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EARLY CHILDHOOD DEVELOPMENT ENHANCING CHILDREN'S HEALTH

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Event Proceedings

IHE Innovation Series
Forum IX

About the IHE

The Institute of Health Economics (IHE) is a not-for-profit organization committed to producing, gathering, and disseminating health research findings relating to health economics, health policy, health technology assessment, and comparative effectiveness. This work supports and informs efforts to improve public health and develop sustainable health systems. Founded in 1995, the IHE provides services for a range of health-sector stakeholders, and is governed by a Board* that includes representatives from government, academia, health-service delivery organizations, and industry:

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Preface

In December 2008, the Institute of Health Economics launched a series of semi-annual Innovation Forums whose goal is to bring together senior public and private sector decision-makers to address policy issues of importance in the health care system, not just in Alberta, but to all of Canada and the international community, as well.

"Value for Money in the Health System" was the eighth in the series of Innovation Forums. The keynote speaker, Mr. Don Drummond, Matthews Fellow and Distinguished Visiting Scholar in the School of Policy Studies at Queens University, and a former Associate Deputy Minister of Finance in the Government of Canada, as well as a former Senior Vice President and Chief Economics at TD Financial Group, presented on *The Imperative of Greater Value for Money from Health Care*. Mr. Drummond most recently served as Chair of the Commission on the Reform of Ontario Public Services, which released a major report earlier this year on ensuring the sustainability of health care and other public services.

Mr. Drummond's presentation can be found on the IHE website at http://www.ihe.ca/research/innovation-forums/---value for money in the health system/.

IHE Innovation Forums

Forum I: Paying for What Works. Comparative Effectiveness of Health Technologies and Programs – December 2, 2008

Forum II: Making Difficult Decisions – May 25, 2009

Forum III: Maximizing Health System Performance. Cost Containment and Improved Efficiency – December 1, 2009

Forum IV: Innovation and Economics. Investing in the Future Health System – April 22, 2010

Forum V: Innovation and Sustainability in Health Systems – October 14, 2010

Forum VI: Maximizing Health System Performance – Assisted by Evidence, Science, and Information Systems – November 29, 20122

Forum VII: Social Determinants of Health – May 31, 2012

Forum VIII: Value for Money in the Health System – December 6, 2012

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EARLY CHILDHOOD DEVELOPMENT ENHANCING CHILDREN'S HEALTH

Welcome and Opening Remarks

Introduction: Ms. Robyn Blackadar, President and CEO Alberta Centre for Child, Family & Community Research

Hello everyone and welcome. I am very delighted to open the ninth of a series of Innovation Forums that the Institute of Health Economics (IHE) has been hosting since December 2008 in conjunction with their semi-annual board meetings. These forums are a great way to bring people together; and as IHE chair Dr. Lorne Tyrrell always says, good things happen when people get together. The forums have become part of the health system landscape in Alberta, and all of us look forward to them. At the last forum, the topic was financial sustainability in our health system, with bank economist Don Drummond as the guest speaker. Today we are hearing from a children's advocate and two pediatricians. This diversity in the agenda means that we usually have people in the audience from outside the health system as well as within the system. That gives us a wonderful opportunity for creating synergy and working together.

I would like to recognize the board of directors of the IHE and to thank Egon Jonsson, the CEO, for bringing his expertise to these forums and ensuring that they are as interactive and knowledgeable as possible. Thank you, too, from the many of us who recognize the strong focus that you have brought on determinants of health and early childhood development. I also want to acknowledge the board and management team of Alberta Health Services and to thank Dr. Chris Eagle.

Finally, of course, thanks go to the Government of Alberta. The Honourable Fred Horne, Minister of Health, has certainly been a friend and colleague of the Institute for many years. He is unable to be here today, but as you know, things have been quite busy in the legislature these last few days. On Tuesday, the Alberta government introduced the Children's First Act, and we have Michelle Craig here from Human Services who will talk a little bit about that. One outcome of that legislation will be the development of a Children's Charter, which is very relevant to what we are going to hear from our guest keynote speaker. Along with the Ministry of Health, the IHE's other key government partner is the Alberta Ministry of Enterprise and Advanced Education. The deputies of both ministries sit on the IHE board. It is another demonstration of the strong commitment of government to what this organization does. Finally, thanks to Steve Buick and the organizing team from the IHE for managing this program the way you have.

Today the IHE has invited Professor Sir Albert Aynsley-Green to give us a lecture called "Children, Childhood, Child Health Today — Challenging Perspectives From England." It is a fitting title. Sir Al has made a second career out of challenging governments to do better for children. He made his first career as a pediatric endocrinologist. He was a distinguished clinical scientist, and by the early 2000s he was among the leaders of the great Ormond Street Hospital

for Children, the leading children's hospital in the UK. Around that time, he decided to move on from endocrinology to something much more exciting, although much more complicated: the area of public policy. In 2000, he became National Clinical Director for Children and chair of the National Health Service Taskforce for Children, and in 2005 he was appointed as the first Children's Commissioner for England. He served a five-year term and created a new kind of office, one that has been an essential reference point for any debate about how government should promote the interests of children.

I could talk for much longer about the impact that Sir Al has made, as he has been an inspiration to me personally. I have had the great luxury of listening to him and learning from him, and it has been wonderful to bring his ideas back to my organization, which is all about improving the welfare of children. What did he do that was so inspiring? First, he did something that sounds fairly simple and very obvious. He talked to children. We often talk about children. We talk for children. We talk around children. But what Sir Al did was talk to children. He not only talked, but he listened to them. He then told the country what they said, and it was not always what people wanted to hear.

Second, he did a great thing by making children the brand and identity of the Children's Commission. They were the centre of his universe, as they should be of ours. He created a logo out of the number 11 to represent the 11 million children in England. He insisted they be acknowledged as a constituency, even though they don't vote. He insisted they be seen as people with needs and rights of their own, not just extensions of their parents' private domestic lives, not just future units of economic productivity. A lot of people recognized that Sir Al was onto something. In fact, one of those was an extremely important woman, the Queen. She knighted him in 2006 for his services to children and young people.

I ask you to join me in welcoming the keynote speaker for the ninth IHE Innovation Forum, Professor Sir Albert Aynsley-Green.

Keynote Address:

Professor Sir Albert Aynsley-Green
Childhood and Child Health Today: Challenging Perspectives from England

I am delighted to be here today. I am an incurable Canada-phile. You see, I come from a small, poverty-stricken, primitive island off the coast of Europe. And from our lens, Canada is the Promised Land. We see your fabulous wealth. We see the land of opportunity. I have been here many times and admired your institutions and visited most of your children's hospitals, and I have contacts and friends across the country, so I'm really delighted to be here.

My title is "Childhood and Child Health Today." What can be more important than children? That is the theme I want to develop. I want to persuade the agnostics of the error of their ways, and I want to bring some challenging perspectives from England. I don't come in arrogance like Moses from the mountaintop with tablets of stone to tell you what to do, because we are not doing very well in the UK. What I can do is to share with you some of my experiences in the various jobs I have been doing and try to extract from those experiences some messages that might be of relevance and resonance to you. Against that background, I am going to be challenging. If you have a nervous disposition, then fasten your seatbelts now. If you have angina, take your angina tablets now. But please take my challenges in the spirit in which I give them: to try to improve the outcomes for our children, which is the most important mission in our lives.

Here is the exam question that I want to dissect and explore: Is Canada failing its children? I also want each of you to think of one thing you are going to do that you had not thought of doing before you came here today. Two hundred movers and shakers, 200 action points — what a momentum for getting some changes for children.

I would love to have a child here, but the best I can do is to show you a slide of the species we are talking about. Here is a truly beautiful human citizen who is only a few days old. You can see that already she is manipulating her adult carers by wonderful eyeball-to-eyeball contact. That is the biological basis for attachment. That triggers prolactin and oxytocin surges in the mother's and father's brains. That triggers the baby's own brain to start its journey of developing emotional resilience. What a fantastic biological process that is.

Now, this baby actually is the most beautiful baby in the world. I know that because she is my granddaughter. You would laugh, my friends, but here is the key point: We care passionately about our own children. But do we care about the children of others, especially those who don't have the privilege of coming from our social background, the children who may be causing trouble in families that are dysfunctional? Do we care enough as a society for those children? If not, why not? That is the start of my presentation, to remind you of the species we are talking about, a newly born human citizen, a person in her own right, not someone of the future, but a person today who is entitled to all the rights and privileges of membership in our affluent societies.

I want now to move to a larger construct in your thinking, the construct of the nurture of children. We are preoccupied in our professional silos and bunkers of health, education, and social care. Let's knit it together with an overarching construct, which is the nurture of children. What we should be achieving from that start in life is looking after children so that they grow up to be healthy, to be competent, to be confident, to be resilient and effective adults in the fullness of time. How do we make sure that children achieve those outcomes? Here is my simplistic checklist of what babies and children need to become the resilient and healthy adults of the future:

Children need love and care. We cannot prescribe it, but love is absolutely vital for the survival of babies. On Tuesday night, we had a wonderful symposium here on the theme that love builds brains, and how true that is. Love is very, very important, and we should promote it.

Children need physical contact and comfort. That need is a human attribute throughout our lives. Even I, as an old fogey, still need physical comfort with my wife and contact with human beings. It is a human attribute. So why do we in Anglo-Saxon worlds make it so impossible to show our affection for children and to give them comfort? I hear of primary school teachers being taught not to hug or to cuddle children because of child-protection issues. Of course, child protection is vitally important, but how crazy are we in denying distressed children human warmth and comfort?

Babies need security and stability. Kids told me, as Children's Commissioner, that their greatest challenge was the threat to their safety and security through family breakup. They need nutrition, warmth, protection, play, exploration, encouragement, managed risk. We are growing a generation of kids in the UK, the "cotton-wool" generation," who are not allowed to experience risk. How can we expect kids to become confident adults if we don't allow them to experience and manage risk? In England in some schools, it is alleged that kids cannot play conkers without wearing eye protection. They cannot go out in the rain in case they get wet. What sort of world are we letting these kids grow up into? Children need to have friends, education, expectations, values, and a purpose in life. A study done in England a while ago showed that 40 percent of our 16-year-olds have no purpose in life. They have no expectations. Why? What are we doing to give kids that sense of futility in life?

Now, all of these attributes or components — and you can have your own checklist — must be supported by accessible services based on needs, on what works, and on protection of children's human rights.

That is the construct that I want to offer you: the nurture of children. It is a holistic construct in which children should be everybody's business. Parents and families are critically important, and in my heretical view we do not invest nearly enough resources in preparing young people to be parents. Communities are important. As Hillary Clinton says, it takes a village to raise a child. Nelson Mandela has spoken the same way about a village being needed to allow a child to thrive. School is very important, as are faith and voluntary organizations, and, last of all, local and national governments. Government is very important, but the other components of nurture are even more important.

How do we build communities? How do we build villages that have children at their hearts? I would argue that to improve nurture, we must understand a few things. First, we must understand childhood today. You are trying to deliver services for children, such as health services and education services. How can you hope to do that without understanding the construct of childhood in Edmonton today? To do that, we need facts and clear evidence of the outcomes of our children. Here is the elephant in the room: We have to understand politics and politicians. And here is my first Exocet missile coming to you: As professional staff, we have been remiss in understanding politics and politicians and how to advocate for children's needs. We have to get professionals aligned. Here is my second Exocet missile: We have to herd frogs, frogs being a metaphor for professionals who are leaping all over the place because of their vested interests. Trying to herd them is a very, very difficult matter. But unless we try to do that, we will not be successful. Finally, we have to inform parents and the public. All of these are underpinned by effective advocacy, speaking for the needs of children and young people. I am going to explore this construct in a moment.

We need to understand where we have come from. Ten years ago, I was a clinical scientist working on rare diseases. Over the last 13 years, I have been doing research into the history of childhood in order to understand where we have come from — Greek and Roman times, the Middle Ages, Victorian England — because attitudes in our societies are profoundly influenced by where we have come from. Lloyd deMause, in his famous book, *The History of Childhood,* and Philippe Ariès [*Centuries of Childhood. A Social History of Family Life,* 1962] were the first authors to describe the history of childhood. Another wonderful book, by James Walvin in the UK, is *A Child's World: a Social History of English Childhood 1800–1914*. And an amazing book that was just published is the story of British childhood from late Victorian period through Edwardian times until the current time [Fran Abrams, *Songs of Innocence: The Story of British Childhood*, 2012]. It documents all the education bills and social bills that have been put forward, in order to give us an understanding of what childhood is like in our country.

Here is my next question: How has the history of childhood in Canada shaped your cultural view of children today? I suspect that it may have some resonance with your heritage from the old world, but you have had a pioneering development. There were children here in Edmonton 100 years ago. You now have immigrants from many different cultures all coming together in a very powerful mix. But what is your construct of childhood today? I have tried to find it, and I can't. There are plenty of books in the US about the current circumstance of childhood. I have yet to find one about Canadian childhood. This is perhaps an area for research. What is the history of childhood in your own country?

And where are we today? I had the great privilege of being a member of the panel that drove the landmark 2009 report of The Good Childhood Inquiry, which analyzed the circumstance of 35,000 children in our country today. This was an extraordinary development driven by The Children's Society, one of our leading NGOs, and the

conclusions were stark. On the one hand, it is quite clear that many children have never had it so good in terms of material affluence: travel, Internet, you name it. On the other hand, with the input of children and others, our panel defined five key issues that are the big threats to childhood today.

The first threat is excessive individualism. In the UK there has been a collapse of community involvement, of membership in trades unions, membership in Freemasons, membership in church communities, driven by excessive individualism. Who cares about anybody except me? The second threat is soaring family breakdown. Kids tell me this is the greatest threat to their security and safety. The third threat is commercialization: the billions — literally billions — of dollars spent in targeting young minds for commercial benefit. Do you think that childhood has been commercialized? Is the sexualization of young girls by means of sexualized clothing a threat to childhood? If so, what are you doing about it?

Next we have overly competitive education. This morning, I read in *The Globe and Mail* a very good article comparing Canadian education with education in Finland. It is very challenging indeed of the culture that you have (and we have), with ever increasing education attainment and targets and league tables. Finland is very different.

And, finally, of course, dire poverty is a threat to childhood. People say to me, "Poverty? That was Victorian times — kids with bare feet running around without food or clothes." You know as well as I do that poverty is a very, very serious issue in all developed societies.

These are analyses from The Good Childhood Inquiry. My question now to you is, are these issues relevant to Canada? And what is the construct of childhood today in Canada? I urge you to explore this, because you will uncover some very important issues that are relevant to your policymakers.

What I have tried to encourage you to think about so far is that the nurture of children demands a holistic construct. It is not just health. It is not just education. It is not just social care. It should be everybody's business, and it should incorporate an understanding of where we have come from and of childhood today.

To take it forward, we need to have some facts about childhood today and international benchmarks, national data sets, local information, and the views of children and young people. First, let's look at the international benchmarks. I'm going to show you the cover pages of two very important UNICEF reports on child well-being in rich countries: the 2007 report [*Child poverty in perspective: An overview of child well-being in rich countries*], and the 2013 report [*Child well-being in rich countries: A comparative review*], published just three weeks ago.

The UNICEF international league table ranks countries on various indicators: material well-being, health and safety, educational well-being, family and peer relationships, behaviours and risks, and subjective well-being. The UK was at the bottom of the 21 countries analyzed in 2007. This position was a golden opportunity for us, as Children's Commissioners, to kick the doors down and get some action, as I will explain in a moment. Where was Canada? Number one? No, it was 12th overall, with some quite challenging issues: for example, it ranked 18th for family and peer relationships and 17th for behaviours and risks. That was in 2007. In 2013, the UK has moved up the league table to 16th place. Canada has fallen from 12th to 17th place. You have not improved your position in regard to these very important aspects of the well-being of children.

A lot of criticism has been thrown at these data — they may be out of date, the methodology is flawed, et cetera — but I argue that they are a serious wake-up call to people to understand that, despite our countries' self-satisfaction, we are not doing as well as we could. Overall, you have gone from 12th to 17th place, but Canada is third from the bottom in health, superior only to Latvia and Romania, and even worse than the United States. Your low ranking is

due to poor immunization, low birth weight, high infant mortality, and high child and youth mortality. I read in your *Globe* newspaper this morning about the failure of Canada to do universal screening for cystic fibrosis, although I believe that Alberta is one of several provinces that do have universal screening. Screening saves lives. It extends lives. Why then haven't you got a national program? And where is the outrage that you haven't got it? Who cares? I spent two months preparing to come here. I scrolled through your national media looking for evidence of outrage. I called many friends across the country, in Vancouver, Ottawa, and elsewhere, to ask what has been the reaction to this publication. I am told that there has been almost no reaction. *The Metro* and *Huffington Post* are the only two publications I could find with any commentary at all about what many would perceive to be your disappointing performance. Why is this the case?

The key question is, what makes the best countries for children the best? Let me remind you of which are the best countries. The Netherlands is at the top, followed by Scandinavia, Germany, Luxemburg, Switzerland, Belgium, and Ireland. What is it that makes these countries the best in the world for children? There are many different reasons that some countries are better than others (social background, social mix, government policy, children's rights being taken seriously, et cetera), but why is Canada performing so poorly in the context of your fabulous wealth? And what has happened in the UK to improve our position? Our improvement is due to Tony Blair and Gordon Brown. In the nine years that they were in power, they introduced serious policies in response to the challenge of the UNICEF report to put children at the heart of government with overarching policies. And I am fearful that we are going to fall down, because our current coalition government is systematically unpicking much of the good work that was done under the previous administration.

What can be done to improve media coverage and public perception? I am told that Steve Buick [IHE Director of Policy and Communications] yesterday tried to set up an interview with me with some of your media about your new Children First bill, and your reporter said, "Children? Why should we be interested in children?" How do we get your media to recognize what is going on? And what are the opportunities for political leverage?

An amazing book that you really must read tonight along with the UNICEF report is *The Spirit Level* by Richard Wilkinson and Kate Pickett, which analyzes systematically the impact of social inequality on every indicator of life. Its comparison of different states in the US leaves no doubt that social inequality is one of the greatest drivers of poor outcome. Another set of fascinating facts that you may be unaware of is the World Health Organization's (WHO) measures of the social determinants of health and well-being among young people in Europe. The WHO report showed the percentage of 15-year-old girls and boys in Europe who think they are obese. There is an interesting country-by-country variation, but by and large in most of Europe the kids don't think they are particularly obese. In contrast, in North America the majority of kids think they are obese; and indeed, there are hot spots of obesity across Europe, but nothing compared with the youths of North America. One has to take these data with more than a hint of caution, but nonetheless they do expose, yet again, some quite stark differences between countries — in this case, the social determinants of young people's health.

Coming down to national data now, I have the huge privilege of being a patron of the Association for Young People's Health, an amazing volunteer organization that systematically collects all data about adolescents in the UK and publishes an analysis every year. One in five of our adolescents lives in a lone-parent household. Seventeen and a half percent live in workless households, compared to the European Union norm of ten percent. There is a marked increase in the numbers of young people in care and a staggering increase in emergency admissions of young people to hospital. There are all sorts of reasons for this, but there are very important trends. My question is, who is responsible for monitoring those trends and then using them to influence policy and practice?

The 2012 update from the Association of Young People's Health is an overview that broadly identifies trends. Teenage conceptions are going down for the first time. That's a staggering achievement. Suicide rates among young men are going down. Cigarette smoking and cannabis use overall are going down in the UK. Some things are staying the same: mental health problems and the number of kids drinking alcohol. And some things are worryingly on the increase: sexually transmitted infections; some forms of alcohol abuse, such as binge drinking; and obesity. And, of course, as a result of the success of pediatrics, we have many, many more adolescents who survived serious illness as babies.

My next exam question for you is, what is happening to adolescent health in Canada? Who is charged with collecting data, collating it, and making use of it?

The third dimension of data is local data. I am a passionate supporter of Clyde Hertzman's early learning program in Vancouver. His approach of mapping the lives of children is revolutionary and has transformed our understanding of children's issues by locality. Each of the red dots on his map of Vancouver indicates ten children living in that locality, and you can see the clustering of children in some parts of the city. This is a staggering achievement in its own right, but they then overlaid on top of this every indicator, every piece of information that was postal coded, to look at the lives of children in localities.

Your community mapping project, HELP, looks at social vulnerability levels in the neighbourhoods here in Edmonton and reveals the stark differences from neighbourhood to neighbourhood. This is reflected in the UK: I can go to any of our big cities, and the life expectancy of a child in the leafy suburbs can be 20 years longer than the life expectancy of a child in the deprived part of the inner city.

So you have international comparators, you have national data, and you have local data. I am fascinated by how this health data is being used to create communities for young children, as a toolkit for change. I saw in Vancouver last year that by pressing a button you can get a printout, by school locality, of the nurturative assets of that locality — where there are crèches, where there are football clubs for after-school activities, the things that build communities for children. This is a simply stunning approach, and you should be really proud of it in Canada. However, is enough use being made of these data to gain political traction and to get policies and services? Who can do this, and where? The IHE is a glorious example of potential here. You collect data, but how are you able to use the data politically? I am going to return to this very tricky point in a moment.

My next set of challenges has to do with understanding politics, because politics is the engine for change. Politicians are the drivers of change in communities. Policy is the vehicle. And policy put into practice through professionals transforms lives. Public pressure is important, but how well do children's professionals understand the importance of being effective politically? When I was parachuted from humble obscurity in Great Ormond Street Hospital into government, the scales fell from my eyes. I had never understood politics. I had never understood how government bills are prepared. I didn't understand our parliamentary process. I didn't understand how ministers were educated for which issues they should take note of.

I do know that in the UK pediatricians are remarkably uninformed, or have been until recently, about how to be political. It is actually slightly worse than that, because people self-select to be pediatricians by being lovely people. This was told to me by some officials who said, "Al, when we know that the adult surgeons are on the warpath, our heart sinks. When we hear that the pediatricians are on their way, we wonder if they can find the front door." Now, this is serious hyperbole, but is there not something in the persona of the pediatric workforce that is caring and

compassionate, that kills itself for the benefit of children, yet does not understand the fundamental importance of being political?

How do we develop effective political influence? This was the challenge for me as the first Children's Commissioner, appointed by Parliament to be independent and to speak for the needs of 11 million children in England. I had a very difficult tightrope to walk — on the one hand, building relationships and trust with ministers and, above all, their officials behind the scenes, and on the other hand, raising the public challenge. Governments are always looking for constructive suggestions and they don't have much time for wingers who bleat on about difficulties. Thus the question is, when do you raise the public challenge? The risk is that you will encounter the knee-jerk reaction in politics to exclude those who cause trouble. It is a very difficult tightrope. Where do you draw the line in the sand and say, "Sorry, that is just not good enough"? And does the end always justify the means? Do we leap into bed with government because the end may be okay? For me, the role of commissioner demanded tough personal integrity and courage, not least with the media who loathed everything I stood for. So we've got to understand politics.

For your education in this area, I recommend a book by Jeremy Paxman, *The Political Animal*. It is an amazing dissection of the life history of a politician, from being an aspirant in a constituency to being elected to Parliament and becoming a backbencher, a junior minister, and a senior minister. And it is a fantastic exploration of why people become politicians. I think we need to have a dialogue with politicians to understand what drives them, what gets them out of bed in the morning. By understanding politicians and understanding Parliament, we learn how to lobby effectively and how to be effective advocates.

Here is my list of what we need from government to improve the lot of children. We want a political ideology that treats children as a vital priority, as a resource, and as citizens in their own right. I have been going to eastern Europe for the last 30 or 40 years, and when I first went to Hungary it was then a Marxist society in which children were very, very important because they were the workers of the future. There were health services, education, and so on focussed on children. I have seen that diminish in priority as those countries have become capitalist. Do any of your political parties in Canada have a political ideology that really does see children as a vital priority, as a resource, and as citizens?

The second thing we need from government, from the very top, is an explicit commitment to children, especially the most vulnerable.

Third, we need an intellectual framework for an overall policy. My insight into the Westminster government is that it is bunkered and seriously siloed — Department of Education, Department of Health, Ministry of Justice, Home Office, et cetera — but all of those departments of state have responsibilities for children. Who is knitting it together? Where is there an overarching policy for children, with a clear vision, objectives, and desired outcomes? We need an integrated responsibility for all aspects of policy affecting children across government. Who is in charge? Who is responsible? Who is accountable for making sure that children are getting the attention and the resources they need across governmental departments?

And then, of course, we need resources and a delivery framework.

Here is a stark example of what I mean by commitment from the very top. I have enormous admiration for Tony Blair, who issued the following explicit statement from Number 10 Downing Street: "Our objectives are to make sure every child of the next generation has the opportunity to flourish regardless of where they're born, where they grew up, and where they're educated." Gordon Brown, as the Chancellor of the Exchequer and, later, Tony Blair's

successor, introduced an initiative to end child poverty. There was no doubt that this government was intent on looking after the best interests of children. Two very important policies came out of that administration: the National Service Framework for Children and the Children's Plan.

The National Service Framework for Children was triggered by a scandal. We had in Bristol a cardiac surgical unit where children had very poor outcomes compared to the rest of the country. The scandal was that people knew, but nobody did anything about it until parents became enraged and demanded a public inquiry. One of the consequences was that the Secretary of State for Health said we should appoint someone in government to be responsible for children's health services. I was the guy they asked to do that, the first pediatrician appointed to government. Have you got any pediatricians in government? Do you need to have a national clinical director for children? Over the course of four years, I worked with 300 colleagues across the country to produce, in 2004, the National Service Framework, which was based on rigorous evidence and clearly defined the standards of care for every aspect of the health of a child, from the ill child in hospital and the ill child in community, to mental health, and, above all, healthy children — what do healthy children need to be successful?

The National Service Framework was swiftly followed by a policy declaration from the Blair government called the Children's Plan. This was the first time ever that we had a comprehensive plan for every aspect of the lives of children. The plan had five defined outcomes for children: to be healthy (largely the National Service Framework), to stay safe, to enjoy and achieve, to make a positive contribution, and to achieve economic well-being. That is what government wanted for its children.

Have you got a holistic approach to children across departments of state? We moved from having a Department of Education to having a Department for Children, Schools and Families with a Secretary of State for Children, Schools and Families. We mapped the outcomes, the aims, and the support, including the indicators and the data that needed to be collected from inspection and assessment frameworks. Every department of state — Home Office, Justice, Education, Health, whatever — had to fit into the grand map of outcomes and aims and to account for what it was doing to help children. This was, in my view, an amazing holistic approach to improving outcomes for children in our society.

What happened to it? Well, here's the bad news. These policies were betrayed — and I use that word quite deliberately — by politicians in Parliament, because there was a lack of political will and resources to implement the wonderful standards of the National Service Framework. And with our new rightward-facing coalition government, there is a systematic dismantling of the principles of the Every Child Matters program. But I am pleased to tell you that so many professional staff had this embedded in their DNA that there is still a momentum to have integration, collaboration, cooperation, information sharing, and strategies.

Let's pause again. I've told you of the ephemeral nature of political commitment. Why is it so impossible to get cross-party support to recognize the importance of children? Why is that beyond the capability of human societies? It is possible, as I have shown you, to define world-class standards for care and to develop holistic policy. But there remains the crucial need for concerted, relentless political advocacy based on fact. Where is this to be found? And what is it built on?

This brings me to my last part of the international dimension, which is the United Nations Convention on the Rights of the Child (UNCRC). Let me explain what happened in the UK. Every five years, every country that signs up for the UNCRC submits a report and is assessed by the UN Committee in Geneva. We, the four Children's Commissioners of England, Scotland, Wales, and Northern Ireland, came together to write a hard-hitting dissection

of the state of children's rights in our country. NGOs did the same. But here was the innovation: we asked children and young people from the Children's Rights Alliance for England to identify and define what they thought was the importance of the UNCRC. The submission that the kids produced is very important reading. It is what they themselves thought about their lives.

In June of 2008, all four of the commissioners went with the NGOs and the young people to Geneva to meet the UN Committee on the Rights of the Child. We met at the UN headquarters in La Grande Salle, a very famous room where the League of Nations had its origins. Around the periphery of the room were the 30-odd members of the Committee. The Committee had read all the documentation and then threw about 50 questions to us in the first hour of the interrogation. We had an hour and a half to prepare ourselves to respond to the questions, and we did.

The Committee told us two things. First, they were impressed that kids had come (and they had a separate session with the kids without the rest of us there). Second, they were impressed that the UK Children's Commissioners had produced the report. They believed us rather more than, perhaps, they would have believed government submissions, which inevitably tend to put a gloss or a spin on what is happening. In our report, we documented 112 recommendations that exposed deep concern over the ongoing failure to give children and young people full protection of civil liberties and the promises of revision and participation under the UNCRC. In September of 2008, the UN committee held the UK government directly to account. Officials had to go to Geneva to be interrogated, and then concluding observations were published, just as yours were published in October of last year.

We had a very orchestrated media campaign before we went, in which we exposed what we were going to say. We then had an equally serious media campaign when the concluding observations were published. So we had media coverage. The government sent a delegation of some 30 officials, which indicates the seriousness with which they took this exercise. And on the morning they were interrogated, they made a key announcement that the government was going to remove a reservation to UNCRC Article 22 on the rights of refugee children. We had been arguing for that for five years, but now they were under the microscope and knew they would be grilled about it. So we know that this process had a clear impact on policy, especially under the Blair-Brown government, which had expressed a commitment to children's rights. And our current coalition government is passing a bill in Parliament as we speak to increase the powers of the Children's Commissioner.

I commend to you this UN Committee approach. It is serious business, because governments are held to account publicly in the most important international forum there is. Now, what does the 2012 review of Canada say? I've read it, and you'll read it tonight — 22 pages and 99 recommendations and subclauses covering important issues for Canadian children: a national strategy; data collection; federal and provincial child-specific budgets, because nobody knows what is being spent on children; a federal children's ombudsman; disparities and access; best interests of children being embedded by legislation; respect for the views of children; violence against children, including physical punishment — now, that's a hot potato if ever there was one; disabilities; mental health; child poverty; and various points about asylum seekers and youth justice. These are very important points. What is going to be done about these searing challenges? Who is kicking the door down at your federal and provincial levels to ask your politicians what they are going to do?

I am going to end by trying to show you how the UNCRC can be made real and how applying it gives benefit. Article 12 of the UNCRC says, "Children have the right to say what they think and to have their opinions taken into account when adults are making decisions that affect them." Our Royal College of Paediatrics and Child Health is a leader in advocating for the participation of children, to the extent that its most recent chief executive was appointed by a

panel of children. It is a stark example of the importance of the participation of children — and it is participation, not consultation. Kids have told me they are fed up with being consulted. Consultation implies that adults ask and adults decide, whereas what matters is that children are seriously engaged in making decisions that affect their lives. My next question, then, is, how seriously is children's participation taken here in Canada?

That leads to the office of a children's commissioner, which in the UK was a new post created by Parliament and given independent statutory powers to make sure that the views, interests, and needs of all children are taken seriously. Your children's advocates are fantastic here in Canada, but my understanding is that their responsibilities are restricted to children in the system of care and welfare support. My remit was to be conscious of all children; to communicate with, involve and consult children; to consider or research anything that affects them; to publish annual reports; to demand information and to enter premises to talk to children. This was the single most important power that I was given by Parliament, the power to enter premises anywhere apart from a child's home. I could knock on the door unannounced and say, "I'm coming in. I'm the Children's Commissioner. I want to talk to your kids." I used that power to go into prisons, refugee centres, mental health facilities, hospitals, schools, and elsewhere. I was not an ombudsman, and I am pleased I wasn't, considering that I had 11 million kids to be responsible for. But some commissioners and ombudsmen have responsibility for individual cases and individual children. Should Canada have a federal model like this? And should you have one in your province to speak for the needs of children?

Here is the next exam question: What is it actually like to be a child or a young person today? You may think you know, but do you really know what it is like to be a child? You may have children in your families. I suspect they are very privileged, affluent, middle-class children. Do you know what it's like to be a child who is socially excluded? My job was to go and find out. Being a children's doctor, I thought I knew how to relate to kids, but I knew how to talk to ill children in a hospital setting. I didn't have a clue how to talk to normal children. I went out to meet young people on their territory. I visited some of the most disadvantaged young adolescents — in one instance on a canal barge, the only place in the locality where the kids could feel safe from the gangs. To hear those young people talking about gun and knife crime, gang culture, and their difficulties in being excluded from school was pretty heartrending, I can tell you.

What is it like to have a disability? How many of you know what it is like to be in a wheelchair? The more I listened to kids in wheelchairs, the more I understood the horror of their lives, not least the bullying that they experience every day of the week. Even more searing were the experiences of kids with learning disability. They wanted to be normal. They wanted to do the things that normal adolescents do, and they were prevented. Nobody was speaking for their needs, let alone those of the family.

And what is it like to be socially excluded? An amazing Iranian lady named Camila Batmanghelidjh has a group called Kids Company in London. She scoops up runaways, kids sleeping rough under the railway arches, and she gives them the thing they have never had, which is unconditional love.

These are the sorts of vulnerable kids that it was my job to find out about. It wasn't only adolescents. We ran a program to explore with toddlers what they thought about being happy and healthy. We gave them cameras to take photographs of what they liked about their lives and what they didn't like, and we exhibited these across the country. These little ones gave us amazing insights about their lives, about diet, about food, about television, about their local communities, about their inability to access play facilities, and so on. Two-, three-, and four-year-olds can give you very important information.

My very first national exercise driven by kids was called "Shout. Turn up the volume." The message was, "Tell us what's on your mind, and we'll try to do something about it." Kids drove this. They designed the logos and the program, and we launched it outside of the Houses of Parliament. From this, we distilled long lists of the issues that kids were concerned about and then prioritized what we could actually respond to.

I want to end by highlighting one specific set of issues that kids told us about: their emotional and mental health. We discovered that in our country one in ten children has a diagnosable mental health disorder. I was told on Tuesday night that it is one in five here in this province. That is absolutely staggering. In the UK, fewer than 25 percent can access the services they need, and I am told that it is worse here — that 60 or even 70 percent of kids in your province cannot access the services they need. And they are especially vulnerable groups: children in care, children with bereavement, children with disability, kids who have been abused, and — a big one — kids experiencing hidden harm, that is, young people who live in households with drug or alcohol misuse. Who is listening to them? Who is identifying their needs? Who is reaching out to help them?

We were told about the plight of youngsters with serious mental health problems who had been admitted to adult mental health wards because we had failed to advocate for adolescent facilities for serious mental illness. And so we ran a program called Pushed Into the Shadows, a title chosen by kids, and worked with a group called Very Important Kids through a charity called Young Minds. Young people documented their lived experiences of being on an adult mental health ward. You can imagine what they told us, being 16 years old with anorexia surrounded by psychotic adults, without appropriate education, denied access to friends and family, et cetera. We documented that and launched the program to coincide with a parliamentary debate on mental health. For four nights before the debate, the BBC ran on the six o'clock anchor news program four ten-minute special reports on the plight of young people with mental health problems.

This forced government to recognize the problem. They said that within two years no young person would be admitted to an adult mental health ward. When we started, 29,306 bed days were occupied by kids in adult mental health wards. By 2010, the last data we have, it was down to 5,166. We also followed it through and named and shamed those localities that were not taking this seriously. This is an example of how listening to kids, documenting their experience, and being astute both politically and with the media can transform politics.

I want to conclude with an individual child's case, that of little M. She is 13 years old. I came into to my office one morning and was told, "Al, you must go and talk to this girl who has tried to kill herself." So I went to the hospital and I saw this little soul with her mom beside her. Across the bed space were four uniformed guards. She and her mom were asylum seekers who had come from Turkish Kurdistan six years before this event. They had been assimilated into local society, the child had done well at school, et cetera. But our border agency decided they were illegal immigrants and had to be deported, not back to Turkish Kurdistan, but to Germany, which was the first European Union country they had entered. When they took them to Heathrow Airport, the mom and the child kicked up a fuss and the pilot refused to take off on his scheduled flight to Dusseldorf. That night, the child tried to cut her wrists, but didn't know how to do it. The day before I saw her, the family was told that the next day they would be taken back to Heathrow Airport where a chartered airplane would be found for them out of sight of the public to transport them to Germany. That night she truly did try to kill herself.

She was in hospital with four guards because the regulations say that a failed asylum seeker who is outside of the secure establishment must be in continuous 24-hour visual contact with two guards. So mom and child… one plus

one is two, two times two is four. There were four guards there. Imagine what it would be like in your pediatric wards if you had four guards with a child and family in serious distress.

I phoned the minister immediately, and, to be fair, he was unaware of this. What we did then was to expose the plight of failed asylum seekers and their deportation out of the UK. Using my power of entry, we went into the deportation centre and documented the lived experiences of families being seized in dawn raids from their homes by the immigration staff, being locked away in a prison for many weeks, and then being deported back. Kids asked us, "What happened to my goldfish?" "What happened to my school friends?" These were the lived experiences we documented. This was picked up by our political journal *New Statesman* which ran a national campaign with signatures to end the detention of children. It was picked up by Juliet Stevenson, one of our famous actresses, and she and her colleagues wrote a play about this girl's experiences which ran for two short seasons in the Young Vic theatre in London. There is an example of how we can get unusual people to join the cascade. Amnesty International gave us an award for this, and then a new national media organization ran the story on their website. Children's authors wrote letters to the prime minister. Colin Firth wrote. Our colleges wrote a report on the impact of detention on kids. The consequence was that in December 2010 the coalition government said, "We will end the detention of children for immigration purposes." That was triggered by one child's experience.

Let me conclude with the lessons to be learned from child M. The first is to focus on the power of the lived experiences of kids in adversity. Second, have courage in exposing injustices and poor practice. Third, work with media, because the way we work with the media is vitally important. Fourth, harness a wide range of individuals "out of the box," apart from the usual suspects. Finally, maintain a relentless citizen campaign.

In final wrap-up, some action points. What do we want from our politicians? We want an ideology that treats children as a vital priority, as a resource, and as citizens in their own right. What do we need from the sector? We need a scientific approach to advocacy: knowing the cause, the facts, the argument; getting the support, knowing who to target; using the media; and following through. Is the science of effective political advocacy for children sufficiently well developed? If not, where should that be done? Universities are the obvious place, but not an institution that receives funding from government because that immediately creates difficulties. It was my independence as Children's Commissioner that enabled me to raise so many of these issues.

I give you an example of something fantastic here in Canada. It is the NeuroDevNet organization, which is brigading basic scientists, clinical scientists, psychologists, psychiatrists, and the public in looking at the neurodevelopmental issues affecting children — a truly mouthwatering resource that we do not have a shadow of in the UK. I was privileged to be invited to Toronto in the autumn to give a keynote, and I am in awe of what is happening. Dan Goldowitz sent me the most recent annual report, packed with data about chromosome analysis, new generic treatments, et cetera. It's wonderful, but there is only one page with one photograph showing a day on Parliament Hill. Now, NeuroDevNet is missing a trick, and I told this to Dan and the audiences in Toronto. You have this resource, but what are you doing about it? For example, you have political endorsement, but what are the major challenges facing children with neurodevelopmental problems? What policy focus and resources are needed? How do you get the attention of key ministers? Never let a good crisis go to waste. Get evidence, raise awareness, and challenge professional cultures.

My ultimate rant to you is to remind you of the professional obstacles to change. We are responsible for many difficulties afflicting our children, because of our territorialism, tribalism, traditionalism, television, timidity, terror, treasury, and tiredness, exhaustion, and cynicism.

Territorialism: *Oh, I'm in Alberta Health, and you are in Education. I'm a school nurse. I'm a child psychiatrist. I'm a child psychologist. I'm a community pediatrician.*

Traditionalism: *We've always done it this way. Why should I bother to change? My life is perfectly comfortable doing it this way.*

Tunnel vision: *Sorry. I've got 60 patients waiting for me in the clinic, and politics are somebody else's job.*

Timidity: *What if we get it wrong?*

Terror: *What are the consequences for me of standing up and speaking out?*

Treasury: *Where is the money going to come from?* So many things can be changed without money. They depend on us and on changing our attitudes and our cultures.

Tiredness, exhaustion, and cynicism: *Oh, Al, please go back to Planet Zog. I'm retiring in six months' time, and thank goodness I am retiring in six months' time.*

Are any of these relevant to you and your professional silos and bunkers in Canada?

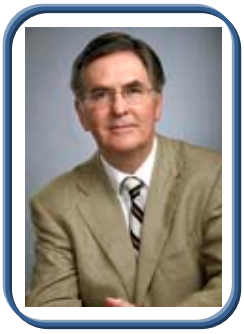
How should we behave? There was an amazing poster, "Keep Calm and Carry On," that was created in the Second World War by the minister for propaganda. I don't think they were ever distributed, but they were meant to be distributed in face of the blitz. The traditional British view: keep calm and carry on, chaps. Two weeks ago, my sister gave me a different approach, a little book titled *Sod Calm and Get Angry*. I suspect you can see which of these I align myself with.

Ultimately, you might care to consider having federal and provincial academic centres, independent centres for political advocacy for children with independent responsibility for garnering and analyzing facts; getting the media on your side; informing the public; and, above all, herding frogs. What can we do to find a common cause and to brigade key organizations?

"Children are the living messages we send to a time we will not see." That is a thought-provoking quotation from Neil Postman's book *The Disappearance of Childhood*. Their future lies in our hands now. We cannot afford to fail them. Margaret Mead said, "Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it's the only thing that ever has."

And my final Exocet missile is this: You've heard me rant here for an hour. Does it have any resonance for you? What are you going to do? Can each of you write down one action that you will do tomorrow that you hadn't thought of doing before you came here to listen tonight? Thank you for your attention.

Response



Moderator: Dr. Doug Miller, Dean, Faculty of Medicine and Dentistry, University of Alberta

Sir Al, I want to thank you for your very provocative and thoughtful comments. That was a real exposé and gave us all much to think about as we go into the second part of our program. As Dean of the Faculty of Medicine and Dentistry [University of Alberta], I can say that in training individuals to become physicians, dentists, and other healthcare givers, we try to instil in them a sense of professionalism, accountability, and social responsibility. You are clearly a role model for

that, and we appreciate your comments.

I am a member of the IHE board and am pleased to represent that organization today. I also am on the board of the Stollery Children's Hospital Foundation, so that even though I am an adult cardiologist, I think about and hear about children's issues a fair amount. I would say that the interface between policy and advocacy is quite active in the field of children's health. There is no question that children are among the most vulnerable members of our society, and any developed society is measured by the way it cares for its children and its older people.

When it comes to advocacy, as Al has said, we have to be truly proactive. We have to be provocative at times. We have to be passionate. But mostly, as we heard from Al, we have to be persistent and not take no for an answer when it comes to the health and well-being of children, whether they be our own children or children who have been displaced or for some reason not cared for well by their families. In the headlines these days is news about children — children who are being kidnapped in Cleveland and held as sexual slaves by depraved people, children who are the victims of bombing at the Boston Marathon, children who are doing the bombing at the Boston Marathon. All are young people that have been led into harm's way, and we are all responsible as members of society. A very powerful message such as Al's points out the fact that in order to make such egregious circumstances the exceptions rather than the rule, we all have to come together to make change and to do better.

I will now introduce the two additional panelists who are going to speak to us today, Dr. Bob Moriartey and Dr. April Elliott. Dr. Moriartey is a practicing pediatrician and Clinical Professor and Division Head of General Pediatrics at the University of Alberta. He started his career 30 years ago and is a key participant in our pediatric department and community. Dr. April Elliott is the Chief of Adolescent Medicine at Alberta Children's Hospital and Associate Clinical Professor in the Department of Pediatrics at the University of Calgary. She has been a driving force in the development of adolescent health as a subspecialty in Calgary.

Dr. Robert Moriartey, Clinical Professor and Division Head, General Pediatrics, University of Alberta

I grew up in small-town Alberta, and, believe me, growing up as a child in small-town Alberta several decades ago is much different than growing up in urban Edmonton or Calgary today. It is a totally different style of growing up, and very hard to relate to sometimes. But as pediatricians, we see it over and over, and it starts to sink in.

I have been in practice for 34 years, and for the first 25 years I was very comfortable being a community pediatrician. But over the last nine years, I have evolved into advocacy, both provincially at the Alberta Medical Association and in the last several years with the Canadian Pediatric Society. It has been a huge learning curve, and no one who does advocacy can succeed overnight. It must be done over and over. I have been to many deputy ministers' and social ministers' offices, and you are right that you have to learn their personalities. You have to know who is serious and who is not serious and how far you can push them. Some of them are very territorial and don't like to be pushed very hard, but it is an important push.

As an example of that, one of our very great local advocates for children in foster care, Dr. Tami Masterson, has done a wonderful job of looking after hundreds of kids. The system was failing those kids. She knew it, and she could have given up on them. But she went to the Child and Youth Advocate and to the executive of the Alberta Medical Association and came to me as a representative of the pediatrics section, and together we were able to develop a

relationship with Child and Family Services such that we have made some great strides in expanding PCIT [Parent-Child Interaction Therapy], which originally started in Calgary and is now in Edmonton.

But there are still huge, huge barriers to care. For example, there are children in foster care awaiting placement in privately-run holding homes. These homes are very important to the system, and many are run by well-meaning people who are contracted by the government. But you can go into some of these holding homes and find that the main source of child development for the kids in foster care is a large-screen TV. Their caregivers have very minimal training, and these extremely vulnerable kids are being wasted. It shouldn't happen, and we are working on that.

Another example is an ordinary family I saw last week, an immigrant family from Europe, very hard-working, lower-income people. It is quite obvious that they are having problems with their young infants' behaviour and sleep patterns. I spent a considerable amount of the time counselling them, talking about reading to the children at night, et cetera. The father said that he has to go to work at night, that his wife can't read English, and he can't either. I never thought to ask. I am sure there are many families like that, but we have to ask those questions.

The initiative of early childhood development is very important, scientifically based, and has been looked at in many jurisdictions. I was surprised, reading through some of the literature, to learn that in Oklahoma early childhood educators must have a university degree and additional early childhood development courses. These children need great education at a very young age. Their brains are at risk for stress that they may never get over, and, economically, it makes a lot of sense to look after them properly. Economists in many jurisdictions have shown over and over again that the benefits of early childhood education are apparent not only in math and reading scores at school, but also in emotional and social behaviour. If we do it properly at a young age, we won't have the problems that Dr. Elliott spoke of.

I would suggest that early childhood education is sellable, and that if we can establish it as a permanent part of the system, it will not be at risk each time government turns over. If Alberta had a provincial sales tax of two percent and put it all into early childhood education, we could make a big difference.

Audience Questions and Answers

Iris Evans: I was the first Minister of Children's Services in Alberta, about ten years ago, for a period of five years. We did go to the United Nations — I accompanied Senator Landon Pearson — and talked about children's rights. It was a huge disappointment, because the African countries that were adjudicating us did not understand why the Canadian government couldn't tell us how to look after our children. No matter that we all worked countless hours — and that you all work countless hours — either in the government or in the learning institutions, simply put, you can't be with that child 24/7, 365 days a year. Therefore, it is not only informing the parents that matters. It is engaging the parents. It is teaching children in school how to be parents. It is teaching them what is a good or best practice in families so that they know how to evaluate the circumstances they find themselves in. It's not just sending a brochure home with parents.

The reason we have Family Support For Children With Disabilities, a piece of legislation that the rest of this country really admires, is that parents of children with autism and several other severe disabilities came and wept and talked to me about the fact that 85 percent of their marriages were falling apart. But when I had the temerity to suggest that parents should be engaged with their children as many hours of the day as possible, I was nearly burned at the stake by some of the people here who said that I probably didn't understand the importance of accredited childcare. That was not the point I was making. The point I was making is that fostering proper child–family engagement in the lives of

those children is one of the best tools not only for educating their parents on how to be good parents but for giving those children resiliency. Happily, thanks to a few churches and others who happened to believe I was right, we carried on. I want each member of the panel to tell me what you see as the most fundamental thing we can do to change the attitudes of parents about their involvement with these children.

Sir Albert Aynsley-Green: Iris, thank you very much for being here and giving your perspective through the lens of a minister. I have enormous respect for you, despite what I may have implied about the political mindset. You have a very difficult job. I do understand that, and more power to your elbow for your obvious passion and care.

There are three points I want to make. First, you made some changes. What has been the continuity of those changes? One difficulty I see is the fracturing of policies when we change from one administration to the next. Why can't we get all political parties to agree to the importance of children and the importance of parenting?

My second point is that you in Canada have the most wonderful parenting program for three- to eleven-year-olds that I have seen anywhere in the world, and that is Roots of Empathy. I have been to Winnipeg to see it for myself in a class of seven-year-olds. It is absolutely brilliant. Mary Gordon has my immense respect because she is trying to instill in very young children the need to understand the world of others through the vehicle of a baby. It has been evaluated and found to have long-lasting effects. I have failed dismally to get our government in Westminster to take this seriously, although Mary is chipping away at the issue. So, yes, engaging with parents is key.

You ask what is the one thing that would make a difference. I think it is getting politicians in general to understand the importance of children. There seems to be a block. I can understand it to a certain extent, considering the power of the gray vote and issues such as dementia and end-of-life-care. But I talk to politicians all the time, and many of them have searing experiences in their own lives of the challenges that some of their children have caused. How do we get politicians to agree, irrespective of party, that children are actually important? That is where we seem to fall down.

Dr. April Elliot: I think we need to empower parents. Because I am an adolescent specialist, people often think that I exclude the parents, but we are very family-centred. Of course, we respect confidentiality with youth, but we encourage the youth to share that.

I think the Roots of Empathy is an incredible program as well. In addition to teaching it in all levels of school, I think that we also have to teach mindfulness as a way of helping people calm themselves. Parents are concerned about how stressed their children are, and they don't know what to do for a child who is stressed or suicidal. We have to give parents that guidance.

We also have to teach healthcare providers about trauma-informed care. I believe that many youth and parents who go to emergency rooms are re-traumatized there. I am not criticising the people who work in the emergency rooms. They work tirelessly, but they are not trauma-informed. One of the ways that we can empower parents is to make sure that they are met in the health care system with trauma-informed people.

Dr. Robert Moriartey: I think we all have to work together. We tend to have our own ways of doing things, and we don't like to share information. That works against children and families. I have advocated that we share a database of our information and resources. If we had a provincial database for children, it would be a huge resource for doctors, nurses, and public health nurses.

Sir Albert Aynsley-Green: In response to what April said about the emergency room, when I was director for children's health care, we wanted to transform the attitudes of staff toward the care of children, to encourage them to see the world through the children's eyes. And so we commissioned some four-minute video clips of children in different health care settings. One of them was Chloe, a ten-year-old girl who had been hit by a bus and had a broken arm. We were able to film her in real time going into a local hospital's emergency room. The camera was at the waist height of an adult, so that it filmed what Chloe's eyes saw.

And what did she see? She saw a busy department. She saw a drunken and bloody adult. She saw policemen. She saw notices: "Don't go beyond here." She went for an x-ray, and all the adults went behind a screen and didn't tell her why. She saw a nurse who spoke to her mom and not to her. When we showed that simple four-minute clip of seeing the world through the eyes of the child, it was transformative. Those passionate, hardworking staff simply had not considered what it looked like to a child coming into the system.

I commend to you this exercise of commissioning some four-minute video clips. What's it like to be on your ward? What's it like to be in your emergency room? What's it like to be coming off the streets as a young person? It can be very, very powerful.

Dr. Doug Miller: I was wondering about how we organize children's health care in our different countries and jurisdictions. There are many models of that, it seems. The question I have for the panel is, do we understand the proper way to organize care for children? If we had all the resources in the world, would we build separate children's hospitals? Would we have hospitals within hospitals? Would we deliver care through specialized care delivery lines that might optimize certain aspects of children's care? Should we have children on adult psychiatric wards? Of course not. But where would we care for children if we could optimize care for mental health and mental stress problems? I'd like to hear your thoughts on that, because having worked with colleagues in London looking at jurisdictional care delivery models, there is no obvious best practice that I am able to identify.

Dr. Robert Moriartey: I have worked at the children's hospitals in Calgary and Edmonton and at Sick Kids Hospital in Toronto, all wonderful institutions. Our children have some of the best institutions in the world. But all of those indicators in the UNCRC assessments and all of our markers of wellness in community have nothing to do with hospital care. They have to do with care of children out in the community. Although it is nice to put a lot of money and resources into a gamma camera to help a few unfortunate children with brain surgery, the money spent on that would go a long way in the community to help other kids.

Sir Albert Aynsley-Green: Bob, you are so right, and I applaud you for what you said just now. This was the question I had to confront when I was responsible for our National Service Framework. With my team and the 300 colleagues who worked with me, I made a serious attempt to look at every aspect of children's health care, and not just in the hospital, dominant though it is. There are more ill children out of hospital than there are in hospital. We tried to recognize that by providing standards, and the vehicle we used to get people to change their views was the idea of a journey, taking a condition — cystic fibrosis or whatever — and identifying the milestones that child and its family go through.

A simple example is head injury, the single most important cause of death and handicap outside of the newborn period. There are five milestones in a child's journey through the experience of head injury. The first one is where it happens and what happens to the child at the point of the injury. What are the needs of the child and the child's parents at that milestone? Obviously the child needs to have expert resuscitation. It needs to have trained paramedics and a system that will recognize the severity of the injury. Our research showed that among children who had died

from head injury, death was caused by avoidable factors in 40 percent of cases. The most common reason was poor resuscitation and poor transport to the emergency room.

The second milestone is in the emergency room. The child needs to be cared for by staff who are trained to understand the volatility of seriously ill children. The mom and dad want to be told, in a manner they understand, what is going to happen to their child. The child then goes to a regional centre for neurosurgery. What are the needs of the child and the needs of family? Then the child goes back to the local area, and then back into society, damaged or normal. Once you have identified those milestones, you can identify the needs.

The next challenge is to determine the competencies — not the professional bunkers — required to meet those needs. If you start building services around a journey concept, you come up with some astonishing answers. For example, when I was doing this in London it could take a child two years to have a speech and language therapy assessment. Two years. That's disastrous for a two-year-old. Now, in one part of London, they stood back and analyzed the reasons that kids were being sent for assessment. They then looked at the competencies needed for each of those categories, and they realized they did not need another 50 very rare, expensive, highly-trained speech and language therapists. They could match the competencies against the need. This is quite an instructive model. It gets away from the bunkering, from the idea that we need more pediatricians, more psychiatrists, et cetera. It is a holistic construct, within which, of course, are education needs. How many pediatricians think about the education needs of the child who has had a head injury? And what happens to the child after that? Who is responsible for coordinating the care afterwards? I commend to you these two models, seeing the world through the eyes of the child and then looking at the child's journey, as a construct to look at a way of designing services.

Dr. Doug Miller: One thing that we don't do, because health systems are not designed to capture this sort of data, is to ask children who are away from the pediatrician's office or out of the hospital how they feel about themselves. We could capture this information in an organized way using technologies such as the cell phones that are so ubiquitous in the hands of adolescent children. The same technology used for cyber bullying could be used as a way of checking in. As we often say to young people with addiction and mental health problems, "Let's do a check-in. How are you doing right now?" They could dial in how they are doing, and we could get a sense of their real-time need before an episode of care begins or an acute illness becomes worse. If there were some way of capturing calls for help, many children who are not being heard or have no one to speak to could be heard.

Michelle Craig, Alberta Health Services
The Alberta Approach to Early Childhood Development: A Transformational Initiative

It is my great honour to be here, and listening to the speakers earlier in the session was very affirming. I think we are on the right track, but I want to hear what you think.

The Government of Alberta has made a strategic decision to focus special attention and effort on early childhood to help Alberta's children realize their full potential. This was one of the critical areas that Premier Alison Redford identified as priorities in her mandate to Cabinet: "Early Childhood Development sets the course for a child's future. It determines how well children will do in school, their physical and mental health, behaviour, relationships and general well-being." Sir Al, you talked about the importance of commitment from the top, and we have that in Alberta right now. This comment obviously speaks to Premier Redford's personal belief and our government's belief in the importance of early childhood development.

The Ministries of Human Services, Education, and Health will jointly drive the Alberta approach to early childhood development. It is our intention to get out of those silos and work together with a one-government voice, so that we are all saying the same things, working from the same values and principles, and setting the same priorities. The specific goal is to improve the measures of child and infant health and development by age five.

We know that we are standing on the shoulders of giants, be they the local giants in the community who have worked every day of their careers to do things better for children and families; or the giants who have worked in the policy realm to pull things together, do the cross-ministry work, and make things happen; or the giants in the field of child development, such as Clyde Hertzman and Fraser Mustard. We are building on the work of those giants, but we are also building on the evolving science that has helped to crystalize our understanding that the foundation for strong and healthy children is set in the early years, even before they are born. We know that a child's brain is rapidly developing and most open to change in those early years, and that experiences in that early period can make a big difference in the life trajectory of the child, affecting health, behaviour, and learning. We know that in those early days of development, chronic stressors, such as poverty, homelessness, family violence, and abuse, can cause some children to become more vulnerable than others. And we know, most importantly, that day-to-day relationships and positive interactions with parents and caregivers are what make the difference for kids. It is everybody's job, as Sir Al has pointed out. It is the parents' job. It is the job of people providing services on the front line. It is the job of everybody who ever interacts with children. We have an obligation to give them the very best that we can. We have known most of this for a long time, but we have addressed it rhetorically rather than through action. We need to move the rhetoric to reality.

Why does early childhood development matter? As I have mentioned, new brain science provides evidence that intervening in early childhood has an impact throughout the lifespan. It changes the structure and function of the brain, and it affects physical health, learning, and behaviour. We know that disrupted development caused by ongoing stresses in childhood can contribute to adult heart disease, obesity, autoimmune disorders, some forms of cancer, poor mental health, type II diabetes, and high blood pressure. The cost of those diseases has a big impact on our systems, on our society, and on all of us as taxpayers.

Early childhood development interventions are an excellent investment, and the earlier the intervention the bigger the difference we make. Research done by Heckman and Cunha, for example, shows that investing in early childhood development is three times more cost-effective than investing in interventions for school-age children and eight times more cost-effective than investing in adult education — unless, of course, we are investing in adult education to improve early childhood development. We need to target the things that are impacting early childhood development, as best we know them. This is an area that is still rapidly developing and in which we are learning a great deal as we go along. It is not the agenda of any one sector or any one person. It's all of our work. It's all of our agenda, whether we are in government, community, or services, and regardless of whether we are in health, education, social services, or justice. It impacts us all.

We now have an entire of cohort of children that have been assessed by means of the Early Development Instrument (EDI) that was referenced earlier. Our children are a little bit like the canaries in the coal mine, and this population measure is a dip in the pond to see how they are doing at age five. It is to some extent an indicator of everything that has happened up until that time. Approximately 27 percent of children in Alberta at five years of age are having difficulty or great difficulty in one or more areas of development. That's a lot of children. It has huge potential societal costs and human capital costs. From a human perspective alone, we have to do better than this. On the basis of biological factors, we should be able to get this down to 12 or 15 percent. Evidence from other Canadian

jurisdictions and other studies shows that the Early Development Instrument done at five years old is very predictive of results at grade three, grade six, and grade eight, that there is a correlation between low scores now and low scores later.

Now that we know all that, we have a starting point. We have shared experience across government and communities. We know some of the needs of Alberta's children, based on data such as that from the EDI. We have a science base to build on. We also have a relatively new social policy framework, which reflects the voices of the over 33,000 Alberta participants who rated early childhood development and the reduction of child poverty as two of the top issues to be addressed. We know it is important to Albertans. The social policy framework gives us values, principles, and a vision from Albertans that we can now apply to our work on early childhood development.

The social policy outcomes for Albertans are that they will be healthy, lifelong learners, financially secure, resilient, included, safe, active, and engaged. Those sound like the things we should be aiming for with early childhood development as well. The vision statement for early childhood development is based on the social policy framework, which again is the voice of Albertans: "In Alberta, all children have a healthy start, safe and healthy environments, nurturing and supportive relationships and opportunities to learn, creating the foundation for them to fulfill their potential and benefit from our thriving social economic and cultural life."

The current state of early childhood development in Alberta is a reflection of its organic evolution. We have brilliant things happening in a lot of different places, but they are not necessarily connected, coordinated, or going in the same direction. There is a lovely picture in the early years study that shows a bunch of coloured balls all over the table, and that is what our early childhood development is like. Frankly, it is amazing when parents can find their way through the system.

We know where we need to go. We need a cohesive, coordinated system that is evidence-based, in which community services for early childhood development — prevention, early intervention, and protection services — are available to families when they need them. This includes, particularly, services for children and families who are experiencing periods of vulnerability.

How are we going to do that? To move from rhetoric to action, we are going to look at five main areas. Our first commitment is to improve maternal, infant, and child health — to support healthy pregnancies and to provide early screening and follow-up to support children's development. Second, we will provide Alberta parents with access to early-years information and practical tools that support their children's development. Someone commented that this is more than just giving out brochures. It absolutely is. We need a real strategy of engaging families and communities. These resources need to impart information but also to help people build skills and become empowered to take action, to be able to do the best they can do for their children.

Third, we want to assist families who are experiencing periods of vulnerability in providing healthy, safe, and nurturing experiences for their children and to protect children who are not safe. We want to create a made-in-Alberta approach to providing responsive early learning and care options that help children reach their developmental potential by the time they enter school. Finally, all of these endeavours need to be carried out within a cohesive and accessible system of neighbourhood supports to which families have access when they need them most. It's no good having great programs if nobody can find them.

How will we know when we are successful? We will know when more women are experiencing healthy pregnancies. We will know when more children are realizing their developmental potential, as measured by tools like the Early

Development Instrument. We will know when parents are more confident in their parenting role and in how their child is developing. We are looking at the potential of using the benchmark tool of the Alberta Centre for Child, Family & Community Research to measure parenting confidence over the years so that we can see whether or not the strategies we are using to engage parents are having an impact. Finally, we will know that we are making a difference when communities are better meeting family needs — and communities will know this, too — through working together to increase access to the right services at the right times.

We will achieve these changes by working very hard to align government and community programs. The following are some factors, or conditions for success, that will help us with those alignments.

- Focus on common outcomes: As I said earlier, we want to come from a one-government voice. There are three ministries that hold the majority of the child-development programs and services in terms of funding, criteria, and policy, but it happens all across government. We want to align them at the policy, program, and practice levels so that we move forward on a platform grounded in common outcomes: a healthy start for children; parents providing nurturing and stable environments for their young children; children realizing their full developmental potential; and safe supportive communities for children to grow, learn, and thrive.

- Shared priorities: We want to have shared priorities so that we are all working on the same things and moving in the same directions.

- Aligned policy, program, and resources: We want to align the policy, programs, and resources and to identify policy barriers. Information sharing among service providers has been mentioned, and there is a strategy within government now to address that. More action on increasing accessibility to information will be coming forward through the Children First legislation. Getting rid of such barriers will help programs integrate and better meet the needs of children and families.

- Measured success: Sir Al, you mentioned international, national, and local measures of child well-being. We need to look at all of those and to consider how we measure aspects of change in children, families, communities, and society as a whole, as well as in our systems. We are moving towards building a measurement framework that addresses all of those aspects. That, too, will help to align programs. If we are all measuring the same things and moving toward the same outcomes, we will have more success and ease in connecting our programs and integrating our services.

- Targeted action: We need to be doing the things that are going to make the most difference, and we need to be doing them together on that shared platform of common outcomes and priorities.

- Research and innovation: We are partnering with the ACCFCR in developing the one-government approach and in a research and innovation strategy to identify our research gaps. How can we address those research gaps? How can we engage the local, national, and international research communities in helping us get the best information to ensure that the programs that we offer across the province at all levels, from community to policy, are evidence-based?

- Community engagement: This is last, but probably should be first, because it certainly is most important. Community engagement will be very much an integral part of the Alberta approach to early childhood development. It will allow us to learn from parents, children, service providers — everybody — what needs

to happen, and that will help us build a connected system of support. We are not going to pretend that we know everything, because we don't. We have some ideas, but we want to be informed; and we also want to mobilize and engage, and to move rhetoric to reality through that engagement and mobilization. We are looking to create multiple pathways to understandable information in order to drive a shared understanding. We want to leverage that shared understanding into coordinated action to truly make a difference in the lives of our young children. We want this to be a collaborative, integrated, and ongoing engagement, because, truly, if it is not happening out in community, it is not happening at all.

In summary, I will return to some of the questions that were posed on Sir Al's test. Do we have priority? Do we have commitment at the top levels? Yes, we do, and that gives us a fabulous opportunity. Do we have an intellectual framework? We are developing one. We need to engage the community and to talk to more people to continue to develop that framework. Do we have a clear vision, objectives, and outcomes? We are working towards those, and the community-engagement process will add further clarity. Do we have integration? That is where we are trying to go. It might take us a while to get there, but we are going to get there, certainly in the delivery framework. Thank you very much.

Panel Discussion

- Moderator: Dr. Lorne Tyrrell, *Chair, Institute of Health Economics*
- Professor Sir Albert Aynsley-Green Kt. *Children's Commissioner for England, 2005-2010*
- Dr. April Elliott, *Chief of Division of Adolescent Medicine, Alberta Children's Hospital*
- Ms. Karen Ferguson, *Assistant Deputy Minister, Early Childhood and Community Supports Division, Alberta Human Services*
- Dr. Robert Moriartey, *Division Head, General Pediatrics, University of Alberta*
- Ms. Susan Williams, *Chief Strategy Officer, Alberta Health*
- Mr. David Woloshyn, *Education Supports Sector, Alberta Education*

Dr. Lorne Tyrrell, Moderator: Thank you very much, Michelle. We are going to ask people from the government and our panelists to come up. While they're coming up, I just want to make a couple of other comments.

I did read *The Globe and Mail* today, Sir Al, and the comparison of Finland's education system and the education system here was remarkable. The Finnish system stresses having children collaborate and work together, rather than compete, in their early school years. We stress marks and competing, and this puts stresses on kids all the way through early childhood. That was beautifully outlined in that article. I am working in an environment that is the happiest I have ever worked in. It is with Egyptian post docs, Iranian post docs, Canadian post docs, and Israeli post docs, and they are not competing with each other. They are all working on projects, and they work together. I cannot tell you how productive it is to have open labs and people working together, and as I read the article about Finland, I knew it was absolutely right. I should invite a

Ph.D. in sociology to come to our lab, because there is something there to be studied — all of these people whose home countries do not get along, but who came here and suddenly became great colleagues.

Another good article in *The Globe and Mail*, one on Canada's immigration and population, stresses that 28 percent of the Aboriginal community is under the age of 14. In the non-Aboriginal community that age group is around 12 or 14 percent. Those over age 65 constitute 1 percent of the Aboriginal community and 18 to 20 percent of the non-Aboriginal community. The article stresses some of the early childhood issues that we are talking about today. There are three populations that clearly we need to do more with: the Aboriginal community, single mothers, and the immigrant population. Our new census also shows that 50 percent of Canadians were born outside of Canada. We have a large melting pot in this country. We have to make sure that we target some of these populations for the help they need.

I can illustrate this with a story of my own. I grew up on a farm, and my classmates were all Aboriginal kids from a reserve across the way. They were great kids. My best classmate — and we played together every day — was every bit as smart as I was. About 20 years ago, he was talking to some people, and he said, "As a child, Lorne always said he was going to be a doctor. And as a child, I guess I was designated to become an alcoholic." He finished by saying, "We both succeeded." He was killed by a car at age 42 on the streets of Edmonton. There was no difference between us except our home environments. I could not help but think today about this and how important that message is to our Aboriginal community.

Ms. Susan Williams, *Chief Strategy Officer, Alberta Health:*
I am going to make three comments. First, a little bit about process. What Michelle talked about today, the Alberta approach to early childhood development, has been a work of art by the three of us and our ministries. Sir Al talked about how difficult this is to do, even with political leadership. We have political leaders who have set this as a priority, but for us just to get on the same page and agree on our vision, on what is doable, on how transformative we want to be, was not easy by any stretch of the imagination. We had quite a number of breakfast sessions challenging each other as to where we wanted to go. We could not have made this presentation in September. This is a culmination of the last seven or eight months' effort on the part of three very large ministries that are quite siloed to come up with a common vision and common action.

Sir Al talked about the difficulty of keeping this going through the political cycle, but how do we keep it going through any cycle? A momentum arises around the camaraderie that develops in creating a shared vision, but how can that be lived by other groups? Many staff participated in a three-day session that started to bring it alive for them, but this is not easy work, and we recognize this is not a short journey. It will probably take five years to do some of the transformative work that we want to do.

If Minister Horne were here, he would talk about his vision of increasing capacity in community care and primary health care, which is one of his big passions. So the second thing I want to talk about is building early childhood development into the work that we are doing in primary health care. This is not just about seeing specialists in hospitals. Most of what we are talking about has to do with parents and children in communities. It's all happening in the community. What are we doing to build community capacity and programs? How does early childhood development fit into primary health care services? Because it does have to fit. People are interested in seeing social supports built into family care clinics and primary care networks. They are interested in addressing the social determinants of health and in developing better and more robust networks at the community level in places like the

Parent Link Centres. So we are going to be testing the boundaries as we work on the integrated system that we are talking about.

The last thing I want to talk about from the perspective of the Ministry of Health is the work on the maternal health strategy and infant and maternal screening. Much of this work is about building evidence-based practices into community and clinical practice. How do we do that across the system, and not in a series of pilot projects or one-offs in certain communities? How do we build a more robust framework and more robust screening and tools that are accessible to everyone? One of our tenets is that tools and research be used in a manner that allows parents to get information earlier in their child's life, to discuss what it means for them, and to learn what support systems are available and what they may be able to do — not starting at age five when children are in school, but having discussions with parents a lot earlier.

Ms. Karen Ferguson, *Assistant Deputy Minister, Early Childhood and Community Supports Division, Alberta Human Services:*

As Susan said about working on this initiative, one might ask how hard can it be since we know what needs to be done? We are three separate ministries with different mandates, and yet we all support early childhood development in our own ways. Sometimes we don't connect with each other as we should, and sometimes we work quite well together.

The beauty of this initiative is that it is a planned initiative, but it is hard work. We relied on a lot of information that is out there already, such as *Let's Talk About the Early Years* [Alberta Health and Wellness, 2011]. I call it the bible. If you read that, it becomes pretty clear what needs to be done and where we need to start. This is a no-brainer in many respects. So we are not focusing so much on what needs to be done, but rather on how to do it and how to move it forward.

While developing the strategy for government approval, we have already started to take action. I'll give you a couple of examples. We received some money from Alberta Health to train staff in our Parent Link Centres to do enhanced developmental screening. This is screening for social–emotional difficulties in children. Alberta Health uses the same tools, and we will be doing it together. I'll let David talk a little more about some of the things we are doing with preschool and early childhood services. I will just say that our community partners have told us the priority areas, and we are not waiting. We are going to get at it.

Our emphasis, as Michelle explained, was on identifying conditions for success. We are looking at research and innovation, and Robyn is one of the co-leads on that, along with ACCFCR and Harvard University. Through an innovative partnership that we have developed with Harvard University, they are going to help us do some of the testing, looking at quick evaluations so that we don't have to wait two years to see if something is working. The questions will be, What are we learning? How do we test this? How do we scale it? What do we need to change? Again, this is new for government. We don't typically do this kind of thing, but we are doing it, and we got the idea from the community members who identified some priority areas across the three ministries. That's something very different and we are very excited about it.

We have looked at common outcomes. We have started identifying our shared priorities and aligning resources where we know they can be aligned right now. We will do further work on that down the road.

Our next big step, of course, is to develop a formal community mobilization strategy. The community has been involved, but we will be expanding that tremendously. It is going to be different from community consultations in the

past. We won't go out and ask, "What do you think?" We will ask, "How do we do this together? How do we move this?" That's where our focus will be.

We have talked about how to deliver high-quality information and services to parents. Another question is how to reach vulnerable families, those who are not going to Parent Link Centres or to their doctor to ask for help. How do we help vulnerable Aboriginal families, immigrant parents, single mothers, people who are isolated? We've got to figure that out. We can't build something and hope they will come. We've got to be smart. Where do these parents go? And what is the easiest way for them to get the support they need? We have to normalize help for parents, so that going to a Parent Link Centre does not suggest that you are a bad parent or that the court must have ordered you to go. Parents need to feel safe and comfortable going to any sort of hub to get the help they need. Who doesn't need parenting advice? We have lots of work to do there, and it is absolutely critical.

We talk about an integrated system, and that can mean many different things. One thing it does mean is that these three systems, broadly, are connected. It doesn't mean they all have to be in the same building or be exactly the same. But if I am running a Parent Link Centre and parents come in and want to know where they can go for immunization, maybe I have someone doing that in the centre, or I know exactly where they need to go and I help them get there. That is just a minor example. Service providers need to know what goes on in the other systems. We have to make it easier for parents to access these systems.

Mr. David Woloshyn, *Executive Director, Education Supports Sector, Alberta Education:*
We have a great health care system. We have a great human services system. We have a great education system. But we realized that by working in silos — having separate accreditation processes, separate funding, separate legislation, separate processes, separate staff, separate facilities, different standards — we could make only incremental changes. And the stars did align, in that early learning and care is gaining attention around the world. People are recognizing that we need to do a better job in this area, that in spite of how good we are, we can become great, so that all kids can succeed to their capabilities.

We are looking for, as Michelle mentioned, a transformational change so that students and families are at the centre of our work. Currently, if parents of a child with a disability are working and need to place their child in a daycare system, that daycare system may or may not accept the child, depending on staff capacity. If they find a suitable daycare system, that's fine. But if they qualify for program-unit funding, they have to transport their child from a daycare system to an education system for part of the day, tell their story all over again, and, at the end of the day, transport their child back to a daycare system. Then if they want to receive funding for that child, they have to talk to somebody else. And if there are health issues, they have to talk to somebody else. Michelle talked about all the coloured balls on the table. It is a very fragmented system. We want to move to a cohesive system, and, for Education and Human Services at least, an enriched early learning and care system where we are working with aligned purposes, providing accessible services and supports to families and kids, integrating our work, and ensuring that what we do is of high quality.

New legislation passed a little while ago makes it part of our life now in government to be looking at the effectiveness, efficiency, and relevance of all programs that we offer. One of the very first areas that we looked at was early childhood development, and we found out that we didn't have very good data to inform us of how our wonderful programs and services were doing. We recognized that the programs were relevant, but were they effective and efficient? We did not have the data to support that. Michelle talked eloquently about the need to develop clear outcomes and a measurement framework and to move from inputs to outputs.

We also recognize that we are not doing this as government, but that we are working with other key partners. Norlien Foundation has provided great information to inform us. We funded The Muttart Foundation, Success By 6, and Calgary UpStart to provide a draft framework for an early-learning and care system that will help inform our work. As Karen had indicated, we are not waiting for it all to unfold. We have ten pilot projects that next year will be test driving integrated early-learning and care systems, and they will help inform our policy and processes. Karen also mentioned the research projects with Harvard. We are very interested in what we are going to learn from them. We have also partnered with Mount Royal College and Grant MacEwan University on a curriculum for early learning and care. It blows my mind to think of having a common philosophy and approach in early learning and care — isn't it earth-shattering that someone would think of that? But it is very important, because we have many different philosophies in the province, even in early childhood care. Some programs are very play-based; and some kindergarten programs, I am ashamed to say, are miniature grade one and two programs where kids are in rows enduring worksheets.

So we need a common approach to early learning and care that is based on research about what is best for kids, and it is very different from the grade 1 to 12 world that we are in. We need to build it with Albertans, with communities, and with leaders such as you. We encourage you to bring your voice and your wisdom and take an active role so that we can build an early-childhood development program that meets the needs of Alberta kids and families. Thank you.

Dr. Lorne Tyrrell: Sir Al, do you want to comment?

Sir Albert Aynsley-Green: Yes. I'm bursting to say things. Michelle, very well done. I really loved your presentation. You commented that my speech had been an affirmation of what you are doing. Let me tell you, you are all doing the right things. I can't stress that hard enough. I know what's going on internationally, and what you are doing is very important and amazing.

Here is my next point. Please disseminate what you learn from what you are doing while you are doing it because this could become an international benchmark of first-rate practice. The self-evident truth is that if you cannot do it here, what hope is there for us on an impoverished primitive island? You've got wealth. You've got intellectual clout. You've got resources. You've got minds. And you've got a relatively small population. We have 11 million kids in England. That's the size of the mountain to climb. So, yes, you are doing the right thing.

The second point is the magnitude of the cultural shift you are trying to embark on. It will not be easy, and so your delivery program is going to be important. What are the incentives for people to change their traditionalism, their tunnel vision, their timidity, and so on? How are you going to do that? The Blair administration tried to do it through targets. You are looking at outcomes and outputs, which I think is a good way of doing it. But how are you going to persuade the guy at the front line who has been doing this job for 30 years? Why should he change his spots? The manner in which you create incentives and motivate people to change their culture is extremely important.

My third point is the involvement of children and young people. You are looking for community empowerment, but I do think that kids have other important things to say about how they see the world, and we should not lose sight of that.

And my last point, coming back to Michelle's presentation, is that early years development is fantastic, but please don't be seduced into thinking that is all that matters. You gave a very powerful economic argument for investing in early years, but let me remind you that the second major time of life when there are huge brain changes is

adolescence: the adolescent brain is going through a staggering culling of neurons. So I think there needs to be a strategy for adolescent development.

A final point is that we have had a lovely afternoon. I have really enjoyed and been inspired by talking with you and sharing thoughts. I have spent much of my life naval gazing at endless meetings and discussions, so I urge you to think about what is going to be the outcome of this event today. What actions are going to emerge from it? What difference has this event made? One suggestion: I assume that you have the e-mail addresses of every participant. Why don't you follow it up and ask them to answer my exam questions: What are you going to do? And can you think of one thing that will be different? Two hundred folks here, 200 actions — what an amazing resource to think about.

Dr. Lorne Tyrrell: I hope that we will start asking the children what they want. It came out very clearly in your presentation how important it is to ask the children.

Dr. April Elliott: I applaud what you are doing. I spoke at the symposium in 2008, where we had frontline and middle management in Justice, Human Services, Education and Health. Everybody had similar ideas, but they felt unable to implement them, given their position. In the collaborative approach that you are taking, you have to engage the frontline workers. You have to find out what programs are already working. COPE [Community Outreach of Pediatrics and Psychiatry in Education], for example, is an amazing community outreach program with psychiatry and pediatrics in Calgary. Teachers identify youth who are struggling with mental health problems. We provide consultation from health and psychiatric perspectives, and then caseworkers follow them. It is an example of the collaborative programs across sectors that are already in place. I hope that you look at what is already out there and build on that.

Dr. Robert Moriartey: I would like to challenge you. I know this is a long process, and my concern is that the process tends to outlive a government. When the next government comes in, the process and funding fall apart. We have to find a way around that and make it sustainable. It has to be as important to your government as it is to the opposition as to the next leader of the whichever party. Second, the outcomes have to be kids' outcomes: how well they do in school, how often they are accessing mental health services, how well they are doing as adults. There are other outcomes, but those are the important outcomes. The children must come first.

Audience Questions and Answers

Ms. Fay Orr: I'm Fay Orr, the Mental Health Patient Advocate for Alberta. We should not lose sight of the focus on children's rights as a good basis for getting the social change that is needed to lead to improvements for children. In the 20th century, rights-based movements — civil rights, women's rights, human rights, and patient rights — were very successful in getting social change. I would agree with Sir Al. Maybe if we became more familiar with the language of children's rights and started talking in those terms, that might help generate the social movement that is required to make sure this lives past individual governments and becomes a social movement.

Sir Albert Aynsley-Green: That is a very important point, and thank you for raising it. I would like to ask our colleagues here where is the UNCRC mentioned in your profile and your programs?

Mr. David Woloshyn: The Children First legislation speaks about developing a charter of rights for children, and we see that being foundational for our work. Another part of the Children First legislation calls for enabling information sharing for the benefit of kids and families. Those are two major pieces of that legislation that will serve as a foundation for our work.

Sir Albert Aynsley-Green: Is your charter embedded in the UNCRC?

Dr. April Elliott: The charter hasn't been developed yet.

Sir Albert Aynsley-Green: What an opportunity for you. In the very first paragraph, state that this is based on the UNCRC.

Ms. Karen Ferguson: There are already a few challenges, but they will be taken care of soon. It is very exciting. One of the commitments is to review all legislation that has anything to do with kids, looking at it from a new lens. That gives us hope for all sorts of different legislative acts to keep our feet to the fire, so to speak.

Sir Albert Aynsley-Green: I will tell you then about the Rosenblatt in Stockholm. That is the Swedish headquarters where there is an office whose only function is to childproof every aspect of emerging government policy and finance. When I was there visiting, they were looking at road building. New roads were assessed against the impact they would have on children. So what about a child-impact assessment for every piece of emerging legislation and budget from your government?

Unidentified speaker 1: I am a pediatrician with 700 kids who are in care. Prior to this, I worked for six years at the Royal Alexandra, in an inner-city hospital in Edmonton. I have had well kids and lots of developmentally disabled children, and now I have the most socially vulnerable kids in society. In our clinic, we take a multidisciplinary approach. We interact with social workers, the schools, early intervention programs, and mental health services, and we provide the health care. We follow kids from the time they come into care through as many as 15 placements. The reality is that my kids cost the most.

One of the biggest issues that we have is the Freedom of Information and Protection of Privacy Act [FOIP]. When we started this initiative, we got FOIPed from other doctors, FOIPed for hospital records. We get FOIPed from Children's Services. We get FOIPed from Education. I can't talk to a school without the guardian's consent. I can't put a kid through early intervention without someone signing a consent form.

Another big issue is that many of our kids don't come on the radar until they are school age. I have had kids with autism who are too old for early intervention because they are over three and a half years of age. They are not in a formal school program because their parents don't take them to school. And I have to wait for them to be in a stable placement for six months because my healthcare colleagues say they have to do that prior to being sent through a tertiary care program. So we sometimes have kids in our care for a year with no services. Every child that comes into my practice gets an early intervention referral. Sometimes they get pretty good service. Sometimes they get no service. Until they are three years of age, we don't do anything for these children. They sit with pediatricians or family docs or in the community having no services rendered to them.

To speak to Dr. Tyrrell's comments, almost 80 percent of the kids I see are Aboriginal, and so the parents I see are also Aboriginal. This is intergenerational trauma. You can have all the brochures in the world, but if you are a traumatized adult you are not going to parent effectively. A large majority of the kids I see are brain injured from *in utero* stress as well as substances. By the time they are born they are already far behind the eight ball, and we often wait until they get to school to provide them with any services. They often can't get to mental health services because they in the care of Children's Services, and at the ground level there is an idea that Children's Services should pay for the mental health services. Then, to get into routine health services, they have to be in a permanent guardianship status with a forever family.

So this is all fantastic, and I, too, applaud you. But on the front lines where I have been for almost five years, most of the 700 kids in my practice are barely getting the basics. We have a very long way to go, and we have to come back to kids. If you talk to two-year-olds, they can usually tell you what's going on, and certainly seven-year-olds can. But when they are apprehended, we don't even tell them why. We actually have to talk to the kids. And we have to talk to the teachers. And we have to talk to the moms and dads, because even if you're intact, it is hard to negotiate this, let alone if you are traumatized, impoverished, have a mental health problem or an addiction, are in an a violent domestic relationship, and Children's Services is knocking on your door saying, "We're going to take your babies." We need to apprehend the parents; we need to have a family approach. Unless we help those moms and dads, those kids are never going to get healthy. And unless we stop the next baby from being born in trauma and with a brain injury, we have a societal problem on our hands that is going to be bigger than anything we have ever seen. Trauma causes major morbidity, and we are never going to be able to keep up with it.

In each family that I see, almost every child will have ten children. At the minimum, they're having four. So I have a mom who has had ten children, and those ten children will go out and have ten more brain-injured children. There is no way to keep up with that. The reality is that everybody needs to be at the table — justice, education, mental health care, human services, everybody — and we need to start putting some money into these kids long before they are three years of age.

Dr. Lorne Tyrrell: Thank you very much. That's a great dose of realism.

Ms. Susan Williams: You can't have collective action, and you can't have people agree on what priorities are, and you can't advocate for money, and you can't influence Alberta Health Services unless you have a collective vision of where to go. Otherwise, you're just crying in the wind.

Dr. Lorne Tyrrell: I want to applaud government for being here today and for moving in this direction. I also want to applaud you for bringing forth a dose of realism. We have heard it from the pediatricians very clearly.

Ms. Karen Ferguson: I just want to add a comment about parenting strategies. Every parent needs help at some point or another. What about these parents whose kids we are taking into care? We need to figure out how to reach out to them in a non-threatening way. We have to keep the child safe, and no one would debate that, but that does not mean we just take the child away, and say, "Okay, say goodbye to your parent because your parent has an addiction problem and can't take care of you." We have to help that mom or dad. All parents want to be good parents. How do we help that parent develop capacity? We've got to get smart about that.

We often think we have to have all the answers before we go forward, but there are strategies out there. Some of you attended the Early Brain and Biological Development Symposium with the Norlien Foundation and heard some of these strategies. We are bringing some speakers here, too. We want to try some of this stuff, because it's not going to hurt us. We have to start making a dent in this. We have talked with regional authorities in child intervention, and they know something's got to change. We have to focus more on prevention and early intervention. We've got to get creative with our FASD ten-year strategy. There are many pieces to this, and you are right to raise this. And do we have all the answers? Not yet. We've got to talk to people like you as well.

Unidentified speaker 1: I've been to the minister's office. I've been doing this for several years. I've been to every party office saying that this is a problem. I've seen the Liberals. I've seen the New Democratics. They each want me to "out" the other in the legislature. That's not my deal. I want to see kids in care, and I am smart enough to know, as Sir Al said, that if I make the wrong people unhappy, I will not be able to do what I do. When I started as a

pediatrician, I didn't even know what Children's Services was, but I saw kids falling off here, here, and here. We just keep sticking a finger in it. It's hard work, but it's not actually difficult work. It's all common sense.

Unidentified speaker 2: I have been involved with SafeCom [Safe Communities Secretariat] for the past five years and now am with Justice and Solicitor General. SafeCom started five years ago, and a lot of collaborative work was done that resulted in the Alberta Crime Prevention Framework, which looks at enhancing protective factors as well as decreasing risk factors. We have worked very closely with several ministries. Things are happening and, as you said, work has been done. But sometimes things move a little bit slowly.

Dr. Lorne Tyrrell: I want to thank Sir Albert again for coming to Edmonton to be part of this today. I want to thank all of the panelists, and the government for support.

Finally, I want to say that Canada had a great leader in the area of child development, Fraser Mustard, who passed away just about two years ago. He would have been happy to hear the discussion today, but he would want to know how we are going to implement what we are discussing. I just want to end on that note and say thank you to Fraser Mustard for all he did on this issue in Canada. Thank you.

INSTITUTE OF HEALTH ECONOMICS
ALBERTA CANADA

IHE INNOVATION FORUM IX: EARLY CHILDHOOD DEVELOPMENT: ENHANCING CHILDREN'S HEALTH

Keynote Speaker:
Professor Sir Albert Anysley-Green Kt., Children's Commissioner for England, 2005-2010

May 9, 2013
Edmonton, Alberta, Canada
Art Gallery of Alberta

Program

Moderator Dr. Lorne Tyrrell
Professor and CIHR/GSK Chair in Virology, University of Alberta

2:30 – 2:50 p.m. Welcome and Introductions

- Master of Ceremonies: Dr. Doug Miller, University of Alberta

2:50 – 4:30 p.m. Keynote presentation: "Children, Childhood and Child Health Today – Challenging perspectives from England!"

- Introduction: Robyn Blackadar, Alberta Centre for Child, Family & Community Research
- Professor Sir Albert Aynsley-Green Kt.
- Response:
  - Dr. Robert Moriartey, University of Alberta
  - Dr. April Elliott, University of Calgary

4:30 – 4:45 p.m. Break

4:45 – 6:00 p.m. Panel discussion

- Karen Ferguson, Alberta Human Services
- Sheryl Fricke, Alberta Human Services
- Susan Williams, Alberta Health
- Professor Sir Albert Aynsley-Green Kt.

6:00 – 7:00 p.m. Reception

Early Childhood Development: Advancing Children's Health is the ninth IHE Innovation Forum, a semi-annual event bringing together senior public- and private-sector decision-makers to address policy issues of importance in the healthcare system in Alberta, Canada, and internationally. Previous sessions covered:

I) Paying for What Works
II) Making Difficult Decisions
III) Maximizing Health System Performance—Cost Containment and Improved Efficiency
IV) Innovation and Economics
IV) Innovation and Sustainability in Health Systems
V) Maximizing Health System Performance—Assisted by Evidence, Science, & Information Systems
VI) Social Determinants of Health

Speaker Biographies

Dr. Douglas Miller

Dean, Faculty Medicine and Dentistry, University of Alberta

Dr. Doug Miller is the Dean of the Faculty of Medicine and Dentistry at the University of Alberta. He came to Alberta from Georgia Health Sciences University, where he was a regents' professor and dean of the Medical College of Georgia. In 2010–11, Dr. Miller was the Robert G. Petersdorf scholar-in-residence with the Association of American Medical Colleges. He conducted empirical research for the association about the effects of national economies and health-care policies on physician workforce balance. Miller was born in Brockville, Ont. He completed his undergraduate studies at Concordia University in Montreal, and medical school at McGill.

Robyn Blackadar

President and CEO, Alberta Centre for Child, Family and Community Research

Robyn Blackadar is President and CEO of the Alberta Centre for Child, Family and Community Research. Ms. Blackadar joined the Centre from the position of Vice President of Leading Practices and Innovation at Alberta Health Services. She holds a Master of Business Administration from the University of Alberta and a Bachelor of Arts in Social Sciences from the University of Calgary.

Professor Sir Albert Aynsley-Green Kt.

Children's Commissioner for England, 2005-2010

Sir Al Aynsley-Green is one of the world's leading authorities on children's services, child health and childhood. Through his distinguished early career as a pediatric endocrinologist and clinical researcher, he developed a deep interest in the circumstances of children in society, especially the influence of poverty and deprivation. Sir Al has been involved in the political arena of Children's Services since 2000. He was appointed Chair of the UK National Health Service Taskforce for Children, and then the government's first National Clinical Director for Children. He was appointed the first Children's Commissioner for England in 2005, completing his five-year term in 2010. He was Knighted in 2006 for his services to children and young people. He holds five honorary doctorates and is currently Founder and Director, Aynsley-Green Consulting; Professor Emeritus of Child Health at University College London; Honorary Fellow of Oriel College, Oxford; President of the Association of Young People's Health; and an Honorary Fellow of UNICEF UK, as well as many other positions.

Dr. Robert R. Moriartey

Division Head, General Pediatrics, University of Alberta

Robert (Bob) Moriartey trained in Calgary, Toronto and Edmonton, and has been in practice as a pediatrician in Edmonton for more than 30 years. He is currently Clinical Professor and Division Head of general pediatrics at the University of Alberta, coordinating 56 general pediatricians in the ongoing development of community practice. He is also the President-elect of the Canadian Pediatric Society, and a past President of the Alberta Medical Association Pediatric Section. Bob is a strong advocate for children in care, and has been a leader in creating new programs for evaluation and assessment of their medical needs.

Dr. April Elliott

Chief of Division of Adolescent Medicine, Alberta Children's Hospital

Dr. April Elliott is a Pediatrician and Chief of the Division of Adolescent Medicine at the Alberta Children's Hospital, and an Associate Clinical Professor in the Department of Pediatrics at the University of Calgary. She has developed Adolescent Health as a sub-specialty in Calgary, including a large Eating Disorder Program, a Youth Health Program, and a Street Youth Health Clinic, called the Calgary Adolescent Treatment Services (CATS). She is a member of the Canadian Paediatric Society, Society for Adolescent Health and Medicine, and was the president of the International Chapter from 2007-2009. In 2011, she received an Alberta Medical Association Medal for Distinguished Service.

Karen Ferguson

Assistant Deputy Minister, Early Childhood and Community Supports Division
Alberta Human Services

Karen Ferguson is the Assistant Deputy Minister of the Early Childhood and Community Supports Division in the Ministry of Human Services. In partnership with her colleagues from Health and Education, Karen is responsible for leading the Early Childhood Development Priority Initiative, one of five government priorities. In addition, she is responsible for implementing preventive programs and building capacity to effectively use partnerships to enhance community-based services for children, youth, and families; supporting the delivery of child care services, and the integration and settlement of newcomers into their communities.

Sheryl Fricke

Executive Director, Early Childhood Development Priority Initiative
Alberta Human Services Sheryl Fricke is the Executive Director for the Early Childhood Development Priority Initiative, Early Childhood and Community Supports Division, Department of Human Services. The ministries of Human Services (lead), Education and Health are working with communities and leading experts to drive and implement focused, targeted and measureable actions that improve maternal and infant health, enhance parenting supports and enrich early learning and child care environments. The overall vision is to improve childhood health and development outcomes by age five.

Ms. Susan Williams

Chief Strategy Officer, Alberta Health

Susan Williams is Chief Strategy Officer for Alberta Health. She is responsible for strategic services and health policy, research (including health technology assessment), primary health care, family and population health, and addiction and mental health. She leads strategic management and priority-setting, and integrates policy development across the health ministry. She supports the ministry and minister in working with federal, provincial, and territorial health departments on current and emerging intergovernmental issues. Susan holds a Master of Business Administration from the University of Alberta and a Master of Arts from McGill University.