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From Psychology to Policy

by

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Introduction

Thank you for the invitation to address the CPA annual meeting. I am not a psychologist by training but I do know that your expertise and work make significant contributions to the field of social policy in which I am involved. I will discuss these contributions in the subject upon which I have been asked to focus my remarks – From Psychology to Policy.

To be honest, I had not thought explicitly about this link prior to having been asked by conference organizers to address this theme. But I have to admit that since being invited, I have not stopped thinking about it for a minute. Neurotic, you say? Absolutely! But there are good reasons for this obsession. There are connections all along the way from the provision of service for those experiencing some form of mental health problem to the promotion of positive health and well-being.

I would like to focus my remarks today on three major links between psychology and policy. The first relates to the definition of disability and the associated eligibility criteria for a range of income benefits and supports. The second key relationship involves access to psychological services and mental health education for the population, more generally. The third substantive link relates to the core social and psychological factors that contribute to positive mental health.

a. Ensuring eligibility for benefits and services

The first significant link between psychology and policy involves the eligibility criteria for a wide range of disability-related income benefits and services. This area relates closely to the work in which many of you are involved. *You* effectively are the gatekeepers. It is *your* assessment that determines whether someone has a mental disability – thereby opening the door to a range of benefits and services.

There is a major policy challenge that currently plagues both federal and provincial governments and that catches *you* right in the middle. The question as to the definition of disability is an ongoing debate. Our notion of disability is changing because advances in technology, rehabilitation and health interventions are modifying our understanding of capacity and limitation. But the shift in thinking tends to focus largely upon physical disability.

It will come as no surprise to you that there are significant eligibility challenges around mental disability. To this day, questions related to impairment in mental function continue to confound governments – though the recent creation of the Mental Health Commission of Canada may help address this problem. The 2007 federal Budget had set aside \$10 million over two years to establish the Commission and pledged additional annual funding of \$15 million starting in 2009-10. In fact, the Chief Operating Officer of the Mental Health Commission is Dr. John Service, a psychologist and past President of the Canadian Psychological Association. There are two psychologists on its Board of Directors and several more on its advisory committees.

Not surprisingly, the problem of defining mental disability is not new. At the core of the definitional challenge is a profound lack of understanding. We actually need to go back a few years to appreciate the context.

The turning point in Canada's awareness of disability issues came in 1981, which had been named by the United Nations as the International Year of Disabled Persons. In respect of the International Year, Canada appointed an all-party House of Commons Committee whose purpose was to identify the challenges related to disability and to propose recommendations for change.

It was the first time in our country that such an exhaustive inventory had been undertaken on disability issues. The Committee produced the *Obstacles* report, which is still considered a landmark document. The report made recommendations around all major policy issues including human rights, income security, employment, technical aids and devices, transportation and communications.

I had the good fortune of working for this Parliamentary Committee and had been hired at the outset to focus on mental disability in particular. My first task was to identify the pieces of legislation which included disparaging references to mental disability. Unfortunately, these were all too prevalent. In many of our laws, I found frequent use of the terms moron, idiot, imbecile and feeble-minded, which referred to persons with developmental disability.

One of the most important aspects of 1981 was the fact that it preceded 1982 – the year in which Canada repatriated our Constitution. The *British North America Act* of 1867 became the *Constitution Act* of 1982. The *Act* was going to embed a *Canadian Charter of Rights and Freedoms*, which was in the process of being drafted. Several Committee advisors who were devoted to advancing human rights were very excited about this development. They saw the introduction of the *Charter* as a once-in-a-lifetime opportunity to protect and promote the rights of persons with disabilities.

Not surprisingly, the Government of Canada was not keen to include disability protection in the *Charter of Rights and Freedoms*. There was no precedent for this Constitutional inclusion anywhere in the world. The Government was worried about being swamped by lawsuits and associated costs – ironically, a fear that demonstrates how much this legislative protection actually was required.

After extensive deliberation between the Committee and the federal government, an offer was made to the Committee. The *Charter of Rights and Freedoms* would include prohibition of discrimination on the basis of disability – but only physical disability. Mental disability would not be incorporated in the *Charter* because no one knew what it meant and it was felt that the implications potentially were enormous.

Now the senior advisor to the House of Commons Committee, Jim Derksen, faced a serious *crise de conscience*. He knew that this was a unique opportunity to ensure inclusion of

disability in the *Charter*. After all, how many times in the course of history does a country renew its Constitution? But he also knew that accepting the condition to exclude mental disability from the *Charter of Rights and Freedoms* would make the Committee guilty of the very discrimination that its members were fighting to overcome. The acceptance of physical disability alone would have been a hollow victory at best.

After great angst, the human rights advisor recommended that the Committee refuse the offer. The Government was surprised by the response and, thankfully, decided to back down. Canada became the first country in the world to include in its Constitution the protection of the rights of persons with physical and mental disabilities.

Despite the recognition embedded in the *Charter of Rights and Freedoms* and the heartache involved in arriving at that spectacular moment, the practice has been somewhat disappointing. The *Charter* reference was not the turning point – at least for mental disability – that many hoped it would be. The government had, and continues to have, great difficulty understanding mental disability.

Over the years, persons with mental disabilities have become increasingly vocal about the fact that they continue to face barriers gaining access to disability-related benefits and supports because of the inconsistent application of the definition of mental disability. One of the most frequent complaints involves eligibility for a tax measure, known as the disability tax credit.

The purpose of the disability tax credit is to provide tax relief to individuals with severe impairment in function that restrict them in the activities of daily living. The credit is based on the assumption that these individuals likely incur a range of disability-related costs that they are not able to claim under the medical expense tax credit, such as expenses associated with transportation. These are considered the non-itemizable or ‘hidden costs’ of disability.

The problem became so acute that the House of Commons Standing Committee on Human Resources Development and the Status of Persons with Disabilities recommended that a special Task Force be created to address the eligibility problem for the disability tax credit and to provide guidance related to impairment in mental function. The federal government subsequently created a Technical Advisory Committee on Tax Measures for Persons with Disabilities.

I had the privilege of co-chairing this Technical Advisory Committee that reported to the federal Ministers of Finance and of National Revenue. This 12-member committee was composed of a diverse group including tax lawyers, human rights lawyers, accountants, disability consumers, a psychiatrist and a psychologist – your colleague, Dr. Karen Cohen. A total of \$85 million a year had been allocated by the federal government in support of our recommendations; our job was to determine where these dollars should go.

The Committee learned in the course of our work that persons with disabilities related to mental function, notably the perceiving, thinking and remembering currently used in legislation and in the T2201 application form for the disability tax credit, tend to be disadvantaged in

eligibility determination because their symptoms and effects are less well understood than impairment in physical function. Impairment in perceiving, thinking and remembering often has intermittent signs and symptoms – with the result that the prolonged duration as a chronic condition is not recognized. Moreover, the term ‘perceiving, thinking and remembering’ currently used in legislation and associated application conspicuously omits mood.

The Technical Advisory Committee also learned about a more general problem. The conceptualization of disability has been changing over time. Disability used to be understood in fairly narrow terms – as a set of characteristics of an individual. The presence of certain conditions used to mean that a person *was* disabled or *had* a disability.

As the disability rights movement has evolved, the notion of disability has shifted from individual impairment to a social understanding of the concept. In this social view, persons with disabilities are restricted in performing daily activities because of a complex set of linked factors, some pertaining to limitations in the capacity of the person and some rooted in the immediate environment.

So the Committee was facing two challenges: how to broaden the concept of mental function and how to move from a medical to a social perspective of disability. In applying these challenges to the disability tax credit, we proposed that this measure be reconfigured as follows – and I want to point out that Karen Cohen assumed exceptional leadership by chairing a working group that developed this clear and elegant conceptualization.

The working group proposed that the eligibility criteria for the disability tax credit be broadened to include impairment in one or several physical or mental functions. These included:

- neurological functions – diseases and conditions affecting the brain and spinal cord
- motor functions – diseases and conditions affecting the movement and coordinated use of limbs
- sensory functions – diseases and conditions affecting sight, hearing, taste, smell or touch
- structure, organ and other physiological systems – diseases and conditions affecting bodily organs such as heart, lungs, liver, pancreas, bone and other structures, endocrine and other regulatory systems
- comprehension and expressive functions – diseases and conditions affecting the processing and production of language
- mental functions – impairment in such areas as memory, problem-solving, judgment, perception, learning, attention, concentration, mood and affect.

That is the first part of the equation, which basically says that disability involves some *impairment in physical or mental function*. The second part of the equation requires that impairment in one or several functions must result in marked restriction in certain activities of daily living. These include:

- self-care, such as eating, bathing or dressing
- health and safety, such as managing necessary medications and risks to personal safety
- basic life management skills, such as paying bills, using public transportation, purchasing groceries, communicating and getting along with others.

Not surprisingly, the Committee debated extensively the list of activities of daily living. We argued at length as to whether it should include such things as basic academic skills, like literacy and numeracy. The inclusion of basic academic skills as an activity of daily living would help ensure the potential eligibility of persons with severe learning disabilities, who typically have difficulty qualifying for the disability tax credit. Others felt that the inclusion of basic academic skills inadvertently would include persons with low literacy proficiency – certainly not the intent of the disability tax credit.

Despite the need for the further development of these ideas, we believe that our deliberations helped put in place a strong foundation for future work. The proposition that disability results from the interaction of three factors – human functions, daily activities and social context – is consistent with global work on this issue. The World Health Organization designed the International Classification of Functioning, Disability and Health, in which disability is seen to arise from the interaction between impairment in function and externally imposed limitations on activity.

This clarification may seem technical but it is important because the disability tax credit effectively acts as an eligibility screen for other benefits, like the Child Disability Benefit and the newly announced Registered Disability Savings Plan. The RDSP provides tax-assisted savings for the parents and families of persons with severe disabilities to help create a better quality of life. The Technical Advisory Committee had recommended the implementation of such a measure.

The disability tax credit would also act as the screen for benefits not yet in place but that are currently being designed. At the Caledon Institute, for example, we have proposed a new basic income for persons with severe disabilities that would remove them from provincial social assistance or ‘welfare.’ Persons with disabilities currently comprise almost half (46 percent) of welfare caseloads across the country, which is entirely inappropriate. Social assistance was never meant to provide guaranteed income but rather last-resort assistance to tide people over until they establish their financial footing [Battle, Mendelson and Torjman 2006].

You can see why it is so important to get this right. We need to put in place the appropriate eligibility criteria for the disability tax credit – not just to ensure access to that measure but also for the other benefits for which it acts as a screen. Clarity in our conceptualization of these issues is also essential to ensure that *you* can do your job effectively when you are asked to complete those T2201 eligibility forms.

By the way, I am pleased to report that all 27 recommendations of the Technical Advisory Committee were accepted over the course of three governments and several federal Budgets. The

work of the Committee is a clear example of the influence of *your* field and *your* work in moving from psychology to policy.

b. Meeting the growing demand

The second theme that is relevant to the links between psychology and policy involves the growing need for mental health services. Your knowledge and skills currently are in high demand and there will be even greater need for them in future. I honestly do not believe that, as a society, we are prepared for this coming wave.

I raise this issue because it has significant implications for your work and for access to the expertise and services you provide. But it also has important consequences for public policy in that we need to figure out how to address this serious access challenge. We need to think about strategies that build on psychology as a base but which extend their reach more broadly than the current state.

If we were to read nothing other than local and national newspapers, we would conclude from the recent spate of articles that this country is in the throes of a mental health meltdown. An estimated one in five Canadians is affected by a mental health disorder at some point in our lives. Anxiety, depression and stress seem to be rampant and a new form of debilitating condition appears to come to light virtually every day.

The workplace has become increasingly stressful, for example, as a result of many factors including the expectation of 24/7 availability, information overload and the need for continual upgrading of knowledge and skills. We just can't seem to do our work well enough or fast enough. A study conducted by Desjardins Financial Services released in May 2008 found that Canadians are increasingly stressed on the job, with the associated risk of burnout and depression. There are serious implications for personal health and for the economy [Grant and Immen 2008].

The mental health of immigrants is a relatively recent worry in this country. Many new Canadians live in poverty and isolation compared to their place of origin where they had relatives and friends nearby who comprised their community. There are concerns about the need for social supports for girls and immigrant women who face tensions between respecting their traditional values and adopting the practices of this culture. A much-publicized incident in which a father murdered his daughter highlighted the simmering tension for some families.

There is also greater public awareness of the rising incidence of depression among middle-aged men and the need for programs that attempt to counter the stigma of the condition [Anderssen 2008]. Many resist receiving any form of treatment because it would be seen as an admission that something is wrong.

We hear almost daily about the rise in post-traumatic stress disorder experienced by soldiers returning from the mission in Afghanistan and the associated need for mental health support for these individuals and their families. Finally, those of us from Eastern Canada could not help but pay attention to another new trauma that emerged just this year: snow rage. On a serious note, various forms of weather-related disasters will stalk us in future as the climate becomes increasingly unpredictable.

Then there are the mental health problems about which we have known for many years but seem to have become more prevalent. There has been an increase, for example, in the number of children diagnosed with bipolar disorder – considered the most lethal of all mental illnesses with 15 percent of sufferers dying prematurely from reckless behaviour. As in other conditions, the rise may be due partly to improvements in diagnosis, which is important in itself. But it certainly seems as if something more is going on.

North America is apparently a very anxious place – with anxiety disorders the most common mental illnesses in children aged 4 to 17. Report after report talks about the chronic shortage of a range of mental health services at a time when growing numbers of children and young adults are being treated for anxiety disorders and other psychiatric problems. The wait time for some programs is often between two and three months, which is way too long when a young person is vulnerable or is abusing substances.

These wait times are problematic in light of the evidence which shows that early intervention can make a significant difference in the lives of children with mental disorders and, in some cases, spare them difficulties later in life such as problems at school, substance abuse and trouble with the law. We know that early intervention is the key to successful treatment for many mental health disorders. The policy challenge then becomes how to ensure early diagnosis and how to gain access to appropriate mental health services.

Perhaps the most visible public controversy right now with respect to wait times involves access to services for the large number of children with autism spectrum disorder. For parents who suspect that their children have autism, getting an early diagnosis is a crucial opportunity for early treatment. But the signs of the disorder among babies are often missed – though there is some interesting research under way that is trying to identify signs at very early ages.

Once the disorder is diagnosed, parents must enter a line-up of up to a year or more for publicly funded treatment. This is precious lost time. Many autistic children who are diagnosed before age 3 and who receive two years of applied behavioural analysis have seen major developmental improvements.

The access problem persists beyond the very early years. As you know, access to this treatment is limited with respect to both professional staff and the coverage of costs, which are prohibitive for many families. Some households pay \$500 a week or more for private applied behavioural analysis workers, language therapy, occupational therapy and other services. There

are many stories of families losing their homes or being driven into poverty in order to finance professional treatment for their children.

The parental contribution results from insufficient and variable coverage from province to province. Alberta pays up to \$20,000 a year worth of treatment costs a year, for example, for individuals with documented special needs. Ontario children are eligible for up to 30 hours a week of applied behavioural analysis therapy, but only for severe cases and there are long wait lists for the existing services. In a recent class action suit in Ontario, the parents of autistic children sought \$1.25 billion in damages on behalf of up to 1,500 families that have spent heavily on applied behavioural analysis therapy or intensive behavioural intervention [Makin 2008].

In my view, the autism problem represents a glaring example of a broader public policy issue. There is a serious gap between supply of and demand for treatment and we have to figure out how best to bridge this growing gap. While the recommendations of the Mental Health Commission may help resolve the issue, I believe there is a need for broad dialogue on the allocation of professional resources.

Obviously, you need to be part of and help shape that debate. There is a role for your professional association, in particular, to grapple with the policy challenges related to early intervention and access to appropriate services. The Canadian Psychological Association recognized many of these problems in a brief to the Standing Committee on Social Affairs, Science and Technology [CPA 2006]. The ‘system’ – such as it is – is at a breaking point. We need to find ways to ensure that the interventions which help children with autism can be developed and supervised by professionals but delivered by parents and others properly trained in the appropriate techniques.

This proposal has been put forward by Dr. Charles Pascal, a psychologist by training, current Executive Director of the Atkinson Charitable Foundation and former Professor of Psychology at McGill University who ran a major program at the Montreal Children’s Hospital. He has argued, in the case of autism in particular, that we need to find ways of providing intensive training to parents and others so that they can become front-line agents in treatment. This model clearly requires a shift in our current approaches. Quite frankly, it is difficult to consider practicable policy solutions in the absence of fundamental transformation in the delivery of psychological and other mental health services.

But we also need to take into account the broader policy context. The pressure on mental health services is also linked to the financing of health care in Canada. The services of psychologists are covered under medicare only when provided in public institutions, such as school, hospitals and correctional facilities. Psychological services delivered privately are not covered under public health care financing. This means that psychologists, as regulated and specialized providers, are not paid as part of the public health care system even though their services comprise an essential component of health. Individuals and families are left to pay for these services on their own. Those fortunate to be covered by some form of private health insurance will find that these plans typically cover only a small portion of the overall cost.

A related policy challenge has to do with how to enhance mental health literacy among parents, teachers, youth leaders, general practitioners and others who are in a position to identify, at an early stage, the behavioural changes that might point to some mental health problem. Of course, this proposal presents its own challenges.

There are problems related to early identification – in terms of knowing what to do if and when a condition actually is recognized. The role of the key informants or early identifiers is a complex one. The recent suicide of 18-year-old Carleton University student, Nadia Kajouji, for example, sparked an important debate as to whether and how the authorities could have intervened more actively in the face of obvious warning signs. Nadia had been taking anti-depressants, was undergoing counselling and had threatened suicide.

With newspaper headlines like “No one noticed Nadia’s despair” [Adami 2008] or “Life-and-death questions for Carleton University” [Page 2008], the public clearly is struggling with how this tragedy could have been averted. Many anxious parents and concerned authorities are genuinely and often desperately seeking advice on how best to intervene.

There are legal questions as well that are not easily resolved. Confidentiality is a major issue. It is only under the condition of explicit harm to self or another that confidentiality can be broken and parents or authorities informed of the potential threat. At what point then can parents or authorities step in and effectively impose treatment, particularly if the individuals are legal adults? This question of the balance between rights and responsibility is not a new one for you in light of your day-to-day work. But if we agree that there needs to be enhanced public awareness more generally about mental health issues and greater preparation to act, it is difficult to know in practical terms what this means.

Parents struggle with how to get help for their children when they suspect a mental health problem or possible substance abuse. If school authorities take action to get treatment for a university student without their consent, can they be subject to a lawsuit? How far can they go to be proactive? Most parents, teachers and school authorities understand this fine balance but are unsure of how to address the challenge [Tam 2008]. Here is where your guidance would be invaluable. Mental health education is *essential* in order to improve mental health and your practice holds many of the answers that the public needs in respect of mental health – in terms of prevention and coping.

The good news is that more young people apparently are seeking help for various mental health problems. The Centre for Mental Health and Well-Being just released a *Health and Well-Being Report*, which found that the number of young people in Ontario who visited a mental health professional nearly doubled in two years. The researchers believe that the increase is attributable partly to the reduction in the stigma associated with seeking help. This change may be due somewhat to the Mental Health Commission whose role is to reduce the stigma associated with mental illness and to encourage those affected to seek treatment. The trend is being attributed as well to the growing number of celebrities who are receiving, often unwillingly, some form of psychological help [Agrell 2008].

There is no question that we are seeing a dramatic rise in the diagnosed rates of mental disorders and a rise in the number of individuals seeking treatment. The question is what we do about it from a policy perspective in light of the fact that the demand for psychological and other mental health services appears to vastly outstrip the available supply? How do we move from the evidence on mental health disorders to appropriate responses? Let me discuss two examples of areas in which we are trying to find ways to ensure greater access to mental health supports.

Understanding the Early Years is a national initiative, launched by the federal government, which uses a combination of quantitative and qualitative data to enable communities to meet children's developmental needs on an ongoing basis. Under the project, the federal government enters into a three-year contribution agreement with a nonprofit organization. The sponsor then hires a project coordinator and researcher to complete an inventory of community programs, and to map and interpret this data.

The project provides members of participating communities with quality information on the school readiness of their kindergarten children. It identifies family and community factors that influence child development and the availability of local resources to support young children and their families. Parents, teachers, policy-makers and others interested in the well-being of children work together on the basis of the information derived from multiple sources, which they collectively have gathered.

The Early Development Instrument, for example, measures the school readiness of kindergarten children prior to Grade One and is completed for each child by kindergarten teachers. It assesses the core developmental domains related to physical health and mental well-being, social competence, emotional maturity, language and cognitive development, communication skills and general knowledge. Behavioural and cognitive red flags can be identified at an early stage.

For each participating community, multiple sources of information form the basis of a Community Research Report on the health and well-being of young children. By proposing changes to programs and services that enhance the development of young children, the Action Plan serves as a blueprint to encourage the entire community to take concrete action to address identified gaps in the supports and mental health services for young children and their families.

On a related note, it is also important to note that two psychologists co-chair an exemplary initiative called PREVnet. This national network of Canadian researchers, voluntary organizations and governments are pooling their knowledge and research in an effort to prevent bullying.

The pressures of an aging society represent another area in which there will be substantial demand for mental health services in coming years. The demand will come from two related sources. First are the large numbers of seniors expected to experience some form of dementia as they age. An estimated 450,000 Canadians over 65 have Alzheimer's disease or related

dementia. The number of Canadians age 65 and over will double from nearly 4 million in 2001 to almost 8 million by 2026. With growing numbers of ‘old elderly’ – those over age 80 – we will see increases in vascular dementia of which Alzheimer’s disease is the most common.

As you know, Alzheimer’s disease and related dementia are progressively degenerative conditions whose progress can last up to ten years or more. As the disease progresses, people with dementia typically are affected by increasing functional loss in their ability to perform the activities of daily living – both in terms of personal activities such as bathing, dressing or personal hygiene, and in instrumental activities such as preparing meals, managing medication or attending to finances. The symptoms gradually become more debilitating as individuals with dementia experience loss of short-term memory and the cognitive skills needed for daily decision-making.

In a recent study entitled *Caregivers and Dementia*, we learned that it is the caregivers of persons with Alzheimer’s disease or related dementia who will require substantial mental health attention in coming years [Torjman and Makhoul 2008]. The needs of these individuals generally are overlooked because of the focus upon care receivers. Aside from the continual physical caregiving requirement, perhaps most challenging for caregivers are the emotional dimensions of the disease.

Caregivers often need help managing abusive or violent behaviours. Many caregivers feel that they have “lost the soul” of the person whom they love. The care receiver no longer behaves as a partner, parent or friend, and is virtually unrecognizable from the person they were. Unlike persons struggling with illnesses that affect physical function, the caregivers of persons with dementia are unable to communicate with the care receiver other than through superficial conversation about meaningless subjects.

Caregivers of individuals with various forms of dementia or other mental health problem speak about the fact that they are often unsure of how to cope with difficult behaviours, such as verbal or physical abuse. This behaviour can be particularly acute for those with late-stage dementia in which they may hallucinate or experience delusional behaviour, such as mistaking the caregiver for a stranger or attacker.

As in the case of autism, one policy response to this psychology challenge is some form of mental health education and training [Torjman and Makhoul 2008]. But it is not possible to set up training and educational programs for caregivers, for example, without your guidance, assistance and supervision. There are literally hundreds of thousands of Canadians who would benefit from your knowledge of this condition, its early warning signs and symptoms, the various forms of activation and mental stimulation, effective ways to deal with complex and sometimes dangerous behaviours, and the grief and loss that caregivers invariably experience as the person slips away from them. The question becomes how best to harness your individual and collective expertise toward this end.

c. Building protective factors

Clearly, it is essential to address this wide range of mental health challenges and to figure out how best to provide treatment and support in the presence of growing demand for your services. A related challenge – and the third core theme in the link between psychology and policy – is to figure out how to create supportive families and communities.

The policy challenge becomes a question of identifying the measures and interventions that respect and promote mental health and to translate these factors into concrete measures in the form of programs, supports and social infrastructure. Here's where psychology plays an invaluable role. The theory that comprises the foundation of your field and the services that you provide create a powerful evidence base for feasible policy solutions and community action. *The research and interventions from psychology help determine the appropriate policy responses.*

One of the major links in our respective fields can be found in the growing body of literature related to the social determinants of health – the economic and social factors that influence health [Raphael 2004]. Both level of income and mental health factors have been identified as the most significant of these determinants.

Poor physical and mental health among low-income households, in particular, is linked to their depth of poverty – i.e., the extent to which they fall below designated low-income levels. Not surprisingly, their substantive lack of material resources reduces their ability to purchase the goods and services essential for health. Level of income also has a serious psychological impact in that low-income households live under constant stress – struggling with how to feed the kids *and* pay the rent or having to choose between the two.

Perhaps the most devastating aspect of poverty is its psychological impact: lack of safety net, lack of choice and lack of hope for a better future. Children in low-income families have significantly more psychosocial difficulties than other children, including more mental and physical health problems, academic troubles and social difficulties.

In terms of emotional health in particular, there is a strong link between low family income (less than \$10,000) and one or more psychiatric disorders. Among 4- to 11-year-old children, the odds of a poor child having one or more psychiatric disorders – such as attention deficit hyperactivity disorder, conduct disorder or emotional problem – has been found to be more than three times that of a non-poor child.

Parental poverty effectively starts a chain of social risk leading to reduced readiness for and acceptance of school, poor behaviour and attendance, higher risk of unemployment, perceived social marginality and low-status jobs. The school drop-out rate for children living in low-income families is twice as high as for other children and carries lifelong implications for employment and income security. Childhood poverty is associated with lower educational

attainment, greater likelihood of involvement in criminal behaviour, a range of psychological problems and lower earnings in adulthood.

For reasons based on both economic and mental health outcomes, social policy is largely concerned, not surprisingly, with policies to reduce poverty. The Caledon Institute and others have worked extensively on various proposals to reduce the low income rate (the prevalence of poverty in the population) and gap (the extent to which households fall below the designated low income cut-off relative to their family size).

The most powerful and direct lever in the social policy arsenal is the Canada Child Tax Benefit, which delivers benefits to more than 90 percent of families. It was designed not as a uniform allowance that pays the same benefit to all families but as an income-tested benefit – which means that the amount of the benefit varies by family income [Battle 2008].

But the literature on the social determinants of health – and other evidence pertaining to mental health in particular – points to the fact that there is a more complex set of factors at play. Physical and mental health outcomes are affected not only by absolute dollars but also by social rank relative to a significant reference group – whether colleagues in a workplace, neighbours in a community or households in a nation.

The seminal piece of research that informs this approach is known as the “Whitehall studies,” which tracked the health of UK civil servants over a period of three decades [Marmot and Wilkinson 1999]. The studies found significant differences in morbidity and mortality by administrative rank [Marmot, Shipley and Rose 1984]. At the younger ages, for example, men in the lowest office-support rank had a mortality rate four times higher than men in the highest administrative grade.

Just as striking as the mortality differences between the top and bottom groups was the *gradient* – referring to the fact that position in the hierarchy was strongly correlated with mortality risk. Mortality was significantly higher in the second-rank professional and executive personnel than in the top administrative grades, and increased further as one went down the scale. Workers in the group second from the top had higher mortality rates than top-grade civil servants; clerical officers had higher mortality rates than men above them in the hierarchy.

It is particularly significant that no member of any group was impoverished or physically deprived. All were employed, most in office jobs with low risk from the physical environment, and the professional and executive grades were relatively well paid compared to the general population [Evans 1994: 4-5].

The evidence from the Whitehall studies led to the conclusion that income inequality, not just actual level of income, has a powerful impact on physical and mental health. The ‘relative income’ hypothesis postulates that the lack of income relative to others in a neighbourhood or society, more generally, influences health through psychological and social factors. The evidence

means that economic and social circumstances affect health through their *psychological meaning*, not just through the direct effect of material circumstances.

So what, you might ask? What are the policy implications of this research? The relative income hypothesis contends that the overall health of members of a society is determined not only by level of income but also by its *distribution of income*. We know that there has been a steadily growing gap between the have's and have-not's in Canada – and we neglect this stark reality at our peril [Yalnizyan 2007].

In short, there is a key *psychological* dimension to poverty – its *relative deprivation* – in which individuals may be poor not only because of lack of resources but also because of how they perceive themselves compared to others in their neighbourhood, community or country [Townsend 2004]. The redistributive shape of various income security measures within a nation is therefore significant. In terms of policy options, the psychological dimension of poverty points to the need to reduce both absolute and relative poverty, which means paying attention to the level of benefits as well as their distributional impact.

A recent Caledon Institute report, for example, proposed a \$5,000 Canada Child Tax Benefit [Battle 2008]. The proposal involves more than just an increase in benefit for low-income families, crucial as this improvement would be. In addition to enhancing benefits for low- and modest-income households, the proposal directs some increase to middle- and higher-income households. It thereby seeks to address both absolute and relative dimensions of poverty – its economic and psychological components – through a design which delivers its largest benefit to lower-income families but also substantial amounts to the large majority of non-poor families.

Decent housing is another important social determinant of physical and mental health. We often talk about the need for affordable housing in order to meet basic physical needs. But there is also a crucial psychological dimension to housing. Dozens of studies corroborate the profound and wide-reaching connections between poor housing and a range of risks.

Badly maintained housing is responsible for many childhood injuries. Damp, moldy interiors are linked to higher risk of respiratory disease and asthma. Unstable living arrangements, made worse by parents' inability to pay the rent, have a negative impact on the emotional, behavioural and cognitive development of children. Families that lack access to secure and affordable accommodation may have to move frequently, interrupting children's schooling and creating social stress.

As a result of this evidence, Caledon and many others have proposed policies for investment in affordable housing – whether it involves the supply of new units, rent supplementation or the retrofit of existing accommodation. But existing financing agreements between the federal and provincial governments are due to end in March 2009 and we are deeply

concerned about the implications of this expiry – in light of research evidence that points to the profound importance of decent affordable housing for both physical and mental health.

The availability of affordable housing is linked to one of the most serious social problems we see in Canada today – the prevalence of homelessness. The links between mental health and homelessness have been identified in many reports. The problem is the result, to a large extent, of policies of deinstitutionalization and closure of psychiatric facilities beginning in the 1960s and continuing in response to budget pressures and human rights claims. Deinstitutionalization is not a bad policy in itself, having been designed to free individuals from inhumane institutions. The problem is that the closure of institutions was not accompanied by an investment in essential community-based supports.

Compared to the general population, the homeless population indicates a higher prevalence of mental illness, substance abuse and suicidal behaviours. Rather than receiving appropriate treatment and support, homeless individuals are often dealt with by the police. In the absence of essential community-based supports, the Criminal Code has become the *de facto* Mental Health Act. This is one reason why we are so concerned about access to decent affordable housing. Paying attention to shelter through a ‘Housing First’ approach has been found in both research – and practice in cities throughout the US – to improve health outcomes and reduce hospital use among homeless persons struggling with mental illness and addiction.

It is highly appropriate that homelessness and mental health items are high on the agenda of the Mental Health Commission of Canada. In fact, the Commission received \$110 million above their operational funding for national homelessness research demonstration projects in this area.

In short, physical and mental health outcomes clearly are linked to level of income and to the satisfaction of basic needs, primarily with respect to decent affordable housing and food security. But increasingly, the evidence is showing that positive health outcomes are influenced by psychological and social influences that play an equally important role in determining well-being.

Emerging research on resilience in families is investigating the role of non-income resources and behaviours that help them cope with the stress of life below the poverty line and help insulate children from its risks [Willms 2002]. The availability of social support networks within and outside families can provide much-needed support for parents and enriching experiences for children. Wide-ranging research on vulnerable children points to the role of the social environment – including the family, school and neighbourhood – in mediating the impact of low income. This work speaks to the need for a shift in thinking from childhood vulnerability as a problem that stems from poverty and single parenting alone to a condition rooted in the environments in which children are raised [Steinhauer 1996b].

Studies of children considered to be at risk because of vulnerable personal circumstances – such as poverty – have found that those with close, affectionate relationships with parents, grandparents and other adults are better able to cope with adversity and the disadvantages of low income. Positive parenting practices help build resilience in children and counter the grind of poverty.

A burgeoning evidence base rooted in psychology shows that opportunities for well-being throughout life are basically created or denied in the critical early years, when child development is forged along multiple dimensions – physical, emotional, social, linguistic and intellectual. During this vital period, certain parts of the brain need positive stimulation to develop properly. Children who do not receive the nutrition and stimulation necessary for good development in the earliest months and years of life may have difficulty overcoming deficits later on [McCain and Mustard 1999].

Early childhood development programs are an important means of promoting healthy development and overcoming childhood deficits. These programs vary widely in nature and scope, and typically include combinations of health, education and social services in the form of prenatal care, nutritional supplements for pregnant mothers, home visiting for new parents, parenting skills programs, Head Start and preschool programs, family resource centres and regulated child care.

Home visiting programs that target young, single poor mothers and enriched preschool programs that focus upon their young children produce substantial benefits [Greenwood et al. 1998: 3]. High-quality child care can compensate for some of the developmental deficits rooted in childhood deprivation. Quality early childhood interventions have been shown to improve children's performance in school, lessen the learning risks linked to low income and enhance parents' childrearing and coping skills. Good schools help build resilience by providing opportunities for problem-solving and cooperation.

Family supports are also linked with greater success down the road as measured by high school completion and paid employment. These supports and early intervention are estimated to reduce child abuse by as much as 50 percent and stave off the lifelong consequences and costs of living with abuse. Similar programs help prevent aggressive behaviour among young children often associated with failure in school, and subsequent delinquency and criminality.

Young people from strong, stable families with parental support are less likely to engage in serious criminal acts. This research is particularly significant for *your work* in that many of you are helping young people and others involved with the juvenile justice or criminal justice system.

In no other field is the evidence for social investment so compelling and clear. On the basis of this wide-ranging literature, Caledon was asked by some members of Parliament to write

a paper that would make the case for a national system of early childhood development, which would involve substantial federal investment in this area.

In response to that request, we produced a report called *A Proposed Model Framework for Early Childhood Development Services within the National Children's Agenda* [Battle and Torjman 2000]. The paper was brought to a federal-provincial/territorial table and subsequently became the foundation for the Early Childhood Development Agreement announced in September 2000. Under this initial Agreement, Ottawa committed \$2.2 billion over five years to provinces and territories to improve and expand their early childhood development.

In March 2003, Ottawa and the provinces and territories announced another agreement on Early Learning and Child Care in order to increase the supply of child care and preschool spaces, reduce the cost of such services for low- and modest-income families and improve the quality of these services [Battle and Torjman 2002]. This early childhood development story represents a clear and direct pathway from psychology to policy.

Unfortunately, all this significant progress was cast aside in the 2007 federal Budget, which effectively dismantled the newly introduced child care system in Canada. Thirty-five years of hard work to create a national system were swept away on a cold Tuesday afternoon when the federal government announced on Budget Day its intention to phase out by the end of March 2007 the recently negotiated Early Learning and Child Care Agreement.

But all is not lost. Provinces and territories continue to make these critical investments, to the extent that their respective budgets allow. We also know – once again from psychology evidence – that the healthy development of children depends not only on programs and services but also on the social context in which they grow up. Neighbourhoods with high levels of social capital, for example, tend to be good places to raise children. Social capital refers collectively to the social relationships and networks to which individuals belong [Putnam 2000].

The caring and respect that occur in social relationships, and the resulting sense of satisfaction and well-being, appear to act as buffers against both physical and mental health problems. Social networks also furnish tangible assistance, such as money, convalescent care and transportation, which reduce emotional and physical stress, and provide a safety net. Individuals in communities and societies with strong social capital have also been found to be more prosperous and to experience less crime.

Strong neighbourhoods are also created through safe public spaces and through activities that encourage positive participation. Schools are convenient centres for various programs and services, and for the creation of social networks. The notion of school as hub that is being developed by many communities throughout the country makes clear that schools are important not just for their use as public space.

While schools are well placed to act as community hubs, other neighbourhood spaces can also be used for this purpose. Early childhood resource centres play that role, for example, in several First Nations communities in British Columbia. They are creating links among child care programs and other health, cultural and social programs intended to benefit families. These include parenting supports, health education, fitness, alcohol and drug treatment services, and job training.

The co-located facilities and programs allow early childhood care and development to act as both “hook” and “hub.” They act as a hook by attracting community members to the quality child care that many families need. The hook and hub model is able to support, *within* their own cultural communities, children and families that are beginning to experience difficulties, require protective services or have special needs [Ball 2004].

Physical and mental health are also cultivated through opportunities for participation in recreation and cultural activities. Not surprisingly, there are physical benefits to this participation. But what is fascinating are the links now being made to the importance of culture and recreation for social and psychological well-being. Recreation and active living contribute to mental health by reducing stress, depression and contributing to emotional well-being [CPRA 1997: xiii].

Recreation and play are particularly important for child development; promoting the acquisition of motor skills, social skills and creativity, and the development of intellectual capacity. Recreation, sports, and arts and culture build self-esteem and positive self-image for children and young people. They provide safe, developmental opportunities for latch-key children after school. Programs in these areas help build social skills and stimulate participation in community life, thereby producing leaders who serve their communities [CPRA 1997: xiv]. Recreation and the arts have been found to reduce negative social activity in youth. These activities have been found to be particularly effective in reducing crime among young offenders, thereby lowering the costs of social services and juvenile justice [CPRA 1997: xiv-xv].

In fact, recreation is emerging as a crucial focal point for social investment, particularly for families and children deemed ‘at risk.’ Here’s another major pathway in the journey from psychology to policy. A study by Dr. Gina Browne and colleagues at McMaster University used a randomized trial methodology to assess the effectiveness of various interventions in helping families on social assistance cope with their challenges. The interventions included counselling and case management, employment retraining and child care, recreation/skills development and self-directed care [Browne et al. 1998: 7].

The study found that recreational services alone helped psychologically disordered children on social assistance maintain their social, physical and academic competence at a level equal to that of non-disordered children. The interventions consisted of “two years of proactive, subsidized, age-appropriate, after-school child care or recreational opportunities.” Recreation

appeared to pay for itself through reduced use of health and social services, such as child psychology, social work and probation. The impact of providing recreational services alone resulted in a 10 percent greater exit from social assistance compared to the parents of children who did not receive this service [Browne et al. 1998].

Community arts programs help reduce the impact of social problems including drug abuse, violence and teenage pregnancy. The arts have been found to engage students who are not otherwise being reached and help young people become active citizens in their neighbourhoods. Arts provide a reason for being engaged with school and other organizations. ‘Problem students’ often become high achievers in arts learning settings.

But the literature points out that an even more compelling advantage is the striking success of arts-based educational programs among disadvantaged populations. For at-risk youth, the arts contribute to lower recidivism rates for criminal activity, increased self-esteem, the acquisition of job skills and the development of much needed creative thinking, problem-solving and communications skills.

So how do we translate this wide-ranging evidence on recreation and the arts into policy? There are several ways. First, community groups are advised to look at current municipal policies regarding access to recreation. They can encourage municipalities to make their facilities available at no or reduced cost or can provide subsidies to families. Even though many municipalities currently provide subsidies, the eligibility criteria can be so restrictive or demanding that it is not worth the effort. In some communities, for example, applicants must have their doctors fill in a special form in order to qualify for a subsidy sometimes worth only about \$50. But the cost of the form completion may be (at least) \$35 and their time – a serious misuse of scarce health resources.

Another policy response is to support the community use of schools for recreation. A major step recently was taken to address this problem. In November 2006, the Government of Ontario announced a plan to invest \$20 million a year for the Community Use of Schools Initiative. This initial amount has been increased to \$40 million a year. Program funding will continue to rise over the next four years, reaching \$66 million by 2011-12. The annual funding will help school boards reduce or eliminate the fees that community groups are required to pay for the utilization of schools after hours.

Caledon has also called for investment of infrastructure funds in recreational and community spaces. The current federal government preference for tax cuts does not represent the required investment in the retrofit and repair of existing arenas and facilities, many of which were built in the 1960s and 1970s. There is a massive billion-dollar infrastructure deficit in Canada which requires an actual infusion of funds.

There is yet another set of relevant policy responses. The Canadian Parks and Recreation Association sponsors a project called *Everybody gets to play*, which was organized in response to the many barriers facing low-income households. Program fees are only one major obstacle. Sometimes the transportation and child care systems do not link up to match the recreational programming. The project creates opportunities to link recreation with transportation, child care and other supports.

Finally, we try to bring attention to programs such as SKETCH – *working arts for street-involved and homeless youth*, a nonprofit charitable organization that provides arts programming, and job and life-skills training for youth between the ages of 15-29 who are street-involved or homeless. The project offers a way for these young people to experience a sense of safe space and relief from the pressures of street life – effectively tackling sustenance through engagement. The initiative is based on the premise that these young people can best be engaged through alternatives to traditional therapy by reaching them emotionally and through direct participation.

Taken together, these various measures to promote social development have been found to prevent crime by building a more equitable and healthy society, and by addressing not only the symptoms but also the factors associated with youth delinquency and adult criminal activity – e.g., failure in school and illiteracy, unemployment, poverty, poor housing, violence in the home, unsupportive family life and parental behaviours, and alcohol and drug abuse [Waller and Weiler 1984].

A report just published by the Canadian Institute for Health Information entitled *Improving the Mental Health of Canadians 2008: Mental Health, Delinquency and Criminal Activity* found that more than one in four people hospitalized for mental illness had brushes with the law [CIHI 2008]. It was unclear, however, whether mental illness breeds delinquency or whether the criminal justice system – and jail in particular – makes people more prone to psychiatric problems. It is likely that the links actually work both ways and are not linear or unidirectional.

While it is important to work on the reduction and prevention of criminal activity, there is still a need for psychological services for those already involved in the juvenile justice and criminal justice systems. The corrections system is the largest employer of psychologists and, in the course of this work, you deal with many significant problems related to depression, anxiety or long-standing substance abuse issues. These services help prevent recidivism and are therefore a major form of secondary prevention.

While this issue no doubt will remain a challenge, there are some conclusions that can be drawn from the evidence. We know that there are key mediating factors through which we can take steps to influence the root causes of crime. These factors promote positive mental health and reduce the likelihood of criminal activity.

On the basis of this wide-ranging evidence on key psychological and social factors, I recently completed a book called *Shared Space: The Communities Agenda* [Torjman 2007]. It talks about the ways to build resilience in communities by focusing on four broad domains – or clusters of activity – in which communities need to engage: basic needs, supports for families, participation in recreation and the arts, and economic independence.

The book refers to these four clusters as sustenance, adaptation, engagement and opportunity, respectively. The *sustenance* cluster is concerned with wide-ranging conditions related primarily to physical well-being. The *adaptation* cluster consists of the group of actions concerned primarily with basic coping skills and capacities. The resilience cluster related to *engagement* is concerned with active participation in society through recreation, the arts and decision-making. *Opportunity* comprises the fourth resilience cluster involves direct investment in work-related skills, job creation and asset development.

There are two major bodies of research in which the concept of resilience is embedded and which comprise the foundation of this work: its ecological interpretation and its mental health interpretation. The book is anchored in these two major fields – once again linking psychology and policy.

So What Does This Mean for You?

Lots. You play a significant role in policy – both individually as practitioners and researchers, and collectively as a professional association.

Psychology has helped shape the definition of disability and of impairment in mental function, more specifically. Please take note of the important work of the Technical Advisory Committee on Tax Measures for Persons with Disabilities to which your colleague made such a tremendous contribution. Your awareness of and adherence to this work will make a big difference to the many thousands of Canadians who rely every year on *you* and your assessment for completing eligibility forms for access to important disability-related benefits and supports. And bear in mind that eligibility for one benefit often opens the door to other measures – because of the recommendation that our Committee and others have made in efforts to streamline eligibility.

In terms of improving access to mental health services, think about the ways that you as individuals can contribute to mental health education. The policy world requires your skills and expertise to help in the early recognition of troubling behavioural and emotional signs. Consider as well the ways that you, as individuals and as a professional association, can make mental health interventions more readily available through training of key actors, including parents, teachers, child care workers and caregivers.

As just one example, you might organize sessions in child care centres to help parents and early childhood educators recognize the early signs of autism and other disorders. You might work more actively with schools to enable parents and teachers to recognize the symptoms of anxiety, depression, substance abuse or conditions, such as bulimia. You can partner with national and local voluntary organizations to provide advice on maintaining healthy brain function and to recognize the early stages of dementia. Your intervention would be especially helpful for caregiver training on coping with difficult behaviours, such as paranoia or aggression.

Finally, your work forms the foundation for healthy families and communities that contribute to positive physical and mental health outcomes. It is evidence from psychology research that helps create a powerful evidence base for investment in stable decent housing; early childhood development; family supports; recreation and the arts; and crime prevention.

Even the design of income security measures, while shaped primarily by economic analysis, takes into account the psychological impact of the distributional design and how households at various income levels will be affected by any change – in terms of their own financial circumstances and how they will fare relative to others.

Clearly, there is a direct and profound relationship between our two fields – though I don't believe that it has ever been explicitly recognized, let alone explored. I hope that this is the beginning of a long-standing relationship that formalizes the crucial links from psychology to policy. Thank you for the opportunity to consider this important question.

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