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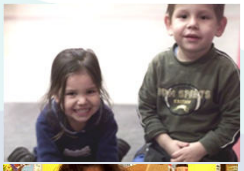
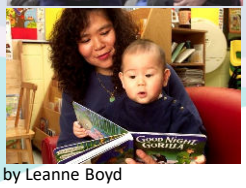
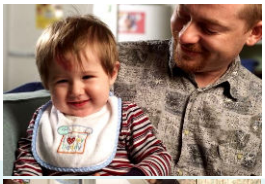
Innovating Evidence-Based Horizontal Policymaking:

The Healthy Child Manitoba Strategy



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Presented by Leanne Boyd
Healthy Child Manitoba, Government of Manitoba
Atlantic Summer Institute on Healthy and Safe Communities, August 23, 2017

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Our Challenge:

Bridging the gap between what we **know** and what we **do** to build what we **need** for children and youth.

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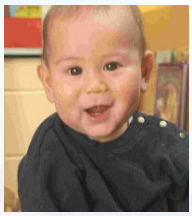
Healthy Child Manitoba Vision

Best possible outcomes for Manitoba's children and youth (prenatal – adulthood)



- Physically and Emotionally Healthy
- Safe and Secure
- Successful at Learning
- Socially Engaged and Responsible

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Healthy Child Manitoba Mission

Healthy Child Manitoba works across departments and sectors to facilitate community development for the well-being of Manitoba's children, youth, families, and communities.

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How To:

1. **Reach all** children, youth, parents, and families that need support
2. **Flatten gradients** in child and youth outcomes
3. **Improve developmental trajectories** of child and youth (prenatal to adulthood)

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Structuring for Innovation and Mental Health and Well-being:

Well-Being is Whole-Being

Manitoba's Healthy Child Committee of Cabinet

- A whole-of-government approach for children and youth, initiated to promote positive mental health and reduce mental illness
- 1994: Human Services Committee of Cabinet; Children and Youth Secretariat
- 2000: Healthy Child Committee of Cabinet; Healthy Child Manitoba; only legislated Cabinet Committee in Canada dedicated to the well-being of children/youth
- HCM: the bridge between the political and community organizations/agencies

Condition: Political Will

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4 Conditions for Successful Horizontal Innovation and Collaboration

Political will	(HCCC, HCMA, Premier)
Outside pressure	(community and scientific voice)
Inside engine	(Secretariat)
Resources	(dedicated and shared)

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The Healthy Child Manitoba Act

- Enabling legislation for Healthy Child Manitoba and the Government of Manitoba's long-term, cross-departmental prevention and early intervention strategy for children and youth (prenatal – adulthood), proclaimed in December 2007
- Purpose is to achieve best possible outcomes for Manitoba's children (policy emphasis on ECD)
- Legislated cross-sectoral government and community structures for children and youth
- Authority to collect and link data across sectors and across time (horizontal and longitudinal)
- Requirement for regular public reporting on progress in child and youth well-being

Condition: Political Will

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Language Skills Gap Appears Very Early

(Hart & Risley, 1995; Fernald et al., 2013)

- Significant difference by 18 months in language and vocabulary between low and high SES children
- By age 3: **30-million word gap** between low and high SES children

Condition: Outside Pressure

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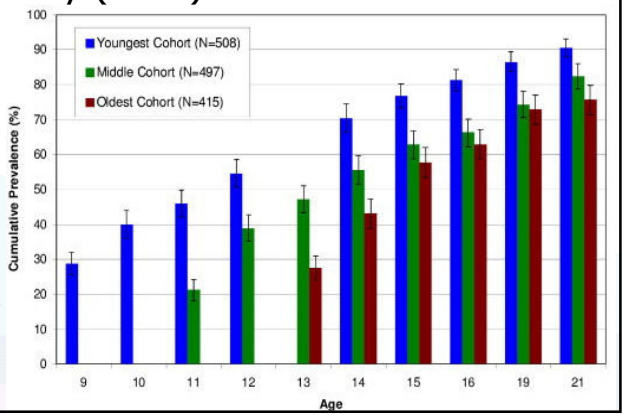
Cumulative prevalence of psychiatric disorders by young adulthood: a prospective cohort analysis from the Great Smoky Mountains Study (2011).

By 21 years of age:

- 61.1% of participants had met criteria for a well-specified psychiatric disorder.
- An additional 21.4% had met criteria for a not otherwise specified disorder only.
- Increased the total cumulative prevalence for any disorder to 82.5%.



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HCMO & MCHP: COLLABORATING TO STUDY CHILD HEALTH AND DEVELOPMENT

Prenatal:
FF screen
Prenatal care
Maternal serum screen

At birth:
Birth weight
Gestational age
Apgar scores
Breastfeeding
Complications
FF screen

Early Years:
Child care

School Entry:
EDI
School enrolment
Special needs

Middle Years (~7-11):
Grade 3 assessment
School enrolment
Grade retention
Special needs

Middle Years (~12-14):
Grade 7/8 assessments
School enrolment
Grade retention
Special needs

Youth (~15-19):
Grade 12 assessments
High school marks
Special needs
High school completion
Youth Health Survey

Prenatal | **Birth** | **Early years** | **School entry** | **Middle years** | **Adolescence**

Condition: Resources

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HCCC Funding to MCHP for Annual Deliverable

Fall 2016
(find on Manitoba Centre for Health Policy (MCHP) website)

Condition: Resources

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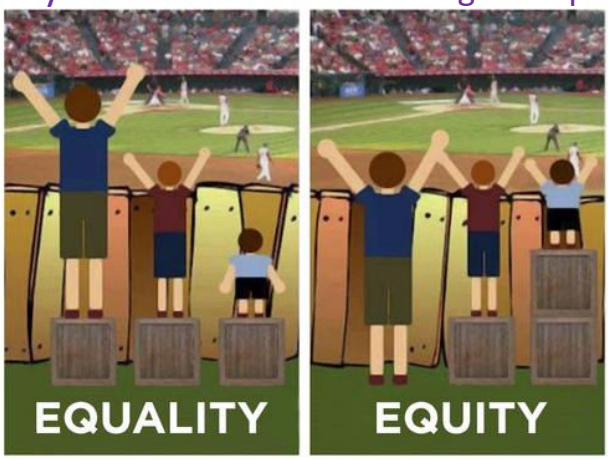
Healthy Child Manitoba: Guiding Principles



Condition: Inside Engine

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The Population Health Approach

- Improves the health of the entire population, while reducing inequities in health within it.
- Encourages continuum of interventions, focusing on upstream prevention
- Includes “proportionate universalism” strategy, where policies and actions are inclusive and offered widely (universally), but with a scale and intensity proportionate to needs

Condition: Inside Engine

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The Lifecourse Approach

- Proportional Investment: There are periods of human development (e.g. ECD) which are differentially impactful on child/youth life trajectories

Condition: Inside Engine

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Evidence-based decision-making

- Using the most relevant and highest-quality evidence possible to inform policy decisions.

Figure 5 – Meta-analysis Summary: Effects of Training and Coaching on Implementation[52]

Components	Knowledge	Skills	Transfer
Study of Theory	10%	5%	0%
Demonstration	30%	20%	0%
Practice	60%	60%	5%
Peer Coaching	95%	95%	95%

Condition: Inside Engine

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Evidence-based implementation

- Using the most relevant and highest-quality evidence possible to inform strategy for implementation
- E.g. Use evidence on effective methods for scale-up and sustainability to improve uptake and impact of program

Mental Health Summit Network

Maximizing Social Impacts and Returns on Investment

Towards a Sustainable Prevention Infrastructure for Population Mental Health Promotion and Mental Illness Prevention in Canada

The Mental Health Summit Network

August 2014

Condition: Inside Engine

Condition: Inside Engine

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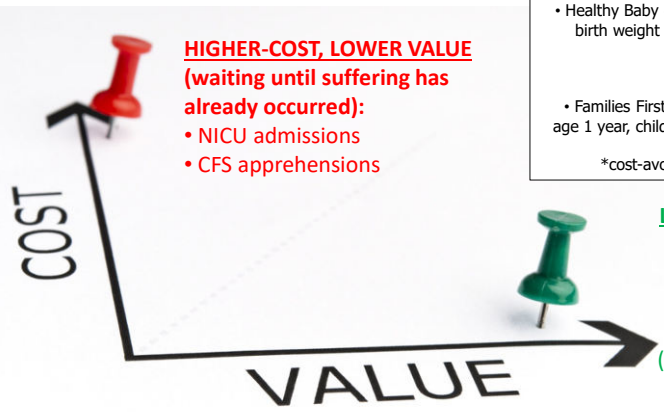
Value for Money and Evaluation: Leaping from Red to Green

IMMEDIATE PREVENTION BENEFITS:

• Healthy Baby (Manitoba Prenatal Benefit) reduces low birth weight births by 21%, preterm births by 17.5% (Brownell et al., 2016)
*cost-avoidance to date = $46M

• Families First reduces CFS apprehensions by 25% by age 1 year, child abuse injury hospitalization by 41% by age 3 years (Chartier et al., 2014)
*cost-avoidance to date = $57M (CFS costs only)



HIGHER-COST, LOWER VALUE (waiting until suffering has already occurred):
• NICU admissions
• CFS apprehensions

LOWER-COST, HIGHER VALUE (save dollars, save lives from suffering):
• **Healthy Baby**
• **Families First**
(both programs announced in 1998)

(This is *not* a leap of faith, but a leap from KNOWLEDGE TO ACTION)

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4 Research-Policy Gaps (McLennan et al., 2006)

1. Not implementing effective programs
2. Implementing programs that are demonstrably harmful
3. Implementing programs that are demonstrably ineffective
4. Implementing programs that are unevaluated

e.g., 1.7% of a CDN province's school based SEL programs are evidence-based (LeBlanc, John, et al. (2013). Social and Emotional Learning Programs for Schools. CPSC Atlantic: SEL Toolkit, v. 1.1.)

Condition: Inside Engine

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First Provincewide in Canada:

PAX Good Behavior Game (GBG)

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First graders exposed to GBG for one year had these benefits at age 21.

OUTCOMES	STUDENT GROUPS	GBG CLASSROOM	STANDARD CLASSROOM
Drug abuse and dependence disorders	All males	19 percent	38 percent
	Highly aggressive males	29 percent	83 percent
Regular smoking	All males	6 percent	19 percent
	Highly aggressive males	0 percent	40 percent
Alcohol abuse and dependence disorders	All males and females	13 percent	20 percent
Antisocial personality disorder (ASPD)	Highly aggressive males	40 percent	100 percent
Violent and criminal behavior (and ASPD)	Highly agressive males	34 percent	50 percent
Service use for problems with behavior, emotions, drugs, or alcohol	All males	25 percent	42 percent
Suicidal thoughts	All females	9 percent	19 percent
	All males	11 percent	24 percent

SOURCE: Kellam et al. (2011). The Good Behavior Game and the future of prevention and treatment. *Addiction Science & Clinical Practice, 6*(1), 73-84.

$64.18 returned for every $1 invested
(WSIPP, 2016)

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4 Conditions in Action - PAX

- 2010 – schools raise alarm of mental health and behavioural issues in schools; HCMO survey scientific evidence
- 2010/11 – pilot with Seine River School Division
- 2011/12 – clustered randomized controlled trial; focus on Grade 1
- 2013 – positive preliminary results; shared with HCCC (*political will*) and community/scientific (*outside pressure*)
- 2013-onward – policy decision to scale province-wide, multiple grades
- 2017 – trained to date: 1001 classroom teachers, 291 administrators, 258 Student Services, 643 schools, 21000 students

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MB RCT Outcomes:

•Statistically significant/clinically meaningful immediate effects in preventing/reducing children's mental health problems.
•Statistically significant/clinically meaningful immediate effects in reducing total difficulties (reduce emotional symptoms, conduct problems; increase prosocial behaviour) - equally effective for boys and girls.
•PAX even more effective across all outcomes for children with challenges measured on pre-test.

2017-onwards: innovation by and with community – whole school/community, youth Dream Makers, Indigenous research

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Our Challenges:

1. **Reaching all** children, youth, parents, and families that need support
2. **Reducing inequities** in child and youth outcomes
3. **Improving developmental trajectories** of children and youth (prenatal to adulthood)
4. **Building an integrated information system** to measure cross-sectoral progress in child and youth outcomes

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A Call to Action

- Children's outcomes are the product of multiple determinants. We need **government structures** that reflect this reality.
- Families are best served and their needs best identified together with local service providers. We need to support **community structures** that recognize this.
- Sufficient **scientific evidence** is now available to combine with political will and inform cross-sectoral action to improve the outcomes of our children and youth.

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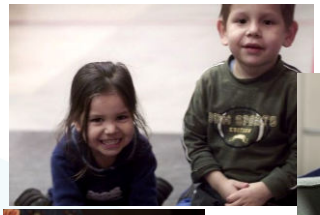
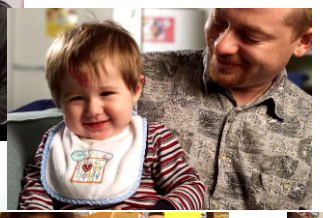
Thank You

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