveys along with plans for

the subsequent survey would be presented to the CACAP Advocacy Committee for comment and changes by members of the committee. The author was project leader doing the surveys, determining the recipients, searching their web sites for the appropriate department or ministry (department only will be used hereafter) and for publications, constructing the reports, reviewing and incorporating any suggestions from the Advocacy Committee and writing up all results. Two reminder letters were sent to any government that did not respond. All governments were offered the opportunity to contact the author by e-mail and receive the information in digital format for dissemination and reporting back.

2004 Purpose: Designing the Processes and Steps Leading to Published Reports

For 2004, the purpose was to begin a more regular survey process and learn the progress stages governments were using. In the absence of published reports, a number of items were identified as steps or factors defining and leading to a report (many came from the replies of governments to the 2002 letter). These were placed in a list with a 'Yes' (or other appropriate entry) in cells that were clear from the 2002 response. Governments were asked to correct, change or document their assessment of the status and progress with respect to the 20 items.

Table 2. Items for governments to self-rate their status on steps to producing monitoring reports

1. Had plans for indicators (Yes or No)
2. Had a committee producing indicators
3. Committee is inter- departmental/ministerial in membership
4. Provided locating information for chair or members of the committee
5. Had a list of indicators
6. Named measuring tools (if using a standardized survey instrument)
7. Rationale for choice of an indicator was explained
8. If using indices (construction and rationale explained)
9. Had indicators with actual statistics
10. Published report
11. Mailed a copy of report
12. Produced previous reports
13. Reports available on government website
14. Report showed year to year changes
15. Report showed within jurisdiction regional differences
16. Report allowed F-P-T comparisons
17. Indicators reflected mental, emotional and behavioral well-being of children
18. Expected interval between reports
19. Planned for incentives/ rewards for improvements over time
20. Please Note Any Additional Suggested Categories

2005 Purpose: Reviewing the Progress of Governments on their Processes and Steps

In 2005, collated results of the 2004 survey were sent to governments, asking for an update. In addition, two appendices were sent: a small bibliography of references with respect to monitoring the mental health of children and a chart of all available government reports collected by the author from government websites. Reports had to include a minimum five indicators relevant to the mental health of children. The author added comments categorizing the reports (lines 4, 5, 6 and 7 in Table 3). Governments were asked to update the publication list by adding more reports that the author may have missed and to offer reasons to change a listed report category. The collecting and assessing of reports now became a parallel purpose to the initial purpose of learning the intentions and stages of government in producing reports.

After the 2005 survey, it was clear that governments had difficulties producing monitoring reports and the surveys became biennial starting in 2006.

2006 Purpose: Examine Current Monitoring and Uses, Challenges to Monitoring and General Comments

The 2006 survey requested written answers and comments to general questions in three main sections. For each question, governments were asked to provide answers, examples and any additional comments.

1. Current monitoring uses and future goals:

- Does your government believe that it is important to learn about and monitor the mental health status of children and youth? (Yes or No).
- Current use: Do you have measures of the mental health of children that you use for monitoring and decision making at present? (A subsidiary question, since very few had regular measures, sought information on how government decision making was affected by having regional or temporal comparisons in their data.)
- Future goals: What plans do you have and what comparisons would you like to be able to make in the future? What decisions would this help?

Over 20 pages of written comments were received from the 12 governments responding in 2006. All specific items were extracted from responses to the questions related to current uses and future goals. The items were grouped into categories resulting in a table reporting on the number of items in a category with the number of governments that currently used or had future plans for a particular category. Further

details of the categories and some government quotes are reported in the results.

2. Challenges in monitoring:

- What were the major government and scientific challenges? A suggested list was constructed of items in both categories with an invitation to add others (Government: priority setting, funding, inter departmental coordination, skilled personnel, agency to do measuring) (Scientific: qualities to measure, selection of indicators and selection or creation of measurement tools).
- How much delay in actual measuring would result from these challenges? After reviewing the list, each item was rated in terms of effects on preventing or delaying the production of monitoring reports (Rated on a five point scale: 1=prevent, 2=delay by more than 2 years, 3=moderate and of concern but some monitoring is done, 4=mild, inhibits obtaining optimal results, 5=not a challenge, 0=not applicable).

The number of governments, identifying a particular government or scientific challenge (see above) and rating it as a 1 or 2, were counted, giving rise to a table and ordering of the main challenges from most difficult to least. Since governments with small populations could have quite different needs than those with large populations, for comparison purposes, an adjusted total was also created by removing the scores for governments with less than 500,000 people.

3. Additional comments and the role of non-government organizations:

- Did the government have any general comments about monitoring children's mental health, how data might be best collected and whether there was a need for the involvement of other organizations?
- How could non government organizations (NGOs) such as CACAP and others be most helpful with respect to the development of monitoring reports by governments and with respect to the overall efforts of governments to improve the mental health of children?

The first question about monitoring gave rise to very similar recommendations from many governments and led to a closer examination in 2008. Thus, information from 2006 and 2008 was combined in the results section. The second question also resulted in a number of specific suggestions outlined in the results.

With 20 pages of material and examples from 12 governments, the summary points only were extracted and many expressive quotes could not be included.

2008 Purpose: Defining Desired Indicators, Reports and Supportive Environments

The 2008 survey focused on the future, seeking answers to the following:

Please describe the top three (option to add three more) most important indicators or indices you would like to have and why?

To define reports, governments responded to questions in four domains: proposed contents for a report, definitional criteria for a report, qualities of indicators and potential generic names for reports. Governments were asked to tick 'Agree', 'Disagree', 'Not Applicable' or 'Modification' (which they specified) from a predetermined list and were invited to add to the lists. All lists under each domain are identical to the lists in the results section and will not be repeated here.

In follow up to the 2006 survey, governments were asked to answer 'Yes', 'No' and/or 'Comment' about whether they supported the need for:

- a national strategy on the mental health of children and youth
- a national framework for indicators of the mental health of children and youth
- a national organization to do the surveillance
- if a national organization was 'yes', should it be Canadian Institute of Health Information (CIHI), Statistics Canada (Statscan) or other
- if the suggestion was for a new organization, please suggest governance and mandate.

The answers to the above questions were amalgamated with the 2006 answers in the results section.

A general question in 2006 sought information about how governments would use outcome results to improve mental health outcomes for the future. Based on their answers a list was constructed of further options and specific details sought in 2008. The list and the results are reported in the 2008 section.

For both the 2006 and 2008 surveys, the details of the surveyed areas formed the topics of the results in the appropriate sections in Part II of this paper.

All Surveys

All surveys included a copy of the letter with the original accountability question, collated results of the previous surveys and the appendix with commentary of published reports from government web sites. Governments were asked

to comment on or to correct any information. For 2006 and 2008, with the exception of Table 3, all governments were promised anonymity in any subsequent written reports for any comments made in response to the questions in order to focus on amalgamated results and to encourage candour and completion. All surveys were directed to the Minister most relevant to the mental health of children, as identified from departmental mandates and organizational structures on the government website, with requests to share the survey with any other department with major responsibilities affecting the mental health of children.

Lastly, the Partnership Model was assessed by recording the number of P-T jurisdictions that participated in completed surveys.

Part I of this paper focuses on the 2002, 2004 and 2005 surveys and an assessment of the online publications. Part II describes the results of the last two of the five surveys, 2006 and 2008 along with discussion and conclusions.

Results

2002, 2004, 2005 Surveys: Report Development Process and Reports on Government Web Sites to 2010

Over the years of the surveys, 13 of 14 governments replied and affirmed support for monitoring the mental health of children (Table 3, with respondents by years). By later years, it was clear that the significant information was about challenges, definitions, desired goals and actual reports, regardless of internal government processes and stages. Therefore, the list of 20 processes and factors was condensed to lines 1, 2 and 3 in Table 3. When the survey started, only three governments had a total of seven reports on their web sites (federal -5, BC -1 and QC -1). By 2010, 13 governments had 64 relevant reports on their web sites. Although governments had the opportunity and request, they did not add reports unknown to the author or comments about the author's comments. The author's comments were directed at stating the reasons leading to eventually placing the report in lines 4, 5, 6 or 7.

Published Reports

There were several difficulties using the reports for monitoring.

Commitment. The highest concordance between a commitment to publish reports and actual publication came with the *Communiqué on Early Childhood Development, 2000* signed by the First Ministers. Ten governments published 28 ECD reports using NLSCY data for the six mental health indicators. Reports were restricted to the 0 to 5 age range and had no regional reports within the 13 P-T jurisdictions.

Table 3. Progress of Federal-Provincial-Territorial (F-P-T) governments in developing monitoring reports

PROCESS STEPS	CA	AB	BC	MB	NB	NL	NS	NT	NU	ON	PE	QC	SK	YT
2002 (9 respondents)		Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes			
2004 (5)		Yes						Yes		Yes			Yes	
2005 (9)	Yes	Yes	Yes	Yes	Yes		Yes			Yes		Yes	Yes	
2006 (12)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes		Yes	Yes	Yes
2008 (9)		Yes	Yes	Yes	Yes		Yes			Yes	Yes	Yes	Yes	
1 Plans to have indicators (2002-2008) (13)	YES	YES	YES	YES	YES	YES	YES	YES		YES	YES	YES	YES	YES
2 Cross ministerial/ departmental committee for child issues	Yes	Yes	Yes	Yes	Yes		Yes			Yes	Yes	Yes	Yes	
3 Have a committee producing indicators	Yes	Yes	Yes	Yes	Yes		Yes			Yes	Yes	Yes	Yes	
REPORT BASED INFORMATION—Only Online Publications Recorded														
4 Number of ECD reports with indicators (10 F-P-T)	4		5	3	2	3	2			3	1		4	1
5 Population reports NO regional data (6)	9		4	4				2	3			2		
6 Population reports YES regional data (3)			1	2									1	
7 Service user reports YES regional data (1)										8				
8 Partnership Model and EDI surveys by 2009 (11)		Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	
9 Published combined Population/ Service user reports	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO
10 Published regular reports (defined with 2008 criteria)	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO
ECD—Early Child Development reports, 6 mental health indicators, ages 0 to 6 years.														
EDI—Early Development Instrument (age 5 only).														
Blank cells—Information not known.														

In some cases, the way in which the 2000-2001 data were reported (bar graphs of children with ‘hyperactivity’, tables of children with ‘high hyperactivity’ and tables of children where hyperactivity was ‘not high’) inhibited attempts to look at P-T comparisons (Government of British Columbia 2005, Healthy Child Manitoba 2003, Government of Ontario 2006).

Types of reports

General Population, no Regional Statistics. Six governments published reports on the general population of children, without regional data. One or a combination of restricted age ranges, lack of regional statistics, lack of regular monitoring and few mental health indicators prevented these reports from functioning as baselines for child mental health monitoring. Despite this, there were reports with extensive and excellent data (Government of British Columbia, 1998, Health Canada, 1999c).

The nine reports published by the Government of Canada monitored 11-, 13-, and 15-year old children only, had no P-T statistics and were not designed to function as complete status reports as defined in this article. These HSBC reports (Public Health Agency of Canada) represented Canada’s commitment as a member of 41 participating nations in the WHO-CCS.

In the remaining five governments, most reports were one of kind studies. Manitoba reported the results of the EDI in five year old children with regional statistics over 3 successive reports. The Quebec reports were from the Étude Longitudinale Du Développement Des Enfants Du Québec and available for purchase. Numerous reports on this longitudinal study monitored a sample population every two years as the population aged and represented a series of research reports more than a report to the public. One earlier report did not contain regional statistics and since later

reports (Institut de la statistique du Québec, 2010) were not purchased it was not clear if others would have had regional statistics.

General Population with Regional Statistics. Three governments published reports with statistics that could begin to develop into mental health monitoring. The Manitoba reports were an elaboration of two EDI surveys with the addition of regional statistics.

Service Users with Regional Statistics. One government published eight reports that included many mental health indicators for children who used public mental health services (service users). These annual reports focused on characterizing the assessed population, were used for planning services and included some comparisons with previous years using two mandated measuring instruments: the Child and Adolescent Functional Assessment Scale (CAFAS) (five reports) and the Brief Child and Family Phone Interview (BCFPI) (three reports). With service user reports, it is important to keep in mind the research that only about one in five children with a disorder received specific clinical services. It is for this reason that service user reports need to be complemented by population health reports.

Service user reports were commonly restricted to children in a particular department (health, child welfare, education) and usually included regional statistics. Although not reported in Table 3, as an example of other non-health departments, Saskatchewan's department of education annual reports included much outcome and descriptive data that could be considered of value in monitoring mental health.

There was an absence of data about immigrant, refugee and institutionalized children and only a few reports contained

information about First Nations children (mostly federal reports). Given known higher rates of suicide in many First Nations communities, absence of information about these four groups should not be accompanied by any assumptions that there were fewer problems.

Partnership Model: During the decade of 1999 to 2009, the EDI surveys spread to use in 11 P-T jurisdictions (although not in the full P-T jurisdiction in all cases). The ability of the EDI to provide important mental health data on five year old children within postal code regions, yearly measurements and cross Canada comparisons made it an ideal component of one developmental stage in monitoring the general population.

The Government of British Columbia published '15 by 15: A Comprehensive Policy Framework for Early Human Capital Investment in BC' in which it used EDI information and proposed major policy and funding changes for early childhood years (Kershaw, Anderson, Warburton, Hertzman, 2009).

Summary. Even in the absence of a clearer definition (that arose from the 2008 survey) of reports, no government produced a full report. Given that a number of reports have been published on web sites, the lines 4 to 8 in Table 3 may require expansion and clarification in the future to monitor the adequacy of the information available to the public. For now, governments should be commended for the work done to complete as many reports as were noted. It is a beginning.

Part II will report the results of the 2006 and 2008 surveys, and overall discussion, conclusions and references.