



Landon Pearson Resource Centre  
for the Study of Childhood  
and Children's Rights

2014

# Children's Rights Academic Network



Carleton  
UNIVERSITY



The Muttart Foundation

Study of Childhood and Children's Rights  
5<sup>th</sup> Annual Meeting  
February 1<sup>st</sup>, 2014

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Childhood & Children's Rights*

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The Landon Pearson Resource Centre for the Study of Childhood and Children's Rights was created with a powerful vision: every child in Canada will grow up aware of his or her rights and responsibilities and enabled to exercise them within a receptive and respectful society.

The LPRC began with a donation by the Honourable Landon Pearson to Carleton University, which included her extensive collection of books, documents and reports collected over a lifetime of engagement with children. The collection also contains archival material that documents the evolution over time of perceptions of childhood and conceptions of children's rights both at in Canada and abroad.

**The Centre has and will continue to give children and youth a voice in advance their rights by:**

- Creating practical opportunities with and for children and youth for the exercise of their civil and political rights and responsibilities
- Providing children and youth with access to fundamental citizenship rights
- Actively challenging and engaging schools, educational institutions, government and the non-profit sector to systematically and structurally respect the right to be heard of children and youth

- Demonstrating model decision-making processes that involve children and youth in important civil and political decisions

Facilitating a network of child rights academics from Canada, the USA and the UK to respond to what children and youth have to say about their rights.

- Reinforcing and facilitating the network of agencies that shape public policy with respect to children and youth
- Nurturing in adults a culture of respect for children and youth as fellow citizens and the willingness to hear what they have to say

**Previous CRAN reports and *Shaking the Movers* reports:**

- Shaking the Movers I: Speaking Truth to Power: Civil and Political Rights of Children (2007)
- Shaking the Movers II: Identity and Belonging (2008)
- *Children's Rights Academic Network* 2008
- Shaking the Movers III: Child Rights in Education (2009)
- *Children's Rights Academic Network* 2009
- Shaking the Movers IV: Children and the Media (2010)
- *Children's Rights Academic Network* 2010
- Shaking the Movers V: Divided We're Silent, United We Speak: Standing up for Youth Justice (2011)
- Shaking the Movers VI: Standing Up for Children's Mental Health (2012)
- *Children's Rights Academic Network* 2012
- Shaking the Movers VII: The Right to Play and Artistic Expression (2013)

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## FOREWORD

Too many children and young people in Canada today are anxious, depressed and/or full of anger. Caught in the swirling currents of social change magnified by the eruption of the electronic media they are finding it harder and harder to locate something to hang on to that will bring them through to adulthood without foundering. With family and other social structures shifting, sex and gender roles blurring and the world around them, according to the media that has become their natural environment, charged with menace they are encountering major challenges to their security and to that the sense of belonging and identity that can provide a compass for navigating troubled waters.

Unfortunately it appears that the systems we have devised to help them are proving inadequate and sometimes counterproductive. When we brought forty young people together in Toronto in November 2012 to talk about the rights of children and youth with mental health concerns a number of common themes emerged from what they had to say. They were not specifically invited because they had problems themselves but it turned out that several of them did and, if they didn't, they all had friends or family members who were afflicted so the issues the groups raised in discussion resonated strongly with them all. One of the themes, to which they returned frequently during the two-day gathering, was how little they or their teachers, families and friends actually knew about mental health and how ill-prepared everyone was to respond. A second constant theme was the fear of stigma that often prevented them from seeking help even when it was available. A third concern was about being silenced when they wanted to speak up or speak out.

When our academic network (CRAN) gathered to respond to the youth in Ottawa at the end of January, 2014 all of them acknowledged being shaken if not surprised by what the young people had had to say. Their responses came from a variety of perspectives both personal and academic. Some spoke about family connections, others referenced their involvement in a variety of related activities. Since members of CRAN are primarily academics all of their contributions are thoughtful and considered and reflect their profound respect for the young people who had been willing to share their stories. Please read them.

- Landon Pearson

## OVERVIEW OF THE 5<sup>th</sup> ANNUAL MEETING OF THE CHILD RIGHTS ACADEMIC NETWORK

On February 1<sup>st</sup> 2014, following the success of four previous sessions, members of the Children Rights Academic Network (CRAN) met in Ottawa, Canada to discuss and celebrate children's rights. CRAN was developed by the Landon Pearson Resource Centre at Carleton University, with support from the Muttart Foundation, and is Canada's first network of academics involved in teaching, researching and advocating for children's rights.

This year, in the spirit of Articles 23 and 24 of the United Nations Convention on the Rights of the Child, CRAN's annual meeting responded to youth voices on the issue of Mental Health expressed at Shaking the Movers VI (STM). The report summarizing the outcomes of Shaking the Movers VI was distributed in advance to CRAN participants who in turn prepared responses to the youth voices expressed at the STM forum. The meeting's discussion and presentations responded to:

Article 23: The Right of the (mentally or physically) disabled child to benefit from special care and education for a fuller and more independent life

Article 24: The Right to the best quality healthcare services possible and to information to help stay healthy

The CRAN participants discussed a variety of issues across these themes, focusing at large on the widespread lack of knowledge and education about mental health at *all* ages; participants recognized that the way in which child mental health is addressed is inextricable from the way in which it is conceptualized and understood by the adult community. In this context, participants highlighted important but widely overlooked issues such as intergenerational trauma, the language and narrative surrounding mental health, and the need for creative and relevant alternatives to traditional mental health treatment practices.

CRAN members also discussed at length the need to confront the stigma of mental health issues throughout society, and to deconstruct harmful notions of what is "normal" that feed this stigma (ie. gender role expectations). Participants grappled with the fact that the "best interests of the child" are often at odds with one another in the case of mental health issues (ie. psychological vs. physical; long-term vs. immediate), but reinforced the need to include children in decision-making when making this determination.

Ultimately, participant presentations stressed the need for open and inclusive dialogue on mental health at every level – from individual parenting practices to the level of public policy discourse – moving away from a harmful culture of silence. The report that follows is a compilation of the CRAN participants' responses to the Shaking the Movers VI themes. Publishing them demonstrates that youth have been 'heard' and their perspectives integrated into current academic debate.

## INTRODUCTION

On November 16th and 17th, 2012, the Landon Pearson Resource Centre for the Study of Childhood and Children's Rights, in partnership with the School of Child and Youth Care at Ryerson University, supported by Ontario's Provincial Advocate for Children and Youth and the Public Health Agency of Canada, conducted its sixth Shaking the Movers Conference. The area of focus was children's mental health as it relates to Articles 23 and 24 of the United Nations Convention on the Rights of the Child. Of course, there was continual reference to Article 12, the child's right to "voice" and "participation", which permeates every Shaking the Movers Conference. The program for the two day conference was co chaired by Landon Pearson and Judy Finlay. Lauren Akbar, a graduate from the School of Child and Youth Care at Ryerson University, organized and facilitated the conference.

Forty youth were selected from across the province to participate in the conference due to their keen interest in mental health issues and children's rights. Some were advocates for a better understanding of mental health issues in their community. However, only a few identified at the time of recruitment as personally having mental health concerns. The youth participants were divided into four discussion groups according to age. There were two groups of youth who were seventeen or older; one group aged fourteen to sixteen; and a younger group of youth who were ten to thirteen years old. The youth participants were in their designated groups for small group discussions only. Otherwise, the groups were blended, which allowed for all youth to get to know one another.

This was the most powerful and moving conference to date, with youth speaking openly and passionately about how they were directly or indirectly impacted by their own mental health issues or those of family members or peers. In anticipation of the kind of discussion that may arise due to the nature of the topic, special features were put in place to make the conference a safe environment. For example, the youth were provided with an information package prior to the conference in order to have a clear understanding of what to expect during the two days. There was a child and youth care student available for every two youth participants throughout the conference programming. Round the clock support was provided to the youth by mental health professionals with additional supports built in for those who identified as having mental health concerns.

Five Child and Youth Care classes from Ryerson University were involved in facilitating the small group discussions and the activities throughout the two days. One class deconstructed the articles of the UNCRC in order to discuss children's mental health in a language that children and youth could understand and appreciate. This class facilitated the small group discussions. A second class organized and facilitated evening activities, which focused on the theme of mental health through the use of art, music and recreation. Three other classes joined the conference for shorter periods of time conducting interactive games and performances that served to explain the UNCRC, the role of advocacy, "having and using your voice", and mental health. The additional support and guidance that was

available to youth participants through these students served as a necessary safeguard given the age of many of the youth and the nature of the discussion and disclosures. It was also a valuable learning experience for the students as well.

Unique to this year's two-day program was the introduction of two youth speakers. The first youth speaker was a young woman who described her experiences living with mental health concerns, the importance of seeking support and the challenges of navigating the systems. She was an inspiration to the youth and provided encouragement to speak out about what was going on in their lives. The second youth speaker was a young man who described his experiences and his advocacy work with First Nations youth in northern Ontario. He challenged the youth participants and the facilitators to answer the question 'What Next?'

On the first day of the program, the youth discussed problems and solutions identified in Article 23. The key questions asked of the youth were: what is meant by mental health and how has it affected your life? Similar discussions took place on the second day about Article 24. The key questions asked were: What does treatment mean to you and what roadblocks have you/others encountered in accessing services? Each group of youth made presentations at the end of each of the four discussions. On the second day, nine youth volunteered to be in the inner circle to tell their personal stories about mental health and accessing services. They faced one another in a small circle in the centre of the room. This inner circle was led by a trained clinician. The other youth sat in an outer circle and listened and commented at the end of the "circle" discussion. The discussion in the inner circle was moving and at times difficult to hear. There were powerful disclosures of lived experiences and struggles that were faced by those experiences. The youth learned from each other's experience and they expressed their compassion and hope. At the lunch break and after the inner circle experience, other youth approached the facilitator and explained that they too wanted the opportunity to participate in the inner circle. A second inner circle occurred in the afternoon with a different group of participants. Younger youth were separated from the continuation of this activity at their request. The themes that arose throughout the discussion and activities of the two days included:

- Youth need an opportunity to tell their story in a safe place and to those who understand.
- Youth with mental health concerns experience feelings of alienation and isolation.
- Youth understanding of mental health was based on their first hand experience with classmates, siblings and parents who suffered from mental health issues or their own personal experiences .
- Families don't always understand the behaviour of youth that may be symptomatic of mental health issues and consequently the youth are seen as disruptive to family life.
- Youth expressed that they have a right to be different.
- Youth expressed that schools need to be a safe place and that teachers and students need more understanding and compassion related to mental health.

- Youth reported that ‘you never recover from mental illness, you just learn to live with it’.

Based on the discussions, the presentations made through the use of drama and art, and the direct accounts given by the youth, a number of crucial conclusions can be drawn. The youth acknowledged that resources were limited or not accessible to assist them; that their families didn’t always understand; and that school is not always a safe place. For these reasons, they turn to their peers for support and advice. However, hearing the stories of their peers can be overwhelming and become a burden to them. The youth were clear that they didn’t know how to support their peers, felt unwilling to offer advice and were afraid for the wellbeing of their peers who were reaching out to them for support. This was a dilemma for many of the youth for which they could find no remedy. Nonetheless, the youth explained that social media is an important resource that they do use to be heard. They consistently asserted that there needs to be an anonymous online site that is youth friendly, like a chat line, where youth can access assistance for mental health concerns. Finally, youth affirmed that they felt safe at the conference; felt heard, often for the first time; felt that what they said mattered and that they mattered; felt that they had a voice; and a number of youth indicated that the conference was a turning point for them. Many reported to the facilitator, weeks after the conference that they reflected on the experience and knowledge they had gained and used it to engage others in a dialogue about mental health.

Judy Finlay, PhD  
Associate Professor, School of Child and Youth Care  
Ryerson University  
Shaking the Movers VI Co-Chair & Small Group Facilitator



## PARTICIPANT RESPONSES

**SUE BENNETT, MB ChB, FRCPC**

CHILDREN'S HOSPITAL OF EASTERN ONTARIO (CHEO)

*Shaking the Movers 6: Standing up for Children's Mental Health*

The report of the proceedings from Shaking the Movers 6: Standing up for Children's Mental Health states that "although suicide is only one manifestation of the mental health issues facing children & youth, as a theme it came up several times where the youth expressed the importance of discussing suicide openly". I will address this theme briefly with specific reference to the prevalence of youth suicide and the media reporting of suicide.

Interestingly Shaking the Movers 6 came at a time of significant media publicity around the suicidal death of Ashley Smith, a 19 year-old young woman, whilst in detention. It was a story difficult to miss as the media (mainstream print, TV and social media sites) broadcast graphic videos of her struggles.

In 1948, the World Health Organization (WHO) defined health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Suicide is at the extreme of the continuum of mental illness and is still very much an unspoken taboo and open discussion and understanding will hopefully remove the myths and stigma that surround this topic, which is a prime reason for youth not seeking help.

### **Scope of the Problem**

It is important to have the data on suicide to get a scope of the problem in order to be able to better understand its root cause and thereby prevent it happening in the first place through the development of evidence based prevention programs and monitoring. However its existence needs to be recognized before it can be identified and measured. Death by suicide is just the tip of the iceberg.

For every death by suicide there are 200-300 attempted suicides.

For every attempted suicide there are thousands thinking about it (ideators).

For every ideator there are thousands with mental health problems.

According to Stats Canada (2011): The rate of suicide for 15 – 24 year old Canadians is approximately 10.8 deaths per 100,000 and 1.5 deaths per 100,000 for 10 -14 year olds. The rates of suicide for Aboriginal youth are even higher, and are considered to be among the highest in the world. In fact, it is thought that as many as 25% of the "accidental" deaths

among Aboriginal youth may actually be unreported suicides. Quebec used to have the highest rate but it is now decreasing since recognizing that 90% children & youth who die by suicide have a mental health disorder and the province has implemented programs for early identification and wrap around treatment & services.

In 2009 in Canada:

8% of youth 15-19 year olds attempted suicide

1 in 5 youth 9-19 year olds have a mental health problem or illness

70% of mental health problems and illnesses have their onset during childhood.

3 out of 4 children and youth who have a mental health problem or disorder will not receive treatment.

Over 20% of children with a diagnosed mental health issue will wait more than a year for treatment. The average delay is 12 months

Almost 90% of people who die by suicide have a mental illness

23% of all deaths for youth 15-19 years old can be accounted for by suicide

Death by suicide approximates to 3 x the rate of cancer deaths for youth 15-24

Canada has a discriminatory two tier system of care for children and youth needing mental health services unlike the health care system for physical health. Government services only cover the cost of care by psychiatrists with whom there is typically a one year waiting list to get an appointment. However if the family has the financial means they can pay for the services of a psychologist or social worker in the private sector. The provincial governments must ensure that every child & youth in Canada has access to mental health services as needed regardless of family's ability to pay.

### **Societal Determinants of Health affecting Mental Health**

In 2008 a WHO Commission recognized the powerful impact of the social determinants of health on the health and developmental outcomes of children. However, health systems continue to be disease and medically orientated and reactive towards the individual child. There is a fable of a person who sees a child in the river drowning and fighting for life while engulfed in a powerful current, reaches to save the child and sees another child & then another in a continuing stream and starts yelling to passers - by to come & save the drowning children. The passers- by come to assist but one refuses and says "I'm going upstream to find out who is throwing the children into the river and stop that person." This is a metaphor for reactive efforts without understanding why the child is ending up in the river in the first place.

Pope Francis recently reflected on the societal determinants affecting the health of young people when he said that the most serious evils that afflict the world today are youth unemployment and the loneliness of the old. The young need work & hope but have neither one nor the other and the problem is that they don't even look for them anymore. They have been crushed by the present without a desire to look ahead to the future and a family. Can they go on like this? When the interviewer suggested that those issues are largely political and economic problems for governments, the Pope noted that the problems affect our bodies and souls.

A recent UK YouGov poll for the Prince's Trust Macquarie Youth Index reports that 40 % of unemployed young people (16-25 years of age) have experienced symptoms of mental illness such as suicidal thoughts or feelings of self-loathing and panic attacks due to their unemployment. Also self-harm, using large quantities of drugs and alcohol. Of those polled 9% said that they did not have anything to live for. The situation was found to be worse among the long-term unemployed for 6 months or more (166) with 21% agreeing that life was not worth living. There are presently 900,000 unemployed young people in the UK & more than half face long-term unemployment. The vulnerable had suffered most as graduates lowered their career ambitions taking jobs previously filled by people with fewer qualifications. Those at the bottom are really struggling. The report used online interviews Oct & Nov 2013 with 2161 youth 16-25 years old.

### **Suicide and the Media**

I would now like to highlight the issues of openly discussing suicide in the media. The earliest known associations between media and suicide arose from Goethe's novel *The Sorrows of Young Werther* published in 1774. Werther dies by suicide with a pistol after he is rejected by a woman he loves. Shortly after its publication there were many reports of young men using the same method of death by suicide. This resulted in the ban of the book in places. Hence the term "Werther effect" came into the technical literature to describe so called "copycat suicide". This latter term was coined by researcher David Philips in 1974. His reports in 1985 and 1989 found that suicides tend to increase after a well-publicized suicide. Various explanations were given; people imitate those who seem similar; suicides by celebrities or stories that glorify the deceased and simplifying the reasons that lead to suicide; seeing suicide as a glamorous ending with youth getting the attention, sympathy and a national concern that they never got in life; and if glamorized individuals couldn't cope then they couldn't either.

Marilyn Monroe's death by suicide is often quoted as the quintessential copycat suicide with a rise in deaths by suicide by as much as 12% after her death. Another more recent example is the case of death by self-immolation by Mohammed Bouaziz, a Tunisian street vendor, who set himself on fire in December 2010, an act that was the catalyst for the Tunisian revolution that sparked the Arab spring. Several men emulated Bouaziz's act. Anecdotally suicide rates went down when anti-suicide billboards were put up in the streets of London, UK.

There is now a significant evidence-base demonstrating that media reporting of suicides is linked to copycat suicides among youth and young adults less than 24 years of age. Ian Colman's research suggests "suicide contagion" and that the idea that someone else's suicide can influence your own thoughts and behaviors does occur and especially amongst younger adolescents. His study examined 22,000 12-17 year olds and found that the younger set who had been exposed to suicide were x 5 more likely to be thinking about suicide and the 16-17 year olds x 2 more likely. It made no difference whether or not the youth knew the person who died. The study highlights the devastating ramifications that can unintentionally result when too much attention is given to individual cases by the public.

The media clearly has an important role to play in suicide prevention by reporting about suicide, mental health and mental illness in an informed, sensitive, responsible and respectful manner.

The language of suicide reports has a long tradition in the west of stigmatizing individuals who are associated with suicide. The very act of killing oneself used to be a crime in some countries and even now the language associated with the criminality of the act of suicide endures; specifically the phrase "to commit suicide" associates the act with self-murder.

Various countries have journalism codes which range from one extreme of "suicide and attempted suicide should never be mentioned" in Norway to more moderate codes. The World Health Organization endorses using extreme restraint in media coverage of deaths by suicide. Suicideologists, public health officials, researchers, psychiatrists, psychologists, and news media professionals with the Canadian Association for Suicide Prevention (CASP) and the Center for Disease Control (CDC) have provided specific guidelines for the media to report suicide and there is evidence that implementation of guidelines (listed below) actually decreases the rate of copycat suicides and the incidence of suicide in vulnerable children and youth.

**Guidelines for Media Reporting on Suicide generally include the following:**

**Avoid:**

- Details of the method
- The word "suicide" in the headline
- Printing photo of the deceased
- Admiration of the deceased
- The idea that suicide is unexplainable
- Repetitive or excessive coverage
- Inform without sensationalizing
- Front page coverage
- Exciting reporting

Romanticized reasons for the suicide (e.g. saying the victim wanted to be with his deceased girlfriend)

Simplistic reasons for the suicide (e.g. saying the victim was depressed, implying all depressed people are suicidal)

Approval of the suicide

Referring to suicide as a 'successful' or to a suicidal attempt as a 'failed attempt'

Use the words 'died by suicide' not 'committed suicide'

**Convey:**

Alternatives to suicide i.e. treatments

Always include available community resources in all forms of reporting

Warning signs of suicide

Encourage help-seeking behavior

Seek expert advice

Andre Picard, Globe & Mail Reporter and Dr. David Goldbloom, Chair of the Mental Health Commission (2012) challenged the science used by the Canadian Psychiatric Association to establish their guidelines and suggested that they are supporting a conspiracy of silence and actually creating more trauma. They state that these guidelines reflected thinking in the late 20th Century when they were created but are now irrelevant when there are more than 100,000 online sites about suicide and many of them are explicit with 'how to' instructions. They ask does anyone believe teens are reading newspapers?

Supporting their philosophy January 28th, 2014 was the 4th annual Bell "Let's Talk Day" when the issue of mental health was openly discussed across all platforms of national media. Canadians texted, called, tweeted and shared the Bell Let's Talk image more than 109 million times on the one day. This was a 14% increase from 2013. Bell has now donated more than \$67.5 million dollars to mental health initiatives over the past 4 years. The advertising impact on their company is in the billions and it is a great strategy to link their name to a good cause but it remains to be seen if the talk is turned into action.

**A major mandate of suicide prevention is to recognize:**

That death by suicide is a possibility.

That the thoughts and feelings of suicide are a response to a situation that a person sees as unbearable. Another person or counselor may be able to help the suicidal youth to see their situation from other perspectives and teach them different ways of coping. The fact that the best predictor of future behaviour is past behavior speaks to the importance of taking every suicide attempt very seriously and should not be dismissed just attention seeking behavior. Young people are more likely to go to their peers than their parents and may not let an adult know a friend is suicidal. Adults need to keep lines of communication open and advise outside help when needed.

Suicidal children & youth are in pain and want the pain to end and do not necessarily want to die. Often they do not know how to make things better or have the energy to get help. It may be ethically & legally necessary to breach confidentiality when there is:

- Serious risk of suicide or harm to others
- Knowledge of a child in need of protection (e.g. from suspected child maltreatment)

Become informed about your legal & professional responsibility and know your Provincial mandatory reporting laws

Professional organization protocol e.g. confidentiality, crisis procedures, documentation

A person's safety is the first concern and generally overrides others so get legal advice if unsure...

The stigma of suicide is lessening because of an increase in information, education, understanding and awareness. Similar positive progress was made removing the stigma of AIDS in the mid-1980s with widespread communication of accurate information to the public with a normalizing effect that these illnesses could happen to anyone. Suicide should not be accepted or condoned but its prevalence & seriousness should be acknowledged as a preventable injury, and its prevention prioritized.

I have a question to the youth of STM VI regarding their rights & responsibilities. With the evidence that sensational media reports can increase the risk of suicide rates in young people what can they do or what do they recommend be done to keep their friends safe in the new technology/social media communications arena?

The UN Convention on the Rights of the Child further delineates these perspectives on health in a human rights based framework which not only addresses the human rights violation of the lack of the right to health but also addresses the aspirational aspect of the child's right to the best possible state of health and wellbeing and how all the other rights in the Convention are equal and interconnected in order to achieve this state. The Convention gives a holistic perspective for health and well-being including not just physical health but the inextricable connection with mental, social and spiritual health. We need to put mental health on a par with physical health. We cannot have good health without mental health. Artificially separating mental health from physical health in health systems promotes different silos with differential funding sources.

### **Resources**

Ontario Centre of Excellence for Child & Youth Mental Health

<http://www.excellenceforchildandyouth.ca>

613 737 2297

**MARV BERNSTEIN, J.D, LL.M**  
CHIEF POLICY ADVISOR, UNICEF CANADA

*Child Rights Impact Assessments: An Effective Framework for Giving Effect to Children's Voice in the Formulation of Legislation, Policy and Programming*

## **Introduction**

In reading the comments of some of the young people involved in the most recent installment of Shaking the Movers – and their reluctance to come forward and speak about their mental illness for fear of being stigmatized and bullied, it seemed as though they were not only reducing their own capacity to solve their personal issues, but also were denying themselves the opportunity to influence the development of legislation, policy and programming that could benefit other young people in similar circumstances.

An old adage claims that “children should be seen, but not heard.” Of course, concerned Canadians know better. We know that children, even the very young, are rights holders who enjoy the equal protection and benefit of the law because of their equal human dignity. We also know that they have a right to be heard according to their age and maturity when decisions are made which affect them, and we also know that all governments, as duty-bearers to children, are required to act always in accordance with the child’s best interests. Children have vulnerabilities based on their age and development and require special protection to ensure that their rights and well-being are being safeguarded in all aspects of their lives. Where they are supported and encouraged to reach their full potential, they are capable of doing amazing things not only for themselves and their immediate circle of relationships, but also have the ability to become influential agents of significant social change.

One way of ensuring that children don’t remain silenced - or even invisible - citizens when the opportunity presents itself for them to influence government and institutional policy-making and decision-making is through the vehicle of Child Rights Impact Assessments which include, as a core component, consultation with children and a serious consideration of their views as to how their rights are being impacted by government and institutional action or inaction, as the case may be.

## **Defining CRIA**

A Child Rights Impact Assessment is a tool for assessing the potential impacts of a proposed policy, law, program, or particular decision on children and their rights. The Convention on the Rights of the Child is the framework used to assess these impacts. The impacts revealed can be positive or negative; intended or unintended; direct or indirect; and short-term or long-term. The focus of the assessment is to understand how the matter under review will contribute to, or undermine, the fulfillment of children’s rights and well-being – and to be able to maximize positive impacts and avoid or mitigate negative impacts.

### Potential Users of CRIA

While governments at all levels have the primary duty to apply CRIA processes, other potential users are parliamentarians, independent Provincial/Territorial Child and Youth Advocates, professionals, institutions (schools, hospitals), civil society organizations and the private sector.

### Reasons for Using CRIA

Canada has signed and ratified the Convention on the Rights of the Child and is obligated under international law to implement it. Article 4 requires States to take all appropriate legislative, administrative and other measures to implement the rights which it contains – at all levels of government.

The rights contained in the Convention, including the right in Article 3 of children to have their best interests treated as a primary consideration in all actions concerning them, give rise to both substantive and procedural obligations. The UN Committee on the Rights of the Child has provided further guidance on the beneficial use of Child Rights Impact Assessments as a means of ensuring that children's interests and needs are considered in any proposed policy, legislation, regulation, budget or other administrative decision which may affect them and the enjoyment of their rights (see General Comment No. 5 (2003) on the *General measures of implementation of the Convention on the Rights of the Child* (pars. 45-47) and General Comment No.14 (2013) on *the right of the child to have his or her best interests taken as a primary consideration* (par. 99), as well as the 2012 Concluding Observations of the Committee directed to Canada (pars. 34-35)).

### Benefits of CRIA

A survey of literature and experience identifies various benefits to both children and to decision-makers in undertaking a CRIA, including:

- Making children visible in policy and decision-making processes that affect them
- Understanding the full range of impacts for children before decisions are made
- Maximizing positive impacts and avoiding/reducing/mitigating negative impacts for children, including the identification of unintended negative consequences of proposals
- Determining 'the best interests of the child' through a comprehensive analysis
- Bringing research evidence and analysis to bear on policy decisions that affect children
- Bringing consultation with young people, academics and key stakeholders into the assessment process to the extent possible



- Identifying and addressing factors that have life-long impact for children, including future generations
- Avoiding/minimizing discrimination and inequitable treatment of different groups of children
- Considering obligations under the Convention early in the policy formulation process rather than waiting until violations are identified in monitoring reports or challenged in court, and thus avoiding costly mistakes
- Protecting the integrity of the proposed law or policy against later allegations of Charter and Convention breaches
- Increasing the legitimacy of and public support for government decisions impacting children through accountability, transparency and the participation of affected youth and other stakeholders
- Improving cross-departmental government coordination in considering impacts upon 'the whole child'
- Creating space for substantive dialogue and consideration of conflicting rights claims

#### **CRIA as an International Practice**

There are a growing number of countries around the globe using CRIA processes, including Flanders (Belgium), Finland; Sweden; Scotland; Northern Ireland; Wales; England, Australia; Bosnia-Herzegovina and the USA.

The issues that have been addressed by CRIA processes around the globe are varied and include such diverse subject matter as energy price increases (Bosnia-Herzegovina); moving early childcare services from one department to another (New Brunswick); child benefits reform (England); welfare reform (Northern Ireland); identity cards (England); organ donations (Wales); monitoring convicted child sex offenders (Scotland); lowering the voter age (Scotland); and planning transportation routes (Sweden)

#### **The Canadian experience to date**

Historically, there has been little use of CRIs within Canada. There have, however, been a few welcome exceptions. At the municipal level, as part of its implementation of the UNICEF Child Friendly City initiative, the City of Edmonton has developed a child impact tool for assessing the impact of its services.

At the provincial level, there have been exploratory discussions about implementing CRIA between UNICEF Canada and child welfare government officials in Alberta, Ontario and Saskatchewan.

The greatest use of CRIA at the provincial level has taken place in New Brunswick where it has been mandatory since February 23, 2013 to complete a CRIA and attach it to a Memorandum to Executive Council (MEC) whenever a proposed law, regulation or policy is being considered by Cabinet from any provincial government department.

## Lessons learned from the New Brunswick CRIA experience that could be applied in other parts of Canada

Some of the key elements contributing to successful CRIA implementation in New Brunswick are:

- The adoption of a ‘whole of government’ approach, which supported a province-wide commitment and integrated approach to the development of child-related policy and legislation. This is preferable to piloting a demonstration project within a single government department.
- The creation of a CRIA Working Group, with 8 government departments represented, who became the CRIA leads and mentors for their respective departments.
- The co-chairing of the CRIA Working Group by both the Executive Council Office and the New Brunswick Child and Youth Advocate Office. This structure conveyed a sense of strong and respectful collaboration, with the two co-chairs being seen as CRIA champions from within and outside of government.
- The CRIA working group and the 2 co-chairs were supported by UNICEF Canada (for the development of the CRIA tool, training and curriculum development) and the University of Moncton (for future research and evaluation). UNICEF Canada went out to New Brunswick and provided a special CRIA training session to the CRIA working group well in advance of the larger whole-of-government training initiative.
- The model for the delivery of training was well-planned, took place over 4 days (from February 18 to 22, 2013), and was presented to over 100 senior government employees (Deputy Ministers to Policy Analysts) by UNICEF Canada, the Executive Council Office and the Office of the New Brunswick Child and Youth Advocate’s Office. The government is now considering how to make training simple and readily accessible by all policy and program development officials, as in Wales.
- The development by the New Brunswick government of its own CRIA tool, which has a two-part process. The initial screening assessment poses the question, “Are there any impacts on children?” If yes, then the second part of the assessment is activated, with a full CRIA being completed on the basis of a consideration of all the rights in the Convention on the Rights of the Child as well as some other considerations. This has turned out to be a simple and pragmatic approach. The tool is user-friendly and is an electronic self-directed form with key links being provided right in the form (i.e., not a pen and paper exercise).
- The perceived benefits at this stage are:
  - There is a better understanding of children’s rights and the Convention on the Rights of the Child – that the interdependent rights in the Convention help to stretch the frame of analysis and consider elements necessary for children’s well-being that might otherwise be overlooked
  - There is a greater balancing of the interests of various groups in the policy development process

- There is a better level of analysis of the impacts before wiring a Memorandum to Executive Council which has, in some cases, led to changes in proposed policy and to the withdrawal of some proposals altogether
- Ministers and members of the Legislature can be more confident in putting forth new laws, policies and other decisions
- The initial hesitancy in some quarters to adopt a new process has been alleviated and progressed based on experience with the CRIA tool
- There is a better understanding of the role of the New Brunswick Office of the Child and Youth Advocate by government officials and this has forged a stronger sense of mutual respect and support for each other's roles

### Conclusion

From time to time, notwithstanding the best of intentions, legislation and policy set off unintended negative consequences for the very children they are meant to benefit. In some instances, children are not considered at all in the process, even when it is likely that a proposed course of action will have impacts upon them. A Child Rights Impact Assessment could be effectively used to avoid or mitigate adverse impacts and enhance the benefits of policy, particularly for vulnerable children and youth. It can support those with the duty to protect children's fundamental human rights, including parliamentary legislators, with the analysis to make robust decisions, having regard to the views and life experiences of the young people who have been consulted and empowered as part of the CRIA process.

While it has, to this point, fallen to the provincial and municipal levels of government within Canada to initiate Child Rights Impact Assessment processes, there is much scope for CRIA to be applied at the federal level as well. The Government of New Brunswick has taken a strong leadership role by initiating a mandatory CRIA process and creating a new CRIA tool, with early positive results in evidence, and we encourage all levels of government in Canada to explore the benefits of taking similar steps – the children and youth of this country deserve no less.

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### *Mental Health issues for War-Affected Children: Learning from 'Rose'*<sup>1</sup>

This sixth edition of *Shaking the Movers* provides a powerful snapshot of youth's experiences with issues around mental health - the struggles, the impact and the implications. In this commentary, we complement this important snapshot by highlighting and exploring other realities experienced by young people – particularly the reality of mental health issues as they relate to children and youth affected by war.

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<sup>1</sup> An expanded version of this paper is being published in the inaugural issue of the Canadian Journal of Children's Rights (see <https://journals.carleton.ca/cjcr>)

Each year, thousands of children and youth enter Québec, fleeing from countries and communities in which there has been war and armed violence (Ministère de l'Immigration et des Communautés Culturelles (MICC), 2009). These refugee children are sometimes accompanied by a parent or caregiver and sometimes arrive alone as refugees, or without documented legal status, seeking asylum. In Québec, between 1998 and 2007, 8 of the top 10 source countries for accepted refugees were war-affected nations including Afghanistan, Colombia, the Democratic Republic of Congo, India, Iran, Pakistan, Peru, and Sri Lanka, representing 34,838 people, including children (MICC), 2009). Despite the many hardships that this group of children and youth may face, both in their countries of origin and upon resettlement to Quebec, this population has been largely overlooked in provincial and national research, policy and service provision, particularly in discussions pertaining to rights.

We have been working on a study of refugee youth who have fled their countries of origin and come to Canada as a result of war, genocide and armed conflict. The study explores several aspects of their experiences:

- Their wartime experiences in their countries of origin and how this has affected them;
- The migration process in coming to Canada;
- Their experiences of resettlement to Quebec, exploring both the opportunities and the challenges.

Throughout the interviews, we realized that the issues of mental health were prevalent in complex and intense ways. This leads us to identify three areas to consider for standing up for the mental health needs of war-affected youth.

### **Rose's story**

For war-affected youth, mental health issues may present themselves at all points: during war, the migration process or resettlement. Our goal is to highlight some of these mental health issues by sharing the story of a young woman originally from Rwanda, now living in Montreal. We will refer to her as Rose. Rose's narrative highlights not only her life story both in her country of origin and in Canada, but also the mental health issues that she has faced.

Rose describes the context of profound violence and insecurity in her country of origin:

I was eight years old in nineteen-ninety four. They did come after me. I was hiding...I stayed in the forest, [in the] bush for months, yeah two months, because I was hiding, so that they won't kill me. They had killed all my family members, and they were looking [for me]. Because, it's like, your neighbours, they know everybody at home. They know they have already killed this and that, this and that, and this one is remaining. Yeah, they knew I was still there, and they were looking for me... They don't want anyone to remain. So, like I think they had a list of people...They

put a check[mark], this one is killed. This one is remaining, question mark. Where is this person? And they start searching for you.

The glaring rights violations of the young people are revealed not only in the profound lack of protections provided to them during armed violence, but also in the significant losses of loved ones. The violent and senseless murders of family members profoundly marked Roses' life:

I lost my entire family [in the genocide]...I was born in a family of six kids. I was the fifth. I had a father and mother. I had a grandmother, my mother's mother. I had my aunt. I had three aunts, one uncle on my father's side. Then I had two aunts, one uncle on my mother's side. And, yeah, I lived happily. But, during the Rwandan genocide, they were all gone. I lost my entire family...the entire family. Sisters, brothers, father, mother, grandparents, aunts, uncles.

Rose discussed her decision in choosing to leave Rwanda, where after the war she continued to experience fear:

The reason why I left is because Rwanda was a peaceful country. Like, at the moment I left, there was no longer genocide, no people killing others. But [it was] the reconciliation thing. The president or the government wanted people to reconcile. People who killed to reconcile with the families they killed. So, I don't know whether there was a chance. I met the person that killed my father. And, yeah, like, he told us the way he killed him. Like, they gave us details which was so scary. I couldn't stand that. And so, I was afraid. Very afraid. I wouldn't sleep, I was like: tomorrow he will come and kill me... After that, I said, I can't stay. He will kill me...To me, it was just like, I know [in Canada], the country's secure. So, no one will kill me. That's what I was thinking. If no one will kill me there. I will be alone, independent...I was looking for security.

The long-term impact of the genocide remained with her:

I was also traumatized. After [the] genocide, I couldn't sleep. I was traumatized...I had everything I needed [food, schooling etc.]...but the real problem was on the inside."

Sometimes I fear that there are other people who can kill me, so that affected me so much. [I hear people running after me... people hunting me. [laughs]

Roses' narrative provides a snapshot of the ways in which war ravaged her family and in multiple ways truncated her childhood. Her story bluntly reveals the continued breaching of her rights, where the obligation to provide "protection and care" to children has been infringed upon repeatedly and violently. As such, one would be tempted to conclude that Article 38 of the UN Convention on the Rights of the Child which obliges states to "take all feasible measures to ensure protection and care of children who are affected by an armed

conflict” makes no (or little) difference to their lives. However, as contended in this commentary this conclusion would be limiting – as applying a child rights perspective equally entails giving voice to children’s testimonies. In listening to young peoples stories we learn about their physical, emotional and environmental pain. It is in light of youth’s reflection of their past, that one can begin to understand their views on resettlement and the challenges and opportunities they faced.

Rose describes her arrival in Canada as first feeling fortunate and thankful but then the hardship of finding herself alone and misunderstood:

When I got here, it was like a shock. Nothing was clear to me. Like, in my mind, I was -- I didn’t ask myself, where am I going, and when I get there, how will life be? I did not ask myself all those questions. No. It’s just like, I fell from heaven. [laughs] Yeah, lucky to come in. That was my wish. My wish to come to Canada. And they said yes. Welcome to Canada... If you ask me to describe it I would just use one word and say it was “wonderful”...But life in Canada was harder than I thought. Life was like, you’re alone. You have to struggle. Now it’s me, myself and I...You feel like you’re alone.

She reflected on the inadequacies of the support system, and how she experienced multiple mental health issues:

I was able to go to school, but I did not study well as I would be before... Yeah, [the genocide] affects my studies, because, sometimes it’s like I remember, my memory goes back [to the genocide]. And then I feel I don’t want to study. Sometimes I say, oh, why do I have to study? My father studied, but where is he? Yeah. Sometimes I feel like I don’t want to study.

There is also hopeless, yeah, and some depression

Interviewer: Do you ever go to see anybody [for assistance]?

No.[Laughs]. I don’t see how someone else can help. I don’t think someone can help me. I have frustration, yeah. I don’t know, who can help? How can that person help?

Later in the interview she commented:

War-affected youth need therapists to help them. Because they are affected mentally. Yeah. Sometimes they are traumatized. They can help [with others], but not me.

Her comment was somewhat disconcerting: while identifying a need for services, they could not adequately help her.

In contrast, she speaks positively about the informal support system, such as connecting to people from her church and her Rwandan community. She explains how she feels comfortable with them:

I have a group at the church. They are all from different countries. So, talking with them helps me to come over the challenge.

This point is similar to the one made by participants in *Shaking the Movers*, who identify the critical role of peer support.

In responding to the critical importance of listening to young people's perspectives, what can one learn from Rose's story?

### **Standing up for war-affected young people's mental health**

Our study points to three areas that require further attention to support the particular mental health needs of war-affected young people.

1. *Creating the space to actively and appropriately listen to war-affected young people's experiences.* As illustrated in Rose's story mental health issues are not talked about and there are few spaces where war-affected young people feel safe to talk about what is going on in their lives. They felt that their mental health issues would not be understood by others – that their experiences of violence and survival in relation to war and armed violence were so far beyond the norms of what other Canadian youth have experienced, that no one could possibly understand.

Rose wanted to share her experiences with others, and noted the importance and positive impact of speaking and sharing but this needed to be in a safe and secure context:

I feel free. I feel like I want them to know. Because I don't want this to happen again. And, once you know, you can -- I think you can help. In which way? By communication. You can tell others, this and that happened, and we don't want this to happen again. So, if I tell people around me what happened to me, they will help next time this happens to someone else...Speaking is like therapy.

In the absence of a safe space there was an overall reticence to share or speak about what she had gone through. This deepened her feeling of isolation. Thus creating a space for truly listening to young people's stories is a critical starting place.

2. *Capacity-building for mental health professionals.* Related to creating a safe space our study points to the need to revisit the training of mental health professionals. Young people in *Shaking the movers* identify "EDUCATION is Key" (p. 18) but further attention needs to be placed on the type and form of education that will appropriately provide for the support of war-affected young people. In seeking answers to this question, there may be value in

examining what defines the success of the informal support system. Are there elements of success in the informal system that could inform capacity-building of professionals?

3. *Informing practice by furthering research with young people who have experienced war.* Finally, equipping adult allies including mental health professionals involves doing more research with young people who have experienced war and have the ability to reflect and inform us on ways of creating a system that can support the mental health needs of this population.

Our study has shown that the traumatic lived experiences of war etches these young people's lives in profound and multiple ways, professionals need not only an awareness but also an understanding in how best to listen and to work with these young people in ways that acknowledges their past, and future. Increasing the knowledge *about* young people can only happen *with* them.

The above points are a starting place to enhance Canada's obligation under the UN Convention on the Rights of the Child. It is also part of our society's responsibility because as evocatively expressed by the young people in *Shaking the Movers* mental health issues affect us all directly or indirectly. Rose's story is powerful and painful; we have a collective responsibility to respond to her needs in ways that allows her to cope with her mental health issues, and provide for the human dignity of all.

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### *CRAN Response to Standing up for Mental Health from Shaking the Movers VI*

Dear Shaking the Movers (STM) VI Participants:

Canadian society is making some progress with respect to mental health. Once a taboo topic, some measure of success is evident from Bell's "Let's Talk" campaign on January 28, 2014 with 109,451,718 tweets, texts, calls and shares, a 14% increase from last year.<sup>2</sup> The young people in STM noted however, that it is easier to advocate and do something for others than for oneself (p. 17). Thus, tweeting or texting is a simple, quick gesture that does not and cannot indicate commitment or dedication to an issue. When one has a mental health problem, how quickly does the individual or a loved one acknowledge it, and respond appropriately? There are many barriers in practice whether they are psychological, cultural or social to seeking help. As STM identifies, there is a need for much more education of the population including teachers (p. 29).

<sup>2</sup> Charity Village, "109,451,718 tweets, texts, calls and shares make Bell Let's Talk Day a resounding success" January 29, 2014,

[https://charityvillage.com/Content.aspx?topic=109\\_451\\_718\\_tweets\\_texts\\_calls\\_and\\_shares\\_make\\_Bell\\_Let\\_s\\_Talk\\_Day\\_a\\_resounding\\_success](https://charityvillage.com/Content.aspx?topic=109_451_718_tweets_texts_calls_and_shares_make_Bell_Let_s_Talk_Day_a_resounding_success) (accessed 31 January, 2014).



Voltaire (1764) expressed in 1764 that: “Minds differ still more than faces.”<sup>3</sup> The Canadian Coalition for Rights of Children (CCRC) notes: “It is estimated that 15% of children and youth are affected by mental health issues at any given time. Many mental health problems start before the age of 18. Early attention would benefit young people for a lifetime.”<sup>4</sup> Consequently, STM’s consideration of the important topic of mental health is necessary and valuable. You have offered much insight about the realities of mental health and implications for young people and others.

The following response as well as some suggested next steps are organized by the four general principles of the Convention on the Rights of the Child (CRC): non-discrimination (a. 2); best interests of the child (a. 3); maximum survival and development (a. 6); and views of the child (a. 12). Then some suggestions for next steps are offered before concluding.

### **Non-Discrimination**

While our society subscribes to non-discrimination as a Canadian value, as provided in Canadian Charter section 15, STM illuminated the reality of societal divisions and how difference leads to labeling and stigmas (p. 22).

We are surrounded by difference and should not use it as a reason to discriminate against others. After all, as Andrew Solomon points out, health issues results from the configuration of chromosomes and the influence of external processes facilitating or suppressing gene expression.<sup>5</sup> The results of our genes and our environment should never provide reasons for considering someone or a group of people as the “other” or less than someone else. Indeed, as a STM participant enunciated: “there is no normal” (p. 22).

### **Best Interests**

The issue of mental health illuminates how the principle of best interests of the child is not well respected in Canada. As STM participants highlight, we are not focusing on young people in our community who are in pain and isolated from others. It is also not in the best interests if we allow mental illness to define young people as “problems” since a 14 year-old female participant explained: “My illness does not define me” (p. 12). It is in children’s best interests that we focus on comprehensive approach to mental health, not mental illness.

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<sup>3</sup> Voltaire, “Wit, Spirit, Intellect”, *Philosophical Dictionary* (1764).

<sup>4</sup> Canadian Coalition for the Rights of Children (Vandergrift, Kathy, Lisa Wolff and Tara Collins (eds.)), *Right in Principle, Right in Practice: Implementation of the Convention on the Rights of the Child in Canada*, Ottawa: Canadian Coalition for the Rights of Children, 2011, available at [www.rightsofchildren.ca](http://www.rightsofchildren.ca), p. 43.

<sup>5</sup> Solomon, Andrew, *Far from the Tree: Parents, Children and the Search for Identity*, New York: Scribner, 2012, 306.

## Maximum Survival and Development

Maximum survival and development of children and youth in Canada is questionable in light of the situation of mental health. STM confirms the general consensus that not enough is being done on advocacy and awareness about mental health (p. 16) including a lack of support for young people (p. 29). Furthermore, development is hindered by young people's difficulty in maintaining relationships (p. 29).

## Views of the Child

The views of the child are incredibly powerful to illustrate the reality of mental health as STM illustrates. We should not be afraid of these views. When children express problematic or incorrect understandings of mental health or utilize labels or rely on stigmas to express themselves, there is an opportunity for communication and learning. By not talking about mental health issues, lack of understanding is allowed to fester.

The report concludes that we are all affected by mental health directly and indirectly (p. 31). Since the aim of STM is to facilitate youth involvement in the development of "workable solutions to challenges", some modest suggestions are offered at various levels for moving forward.

Legislation, policies, programming and awareness efforts should be advanced in relation to children's mental health at the national, provincial and local levels. For example, the fact that there is a Canadian Mental Health Strategy is a positive development. This strategy clearly outlines the following valuable priority:

"Increase the capacity of families, caregivers, schools, post-secondary institutions and community organizations to promote the mental health of infants, children, and youth, prevent mental illness and suicide wherever possible, and intervene early when problems first emerge".<sup>6</sup>

Hence, as the strategy recommends, there should be increases in supports to young people and their families, with expansion of identification, health promotion and mental illness prevention efforts directed to young children, school-based, community other initiatives.<sup>7</sup> However, the CCRC outlines that: "implementation and funding [of this national strategy] will be a challenge."<sup>8</sup> Hence, attention must be directed to support the effectiveness of this strategy.

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<sup>6</sup> Mental Health Commission of Canada. (2012). *Changing directions, changing lives: The mental health strategy for Canada*. Calgary, AB: Author, p. 18  
<http://strategy.mentalhealthcommission.ca/pdf/strategy-text-en.pdf> (accessed 31 January 2014).

<sup>7</sup> Ibid., p. 20.

<sup>8</sup> Canadian Coalition for the Rights of Children (Vandergrift, Kathy, Lisa Wolff and Tara Collins (eds.)), *Right in Principle, Right in Practice: Implementation of the Convention on the Rights of the Child in Canada*, Ottawa: Canadian Coalition for the Rights of Children, 2011, available at [www.rightsofchildren.ca](http://www.rightsofchildren.ca), p. 43.

While there are important contributions from PREVNet and various mental health organizations including Children's Mental Health Ontario (CMHO) and The New Mentality,<sup>9</sup> more research and advocacy are needed to support mental health.

We can also make more modest, significant steps because human rights do not only represent legal commitments. Child rights have significance in social, political, economic spheres and at the inter-personal level.<sup>10</sup> As the Honourable Landon Pearson has expressed, child rights are about relationships.<sup>11</sup>

Consequently, mental health has both direct and indirect effects young people and those around them. STM reveals that we all need to be doing a better job in connecting with young people and supporting positive relationships with and among young people. For example, STM should not provide the only opportunity in one young person's life to connect with other youth who understand "what it's like to be misunderstood." (p 35). Why are youth not helping each other and why are adults not helping youth seek support? (p. 22). "By no means should the onus be on the youth; the BIG question is why aren't adult allies helping the youth seek support? Why was this the first time many youth had shared their stories and why was this the first time they had discussed possible supports?" (p. 22)

It is clear that we need to relate better to each other. How is it that people only respond when a situation is at a crisis point, and beforehand, there is little or no support? (p. 22). One 17 year-old in STM notes, that "we only notice it [mental illness] once it gets bad and this is a problem because we need to be noticing it from the beginning to be able to help people" (p. 23) Our society does not adequately appreciate prevention, reacting in an inconsistent, ad-hoc way. Advocacy means that we should reach out and speak as 12 year old stated (p. 17).

Our communication efforts amongst ourselves could improve. For instance, that individuals in our society ask endlessly: "How are you?" with the standard, unthinking response of "fine".<sup>12</sup> Such standard communications protocol in the North American context does not allow for an honest exchange. Consequently, we should also consider other generally unproductive questions that we ask young people each day as: "How was school?" A child

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<sup>9</sup> See further [www.prevnet.ca/](http://www.prevnet.ca/), <http://www.cheo.on.ca/en/cheo/mentalhealth>, <http://www.thenewmentality.ca>

<sup>10</sup> See further Tara M. Collins, "International Child Rights in National Constitutions: *Good sense or nonsense for Ireland*", *Irish Political Studies*, vol. 28, issue 4, 591-619, 2013 <http://www.tandfonline.com/doi/full/10.1080/07907184.2013.838951>.

<sup>11</sup> Pearson (2012) *From Strength to Strength: Children's and Women's Rights over the Lifecycle*, Florence Bird Lecture, Carleton University, Ottawa, 8 March, <http://www.youtube.com/watch?v=TgHGOo7yvwQ&feature=youtu.be> (accessed 14 May, 2012).

<sup>12</sup> Allen, Tom, CBC Radio, "Shift with Tom Allen", <http://music.cbc.ca/#/Shift> (accessed 31 January 2014). Allen also remarked that in contrast, in Russia, everyone would say "awful" or "horrible."

may find this question too broad, complex or overwhelming, potentially wondering how to answer with a range of potential considerations from the day including:

- how embarrassing it was to be late in class by the teacher;
- that my “best friend” told me that I no longer hold that position at first recess;
- how another classmate was not very nice to someone is “different”;
- how I wish that I had the same toy or shoes as someone else;
- how my sandwich was soggy;
- there wasn’t enough snack in my lunch bag;
- how I know the difference between a pentagon and an octagon now;
- how I found a great book at library time;
- how I fell over at gym; or
- how I was lonely at recess, etc.

No wonder a child may find it hard to answer these “simple” questions. If asked every day for weeks or even years, it would be reasonable for the child to decide that the question is as meaningless as “how are you?”. Perhaps we could start with a genuine interest in each other and a commitment to communicate well.

In addition, when communicating with each other, we need to ask do we want to hear what is said? Sometimes as adults, we don’t have the time as there is a paper to write, deadlines to meet, dishes or clothes to wash, and so on, but we must make the time and effort. In order to be true to each other, we must truly listen and give “due weight” as CRC a. 12 provides. Then, we can be aware of the state of mental health of those we care about in our lives. As young people highlighted, things should not be at a crisis point before there is an appropriate response (p. 22). STM VI has illustrated the situation of children’s rights in relation to mental health for many young people today. Thank you for the opportunity of learning from you all.

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### *Crossing the Arc from Children’s Mental Health to Justice*

I would like to speak on children’s mental health and in doing so create a metaphoric arc to last year’s Shaking the Movers theme of juvenile justice. Children’s mental health is in the norm primarily perceived as a health issue, yet there are strong themes of justice and injustice that run through the children’s narratives in this years Shaking The Movers (STM). These include fundamental issues of justice and rights in relation to the UN Convention on the Rights of the Child (CRC), concepts of social justice, and deeply held expressions of personal justice.

In responding to the two articles in the CRC most pertinent to children’s mental health, Articles 23 and 24, the following questions were asked of the young participants:

**Art 23** What is meant by mental health? What does it mean to you? Has it impacted your life? How?

How do you think the perceptions of others affects youth your age who have mental health concerns?

**Art 24** Consider problems primarily related to services and to access. What does treatment mean to you? What mental health services have you or others you know been involved with? What roadblocks have you or someone you know encountered accessing services? Are young people included in developing treatment plans?

At the root of the CRC lies an inherent concept of human dignity, and it this concept of dignity that requires exploration in relation to Articles 23, 24. In particular this implies better understanding concepts of personhood, healthy identity, enjoyment of rights, belonging, well-being, and protection and justice in relation to rights.

Within Article 23 section “C” articulates:

*“States Parties shall promote, in the spirit of international cooperation, the exchange of appropriate information in the field of preventive health care and of medical, psychological and functional treatment of disabled children, including dissemination of and access to information concerning methods of rehabilitation, education and vocational services, with the aim of enabling States Parties to improve their capabilities and skills and to widen their experience in these areas. In this regard, particular account shall be taken of the needs of developing countries.”*

One of the youth participating in the Shaking the Movers: Mental Health workshop sagely expressed: “The CRC - It teaches us about what we should be receiving, but not necessarily what we are receiving.” This is the unfortunate reality for many children living in the Global South/Majority World countries, where most children have some access to the rights enshrined in Article 23, but almost no possibility to realize the commitments of Article 24.

World Vision’s Definition of MVC:

**“Most vulnerable children are children whose quality of life and ability to fulfil their potential are most affected by extreme deprivation and violations of their rights. These children often live in catastrophic situations and relationships characterised by violence, abuse, neglect, exploitation, exclusion and discrimination.”**

In its literature, WVI and WVUK have outlined **four factors of vulnerability**:

- **“Abusive or exploitative relationships:** relationships which are characterised by violence or use of a child to benefit others sexually or commercially, or which consistently harm the child through intentional acts or negligence
- **“Extreme deprivation:** extreme material poverty or deprivation of caregivers
- **“Serious discrimination:** severe social stigma which prevents children from accessing services or opportunities essential to their protection or development
- **“Vulnerability to negative impact from a catastrophe or disaster:** natural or manmade events can seriously threaten the survival or development of a child, and certain children are more likely to be affected negatively and less likely to be able to recover.”

I would like to highlight this rights deficit in a recent three country study carried out for World Vision International (WVI), with Rebeccah Nelems of IICRD and Dr. Mike Wessells a colleague from Columbia University (Cook, Nelems, Wessells., 2014) The study focused on better defining who are the *most vulnerable children (MVC)* living in WVI communities, and how can WVI child protection programs better include these children as well as increase the positive impact of their protection programs on them.

Methods used in the study were participatory, child centred, and combined playful, experiential engagement with deeper discussion and reflection. Adult child protection focus groups and key informant interviews were also conducted.

The six participating WVI community sites, two in each country, were located in Tanzania, Cambodia and the Eastern Democratic Republic of Congo (DRC). Each country exhibited a broad variety of mental health challenges for vulnerable children.

What did we find? In Tanzania we encountered extreme social isolation for boys herding cattle for long periods far from their homes, often in very remote and wild locations. Girls working as domestic servants, frequently in towns and cities a great distance from their rural villages, told us of suffering from despair, loneliness and social isolation as well as physical violence and mental abuse. In Cambodia we learned of the discrimination against ethnic minority children, and of ethnic minority girls forced to migrate for exploitive work and sexual exploitation as a result of government land grabs.

Listening to children, seated under a Neem tree in the town of Beni in the Eastern DRC was like re-living a Grimm's fairytale, with their mytho-poetic narrative of being taken by strangers, or sometimes a distant family member, to a dark place, with no hope or help. Usually these were teenage boys, led far into the deep, dark tropical forest, told they would find decent work, but in the end being forced to fight a war they didn't believe in. These experiences included stories of children who were given magic spells from witch doctors to protect themselves from bullets that are all too real, seeing friends shot and die in the bush and experiencing a living nightmare of killing and witnessing untold atrocities.

In a very contemporary context, other children, many of whom were abducted, spoke of being forced to work in informal coltan mines, toiling in the ochre African mud to extract the mineral used in the production of tantalum processors used in all cell phones. These young boys and girls deprived of their liberty and missing the possibility of school, stand on the opposite end of a spectrum of opportunity for children in most other parts of the world who are using these very cell phones to create possibilities in their lives and navigate the perils of the 21<sup>st</sup> century.

Finally, our interviews engaged young girls, who were working in the aptly named "Maison de Tolerance" (houses of tolerance), child brothels. These young women, old beyond their years, often took the only possibly route to economic survival, expressing their "thin" agency in choosing to leave their communities where there was not possibility of employment, to earn money to survive and at least be with their peers in suffering the

exploitation and abuse of men much older than themselves.

In the midst of this high level of human suffering and mental anguish, we need to re-examine our understanding of children's mental health concepts such as trauma. If we understand trauma as "overwhelming physical arousal combined with overwhelming cognitive arousal" (Garbarino, 2011), then a compelling question is: when trauma is the norm, and what are the present and future social implications of collective childhood trauma?

These vulnerable children, like their peers in the STM workshop, also taught us about resilience. We saw this in their personal coping skills using their imaginations to escape their captors, reintegrate and create a future to live into, their capacity to trust adults again and be a part of strengthening non-formal protective systems and healing modalities for themselves and their peers. There are important lesson here in the human capacity to overcome, the key roles of extended family, engaged peers, the role of spiritual belief, the creative arts, education and employment – helping young people and their communities "stitch" their lives back together. This becomes the human fabric of resilience.

One thing the children in the Eastern DRC showed us that is that no matter how resilient and creative some children are, there is still need for high level advocacy. We cannot rely on children's capacity to cope and overcome in dealing with ongoing civil war and the legacy of community and family violence this breeds.

In the context of CRC Articles 23 and 24, children's rights to mental health also require the right to rehabilitation, reintegration, and provision of appropriate psychosocial services referenced in CRC Article 39. Article 4, rights to economic support must also be addressed in tackling the structural injustices of poverty and discrimination.

In completing the arc from youth justice to mental health, we realize that many of the most vulnerable children are stigmatized, persecuted, in some instances incarcerated and tortured. This requires the highest level of national and international advocacy.

If we scan this arc from justice to mental health, there are signs of hope. In Uganda, a neighboring country to Eastern DRC, children who experienced the horrors of the Lords Resistance Army and its legacy of civil war, are now participating in a child centered truth and reconciliation process, similar to the ones recently conducted in Sierra Leone, and Liberia (Heykoop, 2014). These quasi-judicial processes are imperfect, yet they do provide a mechanism to partially redress the mental wounds of children and communities scarred by war.

We would do well in Canada to head these historic processes. Indigenous young women in Canada, moving from child welfare to the justice system are now the largest growing population in Canadian jails. Clearly our own arc has yet bend from mental health to social justice.

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### *Response to Shaking the Movers 2013, Children's Mental Health*

As noted in the youth's comments, one of the saddest reflections of Canada's poor record on children's mental health is reflected in the youth suicide rate. According to Statistics Canada, suicide is the second most common cause of death among 10-19 year-olds. It is surpassed only by accidents. We do not have the statistics on the numbers of self-harmers or attempted suicides. Reducing the rates of suicide is a critical human rights issue. However, it is unlikely that the youth suicide rate will decrease unless the focus of intervention is on family and community rearing conditions rather than peer behavior.

Media reporting of high profile cases of youth suicide lead many to believe its primary cause is peer bullying – especially cyber-bullying. But the evidence suggests otherwise. Whereas cyber-bullying may sometimes be a precipitating factor, actual causes of suicide are more complex. Longitudinal research shows that a history of psychological maltreatment in early childhood – neglect, emotional, and verbal abuse -- is predictive of a range of mental disorders and suicide attempts in adolescence. Analyses of youth suicides show them to be associated with untreated mental health difficulties, addictions, a history of abuse, and involvement with the child welfare system. These risk factors are particularly prevalent in disadvantaged Aboriginal communities.

According to chief coroner Padma Suramala, Nunavut had a record number of suicides in 2013 – more than 13 times the national average. A study of the suicides revealed higher rates of childhood abuse, psychiatric illnesses, depression, and substance abuse than in the general population, and an almost complete lack of mental health services. In a 2013 report on children's mental health and suicides in British Columbia, child advocate Mary Ellen Turpel-Lafond noted that youth who commit suicide are predominantly from Aboriginal communities and have a history of being raised in government care systems. Similarly the Canadian Mental Health Association reports that First Nations youth overall are 5-6 times more likely to commit suicide than are their non-Aboriginal peers. Suicides, of



course, are not limited to Aboriginal youth, but the risk factors of childhood maltreatment, and untreated mental illnesses are the common conditions which place children at risk of suicide. In essence, the evidence from multiple sources converges to show that children at-risk of suicide are children whose lives have been characterized by violations of their fundamental human rights.<sup>13</sup>

The Convention on the Rights of the Child (CRC) obligates states parties to protect children from all forms of physical and mental abuse and violence (articles 19:1 & 34). This is to be accomplished through supports for parents (article 27), through prevention programs, and through the provision of supports for children who have been maltreated (article 19:2). Interventions are obligated by article 39: The recovery of children who have experienced any form of neglect or abuse is to occur in “an environment which fosters the health, self-respect and dignity of the child.” To date, Canada has not met these obligations.

Supports for families remain woefully inadequate across Canada despite sustained and unacceptably high rates of child poverty, neglect, and abuse. When children are taken into the care system they most often are not taken until after there is significant compromise to their healthy development, and then the focus tends to remain on rehabilitating the child’s mother rather than permanency planning for the child. The result is highly unstable and inappropriate living conditions for children most at-risk of poor mental health. In the Turpel-Lafond report described earlier, all the children had been in government care – most for more than half their lives. Two-thirds were in care when they harmed or killed themselves. The average number of placements the children experienced while in care was 12. However, some children had been moved 30 or more times. Such instability would challenge the strongest among us.

Canada also has a very poor record of mental health treatment services for children. In contrast to Canada’s obligations under articles 23 and 24 of the CRC, children with mental health challenges have very little access to facilities for treatment or special care. In fact, the Canadian Mental Health Association reports that only 20 percent of children who need mental health services receive them. In the study in Nunavut, noted earlier, it was found that only 17 percent of youth who had committed suicide had received any mental health treatment. In some jurisdictions, there are private clinics available for those who can afford them, but treatment should never be reserved for those with funding. The outcome is clear in the poignant comment from one of the participants in *Shaking the Movers*, 2013 (p.12):  
*“Depression came as a shock to me, it felt foreign to my body. I fell behind in school, felt hopeless. I received therapy, but it was too expensive to continue. I felt bad that it was costing my parents so much money, so I stopped going.”*

Wait lists for psychiatric services are long. Some have estimated up to a year for treatments. A national study conducted by researchers at the University of Calgary and Dalhousie

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<sup>13</sup> Perhaps nowhere is this more evident than in the tragic history of a 14 year-old Aboriginal girl from a rural community who commit suicide. Her history is told in the 2014 report from the BC Child Advocate’s office, *Lost in the Shadows*. The child’s story describes a litany of rights violations in her family, community, and the so-called Child Protection System.

University showed that the wait is a month for a high-priority child, for example one who has exhibited extreme aggressive behavior. For children deemed extremely high priority – suicidal or even homicidal children -- the average wait is more than three days for an initial consultation. Fewer than a third of the youth mental health centres surveyed in the national study were able to meet the wait-time goals set out by the Canadian Psychiatric Association. Children with untreated disorders do not grow out of their problems, as many seem to believe. Rather, they become more vulnerable with development.

Rather than address the needs and rights of children living in at-risk families and environments, and children living with mental health challenges, governments at all levels appear to have chosen to buy into media reports of high profile cases of youth suicide and enact legislation to deal with cyber-bullying. Criminalizing bullying is unlikely to stop its occurrence or accomplish anything other than increasing the numbers of young people with criminal records. And it should be noted that children who bully others usually have mental health challenges or a history of rights violations themselves.

Official recognition of the problem of poor mental health and the lack of services for children would be a more effective approach to healthier children, families, and society. Provincial and territorial governments would do well to incorporate mental health diagnoses and treatments into existing physical health structures. Mental and physical health are inextricably linked. As long as mental health problems are dealt with separately from physical health problems, mental health will be seen as a less important concern.

Schools also can, and should play a key role in improving the mental health of children. Arguably, schools are the ideal environment for the early detection and treatment of poor mental health. As school psychologist Debra Lean and social worker Vincent Colucci describe in their 2013 book, *School-Based Mental Health*, comprehensive school-based mental health strategies would do much to reduce the critical shortage of mental health services for children. But schools also appear to attribute many mental health issues to children's peers – to peer aggression and cyber-bullying. And so rather than introducing programs and policies that allow and promote the early detection of mental health issues among children, and rather than incorporating mental health professionals into schools, educators introduce short-term anti-bullying programs. Anti-bullying programs and posters in schools like pink shirt days may be reasonable strategies for reducing bullying. But they do nothing for the mental health issues faced by millions of Canadian children and youth. And they are unlikely to reduce the rates of suicide.

Band-aid solutions to critical problems are clearly inconsistent with the promise of the Convention on the Rights of the Child. Ultimately a cultural shift is needed in which children are understood to be independent bearers of rights, rights that are essential for healthy development and healthy futures: Rights that are respected.

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### *Standing Up For Offending Youth's Mental Health*

The Shaking the Movers' 2012 Workshop on "Standing Up for Children's Mental Health" sheds significant light upon young people's impressive concern about, and inspiring dedication to mental health among youth. Given how the participants' questions and contributions demonstrated compassion, openness and care, they should be commended for their courageous commitment to the well-being of young people.

Their explanations and examples of mental health concerns were all-encompassing; their consideration of varying levels or capacities of decision-making abilities as a result of learning challenges was very thoughtful and quite relevant. As has been well documented, youth who struggle with learning challenges are often stigmatized, marginalized and bullied. We also know how essential it is for these young people to be protected from stigmatizing reactions.

#### **Wider Concerns and Considerations**

In this light, I recommend that the mental health concerns emphasized at the 2012 conference take into account even broader challenges that some particularly marginalized young people face. While a great deal of emphasis is, and should be placed on bullying and other forms of harmful or victimizing behaviour, it is also important to be attentive to the challenges faced by young people who make mistakes or who harm others, and who are thus often criminalized. While the rights of victims, particularly child victims, are of the utmost consideration, attention must also be paid to how the consequences and reactions to young people's offending and harm-generating behaviour can be stigmatizing and isolating, and can as a result, exacerbate their mental health challenges. While it is important for young people to be held accountable for their offending behaviour, we must also be mindful of the fact that they are also children who have rights (*Convention on the Rights of the Child*, Article 40). We must be especially considerate of the young people who are genuinely remorseful and who seek to take responsibility for, and to learn from the harm that they may have caused others.

My suggestion of this wider inclusion and consideration is based on the results of a study that Dr. Elisa Romano (Associate Professor in Psychology at the University of Ottawa) and I have undertaken among parents of youth who have sexually offended. Our broader study is entitled: "The Collateral Consequences to Parents and Relatives of Young People who Sexually Offend in Eastern Ontario." The study is sponsored by the Law Foundation of Ontario and supported by the Laboratory on the Rights of the Child within the Faculty of Law at the University of Ottawa. We have been conducting interviews with parents of adolescent boys who have been receiving support services from CHEO (Children's Hospital

of Eastern Ontario)'s Mental Health Outpatient Services in the aftermath of their sexually harmful behaviour. Consistent with Article 40.3(b) of the *Convention on the Rights of the Child*, yet contrary to the responses towards the majority of youth-based sex-related cases brought to the attention of police, in all of the cases in our study, the young people were diverted to treatment, counselling, education and skills training; thus, they have not been constrained by the limitations and often counter-productive outcomes associated with the retributive punitiveness of the criminal justice and correctional systems.

Through our research, we have found that over eighty-five percent of the adolescent boys, whose parents we have interviewed, struggle with a wide range of learning and mental health challenges that the parents believe may have affected their child's ability to engage in appropriate sexual behaviour. While we, as researchers, are not suggesting a link between learning or mental health challenges and sexual offending, we are nevertheless mindful of the parents' worries and interpretations as they attempt to address their child's inappropriate behaviour.

### Reducing Stigma

In our interviews, we have also encountered impressive parents who are responsible and resourceful about ensuring that their child is held accountable for their actions and that they receive adequate rehabilitation-oriented support in order to minimize the risk of future harm.

Nevertheless, the resulting stigmatization and isolation experienced by both the parents and the offending young people have been devastating and have in many cases either exacerbated existing mental health challenges or have led to new and more profound ones for both the parents and the young person. In this light, a 16 year old female STM 2012 participant's realization that "*it may impact yourself and your family*" (p.17) also applies to the circumstances of sexually offending youth. The wider repercussions for all involved, including for those who support the victims and the offenders, are extensive. Furthermore, in light of the shaming and social segregation that many young sexual offenders face, and given the mental health struggles that may be associated with their harmful behaviour both before and after it has occurred, the view of a 17 year old female STM 2012 participant that "*judgement needs to stop*" (p.17) is also pertinent to the context of youth who sexually offend, as well as of their relatives. Relatedly, a 15 year old female STM 2012 participant stated that "*You need to remove the stigma, not the people.*" (p.17). Such an outlook corresponds to the non-stigmatizing approach of Richard Voss, a social worker with CHEO's Mental Health Outpatient Services who works with the families within our study. He was recently quoted as saying "*I treat the child, not the diagnostic label ... stigmatization is reduced significantly if we treat the person as a whole, with full recognition of their struggles and their strengths, not the label.*"<sup>14</sup> As parents have reported to us, such a non-judgmental

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<sup>14</sup> Permission to include this quotation was obtained by Richard Voss. Mr. Voss' approach involves a balanced protocol that protects the rights of the perpetrator, attends to the victim's needs, recognizes society's expectations of accountability and considers the needs of the families of both the perpetrator and the victim.

and empathetic approach has not only been beneficial to the youth's and parents' emotional comfort, but also to the enhancement of offending youth's skills development and decision-making abilities.

The STM 2012 participants so aptly recognized how certain rights, including the rights "not to be judged", "to resources" and to "special accommodations" are still very hard to access (pgs.8, 17). As parents reported to us, despite the existence of some programs, including the aforementioned one at CHEO, the services required to support such rights among young people struggling simultaneously with mental health challenges and sexually offending behaviour, seem to be limited both in their availability and duration. As a result, the challenges experienced by the young person, as well as by their parents and extended families, are intensified by the lack of services. As such, they become deprived of their right to the support that could optimize their development and lessen their risk of re-offending; such limitations and deprivations should be of concern to all at both individual and societal levels whether one refers to the ultimate goal as the prevention of crime, the prevention of harm and/or the prevention of victimization.

### **Harm Prevention**

While it is essential to provide support to all young people who struggle with mental health challenges, it is also indispensable to provide support for the well-being of young people who struggle simultaneously with mental health difficulties and with offending behaviours in order to minimize the risk and damaging effects of isolation and quite possibly of self-harm or harm to others in the future. While the prevention of recidivism is critical, if a comprehensive strategy is to be in greater accordance with the *Convention on the Rights of the Child*, it must also emphasize early intervention. As parents in our study reflected regretfully on how their child's sexually offending behaviour could have been prevented, they pointed to the need for more comprehensive education that moves beyond a focus on 'stranger danger' and the prevention of the victimization of sexual abuse, and towards additional emphasis on the prevention of perpetration of sexual abuse.

In the spirit of harm prevention, it is also essential that, without minimizing or compromising accountability on the part of young people who offend, that their mental health and well-being also be taken into consideration through more supportive and restorative approaches, not only by adults or support-oriented professionals, but also by other young people whose opinions and relations with the young person who has offended are so crucial to them especially during the delicate phase of adolescence when peer perceptions are so influential.

### **Comprehensive Consultation with Youth**

The 2012 Shaking the Movers gathering provided meaningful opportunities for young people who actually struggled with mental health challenges to share their experiences.

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Greater understanding seemed to have been gained from such an inclusive integration. Yet, if we are to engage in the most collaborative and comprehensive consultation among young people on the topic of mental health, should we not also be consulting with those whose challenges with mental health have led to deeply stigmatizing circumstances? A 15 year old male 2012 STM's participant stated that *"Education is key in learning, knowledge leads to empathy and understanding, compassion and communication."* (p.16). If we are to take this young person's suggestion seriously, then should we not also be consulting with young people who offend in order to provide them with opportunities to shed light on their challenges with mental health as they are experienced both before and after their offending behaviour? By respecting their right to be heard, and that of their parents and relatives, we can all gain a greater understanding of the unique and complex circumstances. Their perceptions may not only lessen the sting of stigmatization, but they may also provide insight into greater possibilities of prevention of both perpetration and victimization.

### Conclusion

My main recommendation has been to expand the STM 2012 participants' compassionate outlooks and to extend their courageous commitments in order to consider the voices and experiences of young people who struggle with mental health challenges and offending behaviour simultaneously. By extension, as the STM 2012 participants have duly recognized and as we have found in our study, services for young people struggling with mental health challenges, whether they be related to offending or non-offending behaviour, must be delivered with compassion, empathy, respect, sensitivity, support, transparency and efficiency. By contrast, approaches that generate contradictions, inconsistencies, judgement and exclusion, and that exacerbate already marginalized and stigmatized conditions, must be avoided.

As we move forward through our multi-disciplinary approaches within CRAN, may we continue to collaborate to our fullest potential by drawing not only on our professional strengths, but also and most importantly, on the voices of children and youth.

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### *Raising Children Who Have Mental Health Challenges*

How did I, as a parent, and a psychologist, find out about our children's mental health challenges, particularly their anxiety?

What did our daughters say to us, from a very early age, to alert us to their mental health challenges? We knew they were different from many of their peers, but they both were able to build good friendships with others like them. **So the " normal " for them was what they and their friends were like.**

One 19-year-old participant at the Shaking the Movers VI: Standing up for Children's Mental Health conference, made this statement " *What is normal? No one is normal, normal is a word that was made for the rest of us to try and reach unreachable standards, and judge others on what they are or are not*". (See Shaking the Movers Report, page 22)

Even though our daughters did find friends, and friendships evolved, we noticed they were very picky about whom they wanted to spend time with.

Our children didn't have words to explain what was bothering them at a young age. They may have said: "I am bored. I am lonely. I feel tired. I don't want to go to school today." These thoughts usually came when we were with them alone. After a while, we started asking them what they wanted us to do to help them. Perhaps this questioning helped us, but it really did not help them. They always seemed to be better off when they were with their friends, or participating in an activity, which they chose.

We discovered, through trial and error, that they loved to participate in activities which absorbed them fully, and physically challenged them. What they enjoyed most was dance, or swim, or sing, or draw, and these activities seemed to distract them from their anxious feelings.

When our daughters became teenagers, they needed comforting from my husband or me a lot more. Also, we noticed that the activities they had loved for many years didn't seem to matter to them as much. One daughter who loved to swim, and was part of a swim club during her pre-teens, gave it up around 14 years of age. The other daughter found new friends among those she danced with weekly. Some of these friends were not in school with her.

Also, this was a time when what they wore and how they dressed suddenly became important. They were unconventional in their ways of expressing themselves, which we encouraged.

They both thrived in arts based high schools, which they chose and competed to get in. They felt more comfortable surrounded by peers who loved to express themselves in more creative and artistic ways, and they wanted to be accepted and to become part of these very vibrant communities of students and teachers.

Once they turned 16, they both took part-time seasonal jobs in retail, which they also found helped them feel valued. Whenever they were feeling down or wanting to retreat, we tried to be available as much as we could. It was at this time when their anxiety was too much for them to bear alone.

During these years we called on the help of a psychologist, and cognitive behavioural therapy began for them. They have had different therapists through their adult lives when they found their lives were stressful, and their anxiety was overwhelming. They both continue to benefit for different medications, unique to their special needs. They are both now in their mid-thirties.

I want to commend the participants in Shaking the Movers VI: Standing up for Children's Mental Health. They honestly and openly explained what they believe has to be done. One of their key themes was to encourage openness about our own challenges with each other.

I believe that a stigma comes from being silent. People who are able share their feelings of anxiety, sadness and fear on a bad day, break their own barriers with loved ones, family and friends. Campaigns such as the BELL "Let's Talk" campaign, and special training programs for parents offered through the Psychology Foundation of Canada, like "Kids Have Stress Too" and "Parenting for Life", reinforce this positive shift in our society's approach. This is how we begin to break down the barriers.

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### *Parenting Education and Children's Mental Health*

The purpose of this brief article is to make the case for parenting education as a necessary means of implementing the rights of children who have mental health challenges. Under articles 23 and 24 of the Convention on the Rights of the Child, children with mental health challenges have the right to special care, effective access to health care services, and the treatment of illness. Although the provision of accessible mental health care services is critical to implementing these rights, comprehensive programs of parenting education are required for detecting, treating, and preventing problems. Before this can be explained, it may be helpful first to provide some background.

#### **Background**

It is difficult to pinpoint a specific cause for children's mental health problems. There are many different types of problems and many different factors related to particular illnesses and disorders. The best that scientific and epidemiological research can do is to identify genetic, neurological, and environmental risk factors, usually in combination. Among the leading environmental risk factors are family poverty, parental psychopathology in forms such as mental illness, alcohol abuse, and drug abuse, child maltreatment, teen parenting, and parental separation and divorce. The more that these and other risk factors are in supply, the more likely it is that children will experience challenges. But the earlier that problems are detected and treated, the more likely the outcomes will be positive.



Key to positive outcomes are quality and accessible mental health services for children. But important also are parenting education programs in detecting, treating, and preventing problems.

### **Detecting problems**

In order for children's mental health problems to be diagnosed and treated, they need to be detected and referred to mental health professionals. Persons who may do this are doctors and health care practitioners before and after birth, day care providers, teachers, social workers, and sometimes the affected children themselves. But parents are key figures. Being with their children more than anyone else, and – in all likelihood – knowing their children better than anyone else, they are well positioned to detect potential and real problems. Although some children may report problems, many may not be aware of having mental health issues, or, if they do, for a variety of reasons, they may not want to report. So this leaves a major role to be played by parents.

However, parents need support and information. They need information about potential or real mental health problems, which can be provided through effective programs of parenting education. Such education can provide valuable information about the age of onset of particular problems and the symptoms of problems. For example, in the case of childhood depression, research reports that this can occur as early as age 9, and that symptoms include loss of appetite and energy, irritability, difficulty in sleeping, and inability to feel enjoyment. With such information, parents can conclude that they need to refer their children to mental health services.

### **Treating problems**

Once children are referred to mental health services, professionals are in a position to make a diagnosis and formulate a treatment plan. Many treatment plans call on parents to play a role either as support persons for their child or as participants in family therapy sessions. In either case, parents can greatly benefit by understanding the nature of the disorder or illness and the nature of the treatment. Such understanding can be gained through a general or specialized program of parenting education tailored to the treatment of a particular child. For example, in the case of depression, the treatment may be cognitive therapy where children learn to reframe their feelings and change their perspectives. In the case of ADHD, the treatment may be behavioral therapy where children are taught to structure their thoughts, control their impulses, and reward themselves for achieving objectives. In both cases, when parents are fully educated about the problem and about the therapy, they are more likely to support their children in an appropriate way and the prospects for successful treatment are greatly enhanced.

### **Preventing problems**

More important than detection and treatment after the fact is prevention. Well-designed parenting education programs have many benefits in promoting the best interests of the

child. Among them is the benefit of reducing the risk and preventing the onset or development of many children's mental health problems. It is well established in research that inadequate or impaired parenting is a risk factor for children's mental health problems. For example, parenting that involves child sexual abuse or physical or emotional abuse is a risk factor for problems ranging from anxiety and depression to suicidal ideation, attempted suicide, and suicide. As another example, during and after separation or divorce, parenting that features high-level conflict, bitterness, and the alienation of a child against the other parent is a risk factor for withdrawal, anxiety, and self-destructive or aggressive behaviors.

To reduce the risks, improve parenting, and promote healthy child development, including in the area of mental health, research shows that parenting education has modest but significant benefits. The reason is that parenting education makes parents more aware of the risks and more likely to engage in parenting practices consistent with healthy child development. But this said, parenting education is not a magic bullet. Some risk factors – such as related to genes or impaired neurological development – are beyond the control of parents. And some parents may be unwilling or unable to improve their parenting behaviors despite education. But overall, for parents willing to participate, evaluations show that well-designed programs of parenting education have significant though modest effects on positive parenting.

A problem in Canada, as elsewhere, is that parenting education is scattered, limited, and largely reactive rather than preventive. In order that there be substantial progress in the prevention of children's mental health problems, parenting education needs to be systematic, comprehensive, and well implemented, especially during the early years. This would be consistent not only with the child's right to special care under articles 23 and 24 of the Convention but also the Convention's principle of the best interests of the child. Under article 18, parents have the obligation to provide for the best interests of the child, which includes promoting good mental health. And to assist parents, under article 3, governments have the obligation to take actions aimed at the best interests of the child, which as research suggests, includes establishing comprehensive parenting education programs. One objective of the principle of the best interests of the child is to establish conditions for the enjoyment of children's rights. Parenting education is one such condition.

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*“Madness is childhood:” A response to the Children at STM VI*

For Foucault, madness is childhood.<sup>1</sup> He meant the infantilising of asylum inmates but the phrase captures childhood as a state of mental disorder, to be cured by age. That children lack capacity to make decisions in their own interests, and so lack rights, originates in Roman law.<sup>2</sup> Canada's early Criminal Codes similarly classed children with the mentally-disordered. The tests for legal capacity were identical: appreciating the nature and quality of one's act, and knowing it was wrong. Actual mental disorder in children was for centuries

masked by conceptions of childhood having little to do with the child and childhood became a screen for the infinite projection of adult desires. Tainted by original sin, the child was inclined to disobedience, selfishness and sex, cured by regular and severe beating. The child is a blank slate on which anything can be written. Born innocent, the child is corrupted by knowledge and must be shielded by piety and ignorance. Most pernicious is the idea that childhood does not matter. Children grow out of it. They get over it. The decades following WWII saw increasing acceptance of the fact that children matter not (just) to us or the future, but in themselves. Childhood matters to children. The right to participate in directing their lives took legal form in the Convention on the Rights of the Child. With growing respect for children, mental disorder gained new visibility.<sup>3</sup>

The madness of childhood complicates the detection of mental disorder. Lines are unclear because of what children are evolved to do. "Human children are the most voracious learners planet Earth has ever seen, and they are that way because their brains are still rapidly developing after birth."<sup>4</sup> Prematurity and neotony "not only extended the time during which we grow up but ensured that we spent it developing not inside the safety of the womb but outside in the wide, convoluted, and unpredictable world." This extended childhood is why, of twenty-seven known hominids, only we survive. To learn, children must push boundaries to know the nature of boundaries, in ways that would be madness in adults. Children challenge authority, establish the self, assess that developing self in terms of the other, and assess others in their self-assessment. Nowhere is identity and conformity more urgently interrogated than in childhood: "What is normal? No one is normal, normal is a word that was made for the rest of us to try and reach unreachable standards and judge others on what they are or are not." If there is no normal, this is not the premise of the psy sciences responsible for treating mental disorder, who study deviance to define the norm.<sup>5</sup> Others' assessment matters intensely to children: "I don't think there are enough people for us to talk to...this is the first place I have felt safe to talk about myself and not feel judged." The search for normal is about avoiding stigmatization and shunning: "You need to remove the stigma, not the people." We are an intensely social species. Shunning is social death.

Where is the line between self-judgment (different, ugly) and the self-hatred and dysmorphism of clinical depression? "Mental health is such a broad term, this is why there is so much ambiguity." Between 800,000 and 1.2 million (14 to 25 per cent) of Canadian children experience significant mental health issues,<sup>6</sup> most detectable before age 24 and half arising before 14:<sup>7</sup> "My earliest experiences with mental health issues began when I was a small child. I suffered from extreme shyness ... I couldn't talk, as if I was paralyzed by fear." Over two-thirds of adults with mental health issues report that symptoms first appeared in childhood.<sup>8</sup> Symptoms may intensify with the neurological and physiological changes of early adolescence: "My experience with mental health started around the time I entered middle school which was around 13 years old." "My experience with depression began when I was around 14. It started quite mild with a little loss of energy, withdrawing a bit from friends, and being frequently down ... I lost my hobbies, my ability to concentrate, and my will to live."

Fear of alienation, of shunning and shaming, underlies the search for identity. Alienation is symptomatic of depression: “The onset of my depression had no identifiable trigger; perhaps growing up was my trigger ... the shot fired by this anonymous trigger silently shattered my grip on existence ... sinking into the foggy, draining tendrils of a depressive episode ... food tasted like ashes, every image was in gray scale and I felt alien toward every person.” Peer-assessment is about self-assessment and identity. Assessment may become bullying: “Many people bully or make fun of the kids who are different and may be suspected to be living with mental health issues. I feel very sad for these kids who are being made fun of and angry at the kids who are doing it. Mental health is very misunderstood.” Bullying may itself be symptomatic of mental disorder, a response to punishment, abuse or emotional maltreatment. Opposing authority, a standard symptom of mental disorder, may be an attempt to assert rights in a hostile social environment.

Mental disorder messes up academic and social functioning.<sup>9</sup> Children “struggle on without support.”<sup>10</sup> “I don’t feel like there is enough support ... teachers should be more educated on mental health issues and signs of problems. Schools should offer counselling and have an office for people with disability ... encourage students to seek out those services ... make it clear that mental illness is also considered a disability ... shortage of counsellors, psychologists, and psychiatrists [means it] can take weeks to talk to someone.” Fewer than 20 per cent of children with mental disorder receive adequate treatment.<sup>11</sup> The Committee on the Rights of the Child expressed concern over the continued high rates of child suicide and called on Canada to strengthen early detection and intervention strategies and to provide access in all schools to psychological and counselling services and social work support:<sup>12</sup> “Ramps are visible for physical accessibility, accommodations for mental health are not visible.” The Committee also expressed concern over the increasingly high rates of children diagnosed with behavioural problems and the inadequacy of treatment. Whether the diagnostic rate for childhood disorders has increased due to better techniques, new knowledge or heightened concern or to environmental change (toxins, allergens, non-foods), cultural change (media violence, lack of intellectual and emotional stimulus) or family change (poverty, stress, instability, violence, homelessness) is unknown. The polarization of income equality in wealthy western nations is at its highest level in over a century, severely affecting the health of the poor and increasing bullying and antisocial behaviour by the rich.<sup>13</sup> For those outside the economic elite, “rising economic inequality means rising inequality of health and wellbeing [constituting] a barrier to improving not only their circumstances, but those of generations to come.”<sup>14</sup>

Children once found meaning in the mythic elements of stories.<sup>15</sup> Social and entertainment media now occupy most of their time. Corporations control story-telling and vitiate myth in the cause of consumerism. Loss of myth is loss of meaning. Social media and loss of meaning are associated with a steep rise in children’s self-harm.<sup>16</sup> Health-care admission of adolescents with suicidal thoughts who cut, burn and bruise themselves has risen two to five times across Canada in the past decade. Medical explanations range from existential crisis to social media. Self-harm “is a way of kind of giving the body a whole different set of inputs that allows them not to feel so awful inside”. Most self-harming children now “go from pretty average, functioning kids to suddenly they can’t cope ...

They're presenting to emergency departments, hopeless." Many meet no mental disorder criteria: "Instead, they seem to be suffering an existential crisis ... 'I'm empty, I don't know who I am, I don't know where I'm going, I don't have any grounding and I don't know how to manage my negative feelings." Many live affluent lives, have supportive parents, and experience few "adverse events". A break-up, bad grades or a death "completely throws them." Self-harm is "almost a fad". Many belong to self-harm groups and post their injuries on Facebook. "Personally," one doctor said, "I would love to see that access to social media was significantly restricted until adulthood."

For Amanda Todd and many other children, social-media shaming triggered or intensified depression leading to suicide. Ashley Smith tested the limits of prison rules but could not control the limits of her testing. Failing to ascertain whether she suffered from a mental disorder is perhaps the worst of the many violations of her rights. As her death dramatically showed, children's rights are embodied rights. Violating children's rights damages delicate neurological and physiological development. It slows intellectual, emotional and physical growth and functioning and intensifies the impact of disorders arising from prior causes. Violating rights plays Russian roulette with those "born with high susceptibility for mental illness". Reading the rights of children with mental disorders together with their rights to be heard, live free of violence and exploitation, and be raised and educated in a rights-respectful environment is the ramp to mental health. Knowledge of children's rights, the risks inherent in violating their rights, and a nuanced understanding of childhood mental disorder must be embedded in legislatures, courts, schools and families: "my family and peers seemed as ill equipped to handle my depression as I was. I soon discovered that mental illness was not something that many people talked about or had knowledge of." Without children's rights, it is not easy to tell the difference between madness and the madness of childhood.

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*Young People's Views on Mental Health and Access to Healthcare: Reflections on Shaking the Movers VI and Articles 23 and 24 of the United Nations Convention on the Rights of the Child*

In Canada, over a million young people experience mental health issues and only one-in-five of them currently receives mental health services<sup>1,2</sup> Anxiety, behavioural, and depressive disorders are some of the most common mental disorders among young people<sup>3</sup>. Two-thirds of adults living with a mental problem report that symptoms started during childhood.<sup>4</sup> Child and adolescent mental health services being poorly developed across Canada has already been denounced by clinicians and researchers<sup>5</sup>. Moreover, until the development of the Evergreen Framework in 2010, only four provinces in Canada had a child and adolescent mental health policy and/or plan, and there were major gaps in

essential content areas such as legislation and human rights, information systems, improving access to and use of psychotropics, and human resource development<sup>5</sup>.

In its 6<sup>th</sup> edition, *Shaking the Movers* (STM-VI) chose to focus on children's mental health and access to healthcare services. Thus, it brought together for two days a diverse group of 40 young people to discuss the concept of mental health, its impact on young people's lives, and related issues such as bullying, stigma and peer support. The voices of participants, both as attendees and as facilitators, were captured in the summary report. The following pages comment on some of salient issues brought up by these groups.

## Concepts of Mental Health and Right to Health

### *Mental Health & Wellbeing*

Understandings and misunderstandings of what mental health is are varied and the report is very rich in this regard. It illustrates the confusion that exists between mental health and mental illness and problems, the common perception that mental health is not 'a real illness' and it cannot be 'seen', mental health as 'learning differently' or 'acting differently', and mental health as something that changes 'day to day'. There is also a lot of discussion about stigma, and one of the ways to start combatting stigma is with information and reframing of mental health as something that we all have—it may be good or bad, but we all have both physical and mental health, and that goes beyond the absence of mental illness. The World Health Organization (WHO) defines mental health as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively, and is able to contribute to their community"<sup>6</sup>. Children's ability to develop into well-functioning adults is determined by individual, familial, and collective factors and contexts that dynamically shape development over the life span<sup>7</sup>. The identification of support resources by youth participants such as showers, music, food banks, and parks (p. 21 of the STM report) corroborates this broader definition of mental health and wellbeing, and acknowledges the importance of nutrition, arts, and environmental factors in achieving and maintaining good mental health.

The transcultural aspects of many mental health conditions have been understudied—particularly the local set of beliefs about the condition and health-seeking strategies. This creates problems when formulating health policy and planning service provision based on evidence obtained from a very different population<sup>8</sup>. Additionally, access to mental health services is further complicated for youth from ethno-culturally diverse backgrounds due to language, stigma and lack of awareness of appropriate health and community resources<sup>9</sup>. This is relevant given the unmet needs of many aboriginal young people as well as the increasing ethno-cultural diversity of the population in Canada (immigrants make up 19 percent of Canada's population)<sup>10</sup>. In this line too, the Evergreen Framework emphasizes the need to contextualize & tailor approaches & interventions to the unique needs and characteristics of the populations, groups, and individuals<sup>11</sup>.

*Right to Health*

Access to healthcare for children is of special concern because of the long lasting consequences of inadequate care on development as well as the State duty of protection of the most vulnerable<sup>12</sup>. Article 24 as interpreted by the Committee on the Rights of the Child on General Comment no. 15, which was adopted less than a year ago (although this interpretation is very much in line with the interpretation of the Committee on Economic, Social and Cultural Rights as presented in its General Comment No. 14 on Article 12 of the Covenant on the right to the highest attainable standard of health, adopted in 2000) really means that all States parties are under a legal obligation to respect, protect, and fulfill the right to the highest attainable standard of health for all, i.e. to take whatever steps are necessary to ensure that all children have access to available healthcare programs and that they can exercise their right to health without discrimination<sup>13</sup>. Other principles and premises for realizing children's right to health include the indivisibility and interdependence of children's rights and the right of the child to be heard. A decade ago already, the Committee on the Rights of the Child emphasized State party's duty "to implement measures for the prevention of mental disorders and the promotion of mental health of adolescents" (p. 11)<sup>14</sup>. In the provision of health facilities, goods, and services, both the CESCR (2000) and the Committee on the Rights of the Child (2003, 2013) have urged States parties to pay attention to: a. availability; b. accessibility (economically, physically, and socially) to all children, without discrimination; c. acceptability (i.e., gender sensitive, respectful of cultural values and medical ethics/confidentiality); and d. quality (i.e., scientifically appropriate facilities, drugs, methods, and trained personnel). Human rights law acknowledges that States must address legitimate public health, safety, and other concerns, and that the right to health is subject to progressive realization and resource availability. States are not expected to realize the right to health immediately; rather they have "a legal obligation to take 'deliberate, concrete and targeted' steps towards the realization of the right to health for all" (HRC, 2007, para. 66).

**Mental Health Promotion, Prevention, and Intervention**

As stated in the report, there is a need to increase mental health literacy at all levels. Promotion (and prevention of mental disorders & early intervention) of mental health & addressing social determinants of health across the lifespan in homes, schools, and workplaces are key towards preventing suicide and a number of mental illnesses. Increasing adults and youth's understanding of mental health is crucial and should be done with involvement of youth, families, and communities (p.10)<sup>13</sup>. Indeed, results from our systematic review of the literature for the Child and Youth Advisory Committee of the Mental Health Commission of Canada (MHCC) underlined the importance of 3 elements<sup>15</sup>:

- a. Parental and community involvement in program development for the promotion of adolescent mental health, particularly in ethno-culturally diverse communities to culturally ground them and benefit youth from ethnocultural groups. For example, the content of *novelas* used in the Esperanza del Valle intervention (to improve parent-child communication about alcohol in Hispanic community) were influenced by information gathered from focus groups with parents and members of the

community. A collaborative approach to designing the intervention resulted in *novelas* that addressed issues of importance to the community, and the intervention received positive feedback from participants particularly for its cultural relevance. Frequently, integrating programs within the community also result in high program participation and retention. A few studies also indicate that parents can promote positive identity development and hence protect youth against risk behaviors such as smoking and sexual behavior.

- b. Strengthening the family unit. One of the participants shared her frustration because her “family often has to take me to appointments and I feel they don’t understand me and my illness” (p. 12). Increasing family cohesion, management and organization, as well as encouraging positive parental involvement, monitoring, and consistent discipline and expectations are all important elements of strengthening the family unit. These elements may vary however from community to community reflecting the cultural norms and values of the families. The importance of the family in supporting adolescent health is evident in programs such as PDFY, “¡Cuidáte!” Promueve tu Salud, Parents Who Care, Bridges to High School, the Family Competence Program, Familias Unidas, etc.
- c. Improving communication between parents and their children. On the one hand, improved parent-adolescent communication has been shown to result in positive outcomes, such as reduced adolescent externalizing behaviors as seen with the CHAMP program, reduced substance use for adolescents who participated in Sembrando Salud, reduced violent behavior and reduced favorable attitudes towards drugs for participants in Parents Who Care, and decreased behavioural problems and increased condom use for adolescents who completed the Familias Unidas program. On the other, increasing parent knowledge has been shown to increase parent-adolescent communication too. For example, increasing parent knowledge of adolescent substance use (e.g., the Home Party intervention) resulted in increased knowledge transmission and communication with youth. It is to be noted that programs were formed on Western forms of family communication, emphasizing verbal communication and dialogue.

### Stigma

There is significant scholarly literature on stigma and mental health (e.g., see the work of Graham Thornicroft (UK), Patrick Corrigan (USA), and Rob Whitley (Canada), to name a few) but stigma is fundamentally a social justice issue. Stigma is a complex social issue that operates at three levels: (a) knowledge (ignorance & misinformation), (b) attitudes (prejudice), and (c) behavior (discrimination)<sup>16</sup>. Most people have limited knowledge about mental illness and much of that knowledge is wrong. Structural and public stigma (when institutions and/or people have negative attitudes about mental illness & discriminate against the people with the illness) as well as self-stigma (ill people turn those negative attitudes and practices against themselves) are best combatted through public education (e.g., social marketing campaigns) and personal contact (e.g., Opening Minds initiative of the MHCC<sup>17</sup>).



The Committee on the Rights of the Child's cautioning States against over-medicalization and institutionalization resonates with this broader understanding and prioritizes public health and psychosocial approaches to promote mental health and prevent mental disorders and "among children and adolescents and to invest in primary care approaches that facilitate the early detection and treatment of children's psychosocial, emotional and mental problems." (p. 10)<sup>13</sup>. In this line too, the Evergreen Framework emphasizes the role of school-based (embed within school curriculum) and youth organization-based activities in anti-stigma initiatives, mental health literacy and mental health promotion activities. This should be done in a way that is contextualized and involves young people and families. STM-VI makes an important contribution in securing a space where young people are able to express themselves and, in so doing, it illustrates how contact-based education has the potential to change lives.

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### *The Three C's of CRAN*

To me, CRAN is about *Courageous Critique and Collective Advocacy*. At least that is how I envision our network of Canadian academics concerned with Children's rights. My comments are, at least in part, inspired by two women I view as exemplars – as unapologetic and brave voices that say children's voices matter; that children's voices are valuable and that they are, in fact, central to anything we as a network say, do or call for. Landon Pearson's legacy as an often dissenting voice and Judy Findlay's history as the untethered advocate who ensured children's honest experiences behoved practitioners to change what they do, how they do it and whose voices were to be upheld when policies and practice directives were created. Who can forget the studies she ushered where youth in care called themselves *Garbage Bag Kids*, and that visual of a garbage bag full of their belongings dropped at the front door of a residence every time a child supposed to be in 'our' care was transferred...and transferred...and transferred.

My own Canadian research exploring the over medicating of girls' anger and as of late, women's lived experience of psychiatric hospitalization showed me that for many, it was rights infringements that both led to their *distress* in the first place, as well as when they engaged with the mental health system. Of this I refer to troubles with informed consent, experiences of coercion, plus side maleficent outcomes of chemical and other treatments. And so to take a rights-based approach to how we understand and conceptualized children's mental health is precise.

I am excited where we courageous child rights academics can take *Shaking the Movers VI*. So, some offerings...

**What if** when we consider children's mental health, we shift the focus to that of an upstream one? Where in addition to thinking about what to provide children when they experience distress, we seek to *avoid or prevent* the distress in the first place. To do this, we'd need to fully adopt a trauma-informed approach to preventing children's distress – especially given the long-understood statistic of 1 in 3 girls and 1 in 6 boys will experience some form of sexual violence by the time they are eighteen...

**What if** we placed a *Social Determinants of Health* lens on mental health – where we know that inclusion and mattering is the number one predictor of emotional well-being. Where we explore how poverty, systemic racism, ableism or sizeism, for example, all collude

to create spirit injury after spirit injury. A *Social Determinants of Health* lens where we think about gender role expectations that silence both boys and girls and force them into crowded inauthentic boxes. Or where we think about safety/violence/peace, housing, first nations status, immigrant status, and of course inclusion. “Health, to me, is often a matter of who matters...”<sup>15</sup> (previously published quotation)

**What if** we centre child/youth voices who have experienced the mental health system amidst adultist protectionist beliefs that they’re too fragile – or worse the often unnamed assumption that persons given a mental illness diagnosis are unreliable. What if we adopted the mantra from the Convention on the Rights of Persons with Disabilities (CRPD) of “*Nothing about us, without us?*”

CRAN and our collective **courage** can bring the actual lived experience forward... like in the Ontario Provincial Advocate’s report *Snakes and Ladders* .... Who else if not us? Some of the missing discourse in mainstream mental health discourse that I believe CRAN can call into question, initiate and/or advocate might include:

- A need to be trauma-informed and centre the Country’s major efforts in prevention strategies that understand that emotional distress is trauma-related – *especially* for children and young people.
- The assumption that the person him/herself needs help to ‘cope’ or somehow be more resilient and how this lens somehow *blames the victim*
- The individualization of the person is privileged in non-critical mental health discourse, especially when stigma is named as the culprit of people not getting the help they need
- The lack of exploration/critique of the system itself, i.e. no critique of labels, no critique of psychiatric drugs, no critique of the alarming trends in the DSM and the implications for children, the growing-in-popularity belief that diagnosing more kids earlier is a good thing, and the related pill-for-every-ill mentality popularized by the enormous pharmaceutical influence

**What** is the impact of working within a belief that the DSM is unproblematic, that psychiatric drugs for “some” children are ok, that if only we increase access to help while concentrating our efforts on decreasing stigma, that more kids will be helped?

I think it is CRAN who can **collectively** initiate these discussions. If not us, who walk, work and speak with a rights-based lens on children’s mental health (amongst other issues), then who? It probably can’t or won’t be people whose livelihood is tethered to an institution, an industry or a government. I am excited to see where we now can take CRAN – especially in regards to children’s mental health.

**Why** shouldn’t it be CRAN and some **collective** advocacy efforts who can explore, for example, how classism, sexism, racism, and ableism, for example are perhaps unknowingly

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<sup>15</sup> *Cheryl van Daalen-Smith’s quote from a previous publication*

perpetuated in how and who gets deemed mentally ill – and worse who gets completely ignored if not blamed for their circumstances?

**Why** shouldn't it be CRAN and some **collective** advocacy efforts who can also explore what a diagnosis of mental illness actually does and doesn't do?

**Why** shouldn't it be CRAN and some **collective** advocacy efforts who explores how a focus on the prevention of trauma and other rights-infringements would impact the mental health of Canada's children and young people?

I appreciate the opportunity to respond to the important work of the Landon Pearson Centre, of the Shaking the Movers initiative in general and especially the most recent one inviting young people to think about mental health and to the 2014 question exploring what we as CRAN might do in order to support these important efforts.

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*Connections – Children's Mental Health and Marginalized Populations:  
The Case of Child Welfare Involvement*

Congratulations to all involved in the Shaking the Movers VI workshop for giving youth the opportunity and forum to discuss children's mental health. For me, the most striking feature of this particular workshop was the extent to which youth engaged in an honest and open discussion of difficult issues, especially since the youth themselves identified the stigma associated with mental health issues as a major barrier in this regard. It is commendable that their participation was encouraged by an environment that clearly facilitated this discussion – for example, by the use of creative strategies like the discussion circles. Their desire to continue with this format beyond the allotted time speaks to their level of comfort with the process. It also demonstrates the empowering nature of such youth-led initiatives, when youth participation is respected, and adults indeed recognize – as Landon notes in the Preface – that children and youth “are experts in their own lives.” (p. 2)

My brief comments relate to the Convention requirement that children with mental health challenges *and their caregivers* receive assistance appropriate to their conditions and circumstances, taking into account financial resources and ensuring effective access to health *and rehabilitation services* (Article 23). Article 24 further stipulates the goal of the highest attainable standard of health for all children, – with no child being deprived of this right – and the requirement for treatment associated with rehabilitation.

An important theme related to these rights surfaces early in the Shaking the Movers Report (Overview, p. 3), and it consists of the recognition that certain groups of marginalized youth are at particular risk. The example discussed relates to higher rates of suicide for the Inuit peoples in Northern Canada, although other populations of youth at risk are referenced as

well. A kind of ‘double-whammy’ exists for such marginalized youth, because they may be at risk in terms of their general status as youth, or as youth with mental health issues, but also because they are members of marginalized populations. I think that this recognition speaks to the intersections or connections between youth mental health and the situations of particularly vulnerable populations of youth. The latter, along with their caregivers, can be more greatly disadvantaged in relation to the social determinants of health, and there may be inadequate or ineffective treatment and rehabilitation services. If Convention requirements around appropriate assistance to youth and their caregivers – with regard to conditions and circumstances – are to be met, a holistic approach to mental health is required that focuses on the fundamental reasons for disadvantage or discrimination, and addresses the broader context of marginalization.

The Report also draws our attention to related issues such as stigmatization, and emphasizes the importance of advocacy and supports. Youth emphasize these factors throughout the workshop. They note that rights are not accessible if mental health stigma reigns, and support systems are unavailable. (p. 8-9) With regard to stigma, for example, youth noted that those viewed as ‘different’ get made fun of and are at times bullied. (p. 22) Youth also spoke quite candidly about their own personal experiences with mental health issues and reflected on whether or not supports were available. For example, in discussing issues with depression, one youth (Youth Story # 2: E.P.) lamented ‘an abusive family’ (p. 28) while another (Youth Story # 3) commented that he/she was lucky enough to have a “support system of family and friends” during difficult times. (p. 29) Here again, in relation to issues of stigmatization, advocacy, and support, the broader context of marginalization needs to be addressed, and certain populations of youth will be even more vulnerable as members of particular populations. Stigma will be enhanced, – likely multidimensional – advocacy may have more obstacles, and supports likely will be even less available.

I’ll briefly discuss a pronounced example of this – the case of children with child welfare involvement. Child functioning issues and mental health service utilization are greater for these children as documented not just in Canada but in other jurisdictions as well – for example, in the U.S. and Britain. A study in Ontario suggested a prevalence rate for mental disorders of approximately 32% amongst permanent wards (Burge and Gough, 2007), – compared to the Canadian Mental Association’s estimate of 10-20% of the general youth population (<http://www.cmha.ca/media/fast-facts-about-mental-illness/#.UusQJyju4M>) – while others have suggested even higher figures for youth in care (Leslie et al., 2000). Based on initial intake investigations (substantiated) by child welfare workers and findings of confirmed/suspected child functioning issues, the Canadian Incidence Study of Child Abuse and Neglect noted that at least one child functioning concern was reported in 46% of these cases (Public Health Agency of Canada, 2010). As a category, depression/anxiety/withdrawal was reported 19% of the time. In the U.S., a National Institute of Mental Health national survey found that nearly half (47.9%) of youth in foster care had clinically significant emotional or behavioural problems (Burns et al., 2004), with other studies suggesting higher rates, somewhere between 50-75% of children and youth. A British study put the figure for psychiatric disorder at 57% in foster care, far beyond the 15% figure of the comparison group (McCann et al., 1996).

Such figures are not surprising given the overall context within which these children and youth find themselves, perhaps struggling with issues of abuse and neglect, other traumatic events, and unpredictable futures. While beyond the scope of my time here, suffice to say that the child welfare system has not been as productive as it should be in providing children/youth with the help that they need, and obligations associated with the rights of these children have yet to be fully addressed. Sadly, the system of care itself has been in crisis for decades (Waldock, 2011). Instability of placements has been a defining feature of experience while in care, and the kind of caregiver support and advocacy that the youth in the workshop identify as important is less available.

In terms of access to mental health services, to the treatment and rehabilitation emphasized in Articles 23 & 24, the literature identifies many barriers. The instability of placements is a factor, inappropriate placements, the failure at times to conduct screening assessments, inadequate training of workers and caregivers, lack of coordination and collaboration between the parties involved, and scarcity of services or providers (waiting lists). The good news is that mental health issues for these and other youth are definitely getting more attention. Children's advocates across the country have really been very active in this area. For example, Mary Ellen Turpel-Lafond, B.C.'s Representative for Children and Youth, has produced a number of recent reports, including one that received a good deal of coverage, focused on a child who had been tasered by police – "Who Protected Him?: How BC's Child Welfare System Failed One of Its Most Vulnerable Children" (Turpel-Lafond, 2013). The report chronicles the child's history or 'story' leading up to this event, – essentially what went wrong – and is very revealing in terms of identifying the intersection between child welfare and children's mental health.

Yet for all of this, the resiliency of children and youth is enhanced through the kind of empowerment that results when marginalized kids themselves become involved through actual participation – through simply discussing their situations and seeking strategies to address issues and solve problems. This is the kind of participation that Shaking the Movers represents – when child/youth participation not only exists but is supported, fostered and valued.

In closing, it is fitting to focus on real success stories in this regard, where youth participation in this most difficult area has been effective in drawing attention to issues, and at times 'shaking the movers' to action. I'll provide two examples: 1) youth in Ontario recently addressed the legislature with the assistance of the child advocate (Irwin Elman), and were successful in getting more educational supports when transitioning from care; they were also instrumental in terms of providing momentum for legislation (Bill 88) to extend the age of protection services in Ontario to 18; and 2) the National Youth in Care Network (NYICN) has participated in research – "Drugs in our System: An Exploratory Study on the Chemical Management of Canadian Systems Youth" (2009) – and advocacy around the over-medication of youth in care (psycho-tropic drugs), and this has really put this issue front and centre within child welfare circles. Both of these examples represent the power of

youth participation in addressing the intersections between child welfare involvement and youth mental health.

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